THWAITES REPORT

The Education and Training of Senior Managers in the National Health Service

—a contribution to debate

Report of a King's Fund working party

Published by King Edward's Hospital Fund for London

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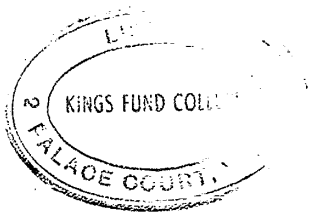
The Education and Training of Senior Managers in the National Health Service—a contribution to debate

Report of a King's Fund working party

Foreword by **G A Phalp CBE TD**
Secretary of King Edward's Hospital Fund for London



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Acknowledgments

We are greatly indebted to all those individuals and organisations, listed on pages 79-81, who have helped and advised us, orally and in writing. Attention is also drawn to the bibliography on pages 91-94 which we hope other students of the National Health Service may find useful.

We wish too, to place on record our admiration for our secretary. It was a happy thought that led the King's Fund to draw on a sister foundation, the Nuffield Provincial Hospitals Trust, for the high expertise required of the secretary of a working party such as ours, and we pay tribute to the immense contribution which Richard F A Shegog has made to our work. His assistant, Elizabeth Haynes, also has earned our deep gratitude.

Foreword

Although the King's Fund has for some 25 years been deeply engaged in the practice of management training for the health service, it was never envisaged that the working party engaged on this study should see their terms of reference in the narrow context of how a particular institution might realise its own responsibilities. From the first it was made clear that, if the report was to be of value, it must present a national conspectus, and the King's Fund is obliged to the working party for having responded to their brief in this way.

In setting up the working party, the King's Fund held the belief that a sufficient period had elapsed since the reorganisation of the National Health Service to ensure the relevance and effectiveness of a study of the educational and training needs of those responsible directly to the health authorities for the working of the new service.

Since then, events have seemed to confirm the timeliness of this decision. Uncertainties about the effectiveness of the reorganisation and a certain loss of morale of health service staff have aroused criticism of politicians, of those who planned the reorganisation, and of the managers who now have to work it. In response, a Royal Commission has been appointed and is expected to study with particular attention the doubts being expressed about the reorganised structure of the service.

The value of this report should chiefly lie in its analysis of the problems of senior management and how to train for it. Such problems are by no means particular to the NHS.

Those not closely acquainted with the NHS may be surprised to discover that so much of the subject matter presented in this study has hitherto been little explored in this country. For example, it does not appear that there has previously been any published analysis of the role of the universities and of professional associations in the vocational preparation of senior managers. Nor, again, has there been much public discussion of the means of providing a continuing education for a senior manager whose duration of office may quite normally run for some 20 years.

For these reasons it is not easy to predict how the findings of this study will be received. But certainly it is to be hoped that publication of the report will provide a valuable insight into the problems and complexities of the subject, and at the same time stimulate a timely and constructive discussion which could help pave the way for decision by the Royal Commission, the National Training Council, and by regional and area health authorities.

The scope of the report is extensive, and it is perhaps therefore unwise to particularise upon the many issues raised. But there are perhaps a few general considerations which could be usefully mentioned by way of introduction. For example, there is throughout the study a firm belief in the value of good management from the point of view of the patient. There is too a conviction that, suitably handled, resources already exist for the achievement of an appropriately high standard of management education for this purpose. Within this context, there are three aspects of the educational process which are emphasised as needing special consideration.

First, there is the role of separate professions, each with its own high level of professional qualification, which must adjust to new responsibility for corporate advice and decision. Second is the need for a policy for the use of universities and other institutions of higher education as the source of conceptual development and research. And third, the evidence is reviewed and a case is argued with conviction for the establishment of a system of continuing education and preparation for change.

The working party has avoided the option of listing a series of recommendations, and there may be some readers who will at first sight be disappointed that this should have been their choice. Much of the working party's effort has, however, been in establishing assumptions which others may use as a base for planning action and this has surely been right. All the professions and institutions closely concerned with senior management in the health service have major problems awaiting internal solution, and at this stage it would have been inadvisable for an independent group such as the working party to become too involved in detailed prescription.

It is clear that the present lack of a general structure for management training is, in part at least, due to the

existing diffusion of responsibility for training which the Department of Health has been correctly concerned to bring about. In that context, the important proposal in the report for an initiative by the chairmen of health authorities would seem to be worthy of further study, especially as it would enable effective action to be taken immediately by those who probably see the needs most clearly.

But even if new training patterns for senior managers are organised as quickly as is deemed necessary, there needs to be in the longer run an agreed national policy for the training of senior managers in the NHS, and it is hoped that this report will do much to help provide a focus for the formulation of such a policy.

The King's Fund is grateful to all members of the working party who gave so willingly of their time in the preparation of this report and particular thanks are due to Dr Bryan Thwaites for his able chairmanship.

The Fund would also wish to express its thanks and appreciation to the Nuffield Provincial Hospitals Trust for its sustained interest in this project and for the generosity with which the Trust agreed to release its deputy secretary, R F A Shegog, to enable him to fulfil the function of secretary to the working party, a duty which he has performed with exemplary fashion.

Lastly, the King's Fund is indebted to the Department of Health for much informal advice and for the cordial interest which the department has shown throughout.

GAP
1977

Contents

*Appendices B and C are intended solely to provide overseas readers with short descriptions of the British National Health Service and of the requirements for entrance to the three main professions.

Terms of reference

The King's Fund established the working party in March 1975. To its letter of invitation to members to serve, it attached the following statement which has been taken by the working party as its terms of reference.

The National Health Service employs more than 850 000 people in a complex enterprise of the greatest importance to the national well-being. The cost annually to the taxpayer is of the order of £3000m representing some 11.4 per cent of total public expenditure, and approximately 4.8 per cent of the gross national product.*

These simple facts suggest that the training of those who are to hold senior appointments in the management of the service – and the measures necessary for the maintenance of a continuing high standard of performance by those who have already achieved senior rank – is a task of the highest importance.

The working party is asked to proceed as follows.

A To review current arrangements for the management development, training and selection of senior managers (and potential senior managers) in the National Health Service of England. For the purpose of the review, the word 'senior' in this context is intended to refer generally to officers holding designated rank in the management of the service at district, area and regional levels.

B To make such proposals as may seem necessary for the establishment of a satisfactory system, having regard to the following considerations.

1 the need for relationship between the training systems of specialist groups – for example, administrators, doctors, nurses and others concerned with management in the health care system – to ensure a satisfactory preparation for the responsibilities of multidisciplinary management practice at senior level

2 the need for a continuing and imaginative system of educational support for those already holding senior managerial appointments in the health service

3 the need for flexibility of approach in the determination of a management training strategy to ensure that individuals may have opportunity for ad hoc educational experience – for example, the undertaking of research or attendance at a university postgraduate course

4 the need to recognise that the provision of a system for the care and protection of the health of the population is but one of the public services necessary for the well-being of our society and that, therefore, the training of those responsible for management in the National Health Service should be planned in such a way as to take this into account.

*These were the figures for 1975-6. In 1976-7, the NHS cost £3525m; about 11.6 per cent of total public expenditure, and 5.8 per cent of the GNP.

Introduction

We began our enquiries early in 1975 in the expectation of reporting to our sponsors, the King's Fund, within about twelve months. In particular, we were encouraged by the feeling that, as the restructured National Health Service moved into its second year, the time was right for constructive enquiry into the needs of the senior managers of the service.

In the event, the NHS went through a particularly difficult period in 1975, suffering, in addition to the strains and stresses of reorganisation, both the need to restrict expenditure most carefully and the disruption of industrial disputes. And now, two years later, the service has become subject to the enquiries of the Royal Commission, with all the uncertainties for the future that that inevitably entails. We therefore feel that any new ideas on the selection and training of those officers who bear managerial responsibilities for the service must be developed at this particular time with sensitivity and sympathy.

We have also become increasingly aware of a reluctance in at least some of the country's institutions and governmental departments to accept either that senior management requires special skills, experience and training, or that rigorous standards and selection procedures are necessary for it. We believe, on the other hand, that the high and demanding responsibilities of the NHS require explicit systems of training for its top managerial posts.

In the event, therefore, all these diverse factors have strengthened our conviction of the need, here and now, for clearer policies on senior management education and training. The quality of the health care available to the community depends not only on the skills of those in immediate personal contact with patients: it depends equally on the skills of the senior managers who have to ensure that the right staff are in the right place at the right time, with the right qualifications, and with the right facilities available to them.

An important question which we asked ourselves at the outset was whether we should base our enquiries on the present scheme of NHS organisation, or whether we should allow ourselves the luxury of postulating alternative schemes. Our answer was that, since we saw no likelihood of changes in the present scheme which would impinge significantly on the managerial needs at senior level, our report should be based unequivocally on the existing organisation. Even so, our findings – though expressed in terms of the existing structure – are in their essence independent of it; the fundamental pattern of selection and career development of those who reach the levels of senior management depends only weakly on the detail of the system which, in any case, is bound to make its own gradual evolutionary changes.

Another complication is the characteristic of the NHS, unusual among our many State services, that it is neither free-standing nor has a single controlling body of its own. The Department of Health and Social Security is unlikely to provide the sole source of leadership, partly because its responsibilities are much wider than the NHS alone, and partly because it would not trespass on the responsibilities of statutory employing authorities. Nor is it yet established that the National Training Council, which sits uneasily as an advisory body in a semi-independent position, is capable of the firm initiatives which we believe are required at the levels of senior management.

We have tried to define for the future the basic characteristics of a system of selection, education and training for senior management, and particularly to perceive what is or should be common to the different disciplines, and to provide a conceptual structure within which the individual professional groupings can organise their own specialist training programmes.

In doing this, we have noted that at least some of the main professional groupings within the NHS are themselves undecided about the essential character of their professions, and about the relationship between their specialties and the wider responsibilities which go with senior management. Therefore, while we have sought evidence from the professions concerned with management about their own needs and activities, and though we comment on these needs in the report, we have thought it right not to list a series of specific or detailed recommendations for each profession, but to rely on the professions to take heed of evident needs which are analysed in subsequent chapters.

Instead, the ideas which, we believe, must underlie rational policies, are set out in chapters 1 and 8 in such a

way as to be most helpful to the King's Fund, and possibly at a later stage to the DHSS, the health authorities and the other institutions which may have the task of interpreting and implementing these ideas. The intermediate chapters are left in the form of papers presented to the working party by its members and no attempt has been made to edit them in a consistent style.

In so far as some of our recommendations open up entirely new areas of activity, we favour an experimental approach to them. Particularly we believe that the universities and polytechnics, and the relevant foundations such as the King's Fund and the Nuffield Provincial Hospitals Trust, have an important 'pump-priming' role to play. We hope that one of the results of our report will be to help them to clarify their objectives and to make new advances.

Last, it should be said that our recommendations and the information on which they are based apply to England, a limitation we accepted in the hope that our task would thus be manageable and yet our findings would have a wider application.

1 Definitions

There are four broad categories of people, other than the Government itself, who organise and manage the NHS: civil servants, members of health authorities, the medical profession and the management teams.*

The first category consists of those civil servants within the Department of Health and Social Security whose responsibilities embrace the NHS. The Civil Service has its own methods, independent of those within the NHS, for selecting such staff, and its own ideas as to the most appropriate methods of inservice training. The working party has, therefore, excluded the civil servants from the scope of this report.

Nevertheless, the intimate managerial relationship between the DHSS and the NHS should imply some correspondence between training procedures for senior managers on the two sides. If this report's advocacy of training for senior management within the NHS is persuasive, we hope that the Civil Service will re-examine not only the needs of the senior officers within the DHSS, but also the opportunities for them to share experience with senior officers in the NHS.

The second category comprises the members of regional and area health authorities. At the time of reorganisation, the needs of members were officially recognised in the arrangements for instructional and induction conferences. Since then, however, the DHSS has done virtually nothing to follow up these initial conferences or to provide training for those members of authorities who have been more recently appointed.

The training needs of authority members, especially those at area level, have changed significantly since April 1974. Then an area health authority was, in the words of the 'Grey Book'[17], 'a small body selected for its capability'. Within two years, an AHA had become as often as not much larger than convention and experience would suggest a managing body should be; and its composition and outlook could be markedly different from those originally envisaged. For these and other reasons, there seems widespread uncertainty among members as to their roles, whether individually or collectively (an uncertainty which some authorities are already seeking explicitly to disperse through their own efforts). Here is a very important field of study, but one which we set aside for another body to take up.

The third category consists of clinicians. They can be differentiated on account of their unambiguous personal clinical responsibility for their patients. To the citizens who use NHS, the doctor* is the key figure in their treatment. In this sense, the doctors 'manage' the service. Yet in another, they are totally dependent on the services which the 'management' as a whole provides for them, and on the collaboration of the other health professionals. Nevertheless, because consultants, academic clinical staff and general practitioners manage in a conventional and direct way quite substantial resources within their own clinical activity, and are involved in typical management activity such as priority decisions, they are no different from the other main disciplines within the NHS, with which the medical profession shares responsibility.

The fourth category consists of the four principal professional members of the district management teams, the area teams of officers, and the regional teams of officers – the administrators, nurses, treasurers and doctors (who at all levels include specialists in community medicine, and at district level representative clinicians and general practitioners in addition). These officers form the core of senior managers in the service, and are the main concern of our report.

There are other officers at regional, area and district level who carry a general seniority equivalent to those defined in the previous paragraph. We have been content largely to exclude these from our deliberations since the essential characteristics of a sound system of management training and selection can be adequately developed through a study of the officers within the four fundamental professions mentioned. In general, our recommendations can be extended without difficulty to the other senior officers.

The question at once arises: are there differences between the three levels – district, area and region – which necessitate their officers receiving distinctive treatment in the matter of management training, or their needs being separately considered in this report? We

*See Appendix B.

*Here 'doctor' means the attending clinician, whether junior or senior, medical practitioner or dentist.

have a simple answer to that question, and the line of thought which led us to it will be briefly rehearsed.

It could first be held that the character of the work of the three teams is fundamentally different. One manifestation of this is that the total number of officers varies significantly between the three teams; for example in England, while there are 171 district administrators there are only 90 area administrators and 14 regional administrators. Other things being equal, it is easiest to become a district administrator and hardest to become a regional administrator. In practice, therefore, and whatever one's views of its desirability may be, the career of nearly every senior manager will progress from district team to area or region; and it will surely be exceptional for a regional team member to move to an area or district post.

On the other hand, we note that, in terms of salary, the differences between the three levels are not great. Indeed the officers working in the various teams are not in a hierarchical situation (though there must be occasions when, inevitably, 'orders' are passed from region to area to district). Certainly some officers may have a talent and preference for the operational jobs at district level, and others may take naturally to the supporting, guiding and strategic roles at the level of a region or multi-district area. But all need both operational and strategic skills, and an understanding of the whole range of senior management responsibilities. In short, all are operating at the top level of management.

As a matter of principle, therefore, we make no distinction between the three teams for the purpose of drawing up a pattern of selection and training; though it is clear that, in the detailed implementation of any pattern, the needs of officers in the various teams will often require to be differentiated.

No fundamental distinction is made, either, between the four core members of any one team. This is a potent result of the concept of consensus management which, in the reorganised service, is the formal expression of the trend before reorganisation. Below DMT level, there is no explicit requirement for consensus management, though officers especially at the immediately lower support level, will often be dealing with problems in a multidisciplinary way. It is only when a senior officer becomes a member of a team that he is inescapably face-to-face with the corporate areas of responsibility and the problems of the highest management levels of the service.

In this report, therefore, we use the phrase 'senior managers' to denote the doctors, nurses, administrators and finance officers of the teams at district, area and regional levels.

This definition becomes clearer still if we briefly mention some differences between the ranks of senior managers and those lower down. At the senior level, managers necessarily operate in two dimensions: the professional dimension, in which the senior manager exerts leadership in his own discipline and advises the team from the viewpoint of his professional group; and the team or corporate dimension, in which he participates on equal terms with the other three members in arriving at a consensus on general issues of making policy, priorities, or allocation of resources. But at the levels below the teams, officers work almost exclusively within the first dimension; that is, their work lies primarily within their own special field.

It is to be assumed that the individual who will be aiming at, or who has already achieved, senior management status, will be fired by personal ambition to develop his specialist skills to their fullest extent. What we call in this report the 'first dimension' covers continuously all the stages of an officer's career. Thus, although members of the working party have learnt a great deal about the professional development of each of the four professions, we recognise that it is not for us to comment upon purely professional training, except in so far as it includes components of general education and of preparation for management.

In the second dimension we distinguish two requirements.

Corporate training
This refers to the need, as we see it, for every senior manager to have received, either as a necessary qualification before promotion or as a specific requirement after, a substantial preparation for consensus management. The success of this preparation depends on it being a requirement common to all four disciplines, though not necessarily identical in each case.

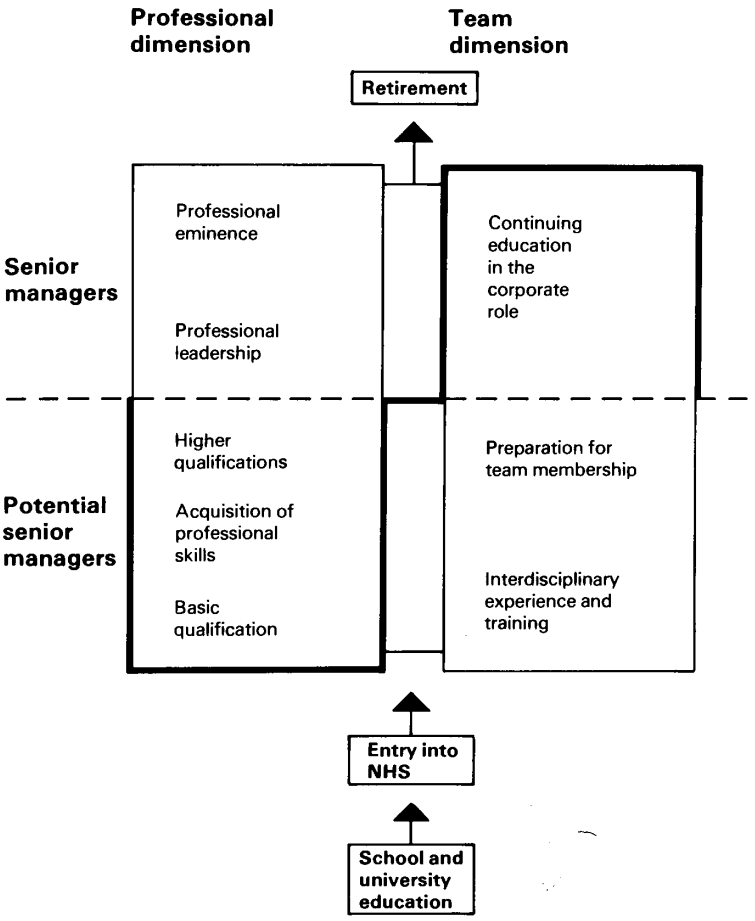
Continuing education
This refers to the need for senior managers to undertake periodical training. Such training will include, though not necessarily simultaneously, interdisciplinary activity; it will be highly heterogeneous, moulded to individual needs; and there will be great scope for experimentation.

For the individual officer, then, the model of his personal development looks like Figure 1.

This figure, not unnaturally, hides some important differences between the four professions, and throughout our report care is taken to balance the requirements inherent in each profession with the advantages of common patterns of training – in other words, to reconcile and match the two dimensions. For the moment, however, we mention just two important differences.

First, the typical age of entry into the NHS varies considerably from 18 for the student nurse or junior administrator up to 24 for the newly-qualified doctor. An important consequence of this is that, age for age at the lower levels, there may be substantial differences in experience of the NHS among the professions. Particular care needs to be taken in forming interdisciplinary training groups from officers at these levels. However, at around the age of 35, good officers in any of the professions should be coming up to team membership

FIGURE 1 A Model of the Senior Manager's Personal Development



and, from then onwards, age and experience should not present problems between the professions.

A second difference is the level of academic qualification before entry into the NHS.* Here we have welcomed the trend for more graduate recruits to nursing and administration, since it is important that the senior levels of NHS management should draw freely upon the most able section of the population. We reject, however, any idea of adding the NHS to the growing list of recruiters who insist on the qualification of a degree for all its potentially senior staff, since the flexibility of having an 18-year and 21-year old intake for all except the doctors is needed both to avoid a narrow élitism and to man fully the executive posts.

So much, then, for the definitions which govern the later chapters. In these we examine successively the peculiar characteristics of management in the NHS; the nature of management in the large; the historical background of management training and selection in the NHS; the patterns within each profession; the role of universities and polytechnics and the role of the DHSS and NHS authorities. The last chapter addresses itself to the problem of the implementation of the main thrust of proposals developed in the previous chapters.

Finally, it is instructive to have always in mind the scale of the operation under enquiry, expressed in terms of the numbers of individual officers going through the NHS system. It has already been mentioned that there are, in total, 275 administrators in the three sorts of teams, which implies, according to our definition, 1100 senior managers excluding the clinicians. If the average senior officer spends up to 20 years as a team member, the total annual throughput over the whole country will certainly be less than 100 a year. In addition, if we assume that provision is made every four to five years for the

*See Appendix C.

continuing education of each senior manager, some 300 or so will be undertaking each year some kind of organised training of a short duration. In sum, then, the selection, development and subsequent continuing education of senior managers represent an operation on a scale so small that the cost of implementing our recommendations would be utterly negligible in comparison with that of the a service as a whole.

2 Special aspects of the National Health Service

The chapter assesses the extent and importance of the NHS as a management system by outlining its characteristics. It does so as a prelude to the review of the manager's role in Chapter 3.

The service's three most obvious characteristics are size, complexity and sensitivity. In size, whether measured by number of staff, finance employed, or number of patients, it is comparable to, or greater than, any other public service. Its complexity can be illustrated in a number of ways, and one has only to study the larger hospitals as considerable social organisations, or reflect upon the wide variation in the characteristics of staff employed, to realise this. As for the sensitivity of the NHS, this is very evident if one considers the emotion and physical pain involved for the patient, or the value judgments needed at all levels in reaching both immediate and long-term decisions. The system consequently requires, for those who manage it, a high level of skills in coordination, monitoring and planning, which have to be exercised both generally, in the conceptual analysis of objectives and priorities, and particularly, as those general objectives and priorities affect sick individuals.

We have already indicated that, in comparison with other forms of public administration, the NHS has some peculiar features. Some of these arise from the very nature of a state health service which is run more as a service available according to the individual's assessment of his own needs, than as an agency ensuring some predetermined minimum standard of health in the community at large. Others arise from the particular organisational structure of the service, especially since April 1974. Others again, stem from the unique two-tier arrangement of the DHSS and the NHS.

Size and complexity

The NHS is remarkable firstly for its sheer size, whether measured in terms either of the number of people who use or work in it, or of the amount of resources it uses. Other services, for example the statutory system of education, may be actively concerned with more clients at any one time; but there are far more potential clients for the NHS, since it is both responsible for, and accessible to, all. Thus, in practice in 1973, when 6.3m people were admitted to hospital and 313m prescriptions were given, the service in the UK employed about 50 000 medical practitioners, 390 000 nurses, and had a total work force of 860 000 covering no less than 49 professions and occupational groups.

The complexity of what is being provided is obvious to even a casual visitor to a general hospital who can see that it is an advanced technological institution – a village, a hotel system, and a community all in one. And general hospitals are only one specialist part of a service which provides other kinds of hospitals including those offering long-stay care for patients with mental illness, mental handicaps and geriatric needs, as well as a complete range of family practitioner and community health services.

Health and politics

In common with other social services, the health service is involved in political problems. The service is not directly ruled by elected politicians, apart from being ultimately accountable to the Secretary of State, though there are political nominees, usually local councillors, at each of its two main levels of government – the regions and the areas.* Yet the health service deals with affairs which easily acquire strong political connotations. The manager cannot, for example, escape being concerned with a wide range of issues, such as the place of private medicine in the country's health care system, the aspirations of national trade unions in salary negotiations, the maltreatment of patients which, although few in number, rightly attract intense political interest to the administration of the service, and issues of moral and

*See Appendix B.

political sensitivity such as abortion and euthanasia. Health services deal with death and pain as well as with cure and improvement.

Health service managers must, therefore, be peculiarly concerned with what we have called elsewhere the analysis of values; they have to take account of a wide range of social and political norms. Yet they have also to be utterly devoted to the concepts of an accountable, highly efficient and, indeed, predictable level of service: in many health matters, the public knows what it wants and expects only the highest quality of service.

Complex structures

If, then, the tasks of the manager encompass a wide range of services, and of social and political values, so do the institutions and the organisational structures which they manage. The totality of health authorities represents an extraordinarily complex and varied system. The nursing services, for example, are explicitly hierarchical: within them, authority and accountability are as specifiable as is ever realistically possible within a system of human relations. By contrast, the medical organisation consists of a pattern of individual discretion which some would even call autonomous. The consultant or the general practitioner is not hierarchically organised but, at most, works in a collegiate structure in which consensual committee systems produce collective policies within which the maximum of individual freedom is exercised. The professional administrators belong simultaneously both to their own hierarchy and to the subtle and horizontal sets of relationships which call upon them to monitor and coordinate work for which they are not themselves accountable.

Within the system, many uncertainties remain – the accountability of scientists or paramedicals, for example. The health service has been described as an organisational zoo, and, certainly, it is a rich area for students of organisational variabilities.

Need for monitoring and coordinating skills

These differences have been explicitly recognised. The 'Grey Book' and other documents defining the reorganisation of the health service were at pains to show how different parts of the service were to converge through consensual organisations – management teams acting corporately – rather than through single, individual points of authority. [17, 18, 19, 52] In this respect, the health service is somewhat similar to the emerging forms of local government, in which the role of the chief executive is increasingly seen to be not that of the manager with subordinate heads of service but of a convenor, coordinator and monitor of a consensual group of managers and services.

Because the health service embraces a whole range of human conditions – from that of the very young and healthy nurses in training to long-stay geriatric patients and people suffering the utmost rigours of pain and impending death – the organisational structure must be correspondingly sensitive and subtle. Hence the manager has to learn to be a monitor, and monitoring is a sophisticated and difficult concept to live with. It requires status in its participants and the possession of skills which might well not be present in those of the individual specialist groups who have to be monitored. Part of our quest has been to identify those skills and see if they are in any sense superordinate to the skills of those being monitored.

Health and social planning

Another peculiar difficulty is that while much of the work of a health service is highly technical and specialist, it cannot be undertaken in complete isolation from social and community planning of a general kind. The attempt to make area health authorities coterminous with the local authority areas has not completely succeeded, yet it is rightly made since there is an increasing awareness of the extent to which social services, education, environmental health, and even town planning and transport, need to be planned and executed in strong concordance with that of health care. If we were to identify a major flaw in the health service up to now, it would be its failure to link closely enough with social planning in general, and with developments in associated areas of social benefit and improvement. This places, however, an extraordinary and difficult burden on the health service manager. For he already has his work cut out in comprehending the spectrum of health services; in becoming an effective monitor and enabler of those services, in understanding social trends, epidemiological movements, and the physical, manpower and institutional capability of the service; and in perceiving how these latter resources can be most logically and beneficially deployed in the public interest. This involves not only the institution of control mechanisms, the establishment of objectives and the understanding of significant deviation from factors leading to them, but the ability to set health services in context with complementary services which provide for other dimensions of human need.

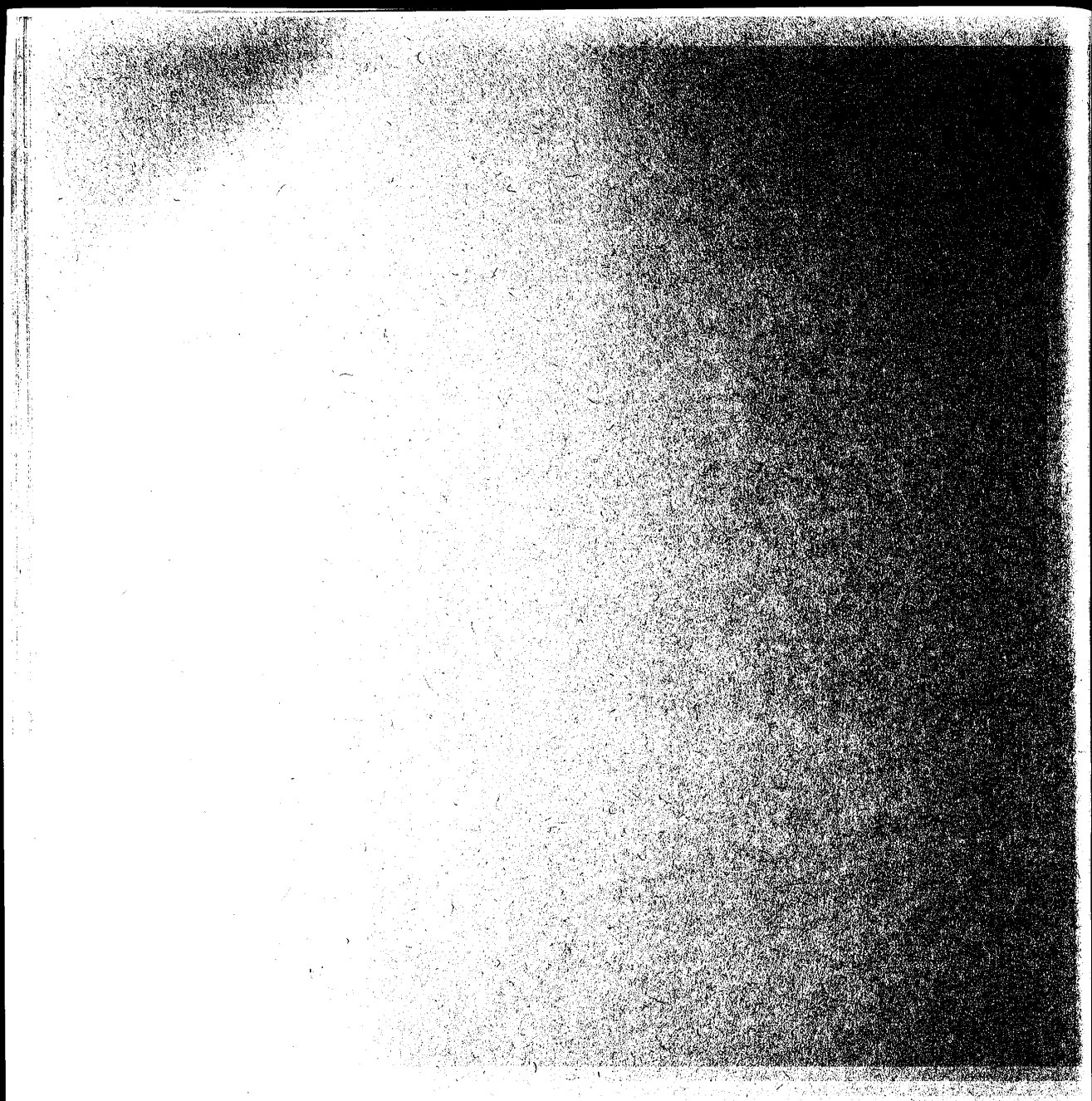
Examples come easily to mind. Social work in hospitals is now an outposting from the social services department of the local authority. Who will link social work in hospitals to social work in the community? Or, again, for some years now successive health ministers have urged the need to 'de-institutionalise' mental health; that is, to move substantial numbers of traditionally long-stay patients to various forms of domiciliary care or to sheltered accommodation provided by the social service department. Were these to come fully into effect, the resource implications are formidable, not only for plant and maintenance costs but also for people. The functions of mental nursing would become different and, reciprocally, the tasks and expertise of social workers would have to change. The implementation of change would, of course, rest mainly with the specialists in medicine, nursing and social work on both sides of the

divide between local authority and health authority. But where do the first initiatives lie? In tackling such tasks as these, senior managers are being expected to clear the tops of their in-trays and get down to work of a long-term importance and complexity that affects professional and institutional boundaries as well as the destinies and care of large numbers of people.

It was explicitly one of the aims of reorganisation that management in the NHS should initiate rather than respond to events.

The health service manager, therefore, has to be able to advise health authorities about social requirements and needs, while recognising that they form part of a hierarchical system with central control. In so doing, he must satisfy not only the politicians and professionals who are members of the authorities for which he works, but also meet the requirements of the growing system of review and inspection – the Health Service Commissioner and the community health councils, as well as those of the complaints and suggestions procedures being developed by his own organisation. This requires political sensitivity and a clear understanding of the values and emphases of changing social climates. But beyond this the health service manager needs to be peculiarly sensitive through a comprehension of economic, demographic, epidemiological and social planning trends to the changing needs of NHS patients. He has to be capable of quick and sensitive action in local institutional crises and when dealing with the troubles of individual patients within a complex system of hierarchies, non-hierarchies and intermediate structures. And once he has learnt all that, and helped to make the system for the patients' care work, he must then look out from the health service towards a social scene and a group of institutions which become bafflingly difficult to understand and to work with. Competence in the two activities – solving immediate and personal problems, and conceiving long-term plans – does not necessarily co-exist.

So, the health service requires managers trained to be both generalists and specialists. They must be people who can shoulder unusually wide and complex responsibilities, and who can respond at once to the immediate needs of individual patients as well as make strategic plans for the wise spreading of scarce resources. For such people only the finest training patterns, designed to recognise the intrinsic importance of the job which has to be done, will suffice. For it is the public and the individual patient who suffer directly and immediately from ill-trained managers.



3 The nature of management and a commentary on management training

Following the outline in Chapter 2 of the challenges the NHS makes to the manager, this chapter comments on the state of knowledge about the nature and art of management. The various functions of the manager are described and linked to an analysis of the kinds of skill he needs. Both in general terms and in the context of the NHS, it is shown that there is no single core to the discipline of management but that it consists of an array of skills and types of knowledge which, according to the level of operation, should be mingled in different patterns.

The experience of other public services in creating systems of management education has been studied by the working party, and is analysed here to reveal a spectrum of distinctly different structures, ranging from those used in the armed services where a strict selectivity is applied to progression from one training level to another, to the much looser, decentralised and pluralistic system used in local government. The question which the working party has faced in the remainder of its report is to analyse where in this spectrum the system of NHS management education should lie.

The following questions seem relevant to any discussion of the training needs of senior managers.

1 Who are the managers in an organisation? How do we identify them?

2 What functions are attributed to managers? That is, what functions are managers commonly expected to perform?

3 What do we know about how managers actually spend their time?

4 How may we distinguish between senior and other levels of management?

5 What skills appear to be needed by managers?

6 How can these managerial skills be inculcated?

7 What do we mean by 'management training' and what purpose does it serve?

8 Are there any agreed principles of curriculum design for management training courses?

9 How should training be organised and staffed?

10 Are any generalisations possible about managers and management training?

We shall discuss each of these topics briefly in the present chapter. Other chapters will examine various aspects in greater detail and with more specific reference to the NHS.

1 Who are 'managers'?

In a sense, everyone is a manager who takes responsibility for managing his own time and determining his own priorities. A more specific criterion, however, is the extent to which he is responsible for managing resources other than his own energies. One such resource is manpower and the manager is often seen as someone who works with people and is responsible for the work of subordinates. Another resource is finance and many managers accept, as a central part of their job, the responsibility for acquiring and expending funds, while some managers spend a great deal of their time in advocating, appraising or controlling major capital investments.

In addition to human and financial resources, there are physical resources – buildings, plant, machinery – for which some managers must accept responsibility.

Other resources are less tangible than men, money and machinery. Information is a vital resource to be acquired, processed, stored, classified and retrieved. Even more intangible are power and influence, but these are

resources which are finite and capable of either being squandered or being effectively and sparingly used. An associated concept is that of reputation as a resource to be deployed, including both personal and organisational reputation. Finally, some would argue that the organisation (including operating procedures) is itself a resource and that managers should take responsibility for the design and adaptation of their organisational unit or sub-unit.

To summarise, we can say that, in any given organisation, the title should be reserved for those employees who deploy the resources of the organisation. They 'manage' human, financial, physical and informational resources, and they have some impact upon the organisation's good name and the use made of its power and influence. They also manage the structure and operations of the organisation itself.

On applying such criteria to the staff of an organisation, we may find that some employees – notably, in the health service, some clinicians – are playing an important role as 'managers' even though they have never thought of themselves in that way.

2 What functions are attributed to managers?

From the criteria already listed, and from many textbook accounts of the 'functions of management', what is expected of managers may be analysed under seven headings.

First, managers are usually seen as **decision-makers and planners.** Planning is a systematic approach to decision-making which involves such sub-activities as scanning the organisation's 'horizon' for advance notice of threats and opportunities; establishing (and modifying when necessary) the organisation's priorities and objectives; generating and appraising options relevant to objectives; implementing preferred policy options (often involving programme design and execution); and monitoring, controlling and re-evaluating policies and programmes. Some of the complexities of the planning function have been described in the previous chapter.

Second, managers are expected to be **controllers.** They control programmes and the implementation of policy noted above. But they also control work operations, personnel, finance, quality of produce or service, and much else besides. To be effective, control must involve setting targets and standards, followed by appraisal of actual performance so that corrective action can be taken if expected results are not being attained.

Third, managers are **organisers.** They must find ways of dividing up the organisation horizontally, in terms of allocating tasks and drawing boundary lines around and within departments, and vertically, in terms of delegation and decentralisation. At the same time they must find ways of directing and coordinating the organisation as a whole so that division of labour does not become disintegration.

Fourth, the manager is expected to be a **motivator,** knowing when to prod and when (and how) to lead.

Fifth, he must have some **understanding of personnel management** in its more technical aspects, such as manpower planning, staff selection and appraisal, job analysis and staff development.

Sixth, we expect managers to play some part in **financial administration,** at least in terms of costing, budgeting and budgetary control. (For some managers, of course, financial administration will be their specialist and dominant concern, just as other managers may deal mainly with personnel matters.)

Seventh, it is increasingly accepted that the **handling of information** is an important part of most managers' jobs, especially as the spread of computers and automatic data-processing allows (and possibly demands) increasingly elaborate management information systems. The older management function of communication remains, of course, an activity which goes on within the organisation and between the organisation and its environment (in public and press relations).

These seven functions of management constitute a prescription for management, a normative statement of what management *ought* to involve. But what do we know about how managers *actually* spend their time? Do modern descriptions of managerial activities correspond to traditional prescriptions and, if not, does it matter?

3 What do we know about how managers actually spend their time?

In recent years, several factual studies have been made of how managers spend their time. Rosemary Stewart's study of *Managers and Their Jobs* was an influential analysis based upon the self-recorded activities of a sample of business managers.[74] A more recent study is Henry Mintzberg's *The Nature of Managerial Work* and it is mainly on his findings that the following is based.[67]

Mintzberg argues that, far from being systematic planners who delegate routine tasks, most senior managers tend to react to the stimuli of events and contacts and do little long-term thinking about objectives, alternatives and strategy. Among the real-life (and often very time-consuming) roles of the managers are some which might appear trivial and are rarely mentioned in management literature.

One such role is imposed by the fact that the senior manager is taken to represent the organisation (or his part of the organisation): this is the **figurehead** role as expressed in presentations to retiring employees, receptions for distinguished visitors, and other symbolic activities of varying importance. Some aspects of the **leader** role are equally unsought and may even be unconscious: thus, subordinates assume encouragement or rebuke from the reactions of senior management even when no such messages are intended. The **liaison** role is

one in which the manager 'makes contacts outside his vertical chain of command', contacts both internal and external to the organisation. These three roles are described by Mintzberg as 'interpersonal roles': they derive from the status bestowed upon senior managers and need not be deliberate (or desired) roles.

Three other roles are categorised as 'informational'. Briefly, they involve the **monitor** role, the **disseminator** role, and the **spokesman** role. Because of his liaison role, the senior manager is at the centre of many information flows. In processing, filtering, passing on, and initiating information, the manager is performing a function vital to his organisation. In building his information network, the manager can also do a great deal to establish a personal power base.

Finally, in Mintzberg's analysis, there are four 'decisional' roles. As **entrepreneur,** the manager identifies problems and opportunities and acts to change and improve the circumstances of his organisation. In the **disturbance handler** role, on the other hand, he is dealing with pressures to which he must react although they are often beyond his control (pressures from government, or powerful groups, or sheer circumstances such as an epidemic of influenza). A third decisional role is that of **resource allocator,** involving decisions about, say, who shall have access to computer-time, or which sub-unit should be favoured in next year's budget, or where staffing cuts should fall most severely. This role gives the manager fairly direct influence over many key decisions, and a lever to achieve organisational control and coordination. Finally, since few managers are able to impose their decisions unilaterally in modern circumstances, he must play the **negotiator** role.

Mintzberg and other modern writers, therefore, set out to tell us what managers actually do rather than what textbooks say they ought to do. Such realism is the basis of any useful thought about training for management. Mintzberg argues that classical management theory often ignores skills which the manager actually needs – such as developing peer relationships with his counterparts in other organisations, carrying out negotiations, establishing information networks, or making decisions in conditions of extreme ambiguity.

Mintzberg and Stewart also note that certain activities traditionally thought to be central to management – such as planning and coordinating – appear to be neglected or at least given low priority in practice. Both these observers conclude their analyses with some prescriptions for improvement in the ways that managers perceive and perform their jobs. Thus, to respond to day-to-day stimuli in a reactive manner may be to neglect the active, initiating, planning, objective-setting tasks of management. To seek refuge in busyness may be to avoid uncomfortable questions about effectiveness. To rely on informal information flows and on a personal memory-bank for information storage and retrieval may be easier, but also more dangerous, than to set up a more formal management information system. To rely on experience and intuition to form judgments may be to deny the contributions which can be made by specialists and experts.

4 How may we distinguish between senior and other levels of management?

In this section we examine some attempts which have been made to distinguish between the tasks of senior managers and those of middle and more junior managers.

In his study of *Management in Government*, Desmond Keeling suggests that the very senior or 'policy' level managers (many of them, in the public sector, politicians or political appointees rather than permanent officials) should be concerned with issues such as the values of the total organisation (for example, the place of private medicine in the NHS), basic objectives and priorities, the overall balance between competing claims upon resources, and broad strategies for achieving the organisation's aims.[64] The next 'administrative' level overlaps with policy-making since administrators or senior managers advise on broad policy issues. Once policy is decided, they should accept the basic objectives and strategies laid down for them but, in implementing policy, these senior managers will make important, precedent-setting decisions which, in turn, will provide guidelines for middle and junior managers. The job of middle and lower managers, in Keeling's version, is essentially that of implementing policies in accordance with decision rules determined by senior managers, with as much economy in the use of resources as possible.

Keeling thus sees the essential distinction between levels of management in terms of differences between the decisions taken at each level. Writers such as Horne and Lupton would go even further, on the basis of empirical studies of middle managers.[59] They conclude that 'Middle management does not seem to require the exercise of remarkable powers to analyze, weigh alternatives and decide. Rather, it calls for the ability to shape and utilise the person-to-person channels of communication, to influence, to persuade, to facilitate'. If one accepted Rosemary Stewart's definition of management – 'deciding what to do and then getting other people to do it' – it would almost seem that senior management is about deciding what to do and middle management is about getting other people to do it.

This type of distinction should be treated with some scepticism. Nowadays, even very senior managers may have to spend a good deal of their time negotiating, persuading and facilitating; while more junior managers may, in their own areas of expertise, make the day-to-day decisions which can, in practice, add up to policy.

Above all, there are differences between types of managerial jobs which are perhaps as important as differences between levels. Thus, some managers who are middle level in terms of pay and seniority may influence strategic thinking because they perform research,

planning or advisory roles. Conversely, there are at senior levels a number of managers who are concerned with implementing very large programmes or coordinating a wide range of operational tasks rather than with policy-making in the old Civil Service (or administrative class) sense.

Thus, there are formidable difficulties involved in distinguishing between senior and other levels of management. Many very senior jobs will be distinguishable by the degree of policy-initiative involved. But others may be characterised by the range of operational tasks for which they accept responsibility. This makes it difficult to generalise about the skills required at different levels, but it is to the question of relevant skills we must now turn.

5 What skills appear to be needed by managers?

We have already touched on this in the sections on managerial functions and the observed activities of managers. To avoid repetition, we shall adopt the framework suggested by Robert L Katz in his article, *Skills of an Effective Administrator*.[63]

Katz argues that there are three basic categories of skill: technical, human and conceptual. By the **technical** skill of a manager, Katz means his proficiency in 'methods, processes, procedures, or techniques'. We might include in this category such skills as costing, investment appraisal, project control (for example, using network methods), automatic data processing, organisation and methods, and operational research applications.

By the manager's **human** skill, Katz means his 'ability to work effectively as a group member and to build co-operative effort with the team he leads'. The skills involved are less specific than the technical skills but certainly include some understanding of his own and other people's perceptions and attitudes. By being sensitive to how co-workers perceive problems he can avoid conflicts based on misunderstandings. The effective manager also has an awareness of his own values and reactions and of how these may be seen by other people. This capacity to understand his own and others' behaviour helps him to foresee problems, to handle them sensitively, to communicate and be communicated with. Human skill is involved in the manager's dealings with his superiors and equals as well as with subordinates. It should also extend to clients and contacts outside the managerial hierarchy.

The **conceptual** skill of the manager refers to his 'ability to see the enterprise as a whole'. This involves an understanding of how his part of the organisation relates to other parts and to the total organisation. He must also be able to 'read' the environment (social, economic and political) within which his organisation operates. The effective manager must have a strategic sense. In making decisions, he quickly sees the possible repercussions and side effects of his own decisions and the implications for himself of decisions made elsewhere. He combines a mastery of detail with the ability to distinguish the essential from the incidental. He is a coordinator and integrator who also possesses the spark of creativity and innovativeness.

Any manager who possessed all these skills to a high degree would clearly be a paragon whose indispensability would be matched only by his insufferability. Fortunately, the degree to which particular skills are required varies from job to job and, it might be argued, from level to level. We shall end this section by quoting, without necessarily endorsing, Katz's conclusion that 'at lower levels of administrative responsibility, the principal need is for technical and human skills. At higher levels, technical skill becomes relatively less important while the need for conceptual skill increases rapidly'.

6 How can these managerial skills be inculcated?

Before we go on to discuss the possible contribution to be made by management training, it is worth pausing to note that there are several ways in which skills may be acquired. Some skills may be part of personality – or inborn – and the contribution of training to the development of human skills, say, may be relatively limited. Other skills are learned rather than taught: they are acquired by experience, in other words, and by the hard lessons of trial and error. Some of the conceptual or synthesising skills may be of this kind, and it is also only realistic to point out that a manager's grasp of ever more complex problems must be related in part to his basic intellectual gifts.

Turning to the place of training in inculcating managerial skills, the most obviously useful and feasible type of training is in technical skills. These can be acquired through formal instruction and improved through practical application. They can be taught at any stage in the manager's career although it is probably true that they are best acquired (because most useful) at junior and middle levels of management.

Training's main contribution to the conceptual skills probably lies in 'contextuating studies' – a clumsy term for instruction in the significant features of the manager's working environment as he moves to more responsible jobs. Instruction in macro-economics, law, government and social institutions can help the manager to understand the complexities and constraints of the larger situation within which he must operate. There is also a place for policy studies especially when these employ case studies and exercises in making decisions relating to problems of a sort which the manager can expect to encounter on his promotion.

The aspect of training which produces most controversy is that relating to the human skills. Is interpersonal competence something which can be taught, or is it inherent? Many practising managers believe the latter, but we would argue that training can help even experienced administrators to understand more about motivation, communication, leadership, management of

change, group behaviour, and what used to be called 'man-management' or 'working with people'.

7 What do we mean by 'management training' and what purpose does it serve?

The need for this question may not be obvious at first sight: surely we all know what management training is and the purpose it serves? In fact, training can mean different things to different people.

Training as induction or reorientation Newcomers to an organisation often require a short induction or orientation course. The aim is to help them understand the setting in which they will work. Even experienced staff may require an induction course when their work-setting is in process of change (as in the recent reorganisation of the NHS). This might be described as 'reorientation'.

Training as motivation and socialisation An induction course may well develop into 'indoctrination' or inculcation of the values regarded as important by the employer. This is a quite legitimate training objective, although most trainers would flinch from the term 'indoctrination' and would talk about 'motivation' or 'socialisation'.

Training as accelerated experience Training is directed to the future. Courses may help managers (or professional people moving into managerial posts) to understand what their jobs will be in, say, five years' time; what sort of problems they will then be facing; and what skills and attitudes will be relevant to solving such problems. The case study method of training incorporates accelerated experience by simulating future problems in compressed and simplified form, before they need actually be faced, and in a setting where the desire to do well is unaffected by the dread of making mistakes (which often forces managers into indecision and buck-passing in real life).

Training as appreciation Many training courses are intended to provide a broad overview of the nature of management, the different functions within management, and the techniques and skills deployed by the professional manager. Several sub-aims may be served by such courses: they help managers to understand what is involved in their craft and may deepen their commitment to it; they help non-managers to understand the contribution of management and managers; they create a framework for subsequent instruction in particular aspects of management.

Training as instruction This is usually what trainees understand by training. They hope to be 'added to' in some specific and tangible respect, through instruction in new skills and techniques. The problem is that instruction in management as such involves long periods of intensive training, usually much longer than managers or their employers can countenance. Shorter courses can only deal with aspects of management, such as instruction in a particular technique: but the onus is then on the employer to specify in some detail what skills are relevant and what degree of expertise is required.

The practical point is that the purposes of training are not self-evident, and it is important to be clear about what is being offered by trainers and what is sought by trainees and their employers. Where expectations differ, problems may result.

It is also necessary to distinguish between the purposes served by training courses for junior and middle managers and those aimed at senior (or potentially senior) managers. Training for senior managers rarely involves induction but it may well seek to reorient them to the demands and circumstances of their new posts. Motivation and socialisation may be of some importance in helping new senior managers to adopt a larger perspective of the organisation for which they now share responsibility. There is clearly a place for training as accelerated experience to be available to potential senior managers. But the key distinction is between training at appreciation level and training at instructional level. It is to be hoped that senior managers will have received instruction in specific skills at an earlier state in their careers; but if they have not, the need is probably for courses where depth of instruction is sacrificed to breadth of coverage – appreciation courses, in other words. Senior managers should understand the applications (and limitations) of particular techniques, but it follows from what we have already said about management skills that they probably do not require instruction in such techniques.

8 Are there any agreed principles of curriculum design?

Two important points arise in any discussion of the form and content of management training curricula. The first is about the balance between common and particular training needs. In dealing with a service such as the NHS, there is a place for common or service-wide training courses, not least because, where commonality can be established, there is an obvious link with consistency and economy in the provision of training. But there is also a case for particularity in the design of training courses and curricula. There is no single or homogeneous activity called management, and the training needs of managers are also diverse, because of differences in employment sectors, regions, previous training and experience, and levels of seniority. Thus, there is a case for a balance between what might be called the 'fixed menu' principle on the one hand and the 'à la carte' principle on the other – in other words, between common courses on a service-wide basis and more specialised and/or localised courses.

The second point concerns the supply rather than the demand side of the training equation, and brings us to a first look at the subjects to be taught. For example, any training curriculum should be designed around management activities, skills and problem-areas and not around the availability of particular teaching inputs –

especially when these are unidisciplinary inputs. Academics often want to teach what they have themselves been taught, and that is usually a single discipline such as politics, economics, law, sociology, psychology, statistics or accountancy. But managers – especially at senior levels – do not want or require training in academic disciplines. The academic inputs must be reassembled around managerial activities and problems.

One such problem area is the making and implementation of decisions or what is often called 'planning and control'. The most useful academic approach to this would seem to lie in the interdisciplinary field of policy analysis. Another problematic activity of management is organisational design and coping with the behaviour of people within existing organisations. The relevant combination of academic disciplines is often referred to as 'organisational analysis'. In personnel management there already appears to be a reasonable fit between another set of management concerns and a well-established field of management studies. The same is true of financial administration. We hope that information sciences will provide a fifth nexus of practical and academic interests. Finally, we must recognise the important difference between business and public administration by providing contextual studies incorporating macro-economics, law, political science, public and social administration, and other academic inputs relevant to an understanding of the total environment within which public officials must work.

In debating these questions about curriculum design for NHS senior management training courses, it would clearly be desirable to have full data on such questions as: Is the clientele for such courses likely to be homogeneous or heterogeneous? What appear to be the most important problem areas and managerial activities of the clientele? In practice, available data are often inadequate in such respects and we have had to rely heavily on our own experience and observations.

9 How should training be organised and staffed?

Several different patterns of training provision are to be observed in the British public services. In the armed services, for example, we find the closest approximation to the staff college pattern. The characteristics of the staff college pattern might be described as

a a hierarchy of training, with the possibility of progression from one level of training to the next

b an emphasis upon selectivity and élitism, so that staff are selected for higher training courses, and to be chosen for the highest level courses is to join an élite within the service

c links between training and careers, in that selection for higher courses either follows upon or tends to precede promotion

d where training precedes consideration for promotion, an examination or assessment at the end of the training course used as a method of deciding whether or not candidates for promotion have certain necessary qualities or qualifications

e training seen as serving an integrating function and, at the highest levels, trainees brought together from different parts of the service as a deliberate method of creating a wider service identity and inculcating a broader perspective

f training also seen as having a broadening function in that the curriculum includes study of the larger environment (contextuating studies) as well as the teaching of specific skills.

With the exception of **d** – performance at staff college as a factor in deciding promotion – most of the features of the staff college pattern are to be found in the armed services. Progression is possible from single-service training to the National Defence College and from there to the Royal College of Defence Studies. Moreover, there is a marked element of selectivity in this progression: only 25 per cent of officers of relevant ranks will be selected for NDC and only 2 per cent – who will hold key posts in the direction of defence – go on to RCDS. Career-linkage exists in that, while to be selected for advanced courses is neither a guarantee of, nor a prerequisite for, promotion to the highest ranks, officers who are selected realise that they are regarded as potential high fliers and tend to be highly motivated and anxious to justify their selection. Finally, the integrating and broadening functions of training are emphasised: officers who have been accustomed to think about, say, 'the Army' or 'the Navy' now have to develop a 'joint services' frame of reference, while the broadening element in curricula is reflected in the importance of background subjects (international relations, defence policy) as well as foreground professional studies. The two colleges are staffed by a mixture of permanent academic staff and career officers on secondment, and the broadening element of the curricula involves a wide range of outside speakers.

In sharp contrast is that to be found in local government. A corporate sense is not an obvious characteristic of local government service, or even of many local authorities, because of the fragmenting effect of departments dominated by professionally qualified chief officers. Administrative training was neglected for many years, and most of the present training on a national scale is provided for younger administrators. The main qualification sought by them is the diploma in municipal administration which is offered by a great many further education colleges in England and Wales. A coordinating role is played by the Local Government Training Board, but the board itself emphasises the autonomy which local authorities retain both as employers and in relation to further education. Some more senior courses have been provided by five designated polytechnics but these have been concerned

with fairly specialised and/or urgently needed training.

The only approximation to a staff college for senior management in local government is the Institute for Local Government Studies at Birmingham University. The institute is recognised for certain purposes by the training board but there is no suggestion that it performs anything like the full range of staff college functions. (Nor does it have a monopoly, since other courses elsewhere contribute to the available training.) Indeed most of the necessary conditions (hierarchy, selectivity, career-linkage) for the creation of a staff college system are lacking in local government. The decentralised, pluralistic, pragmatic approach to administration training fits very well with the general ethos and structure of local government in Britain, and it would be inappropriate (and probably impossible) to seek to impose the armed services' pattern upon local government – or vice versa.

Local government and the armed services thus occupy the two ends of the spectrum in training matters. Of the other public services, the police and some of the nationalised industries (notably the National Coal Board) occupy a position closer to the armed services. The Civil Service College is *not* as it is often called the 'staff college' of central government: it provides only 6 per cent of Civil Service training and the levels of training range from 'Mechanics Institute to All Souls' (to quote the Heaton-Williams report).[11] Only the courses for young administration trainees (ATs) are compulsory; most other courses are provided on an à la carte basis – that is, there are many courses, most of them short, and in the last resort it is for the DHSS to decide who, if anyone, should attend. Training is not part of the selection process, even for ATs, and there are few, if any, career-linkages.

Finally, if we were to ask towards which end of the spectrum the National Health Service presently inclines, the answer would be that it comes closer to the local government service. Whether the NHS should, or could, move along the spectrum in the direction of a more unitary, centralised and hierarchical pattern of training on military or police lines is a matter to which we shall return later in this report.

10 Are generalisations possible about managers and management training?

It would certainly be possible to argue that all generalisations about managers are suspect. There is no one management job or one type of manager. We know from empirical studies that managers occupy their time in widely differing ways. Some managers are functional specialists, concerned mainly with managing people, money or information; others are general managers. There are quite different types of management jobs; supervisory, executive, planning and many others. Different levels of management involve different tasks and skills. Management in the public sector differs from business management; but the various public services also vary considerably in structure, staffing and what might be called the 'ethos' of the service. The setting of the managerial job is important, and even within one public service great variations are possible, for example a laboratory setting and a cabinet minister's private office. It would seem to follow, then, that it is pointless to generalise about either the nature of the managerial job or the training needed for management.

However, this is too defeatist an approach. Most of the elements (tasks, skills, settings) of managerial jobs have something in common, although many different mixtures of these elements are possible. We have suggested, for example, that any manager has some responsibility for the resources of his organisation, even if he has a particular responsibility for one resource category, such as finance or personnel. Most managers would accept that they engage, to some extent at least, in such activities as taking decisions, exercising control, organising, motivating and developing staff, administering financial resources, and handling information. Again, although the necessary combinations of skills may vary, all managers require at least some technical, human and conceptual skills.

As for management training, it should be clear that we do not seek to impose any one pattern of provision, training format, or curriculum. But again, many of the training elements are common although different combinations and permutations are possible. We have, for example, noted the argument that the need for technical, human and conceptual skills varies between levels of management, but this is a matter of emphasis and of achieving appropriate mixes of skills. In designing curricula for management courses, too, we would argue that the elements include such subjects as policy analysis, organisational analysis, personnel management, financial administration, information sciences, and contextual studies; some familiarity with all, or most, of these elements seems necessary for any manager, but the weights attached to the curriculum elements should obviously vary according to the length, purpose and level of any given course.

4 The recruitment, training and development of managers in the National Health Service from 1948 to 1974

The structure of the National Health Service as it stands today, the management features of which have been outlined in the previous chapters, is the result of some 30 years' evolution.

It is instructive to review these developments since 1948, partly to understand the reasons for the existence of present facilities for management training resulting from a series of initiatives of the employing authorities, the DHSS, the national staff committees and the various educational institutions; partly to learn from the varying attitudes over the years towards planned career development, and partly to realise that, even after a quarter century, there are few agreed principles governing the preparation of senior managers.

This chapter, then, takes a comprehensive view of the historical basis of the recruitment, training and management development of managerial health personnel in the NHS, that is, of administrators and finance officers, and of community physicians and nurses, though excluding in the latter, recruitment and professional training.

The experience of the 1960s both in the NHS and outside was to lead to a re-examination of the purposes of management training as described in Chapter 3, of the roles of the professional associations and educational bodies and of their contribution to the teaching of the basic disciplines of management which are the subjects of Chapters 5 and 6.

When it became accepted that management development had a contribution to make to the quality of senior management in hospitals, the early emphasis was on administrators and treasurers. Management development for nurses followed later, and for doctors later still. The period has been divided into three; the first being marked out from the second by the Guillebaud report[31], the second from the third by the Lycett Green report[45] and the establishment of the national staff committees.

1948-1955

Section 12(2) and (3) of the National Health Service Act, 1946[51], placed the control and management of hospitals upon hospital management committees and boards of governors. This included the recruitment, appointment and dismissal, and promotion of all staff, except senior doctors and dentists.* The Ministry of Health issued guidance on staffing patterns, and salary scales and other conditions of service were nationally determined, but the hospital authorities could decide the management patterns, the numbers and grades of staff and the nature of their employment.

A total of about 40,000 people was employed by well over 400 authorities. Many staff – doctors, dentists, nurses, midwives and paramedical staff – were either professionally qualified or were in training. Their training was the responsibility of statutory or other bodies independent of the health service, though significant parts of the training required the use of hospital facilities. It was rare to find management subjects in the syllabuses of these training bodies.

The syllabus for the diploma of the Institute of Hospital Administrators did, of course, include management subjects, yet the possession of the diploma was not a condition of employment for administrators. As the years went by, however, recruits were strongly advised to obtain it. Similarly, finance staff were not required to be qualified accountants, though here again recruits were encouraged to study for qualification and in time this became increasingly desirable for applicants for senior posts.

*Regional hospital boards were responsible for these staff.

Within this general framework, hospital authorities set out in 1948 to exercise the 'lively independence' which Aneurin Bevan had promised them. The early years were quickly beset with financial problems and from 1950 the Ministry of Health began attempts to control staff numbers and, therefore, the hospitals' freedom to hire as they chose. The grouping of hospitals for management purposes was producing problems between individual hospitals and between senior staff. The Bradbeer committee, set up in 1950 by the Central Health Services Council to study methods of administration, reported in August 1954.[33] Its recommendations became a kind of guide book though they were not officially endorsed.

One issue of the time was the continuing role of medical superintendents* in hospitals formerly belonging to local authorities. The Bradbeer committee thought that not all the tasks they then performed were necessarily the province of one medical administrator, but that the medical committee system needed strengthening. The list of functions of the medical committee recommended in the Bradbeer report was issued formally by the Ministry of Health.[37]

The report backed tripartite (medical, nursing and 'lay') administration and looked at the effect of grouping hospitals. The Ministry had told HMCs that they could appoint a group secretary, group finance officer and group supplies officer. This inevitably raised the question of the extent to which services should be centralised. The committee had no doubt that there should be one chief administrative officer, and one chief finance officer – and this pointed to the need for more highly qualified staff for group posts. There was doubt about the centralisation of supplies and the argument went on for 20 years or so.

The report said that the head of the nursing services – then called the 'matron' – should be directly responsible for nursing matters to the governing body of her hospital, but in her non-nursing functions she should be responsible in the first instance to the chief administrative officer. The practice of appointing group matrons had already begun, and the Ministry issued a guidance memorandum on it.[36] Yet very few senior nurses were undertaking management training to prepare them for these extended responsibilities.

The new hospital authorities, with one or two exceptions, gave little time to the development of their managerial staff. Opportunities for internal promotion were not great, at any rate for the ambitious. To get on, one had to apply for advertised posts in other authorities. However, some senior officers saw that if an authority offered training and experience, better recruits were attracted. Recruits who made good progress had a distinct advantage when they applied for posts elsewhere. There was, therefore, a growing realisation that training was important for those who aspired to the top posts, and that a recognisable career structure was needed.

The climate was not yet right for national initiatives, but in the early 1950s King Edward's Hospital Fund for London set up staff colleges to provide experimental courses for administrators, caterers and nurses – and even doctors.

1955-1965

In addition to financial problems, there were doubts about the permanence of the NHS structure; some feared – and some hoped – that regional hospital boards would be abolished. In 1951, however, a select committee on estimates had drawn attention to the RHBs' lack of authority to control staff numbers of HMCs, to the incursions of the Ministry of Health in the matter, and to the resulting uncertainty of HMCs about where control really rested.[49] The committee recommended a national review of staffing by the Ministry and more extensive powers for RHBs to control establishments.

The Guillebaud committee, reporting in 1956 on the cost of the NHS, went further: '. . . Regional Hospital Boards should be told, and Hospital Management Committees should accept, that Regional Boards are responsible for exercising a general oversight and supervision over the administration of the hospital service in their Regions.'[31]

All this helped the service to settle down. Another factor which may have helped was a forecast increase in money for capital building. Long-delayed programmes could at last get under way. This too had implications for the quantity and quality of senior staff.

The Guillebaud committee saw the need for an improved staffing and salary structure with sound recruitment, training and promotion policies. In 1956, a Ministry of Health circular, stimulated by Guillebaud and based on recommendations of the Whitley Council for Administrative and Clerical Staffs, provided for a national training scheme, further education of administrative and clerical staff, improved standards for recruiting junior staff, special selection and training of officers capable of filling senior posts, and urged authorities to review their arrangements accordingly.[42] The more progressive regions responded by devising their own schemes for voluntary collaboration of hospital authorities in joint recruitment of school leavers for junior posts, with induction programmes, training and career guidance, and help, including financial, in study for qualifications.

The national training scheme was directed at promising young staff, university graduates and others professionally qualified. It was thought that the hospital service should seek to get a fair share of the potential administrative talent in the country. Training posts were

*In December 1952 there were still 129 of these and the post remained a statutory one in mental hospitals until 1960.[53] Regional hospital boards recruited doctors from the Civil Service, armed forces, Colonial Service, local authorities and public health services. They also recruited trainee medical officers and apprenticed them to the senior administrative medical officers.

held for three years, after which trainees competed for appointments in the normal way. Counselling was provided by the King's Fund Hospital Administrative Staff College* and the department of social administration of the University of Manchester who had agreed with the Ministry to share in the training. In Manchester, this included an academic year of study for the diploma in social administration. Hospitals provided a variety of jobs for practical training, under the guidance of the training institution and in collaboration with senior hospital administrators.

This national initiative was immediately successful. It brought a university into management training probably for the first time. In a parallel scheme, introduced in 1963, recruitment was conducted nationally together with the original scheme, but induction and training on the same general principles were the responsibility of the RHBs. Each region could take three trainees a year, providing a total of 45 in England and Wales. The new scheme gave the regions an important new activity. A senior member of the RHB staff supervised practical training, provided counselling, and collaborated with the training institutions responsible for theoretical training. The two institutions – the King's Fund College and the university department in Manchester – were now joined by the Nuffield Centre for Health Service Studies in the University of Leeds where experimental courses for hospital staff had been built up since 1958.

The Ministry in 1956 thought that appointment and selection procedures, particularly for senior posts, were neither of a sufficiently high standard nor scrupulously fair.[42] Sir Noel Hall referred, in his report on the grading structure of administrative and clerical staff (1957), to 'that strong initiative' taken by the Ministry circular, and drew attention to the difficulties which still tended to inhibit career development: the 'great gulf fixed' between different types of authority and between staff in different departments. He identified the central problem: '. . . to try and devise ways and means by which the advantages of a national service can be secured for the multi-unit service which makes up the hospital world.'[30]

The Ministry circular (HM(59)59) outlined a revised promotion and appointments procedure and other guidance based on the Noel Hall recommendations.[39] Staff advisory committees in each region, representative of members and senior staff, were to maintain registers of all officers in the administrative grades, to advise on the availability of staff, and on career prospects, to make available to authorities the names of outside assessors to be included on appointment committees.

In reviewing the response to this circular two years later the Ministry observed that though much had been done progress was uneven.[43] Some regional committees did not meet often enough; four had not set up registers; some authorities were not making use of outside assessors. A few regions had established training centres with courses for staff with supervisory or managerial duties. These centres performed regionally a function similar to that performed nationally by the King's Fund staff college and other centres involved in the administrative training scheme.

In the early 1960s a number of factors led to the demand for a more sophisticated and specialist approach to hospital management. Some groups, for example, a general hospital group with a psychiatric hospital serving the same population, were combined under one hospital management committee. The amalgamation increased the group staff's responsibilities and identified a need for more specialist officers. The growth in hospital building demanded doctors, nurses, administrative and other staff with knowledge of design, construction and commissioning of new buildings. The introduction of recommendations of the Guillebaud report on hospital costing[31], was showing how useful it was for hospital departments to be aware of the use they made of financial resources and the comparisons which could be made. Though it was often argued that no two departments were alike, the information led to examination of the efficiency of departments in relation to the resources they used. The Ministry set up the Advisory Council on Management Efficiency, with members and officers of the hospital authorities and outside experts, which issued reports and guidance on management methods. Work study officers began to attend training courses at the King's Fund college and elsewhere. All these changes indicated the need for a fresh look at recruitment, training and development.

In 1962 the Lycett Green committee set out '. . . to inquire into the present arrangements for recruitment, training and promotion of administrative and clerical staffs in the hospital service . . . '[45] A year later the Salmon committee was appointed 'to advise on the senior nursing staff structure in the hospital service (ward sister and above), the administrative functions of the respective grades and the methods of preparing staff to occupy them.'[32] The work of these two committees was to lead to the establishment of the two national staff committees.

1965-1974

The Ministry of Health accepted the main recommendations of the Lycett Green report and one of the most important of them, the National Staff Committee, was set up in 1964 to ensure action. Its task was to produce a recruitment, training and development policy for hospital administrative staff which would take into account the manpower needs of the service with a recruitment programme to match, training requirements, a procedure for assessing staff and a more orderly system of making appointments. The first step was to set up regional staff committees to take over and extend the work of the regional staff advisory committees.[44]

*Merged with the Fund's other staff colleges in 1968 and renamed King's Fund College.

Manpower information

The Lycett Green report contained statistics on the number, grades, ages and main characteristics of administrative staff based on a survey done in June 1962. Updating this with less detailed data from the Ministry, the NSC was ready to make recommendations on recruitment in 1965-67.[35, 40]

A comprehensive survey was begun in which all administrative staff in post on 1 January 1969 had to complete their own records and send them to the NSC via the regional staff officers.[22] Collection, checking and collating proved to be very laborious and it was not until 1971 that the NSC was ready to publish analyses similar to those in the Lycett Green report. The decision to get each officer to complete his own record, made in an effort to establish confidence in the system, undoubtedly contributed to the delay. The intention to keep the information up to date, by the regional staff officers forwarding corrections and additions to the Ministry's statistical division, was overtaken by the reorganisation of the NHS.

Recruitment

In 1965 the NSC reported on recruitment of school leavers to clerical grades.[35] Guidance on annual targets was given from the updated manpower information in the Lycett Green report. Regional staff committees were asked to organise inter-authority recruitment; to assist authorities in induction, training and job-rotation programmes; to arrange study courses with various educational bodies to assist recruits in professional examinations and their work generally.

By 1967 the national and regional schemes had combined, with the NSC handling recruitment with help from the RSCs, and the latter responsible for induction and practical training.[40] The NSC and the three training institutions agreed the principles of theoretical training, and the detailed organising was done by the RSCs with the help of the institutions. The annual intake of 45 in 1967 was raised to 60 in 1971 to provide for the growth in numbers of administrative staff required.[13] The training took two years with the final six months in a service post.

In 1971 the Whitley Council extended downwards the junior administrative grade (that for graduate entry) to allow recruitment of school leavers with at least two A levels.* A four-year training scheme for such recruits, introduced in 1971, provided for an annual intake of up to 80 in England and Wales. The RSCs handled recruitment and training arrangements.[13]

The NSC constantly stressed the importance of including recruits for finance departments, and in 1968 recommended that 40 places of the total annual recruitment targets should be reserved for school leavers who wanted a career in hospital accountancy.[41] A condition of acceptance was a course of study for a professional accountancy qualification. It was also felt that of the 45 graduate recruits, 10 might be interested in a career in financial administration, though they were not required to study for a professional accountancy qualification. This allowed recruits who had earlier chosen financial administration to keep their options open, and some changed their minds during training and sought careers in general administration.

The number of places taken up by recruits interested in finance was disappointingly low. It pointed to the need for a specific scheme for recruiting finance staff with a requirement that those accepted should study for a professional accountancy qualification.

In 1974 the NSC introduced the Specialist Finance National Training Scheme for graduates and others with approved qualifications, running alongside but separate from the administrative scheme, and geared to the training requirements of the Chartered Institute of Public Finance and Accountancy. The scheme offered 15 places annually, and a four-year programme with working attachments and instruction at selected polytechnics – Trent Polytechnic, Nottingham, was used for the first two years. The response has, however, been disappointing, with only three trainees in 1974 and 11 in 1975.

Training

The NSC's comprehensive view of training included study for professional qualifications, a variety of practical experience in the health service, particularly during the earlier years, attendance at management courses and, for some, secondments to bodies such as the Department of Health and universities.[40]

For administrators, the professional qualification most regularly sought was the diploma of the Institute of Health Service Administrators* and the NSC had regular discussion with the IHSA on syllabus review and arrangements for study. Variety in practical experience was provided on a small scale by movement from post to post within employing authorities. The provision, however, depended very much on the attitude of senior staff, the size of the authority, availability of posts, and on the views of junior staff themselves on the value of movement within the authority. This last was not likely, of itself, to provide a promising ambitious officer with the increasingly varied experience available in a growing and complex service. A scheme of planned movement between authorities was designed to remedy this.

RSCs provided career counselling to those who sought it, so that both the officers and the RSC knew the kind of post likely to be most beneficial for management development – and this could include employment in a neighbouring authority. Authorities willing to take part

*See Appendix C.

*Formerly called the Institute of Hospital Administrators.

were asked to let the RSC know which posts when vacant could be occupied by an officer from another authority. The RSC could suggest names of officers to be considered; if the authority found one of them suitable he/she would be formally appointed. Secondment of varying duration could also be arranged.

Between 1965 and 1970, 365 officers had secured posts through the planned movement scheme, but numbers fell annually during the period, mainly because there were plenty of posts on the open market which offered promotion and carried greater responsibility. These were preferred to planned movement posts which, though providing varied experience, did not necessarily involve promotion.

The staff side of the Whitley Council had misgivings about planned movement. These included regional variations in practice, the need for more flexibility particularly in the periods and terms of tenure of posts, concern about the extent to which promotion was taking place without the post being thrown open to competition in the normal way, and uncertainty about whether the scheme was for all officers or only for those who had been through a process of selection. Many of these issues were discussed by the NSC and RSCs over the years and the scheme was adjusted to meet some of them.

By 1971, planned movement was operating with a much smaller number of posts. It had become the custom for RSCs, on being notified of a vacancy, to ask an authority to consider an officer known to the staff committee who needed the type of experience which the post advertised. The post might be occupied on a secondment basis for an agreed period or substantively. The role of the RSCs and the staff officer developed into a career counselling service.[13]

Management courses

The Lycett Green committee recommended a three months' residential management course at a staff college, organised nationally for selected officers. This was before the Franks committee[8] recommended the establishment of business schools and the great surge in management education throughout the country which followed.*

The King's Fund and the Nuffield Centre offered to provide the recommended courses. Courses of eight weeks were agreed, and the proposed programmes accepted. A criterion for nomination was that an officer should have demonstrated competence and potential in posts of some seniority. The membership was selected jointly by the NSC and the two training centres. An endeavour was made to balance the membership to be as representative as possible of the various types of experience and discipline. The King's Fund College included medical and nursing officers selected by the college staff.

*In 1964 three universities were offering master's degree courses or the equivalent in business studies with an annual output of about 20 graduates. By 1973, 23 university business schools were members of the Conference of University Management Schools, a further eight were offering master's courses. There are now 42 main centres offering DMS courses in England, Wales and Northern Ireland, and about 35 extra-mural centres in England and Wales.

TABLE 1 Administrative Officers Subject to Staff Reporting

Administrative grade	Total number	Number	Per cent
General	3617	1959	54
Senior	2425	1640	67.6
Designated	2875	1420	50

The NSC felt that courses were also needed for younger officers who had not had the theoretical part of the two-year training programme for graduates, and asked the RSCs and the regional education centres to provide them. They later became multidisciplinary with the institution of middle management courses for nurses on the recommendation of the National Nursing Staff Committee in 1968. They were provided mainly at regional training centres but also in association with the further education service.

The courses were succeeded in 1974 by the administrators' development course[21], instituted by the NSC to provide an early course for all promising officers whatever their mode of entry into the service. This took the place of eight weeks of the three-month theoretical course previously included in the graduate programme.

Assessment and appointment

In 1965 the NSC instituted a voluntary system of annual confidential reports on administrative officers for the purpose of assessing performance, helping to plan career development, identifying training needs, and for use in making appointments.[35] The number of officers electing to be subject to staff reporting in 1970 is shown in Table 1. The system did not extend to chief officers.

In 1967 the Ministry introduced new procedures, recommended by the NSC, for the appointment of administrative staff.[38] These included notifying vacancies to the RSC or NSC – depending on the seniority of the post – together with a job description and draft advertisement. A panel, convened by the RSC or NSC, made a short list of applicants for interview by the authority. The authority was assisted at the interviews by the assessors who had been present at the short-listing.

The use of staff reporting, particularly in making appointments, was criticised by the staff side of the Whitley Council. They wished to see a more open system

to ensure that an officer seeking promotion knew the contents of his report. The system was not used when appointments to the reorganised NHS were made in 1974 and subsequently, and is still under review.

Management development of senior nurses

Parallel action to that for administrative staff was taken by the Secretary of State for Social Services after he received the report of the Salmon committee.[32] This report sparked off management development for nurses on a national scale, though the King's Fund staff colleges for ward sisters and for matrons were providing courses for selected nurses for some 15 years before. The National Nursing Staff Committee was appointed in 1967 and worked closely with the NSC. The NNSC did not recommend regional nursing staff committees similar to those for administrative staff but, for the management development of senior nurses, as set out in the DHSS circular HM(69)2, endorsed on-the-job training for nurses with management duties and placed responsibility for this upon their seniors.[20] The order of priorities for training was senior, middle and first-line management levels, as defined in the Salmon report, and the NNSC stressed that purposive selection for training would give better value. Courses for middle management were to be interdisciplinary and recommended programmes were outlined.

For the senior level, the NNSC endorsed the content and duration of the interdisciplinary courses instituted by the NSC for administrative staff.[40] The two committees jointly supervised these courses and, to meet the growing demand, invited university departments of administration in Manchester, York, Cardiff and Birmingham to take part.

Selection and appointment

The NNSC recommendations aimed at progressive improvement on current methods whilst preserving the sound, well-tried methods of many good authorities and without encroaching on an individual authority's powers of appointment.[16] Standard application and reference forms were introduced, and detailed procedures appropriate to various levels of nurse management were recommended. The value of small interviewing committees, aided by independent assessors, was underlined.

The Secretary of State commended a report of the NNSC on staff appraisal in the nursing service.[15] Unlike the scheme for administrative staff, the nurses' scheme was compulsory. It was introduced group by group after careful preparation, with a publicity programme of film strips, leaflets and instruction courses for everyone. The scheme was still under way when NHS reorganisation was being prepared in 1972.

Further management training

The Salmon committee had recommended that some nurses of exceptional promise should undertake a year's course in a university for a diploma in social sciences or nursing administration, and that some younger chief nursing officers be given opportunity to attend the Administrative Staff College at Henley and appropriate courses at the new business schools. The NNSC endorsed these recommendations[20], the NSC had proposed similar experience for administrative staff. The two committees joined in exploring possibilities and were able to put definite proposals to the DHSS. Since 1971, a few selected officers have attended courses annually at Henley and the London and Manchester business schools.[14]

It was only in the 1960s that interest in management education became at all common in Britain. In some respects the NHS was ahead and the senior management courses for administrators instituted in 1965 and for nurses in 1967 were major developments, with eight weeks multidisciplinary courses, following broadly the content of the administrative trainees' course. They were popular, probably because they were seen as a passport to promotion, but were very difficult to run. Course members, unlike trainees, were very different in age, experience and profession. By 1970 the DHSS began to ask for an evaluation. Studies undertaken by independent researchers recommended closer examination of the needs of the individuals and the institutions where they worked before they were sent on a course. The 're-entry syndrome' was identified. These findings, similar to the observations of other people concerned with post-experience courses, led to experiments in a much closer involvement of management teachers with the problems of the organisation and its staff, for which management courses are not the only solution.

Medical administration and community medicine

In 1966, the Royal College of Physicians of London published a report on training for medical administration.[72] The retirement of some of the able medical administrators who had transferred to the hospital service in 1948 exposed a shortage of suitable successors, and the committee reported that promising medical graduates were needed in a specialty concerned with organisation of medical care in the community. Some of these able administrators had started in local government and had the Diploma in Public Health – a statutory requirement for those wishing to become medical officers of health. The DPH curriculum included public health, medical statistics, law, environmental hygiene and maternal and child health. Management subjects were added later.

The first 'cogwheel' report on the organisation of medical work in hospital, published in 1967, had a major impact.[34] Since medical considerations had a decisive bearing upon so many important policy decisions, it was argued that clinicians must be able to take a continuous and leading part in management arrangements. Subsequent 'cogwheel' reports[28,29]

published while the NHS reorganisation began to take shape, made the point that though the new administrative machinery would be separate from the 'cogwheel' system of medical organisation, clinicians would need to take full part in the new management and planning arrangements.

The Royal Commission on Medical Education (1968), noting the changes in the role of public health, suggested that 'community medicine' would be a more appropriate title and that a faculty be established to control education in and development of the specialty.[55] The working party on medical administrators, reporting in 1972, stressed the key role which community medicine specialists would have in the new regional area health authorities and the district teams, and outlined the necessary training and career structure.[27]

Training of community medicine specialists

The Faculty of Community Medicine, established jointly by the three royal colleges of physicians in 1972, brought together the three groups principally concerned in developing the specialty: public health medical officers; administrative medical superintendents and the medical officers of the central departments; academic and research workers in university departments of public health and social, community and preventive medicine. Some of the changes which the new faculty recognised were needed in training for community medicine were already included in the development of a two-year course in social medicine at the London School of Hygiene and Tropical Medicine, begun in 1968. This comprised study of the four basic disciplines (epidemiology, behavioural sciences, medical statistics and management) in the first year, with a second year of attachment to academic units or service authorities to undertake original projects.

Emergence of consortium training

The two-year course was taxing and very different from the training for other medical specialties. For an experimental period, therefore, a new course has been developed based on the clinical model in which students are appointed to a service post for two years. They receive instruction in the four basic disciplines provided by a consortia of universities in different parts of the country. Over the two years, they are expected to spend about six months in academic work, including one study day a week under the supervision of a tutor.

The first consortium, of the Oxford, West Midland, Wessex and South-Western regions and Wales, began in 1973. The second, comprising the four Thames and the East Anglian regions, began in 1974, and the third, Northern, Yorkshire, Trent and North-Western regions, in 1975.

The MSc courses and the consortium training have so far been restricted to the four basic disciplines. Continuing education is being developed in some university departments, in particular by the two centres for extension training in community medicine in London and Manchester. Secondment to these centres follows the tradition of many local authorities who seconded their medical officers for further training in community medicine subjects, such as child health, and for management training, particularly following the Mallaby report in 1967.[46]

The reorganised NHS

Preparation for NHS reorganisation greatly stimulated the recruitment, training and development of the community physician. For other professional groups, although recruitment and development continued during the reorganising period, the main focus was inevitably on the nature of the new service. Officers wanted to know about the new posts and the arrangements for securing them. Senior management courses for nurses and administrative officers continued at a reduced tempo and duration (shortened to six weeks), and they were renamed 'general management development' courses. The training institutions providing them were also heavily involved in providing courses to prepare senior officers from the merging authorities for impending reorganisation. Well over 1500 officers attended such courses.

The DHSS was being reorganised at the same time, and this included the emergence of the personnel divisions. The personnel function was firmly established at regional, area and district levels in the new structure. The national staff committees were replaced in 1974 by four national staff advisory committees and a National Training Council. Regional staff committees did not survive and the work of the regional staff officer was absorbed into the regional personnel departments. The four committees, for administrative and clerical staff, nurses and midwives, ambulance, catering, accommodation and other support staff, advise the central department on policies and procedures for recruitment and development. The National Training Council advises on general strategy, development and coordination of training, and the common training needs of the different staff groups.

The personnel function – recruitment, training and development, selection and appointment of staff – has undergone many changes since 1948 and the various national initiatives described in this paper have contributed to this. The pace quickened in the past 15 years or so due in part to legislation in employment, the Industrial Training Act 1964[50], and the increasing activity of trades unions and professional bodies. There is now a positive involvement of the central government department where, together with the Whitley Councils, policies are shaped on the advice from the advisory machinery made up of members of health authorities, trades unions and professional bodies. The staff in the service will be looking for solutions to some of their problems from these sources. In particular, it is to be hoped that close attention will be given to the preparation of the top managers of the future.

5 Recruitment and professional development

The previous chapter reviewed the development of government initiative in creating a system of management education to meet the needs described in general terms in chapters 2 and 3.

The professional groups, whether through statutory institutions or their independent professional associations, have also played an increasing role in management education even when this has not been their intention. For most senior managers in the NHS, their professional education and experience have been the dominant influences on their personal development.

This chapter reviews the arrangements for each of the four central professions; at senior management level each team member has a corporate and equal part to play, while at the same time continuing to deal with the distinct functions of his or her own profession. At more junior levels there is a difference in the age at which people qualify as well as a fundamental difference in the nature of the professional vocation. Until their members have reached a high level of experience and skill, the main weight of educational effort for each profession should be separate and distinct.

Although there is a developed programme of recruitment for administrators, there is a serious lack of knowledge about how recruits later perform, and there is no uniform system of selection, training and monitoring such as are available to the Civil Service through the Civil Service Selection Board, or to the armed services, the police or nationalised industries. In view of these process weaknesses, it is not surprising that the quality of general administration is extremely varied.

There is a corresponding lack of information about the characteristics of administrative staff selected for senior posts. Although guidelines were published at the time of reorganisation, there is now insufficient guidance about appointment criteria. Those responsible for filling senior posts should give greater attention to the potential contribution of education for management and of higher qualifications, to which point there is further reference in the following chapters.

In community medicine, the principal problem is the difficulty of attracting and recruiting enough doctors of good quality into the specialty. Although it is known that very few recently qualified doctors consider community medicine as their future specialty, some postgraduate students are attracted at a later date. Why they do so at this stage is unclear and little is known about their reasons, number or quality.

In nursing, there are two problem areas: the fact that no basic management education is systematically provided by any professional institution, and the lack of any set procedure for selecting nurses for senior management as distinct from senior clinical careers. The statutory institutions and the professional associations seem to be aware of the need to investigate the whole subject of career development for senior nursing management and of career satisfaction for senior clinical nurses. Until the many issues are resolved, and responsibilities defined, an acceptable system of education is unlikely to emerge. However, those nurses who opt at grades

7 and 8* for a senior management career will require an education equal to that available to general administrators, perhaps in the form of a diploma or master's qualification.

The Association of Health Service Treasurers is exerting pressure with the aim of requiring all senior members of its profession to have a specified accountancy qualification at an early date. There is, however, still a long way to go and the association requires the support of Government. The knowledge and skills of qualified treasurers also need to be broadened so that they can make a full contribution to the corporate work of management teams.

From this chapter, it can be seen that professional groups are affecting the quality of management to varying extents by influencing the system of professional education. Nevertheless, this still leaves a number of gaps, some specific to one profession and others shared, in the preparation of senior managers.

Professionalism

Since it is this chapter's purpose to consider how the professional development of the various groups contributes to the preparation of senior managers, it is necessary at the outset to discuss professionalism and its implications for a framework of management education. In one sense the term 'professional' can be used in distinction to that of 'amateur' to indicate that a person is specifically trained for a particular task; it is to this first sense that much of this report is directed. But in an extended sense of the word, a profession is a functional group which derives prestige not only from its particular job but from the fact that entry to it is restricted to those with formal qualifications – a restriction that in theory is balanced by the higher standards it also implies. Doctors and nurses, in their clinical roles, and accountants, are professional in this formal sense; and a community physician may achieve additional or alternative status as an epidemiologist, apart from that resting on his medical training. Administrators, however, have nothing like so clear a professional cohesion as do the other three groups.

This chapter includes references to professional development in the second and extended sense, because senior managers in the NHS must have such basic assets as analytical capacity, behavioural skills and knowledge of the NHS – qualities which may or may not have been developed by their earlier training. While, therefore, those who approach closer to senior management positions will always remain dependent on their professional origin for much of their credibility as leaders, they will, after promotion, depend less on the professional expertise which brought them up the administrator's ladder and more on general management skills (technical, human and conceptual), which have been discussed in Chapter 3. It is these coordinating skills which are at the core of general management, whether such management is provided by individuals or by teams. And the foundation for them needs to have been laid much earlier. While professional education is not principally concerned with senior management, it will be hard for anyone to develop such a skill as the ability to conceptualise unless the ground has been laid during his professional development.

Although at certain levels the administrator requires some specialised skills, such as in personnel management or supplies, there is no single body of knowledge which can be taught and applied as 'management'. The implication is that, in looking ahead, we cannot depend on professional groups – or indeed on anybody else – for the introduction of educational criteria to govern the selection of managers, whether administrator, community physician, nurse or treasurer, for the most senior posts. This is a conclusion of major importance for educational strategy, the effects of which will become clear in chapters 6 and 7. However, as we shall argue, the development of potential managers through practice of their distinct professions and study for formal qualifications is the foundation for the later assumption of a senior management role.

We are primarily concerned with the four main professional groups that are involved in the management of the NHS – administrators, nurses, treasurers and doctors. In the last of these groups are included specialists in community medicine at all levels, and representative clinicians at the district level.

The background and training of these groups are, of course, profoundly different, but each passes through a number of stages of preparation from basic qualification until they converge as senior managers. The levels of training required at each stage are not equivalent in each group – thus all community physicians will already know much about the NHS from their medical training, whereas the acquisition of such knowledge is required for treasurers and administrators after joining the NHS. Nevertheless, we have found it useful to assess each profession's current arrangements against a common concept of the stages of preparation through which every NHS senior manager should pass, no matter what his profession.

As described in Chapter 1, at senior management level (that is, district management team, area team of officers, regional team of officers and the DHSS), everyone is

*As described in the Salmon report.[32]

FIGURE 2 Management in Two Dimensions

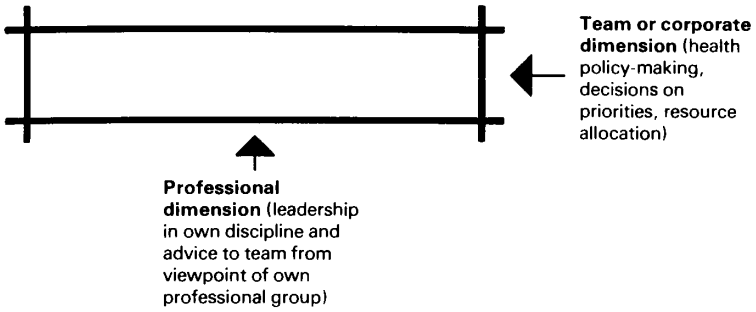
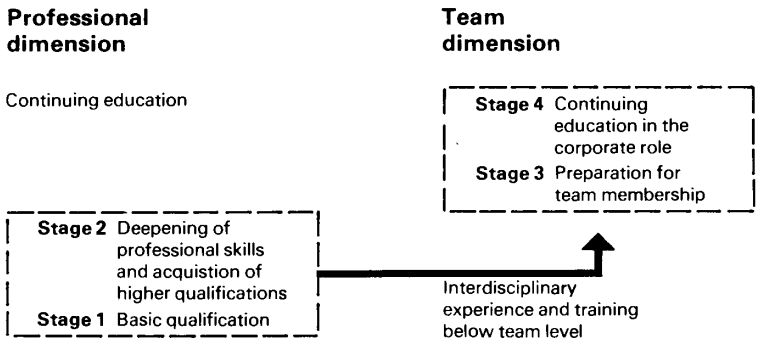


FIGURE 3 Four Stages in Senior Management Preparation



concerned with management in two dimensions (see Figure 2).

In the team dimension, the task is shared and multiprofessional, but each member must first have a solid foundation for leadership in his or her own profession. In the NHS, one never loses the responsibility for maintaining professional expertise and leadership. An army general should lose his earlier identity as, say, an infantryman, but a community physician, nurse, finance officer, or health administrator who wants to serve the NHS well must never cease to develop professionally – he or she takes on the team or corporate role in addition.

Thus, all senior NHS managers must first establish competence in their own professions. Then, while continuing their professional development, they must add a new competence in general management, building upon whatever general management foundation they may already have acquired. Our resulting common concept of senior management preparation builds on the model shown in Figure 1 (page 15) and picks out four stages as crucial for our purposes, as shown in Figure 3.

We shall deal separately with these stages in each of the four professional groups, and assess how far the present arrangements for professional development meet the NHS needs for senior managers, in terms of numbers and skills.

Administration

The information on administrators now in middle and senior management posts is summarised in Figure 4 and Table 2. It shows clearly that a substantial proportion of administrators in senior posts, particularly district administrators, has the possibility of over 15 years further service at team level. Only 54 per cent of administrators who have currently achieved team membership are over 50, and for district administrators the figure is 46 per cent. Of those in 'second-in-line' administrative posts (Grades 23 to 29) only some 40 per cent are over 50.*

These figures highlight two main problems in management development; firstly, the need for special

*The information, including tables and figures in this chapter, has been specially collected by the working party, supplied by the Association of Health Service Treasurers or derived from official sources.

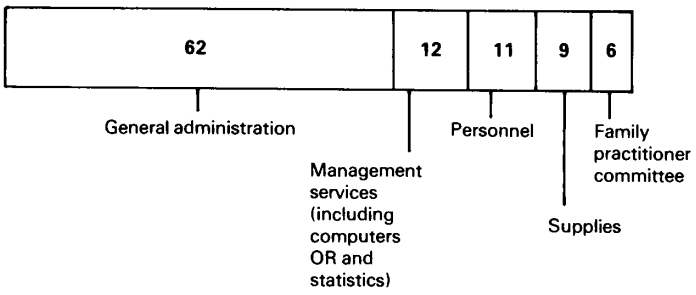
attention to be given to continuing education and revitalising of administrators who are already operating at team level; and secondly, the promotion blocks for second-in-line officers and other junior and middle grade officers who have both the aspirations and the potential for senior posts.

On the other hand, the situation thus revealed provides potential management development opportunities, since it offers scope and time for both a more thorough training of would-be senior managers and a variety of approaches to management development, including long courses and secondments.

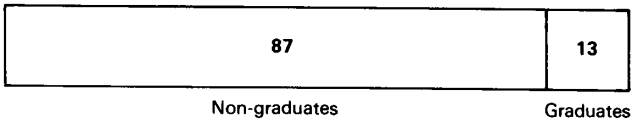
Figure 4 also shows that the number of graduates in scale 9 and more senior posts is very small, and that only a quarter of those in the most senior administrative posts are graduates. Comparative figures for the numbers in these grades who hold recognised relevant professional qualifications (for example, IHSA, IPM) are apparently

FIGURE 4 Administrators

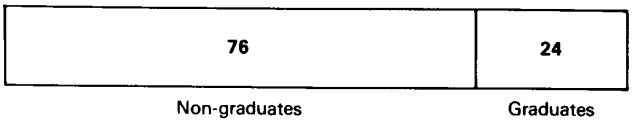
a PERCENTAGE DISTRIBUTION BY FUNCTION*



b PERCENTAGE OF HOLDERS OF ALL POSTS



c PERCENTAGE OF HOLDERS OF POSTS OF 33M AND ABOVE



*England and Wales data 1975, scale 9 posts and above.

Notes:

1 Like the nurses, community physicians and finance officers, many administrators already in top posts have a long time till retirement, showing a need for continuing education/development at the top. This is especially true for district administrators.

2 Administrators include a range of specialist functions but the general administrators are predominant at all grades.

3 Graduates form a relatively small proportion of the total even in senior posts.

TABLE 2 Administrators

a AGE DISTRIBUTION AT 16 OCTOBER 1975

Grade \ Age	20 to 29	30 to 39	40 to 49	50 to 59	60 +	All Ages
Regional and area administrators	–	3	35	53	11	102
District administrators	–	41	45	59	14	159
Grades M, N, 29	20	93	118	162	15	408
Grades 23 and 27	28	72	99	108	12	319
Total	**48**	**209**	**297**	**382**	**52**	**988**

b PERCENTAGE DISTRIBUTION BY AGE WITHIN GRADES

20 to 29	30 to 39	40 to 49	50 to 59	60 +
–	2.9	34.3	52.0	10.8
–	25.8	28.3	37.1	8.8
4.9	22.8	28.9	39.7	3.7
8.8	22.6	31.0	33.8	3.8
4.8	**21.1**	**30.1**	**38.7**	**5.3**

not available and have not been since 1971 and 1972 when the National Staff Committee obtained data on the qualifications and experience of administrative staff. Such data are of course essential for planning management development strategy and should be provided regularly.

Figure 5 attempts to represent diagrammatically a basic career model for the administrator, embracing development in his own sphere and later extension into a more corporate role as he approaches and enters team membership. Further details and explanation of the levels are given later in this chapter. The levels do not imply rigid stages tied to age or grade, but merely indicate the broad framework in which the individual must seek advancement in order to acquire the relevant qualifications, skills and experience for a senior management (team) post. Individuals may be able to pass through different levels at different rates and with differing emphases on the elements indicated, according to ability, aptitude and inclination.

Recruitment and selection

This subject has been discussed in a historical manner in Chapter 4. There are several entry points into the ranks of the administrators.* One is by direct entry at school-leaving age to a clerical or, very occasionally, to an administrative post. Experience is gained by on-the-job training and strong encouragement and help are given to study for qualifications. Another route, described in the previous chapter, is by entry to the junior administrative grade. About 60 university graduates are selected annually from a large number of applicants. They receive training at the centres described as well as being given carefully graduated management experience during the training period. These entrants, too, are strongly encouraged and helped to study for qualifications. There are also late-entry graduates and other entrants with special skills in computer technology, finance or personnel work from both the public and the private sectors.

There certainly appears to be a need for the recognition of these possible routes to the top by recruitment into middle and even senior grades in exceptional cases (particularly into the more specialist posts), where suitably trained people from outside the service may offer a new perspective to health service problems and provide a useful further source of top management potential once they have received suitable training. Obviously, there is a balance to be struck here between encouraging personal development within the service and drawing in talent from outside, especially where there is a shortage of staff with special skills required in the NHS.

A number of those who spoke to us expressed doubts about the present standards of some graduate recruits. The working party was informed that there is no firm information upon the range of their qualifications and later performance on which it would be possible to resolve the doubts, and we recommend in our general conclusions a remedy for this gap in information.

Later, at the time of selection for the top posts, a major problem arises through the lack of definable professional yardsticks in administration and as a result choice may be over-influenced by subjective judgments. Among the objective criteria should be the range and depth of experience and performance at senior levels of management and possession of one or other relevant advanced qualification for management, about which agreed guidelines should be developed.

*See also Appendix C.

FIGURE 5 Preparation and Development of Administrators

Stage	Type of post and experience gained	Formal professional training currently provided
4 Continuing education in the corporate and professional dimensions	**DA, AA, RA** Learning and discharging team role while maintaining skills and responsibility for specifically administrative activities	None
3 Preparation for team membership	**Senior administrative (Scale 14 to 29)** Consolidation of leadership and management experience in one or two senior specialist or generalist posts with management development opportunities	None
2 Deepening of professional skills and acquisition of higher qualifications	**Middle management administrative (GAA Scale 14)** Continuing experience in more senior posts, including some specialist posts (planning, management services, personnel and supplies)	Higher management qualifications (Master's degree — but these are relatively rarely taken at present) Short courses
1 Basic professional qualification	**Trainee and junior administrative (HCO Junior, General)** Variety of general and specialist posts with some supervision	IHSA examinations (graduates and some others excused the intermediate examination) Basic post entry training with elements of induction, theory and supervised experience
Entry	**Entry** from university, from school or from other employment	

Professional training

Whilst the individual line tasks of the senior administrator will vary at different levels in the organisation, his three main roles remain the same.

First, he manages an extensive variety of hotel and support services, ranging from domestic to personnel and public relations services. This is a particularly heavy commitment at the district level. At regional level, where the services managed are less in number and less immediate in their effect on patients, the administrator's tasks are of a more specialist character.

Second, he provides administrative support to the authority (at regional and area level only), to his colleagues in the team and to the services which they manage. As team members become more aware of, and effective in, their management roles, this task could become more onerous. At district level, his tasks include the provision of administrative support to the clinical representatives on the management team and to the medical committee structure ('cogwheel')[28, 29, 34] – a task demanding special skills if it is to be done well.

Third, he coordinates the work of the team, and provides the formal channel of communication for the team. While the emphasis on this aspect may vary from team to team, it represents one of the most important specialist tasks for the general administrator. It leads naturally into his corporate role, for the administrator bears a special responsibility for helping the team reach appropriate consensus decisions on the corporate parts of its activities. Indeed, this aspect of his work is crucial; when conflicts between different professional views arise, it is likely to be the administrator who will have to seek to resolve the problem and enable a consensus decision to be reached. Revealingly, recent public enquiries have held that where responsibility cannot be clearly assigned to someone else, the administrator will be held accountable for what has or has not been done.

These three task areas illustrate the dichotomy in the administrator's role and the difficulty of his management development, in that while he exercises particular influence as the generalist or 'non-professional' in the team, he needs a good deal of specialist knowledge and expertise (professionalism) for his individual tasks. These key individual and corporate roles produce a wide range of tasks which vary in emphasis at different levels in the organisation, but all of which require special training and development.

In later chapters we examine the present arrangements, where they fall outside the scope of the professional institutions.

It seems unfortunate that there can be for general administration no body similar to the Faculty of Community Medicine, although the Institute of Health Service Administrators is the professional body concerned with administrative staff. It aims to provide a good general administrative qualification for health service personnel whatever their basic discipline. The IHSA examinations (even in their revised version [60, 62]) do not seem to us, however, to have more than a limited relevance to the training and development of future top administrators as they cannot hope to provide the same sort of expertise (or status) as the membership examinations of the Faculty of Community Medicine.

It remains a major problem for the general administrator in his team role that, because of his range of responsibilities, he is often seen to be without an easily-defined core of professional knowledge. Our suggestion for his overall development programme looks at a number of different requirements during the four stages shown in Figure 5 and in our basic model (Figure 1).

Stage 1 Basic professional qualification

Following entry, and according to previous education and experience, basic training on schemes like the present regional and national administrative training programmes, and an outline of the history, development and working of the NHS and other health services, should be provided. This should be supplemented by study for a professional qualification such as that of the Institute of Health Service Administrators. During this period, which might last three to four years, the administrator should also be given as part of his management education a variety of on-the-job experience, preferably under supervision. Similar opportunities should be provided for specialists or late entrants so that they can begin to aspire to development promotion in a specialist or generalist field. The multi-unit nature of the NHS, and the fact that it is provided by autonomous authorities, mean that the administrator must seek and obtain this experience by his own efforts. It is essential therefore that there should be an extensive counselling service available.

Stage 2 Deepening of professional skills and acquisition of higher qualifications

Further training in the development of professional expertise in administration in corporate management skills and, in appropriate cases, in specialist functional areas should be included. This could be achieved by a variety of methods but some emphasis should be placed on the acquisition, by full or part-time study, of a higher relevant qualification such as a diploma in management studies or master's degree in one or more of the disciplines relevant to the practice of management. In addition, if practical difficulties can be resolved, the setting up of a number of training posts for administrators, such as the rotating registrar posts in community medicine now being established, would be of great benefit in the development process. One would hope that job experience during this stage (four to five years) would include responsibility for managing specific functions together with general administrative posts and specialist work. The use of

TABLE 3 Community Medicine Specialists

a AGE DISTRIBUTION AT 1 APRIL 1975

Grade \ Age	20 to 29	30 to 39	40 to 49	50 to 59	60 +	All Ages
RMO/AMO	–	4	50	37	13	104
DCP	–	11	63	71	19	164
SCM	–	26	112	117	32	287
Latched on/ transferred	6	30	67	94	55	352
Training	10	18	17	–	–	45
Total	**16**	**89**	**309**	**319**	**119**	**852**

b PERCENTAGE DISTRIBUTION BY AGE WITHIN GRADES

20 to 29	30 to 39	40 to 49	50 to 59	60 +
–	3.9	48.1	35.5	12.5
–	6.7	38.4	43.3	11.6
–	9.1	39.0	40.8	11.1
2.4	11.9	26.6	37.3	21.8
22.2	40.0	37.8	–	–
1.9	**10.4**	**36.3**	**37.4**	**14.0**

semistructured in-house training, possibly with external inputs of the joint development activity type, could also be built into this stage. Again there is the need for opportunities for developing and broadening the skills of specialist officers at this level (for example, managers of support services like catering or work study). The establishment of groups of senior officers, perhaps under the auspices of the regional personnel officer, to provide an information framework and to watch over the career development of administrative officers would certainly be a valuable innovation.

Stages 3 and 4 Preparation for team membership and continuing education thereafter

Before or shortly after selection for a senior management (team) post, there is a need we feel for multidisciplinary corporate training possibly in the form of a workshop or seminar. This is discussed in Chapter 7. Following his selection for a team post, it is important for the administrator to continue his education and training to maintain both his professional development and his new corporate role. This might, as in the case of doctors and nurses, take the form of attachment to training institutions or being responsible for the training of junior staff. For those who have reached the senior ranks, there is a continuing need for personal development which could be helped considerably by attachments to academic institutes, by participating in the education and training of future senior administrators, and by being involved in organisational development projects within their own spheres of work. This could also with benefit involve service in other authorities, such as the DHSS, and secondments to health services in other countries or to organisations outside the health field.

Community medicine

Table 3 and Figure 6 provide disquieting information about specialists in community medicine. As with the administrators, about half those already in post at team level have more than 15 years till retirement. District community physicians, however, are substantially older, on average, than district administrators, and this is even more the case for specialists in community medicine compared with second-in-line administrators. Less than half the specialists in community medicine are under 50. Moreover, the number in training for the specialty (45 people) is very small in relation to the 290 who will be retiring from posts as specialists in community medicine and above in the next 15 years.

In Figure 7 we illustrate the career plan that has developed for this professional group in recent years, as a result of the Hunter report[27] and the efforts of the Faculty of Community Medicine.

Recruitment and selection

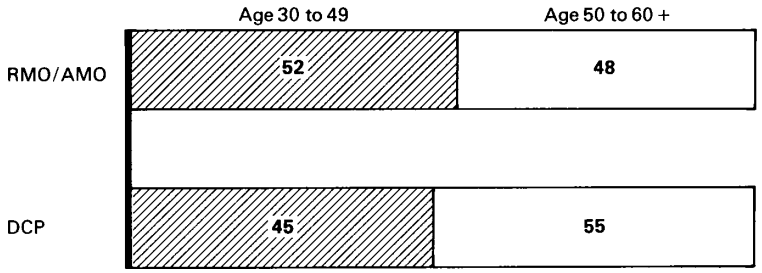
The subject of community medicine does not yet have high status in most medical schools, partly because of its association with old-style public health, partly because the medical student is usually intensely interested in people and thus more concerned with one-to-one contact with individual patients than with the larger issues of community health. The immense contributions made by public health measures in the nineteenth century tend to be forgotten and the preventive aspects of medicine in the twentieth century are much less glamorous than such *tours de force* as cardiac surgery or renal transplantation.

In order to recruit more able doctors to the field, a change in attitude by *all* health professionals is required. The emphasis on care has to be changed to concern with prevention. More questioning of the role of individual medicine has to be introduced at the undergraduate level.

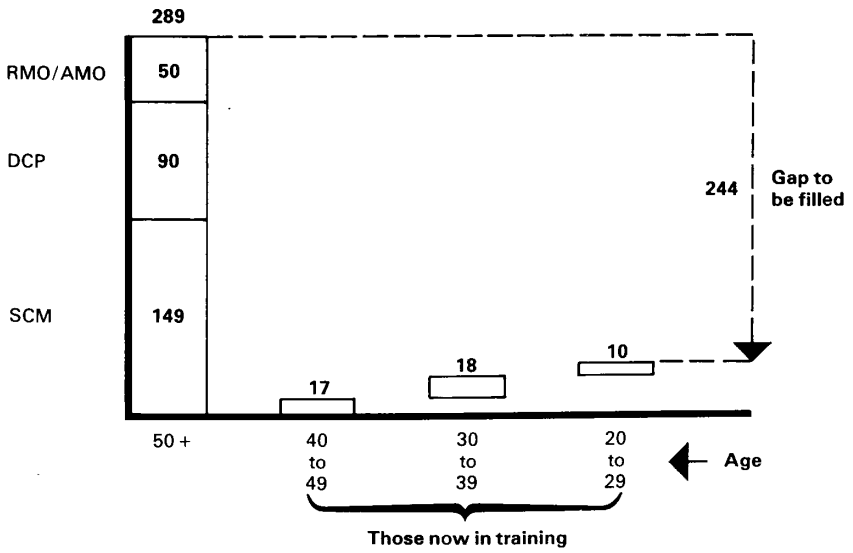
The entrants to community medicine in recent years have been highly motivated and, in general, the standard has been equivalent to that of the clinical specialties. There is, however, a lack of evidence on how and when the entrant is first attracted to this specialty, and upon the question of whether the number of entrants matches the requirement. The selection process to senior posts requires the active participation and intervention of professional assessors. It is hoped that they will apply rigorous standards at the risk of leaving many posts unfilled.

FIGURE 6 Community Medicine Specialists

a PERCENTAGE OF TOTAL BY YEARS TO RETIREMENT



b NUMBERS OF PEOPLE



Notes:

1 Many people in senior positions have a long time to go till retirement, showing need for continuing education and development at the top.

2 There is a shortage of people in training to fill permanent positions when the over-50s retire.

FIGURE 7 Preparation and Development of Community Medicine Specialists

Stage	Type of post and experience gained	Formal professional training currently provided
4 Continuing education in the corporate and professional dimensions	**DCP, AMO, RMO** Learning and discharging the team role while continuing to maintain professional skills and responsibility	Continuing education programme
3 Preparation for team membership	**Specialist in community medicine** Learning and discharging leadership role in the planning and delivery of services	Continuing education programme Fellowship of FCM available by election
2 Deepening of professional skills and acquisition of higher qualifications	**Senior registrar** Increasing responsibility for part of the service, and for a contribution to research	Part 2 of Membership of FCM
1 Basic professional qualification	**Trainee in community medicine** Basic training in epidemiology, medical statistics and so on, and relevant on-the-job experience under supervision	Part 1 of Membership of FCM
Entry	**Entry** to the specialty after basic medical education and qualification	

Professional training

The Hunter report envisaged a new role for those concerned in public health and medical administration. It considered that the major role of the community physician was no longer that of the line manager but was more that of an adviser. The specialist in community medicine was to be concerned mainly with epidemiology and with the assessment of health care needs, although it must be noted that some line management functions remain. While this intention appears, despite some problems, to be nearing fulfilment at stages 1, 2 and 3 (Figure 7), there is still uncertainty at the level of senior manager upon the issue of the extent to which the community medicine specialist in the management team becomes a corporate manager as well as an epidemiologist.

The faculty's role in the training of community physicians is clear. The faculty is part of the specialist advisory committee of the Joint Committee on Higher Medical Training, which itself is in relation with the Council for Postgraduate Medical Education. The objectives of the faculty in education are similar to those of clinical medicine and the procedure for appointments within the NHS follows the clinical pattern. In general,

the faculty recommends a training period of two or three years in clinical medicine after graduation. The trainee community physician is then expected to spend about two years in a registrar grade post where he is taught the basic skills of epidemiology and medical statistics and acquires an appreciation of social science and management theory as they apply to health services. This training may be part-time through modular training schemes which have been organised in the Thames regions, in the Midlands and the South-West, and in the Northern region of England. In addition there are formal MSc courses in London, Nottingham and Manchester which lead to exemption from Part 1 of the MFCM examination. The Manchester course is part-time, the other two full-time. There are other courses, not recognised by the faculty, in Liverpool, Bristol and the Royal Institute of Public Health.

Following the Part 1 examination for MFCM, the trainee will obtain a senior trainee post on the senior registrar grade. In this he will become acquainted with some of the practical aspects of community medicine and may develop a special interest in environmental health, or information services. During his senior trainee period the future specialist in community medicine will also be trained in other aspects of management through attendance at seminars and symposia. Another important part of the senior registrar training is that the trainee has responsibility for part of the service. During this time he will also be expected to complete Part 2 of the membership examination which takes the form of a dissertation or thesis.

Following completion of training as a senior trainee, the community physician will be appointed to a consultant grade post either as a specialist in community medicine in an area or region or as a district community physician. His major responsibilities will be concerned with the assessment of health care needs and the prevention of disease. In his role as officer he has line functions in environmental health. It is important to recognise that there is no hierarchy at the consultant level in community medicine.

The community physician also has specific professional responsibilities for preventive medicine and health education. In these he must adopt the role of advocate and will be competing for resources with other clinical disciplines.

In addition he plays a key role in manpower planning for the clinical specialties at regional and area levels, though it is likely that he will have had little, if any, training in this subject. This is perhaps where the greatest gap exists at the moment, but as this skill will also be needed by nurses and administrators, the gap should be filled by the development of interdisciplinary courses. He will also have a major role in resource allocation and, through his specific skills, will have built up both the means of assessing need and of measuring effectiveness and efficiency. Nevertheless, he will still have to convince his colleagues of his ability to advise on priorities and persuade them of the need to measure effectiveness and efficiency, a problem few clinicians have faced as yet. He can thus play a decisive role in the management teams in decisions on priorities and allocation of resources.

The difficulty in the development of training in community medicine at the moment is that many of those in senior posts have not had the training envisaged by the faculty as necessary for the future. There is thus a discrepancy between the expectations of health authorities of new entrants to the specialty, and of those providing services and acting as trainers for the new entrants. These difficulties will be resolved, but may take time.

Continuing education

The community physician, when compared with his senior management colleagues, is perhaps in a slightly better position to maintain his own professional experience. Most community physician posts have, or will, become allied to teaching institutions. It is thus possible for the community physician to retain his academic links and nurture his ability to question and investigate problems. This does not necessarily ensure, however, his continuing education in the acquisition and discharge of corporate management skills, as a member of the management team.

Nursing

The statistics available on nurses and midwives in senior administrative posts are summarised in Table 4 and Figure 8. Points of interest are the substantial time that many top level administrators will have at this level, since most are under 50, and the variation in age structure by region. The opportunities for promotion of those holding second-in-line posts are much greater in some regions than others. Below this level there are – in marked distinction from the community physicians – very large numbers of middle managers who are potential recruits to the top.

In Figure 9 we have attempted to map the career plan for senior nurses which is necessarily complex because they may, at the middle management level, take any one of three main routes upwards; through clinical nursing, through teaching and research, or through nursing administration.

The introduction and application of a clearly defined system of line management following acceptance by the nursing and other health professions of the recommendations of the Committee on Senior Nursing Staff Structure [32] and later those of the Mayston working party[12], effected fundamental changes in the organisation of institutional and community nursing and nursing education, as well as exerting an influence well beyond the profession.

The new NHS management structure established the chief nursing officer as a member of the management in

TABLE 4 Nurses and Midwives

a AGE DISTRIBUTION AT 30 JUNE 1975

Grade \ Age	20 to 29	30 to 39	40 to 49	50 to 59	60 +	All Ages
RNO/ANO	–	2	36	40	1	79
DNO	–	11	67	54	2	134
Second-in-line region and area	–	44	100	57	3	204
Second-in-line district	1	78	238	215	9	541
Total	**1**	**135**	**441**	**366**	**15**	**958**

b PERCENTAGE DISTRIBUTION BY AGE WITHIN GRADES

20 to 29	30 to 39	40 to 49	50 to 59	60 +
–	2.5	45.6	50.6	1.3
–	8.2	50.0	40.3	1.5
–	21.6	49.0	27.9	1.5
0.2	14.4	44.0	39.8	1.6
0.1	**14.1**	**46.0**	**38.2**	**1.6**

her own right and required from all the disciplines concerned a true understanding of – as distinct from the payment of lip-service to – her management functions, including delegation and control, coordination, communication, authority and responsibility and the use of sapiential authority. The subsequent teaching of such topics on management courses often left nurses feeling that what they heard was not very relevant to their work.

At the middle and upper-middle levels of nursing management, emphasis is now increasingly being placed upon the professional and clinical as well as the managerial content of the work, since in some situations the former yield the higher satisfaction and may be the dominant elements in the job. The nursing officer and certain senior nursing officer posts (as commended by the Salmon report[32]) were intended to be developed in both directions to benefit from, and take account of, individual skills and preferences. For a variety of reasons this development has not happened and the current debate concerning the role of the clinical nurse specialist/ consultant points to a need for the nursing profession to clarify its own views on the proper roles of the nursing officer and senior nursing officer.

The last ten years have yielded valuable experience and have produced some skilled and perceptive nurse managers. Whether the present system can develop the sort of leaders needed is a question to which nurses are giving a great deal of thought, for the senior nurse in management is also a professional leader. Representatives of the nursing associations and statutory bodies made this point very clear in their discussions with the working party, and the Royal College of Nursing put before us an important memorandum on the subject. It is the view of the working party that no satisfactory system of management education for nurses can be created until the debate reaches a conclusion.

One matter which is clear is that in nursing, as distinct from the other professions, selection for management is an issue of far deeper importance than recruitment. Moreover, in the case of nurses, selection is strongly influenced by training at basic and lower levels.

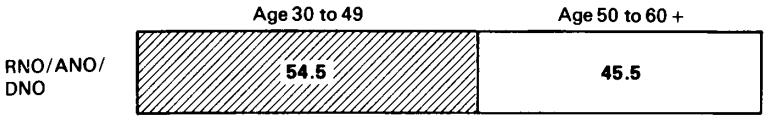
Career development and selection

The task of senior nursing management is a matter of balancing and reconciling the values and aims of the organisation with the values, aims and professional aspirations of the nursing staff and of related and interdependent groups of health professionals, while creating and gaining commitment to a wider concept of the service and of the nurse's role in it. The balancing and reconciling of organisational, occupational, service and educational demands with individual aspirations and expectations are delicate but essential if all available resources are to be optimally deployed. Success in the latter marks out an effective manager, though it is difficult to measure this success. Nor is it easy to sketch out a career progression for such leaders which permits flexibility and takes account of the individual. In the past, nurses have moved into senior management positions partly by accident, partly by choice and design. Preparation has varied widely but during the last eight to ten years efforts have been made to rectify this by the pattern of management training set out in Chapter 4.

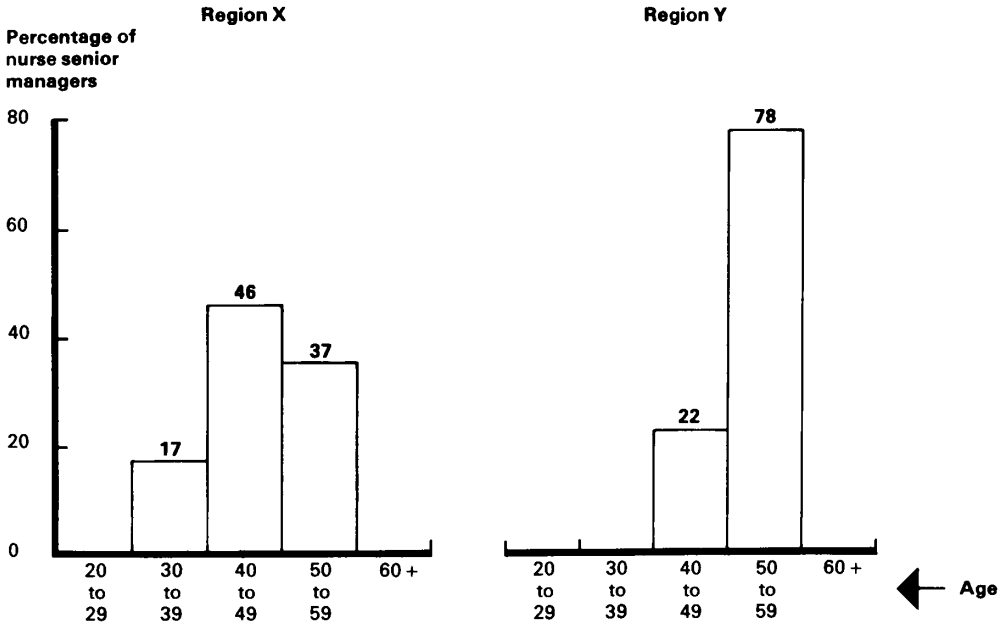
What appears to be needed now is a flexible system permitting professional and clinical nursing and management to proceed together until the point at which managerial development becomes the dominant element

FIGURE 8 Nurses and Midwives

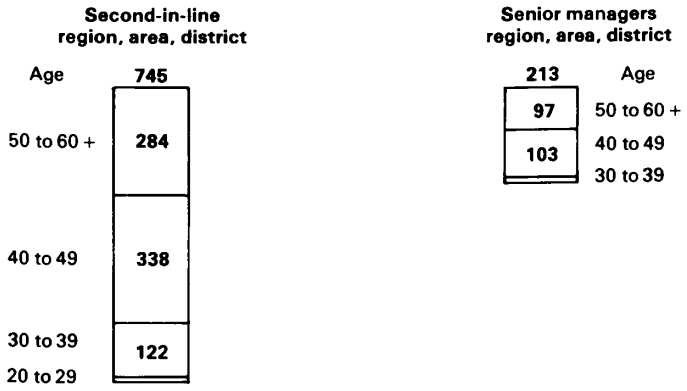
a PERCENTAGE BY YEARS TO RETIREMENT



b VARIATIONS IN AGE STRUCTURE BY REGION



c NUMBERS OF PEOPLE TO FILL SENIOR POSTS



Notes:

1 Over half the senior nursing managers have more than ten years till retirement.

2 There are more than enough second-in-line nursing managers to fill senior posts when they fall vacant.

FIGURE 9 Preparation and Training of Senior Nursing Managers

Stage	Type of post and experience gained	Formal professional training currently provided	
	DNO, ANO, RNO		
4 Continuing education in the corporate and professional dimensions	Learning and discharging team role while maintaining professional roles. For ANO and RNO shift to advisory and consultancy role from operational	Little formal training at this level	
↑			
3 Preparation for team membership	**Senior** divisional nursing officer and director of nurse education	Increasing opportunities to take post-experience nursing degrees and various medium to short management courses, but preparation for corporate management is inadequate	
↑			
2 Deepening of professional skills and acquisition of higher qualifications	**Middle management** a senior nursing officer and nursing officer and tutoring posts in nursing, midwifery and health visiting	**Clinical Education** midwife, health visitor and various other specialist courses, statutory and non-statutory	**Management** various multi-professional management courses
↑	b first line management posts in a choice of role with primarily clinical emphasis (ward sister, charge nurse, health visitor, midwife)		
1 Basic professional qualification	**Post-qualification experience** **Staff nurse** Training 4 year (degree linked) 3 year (other students) 2 year (pupils)	State registration or enrolment and post-qualification experience	
↑			
Entry	**Entry** at minimum age of 17 ½ to 18 (Educational qualifications vary among the nurse training schools, but all aim at a reasonable all-round secondary education)		

and it is necessary for the individual to expand and increase knowledge and experience in that area and in the relevant and changing aspects of its practice.

Training for management

It is accepted that ward sisters and charge nurses shall undertake a short course in management either immediately before or very soon after appointment. This provision is being extended wherever possible to include staff nurses. The group as a whole probably forms the largest in the NHS requiring management training: both the Salmon and later the Briggs reports draw attention to the numbers involved.[32, 54] The backlog is being reduced and the numbers requiring line management courses are presumably known to AHAs and RHAs through their personnel and manpower planning divisions. However, the extreme mobility and wide range of age and experience in this group make accurate planning difficult and figures need constant review to ensure that demand and provision match up. Demand from disciplines other than nursing has to be met as well.

It is less easy to be precise about the numbers for whom provision must be made and to identify gaps in the provision and preparation in middle management (that is, nursing officers and senior nursing officers). One of the constraints on senior managers is the criterion of grade for acceptance on courses at middle and senior management level; the post *held* is considered rather than ability and potential. This criterion precludes some able potential nurse managers from taking a senior management course at a time which would be beneficial, and may involve others who have a vocation for a clinical rather than a management career.

Unlike the other professions, nurses (unless they have taken a relevant academic course) have no organised professional system of education which is directly linked to management development. They rely on courses with unbalanced participation, provided or supported by the NHS, instead of a system at middle management level designed specifically to meet their own needs.

In addition to the contribution required from such a system, senior officers have a major responsibility (as do the other disciplines) for the inservice development of their junior colleagues.

It is essential that middle and upper-middle nurse managers are enabled to operate satisfactorily in both professional and management roles. It is the responsibility of the senior nurse manager at whatever level – district, area or region – to facilitate this. In practical terms, all must be concerned with maintaining safe and acceptable standards of professional nursing care in the service, promoting and developing nursing practice, ensuring that the standards and requirements of nursing education and training are met, providing an appropriate working environment for nurses and, finally, giving objective advice on all these matters and their implications to colleagues of other disciplines.

The senior nurse manager, therefore, has to achieve a balance between these requirements, and particularly between her nursing role and her corporate responsibility, as a member of the management team. Moreover, as she moves away from the operational level (from district to area, region or the DHSS) her role changes sharply towards an advisory and consultancy one, requiring different attributes from those she has required earlier in her career.

The skills needed for all disciplines in the team touched on earlier in this chapter and discussed more fully in Chapter 3 are particularly relevant to nurses. They are probably weakest in the numeracy, analytical and conceptual skills. These are essential for participation in corporate planning to which the senior nurse manager must make her own particular contribution equal to that of her team colleagues. Nurses must also possess the ability to discern potentially sensitive areas and be aware of the changing political, social and economic climate in the health service. Finally, they must have sound judgment, be prepared to take decisions, and be able to explain them.

In Chapter 7 we make proposals for multidisciplinary preparation for corporate management, and suggest that the main approach to the development of the conceptual skills required for top management is through academic learning; so it may be relevant to note that the number of graduates entering the profession through university nursing courses can be expected to increase gradually over the next decade. A list of degree courses now available to nurses is given in Appendix D, page 89.

Opportunities for nurses to study for higher degrees are also growing and, though no accurate figures are available, the numbers achieving or undertaking courses of study for MSc or PhD are steadily increasing. Financial support for these nurses is one of the problems, and it is essential to promote more opportunities for a greater number to undertake a period of higher academic study.

During discussion with nursing organisations, consideration has been given to whether directors of nursing require relevant preparation in the management of the educational function which is critical to the professional wellbeing of any organisation. We make no special suggestions but the point needs further consideration.

No single model can take into account the multiplicity of professional choices open to nurses which influence the individual's ultimate career direction. However, a career in nursing should be regarded as a whole rather than as a series of separate parts. Otherwise the parts become disjointed rather than representative of a planned progression, and skills may be wasted.

We note that a way should also be found in any career model to take account of those who leave nursing but who wish to re-enter at a later stage when circumstances

TABLE 5 Finance Officers

a AGE DISTRIBUTION AT 30 JUNE 1975

Grade \ *Age	35-	35 to 44	45 to 54	55 to 59	60 +	All Ages
† Senior managers (scales A to O)	41	62	100	52	34	289
Senior finance staff (scales 18 to 29)	131	62	79	38	13	323
Middle level finance staff (scales 9 to 14)	141	81	159	80	23	484
Total	**313**	**205**	**338**	**170**	**70**	**1096**

plus vacancies **161**
total posts **1257**

b PERCENTAGE DISTRIBUTION BY AGE WITHIN GRADES

35-	35 to 44	45 to 54	55 to 59	60 +
14.2	21.4	34.6	18.0	11.8
40.5	19.2	24.5	11.8	4.0
29.1	16.7	32.9	16.5	4.8
28.6	**18.7**	**30.8**	**15.5**	**6.4**

* The age bands for finance staff are different from those of the other three groups of staff.

† Includes regional and area treasurers and district finance officers, and some second-in-line posts in larger regions.

permit them to do so.

Finance

Information about the ages and qualifications of finance officers is summarised in Table 5 and Figure 10. The problem they highlight is the shortage of professionally qualified accountants. A quarter of those in top posts lack a full accountancy qualification, while more than half in the service who have such a qualification are already in a top post.

In Figure 11 we sketch the career plan for the treasurer and finance officer in the NHS.

Selection and training

At present, the arrangements for recruitment and training of treasurers are uneven and lack coordination. This is not surprising when one realises that the DHSS and the health authorities have been slow to accept the need for finance officers to be professionally qualified. Recruitment of treasurers to senior posts has been made difficult because of the relatively small number of senior finance staff with a professional accountancy qualification. The finance departments are manned in the same way as administrative departments; promising recruits are given every encouragement and assistance to study for a professional qualification, though the response has been disappointing. Regional schemes directed to recruitment of young people leaving school for careers in finance in the NHS have shown better results. As in many other public services, most senior people in the service have worked their way up and obtained their qualifications while doing so. The national training scheme for graduate finance recruits began only recently, with four recruits in the first year and a build-up to 15 in subsequent years. There is little experience so far with this national form of training, and the view of the Association of Health Service Treasurers is that it may remain weighted towards administrative rather than financial manpower objectives.

The main problems of the treasurers are to raise and maintain standards of those who hold senior finance posts in the NHS, as well as to broaden their understanding of health service problems and health care needs and options. The policy of the Association of Health Service Treasurers is to assume that all district finance officers and area or regional treasurers should hold an appropriate accountancy qualification, deemed to be that recognised by either the Chartered Institute of Public Finance and Accounting, the Institute of Chartered Accountants or the Association of Certified and Corporate Accountants.

It is clear that for finance officers, as for the other disciplines, there are three stages of training.

The first stage should include a foundation course followed by sandwich courses and inservice training covering a four-year period up to obtaining an

accountancy qualification. In this period, there should be rotation of posts to cover both management and financial accountancy and initial job training together with health service orientation. It is hoped that this mixture of technical courses and inservice training will eliminate the problem of finance officers with wholly technical training being frequently out of touch with the practical requirements of the NHS.

In stages 2 and 3, senior management levels, two options open up for finance officers – they can concentrate on the professional or on the management side. To a certain extent, training requirements will be common and will inculcate the skills of senior management in a multidisciplinary organisation. The level of the individuals will determine whether such training should be used for the purpose of merely appreciating the management skills required, or of understanding them in greater depth. When professionally qualified and available through experience for selection to a senior post, treasurers, like members of other disciplines, need serious and deliberate instruction to give them a full grasp of their coming corporate and strategic role.

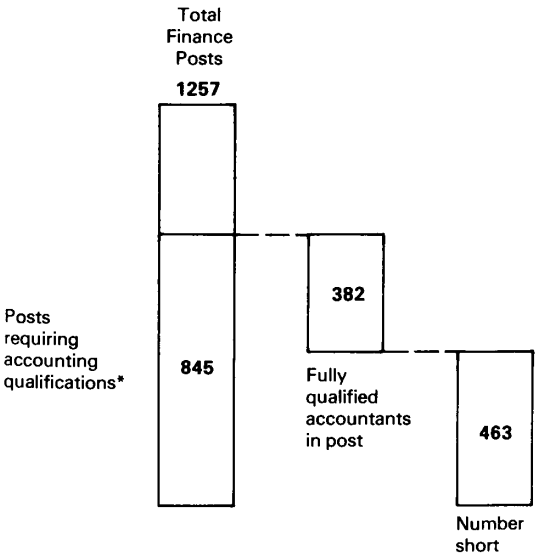
Continuing education

In the long period of active working life after first appointment to a senior post, it would seem that two types of continuing education are needed which are not at present being provided (according to a pattern certainly applicable also to administrators and probably to nurses and doctors).

One type is the multidisciplinary course of substantial length which gives the opportunity of studying the NHS in the context of the national economy and of policy options for the future. Such courses should include speakers at the highest levels from industry, commerce and the universities as well as the NHS. Those attending should probably be selected by a special panel, who would assess their suitability objectively.

The second type is the finance course for those with accountancy qualifications to provide the opportunity to consider the financing of the NHS in the context of the nation's economy, and to open up discussions concerning economics, funding, financial planning and the operation

FIGURE 10 Finance Posts Requiring Accountancy Qualifications, Number of Qualified Accountants in Post and Number Short



*In the opinion of the Committee of Regional Health Authority Treasurers.

Notes:

1 There is a shortage of qualified accountants in the NHS.

2 Of the senior managers (scales A to O) in post, a quarter lack a full accountancy qualification.

3 Of the 382 fully-qualified accountants in the NHS, more than half are already in senior management posts.

FIGURE 11 Preparation and Development of Treasurers and Finance Officers

Stage	Type of post and experience gained	Formal professional training currently provided
4 Continuing education in the corporate and professional dimensions	**DFO, AT, RT** Learning and discharging team role while maintaining accountancy skills and responsibility for all financial matters	Various activities in continuing education by the accounting bodies, but little specific to the NHS or with corporate management emphasis
3 Preparation for team membership	**Senior** Consolidation of leadership and management experience in the finance department of district, area or region	NHS finance officers can attend NHS management development courses, and a range of postgraduate accountancy courses, but there is a lack of provision to broaden people in NHS finance and sharpen their skills
2 Deepening of professional skills and acquisition of higher qualifications	**Middle management** Continuing experience, with increasing responsibility for a finance function	
1 Basic professional qualification	**Trainee and junior**	CIPFA and other recognised accountancy qualifications Induction training
Entry	**Entry** from other employment, school or (in a few cases recently) from university with a suitable first degree	

of the Treasury. Such courses should provide an opportunity to mix with accountants from other public services, commerce and industry, in order to learn and discuss new management techniques. There should also be special selection for these courses. These last two needs, though recognised and identified by the professions, lie outside the scope of a professional association and demand the attention of the NHS or of independent institutions.

The clinician

At present most clinicians have no management training at all. Those who are elected to district management teams by their colleagues have to find their own way into the difficult role they are asked to fill, which is in part that of members of a corporate management team, and in part representative. In many cases they have barely come to terms with their role before their term of office ends. Yet they play a crucial part in the quality of the team's decisions and in its ability to gain support for its actions.

By the time the clinician becomes a member of the team he has had considerable practical experience of the NHS, though inevitably he knows his own specialty much better than any other part of it. During his undergraduate and postgraduate training he will have had some education in epidemiology, medical statistics and the behavioural sciences. Despite his lack of any specific management training, the clinician probably controls more resources than any other manager in the NHS. As houseman or registrar, he has to learn to handle teams, to schedule

activities and to coordinate tasks. Usually he learns this by example. If he becomes a general practitioner, he has to develop some grasp of management if he is to make sufficient money to pay for his activities as an independent contractor, particularly if he works in a group practice or health centre. More broadly, GPs and consultants are the crucial arbiters of how resources are used, through their clinical decisions.

An increasing number of attempts is being made to deepen clinicians' awareness of their role in the use of resources. This was the thrust behind the 'cogwheel' reports and the organisational arrangements they recommended.[28, 29, 34] The King's Fund and others have run short management appreciation courses for consultants and senior registrars for some years, and future general practitioners are concerned with management matters during vocational training. Recently, courses have been mounted for junior medical staff in health care administration.

In the future, medical students will increasingly be expected to understand the concepts of community medicine, and clinicians may become more aware of the need for greater appreciation of management skills. No doubt short courses will continue to be available for this latter purpose. The participation of registrars, senior registrars, consultants and general practitioners in some of the interdisciplinary courses during the second and third stages of training described earlier in this chapter should be promoted. In addition, however, we believe that there is a specific need for clinicians who are elected to management teams to be prepared for their team management tasks in advance. Experiments towards this end should be attempted. (There is also a parallel, though different, need – referred to briefly below – for members appointed to health authorities.)

Certain senior clinicians will be called upon for advice at the highest policy level, and should therefore participate as far as is practical in seminars and other arrangements made for the continuing education of top NHS managers.

Other disciplines

Apart from the four professional groups discussed above, there are of course many others who share in the management of the NHS. Among these are the disciplines associated with building, the works officer being a member of the senior management team at regional level. More broadly, as the number of professional groups involved in health services increases, the range of different professionals involved in leadership roles grows proportionally. Not only, therefore, must many people manage major specialist departments, but increasingly they are likely to be asked in addition to play a coordinating role among departments and professional groups. All need preparation for their management role, should understand the problems of other disciplines, and participate in a wider consideration of the provision and management of health services. Similarly, it is important that the senior management teams should be exposed to the viewpoints of those who lead these many other disciplines.

The management education task raised here is outside our terms of reference. Management education in the NHS is rightly concerned with far more people than the staff who form the senior management teams to which we were asked to address our attention. Nevertheless, we believe that if senior managers of the four professional groups which make up the teams can be more rigorously prepared for their role than in the past – which is what we from our perspective see as the first priority – it will be found practical to apply the lessons learned to the management education of the other disciplines.

Members of health authorities and community health councils

We are aware that members of health authorities and of their 'consciences', the community health councils, deserve help from the educational system in order to prepare them to undertake the responsibilities entrusted to them. The working party has not had time to undertake a study of this requirement which must properly be left to the initiative of members of authorities themselves or of independent bodies. It is our belief that if the policy and mechanisms of education and training for those in NHS top management are soundly based, they will also meet, without distortion or much further expense, the needs of members. We can envisage short courses designed specifically for members but based at the same educational institutions attended by senior officers with whom joint training activities could then be arranged.

Conclusion

The arrangements of the professions for recruiting, selecting, educating and developing their members crucially affect the quality and preparation of senior managers in the NHS. In this chapter, we have reviewed these arrangements and called attention to certain problems which are different for each profession. For senior administrators there are difficulties in establishing high enough standards of qualifications and training, because the core of administration is hard to define and present training concentrates more on the needs of middle than of senior managers. By contrast, specialists in community medicine now have a clearly established training programme, but their problem is one of insufficient numbers in the training grades. Moreover, since few of those now in senior posts have undergone the training that has now evolved, there is sharp variation in the way they approach their job and in the skills and experience they can bring to bear upon it. The nurses are grappling with the difficulty of establishing a range of career choices for senior nurses which includes clinical, educational and administrative options. For those nurses who come to senior management posts by any of these routes there is a need, comparable to that of the administrators, for more rigorous educational preparation in management. Finally, the key needs of the finance officers are for accountancy qualifications as a

prerequisite for senior posts, and for continuing and broadening postgraduate education after basic qualification.

Thus, there are problems in each profession to which we return in Chapter 7 when we discuss the strategy that we believe the DHSS and NHS should follow in senior management education. Also, as we discuss there, the responsibility of each profession only goes so far in senior management training, since this is not the profession's primary concern and senior NHS management is by definition multiprofessional. Some members of each professional group must learn the corporate management role, and once they have become members of management teams, their continuing development and renewal in this role of consensus managers are as important as their continuing education in their own professions.

6 The role of higher education

We have seen in Chapter 5 how the professional groups have evolved systems of professional education which contribute something towards the education of the senior manager but still fall short of covering all that is needed. Before coming in Chapter 7 to a comprehensive view incorporating the service's responsibilities and to the implications for policy, this chapter examines the role of the universities and other institutions of higher education.

The contribution of such institutions is, firstly, the education of the graduates from whom an increasing proportion of NHS managers are recruited as well as the postgraduate programmes to meet their vocational needs; and, secondly, to develop research. Achievement in either field is very often beneficial to the other. **Policy should be framed to recognise this fact and to make best use of the resources available in higher education.**

Undergraduate students potentially interested in a career in NHS management as well as those ambitious for higher educational qualifications should be encouraged to take recognised courses of study by better information. Those concerned with recruiting and promoting managers should also have information available about the value and relevance of university and other courses, although graduates of merit should be welcome recruits whatever their discipline. The working party could not attempt a comprehensive study of research and educational programmes, **but considers that such a study should be commissioned as a matter of urgency in order to make better information available to all concerned, and as a precursor to policy formation.**

In view of the number of graduates now entering the non-medical as well as the medical ranks of the NHS, non-graduates may in future be at a disadvantage in competing for top management posts. **Opportunities should be created for staff with up to five years' service to compete for a limited number of awards of leave and expenses,** to enable them to take relevant first degrees or diplomas. To fill the gaps in higher professional education for administrators and nurses, **there should also be a competition for those entitled to study leave to take recognised courses leading to postgraduate degrees.** Others so entitled should be enabled to take up research or teaching assignments. Sufficient reference is made to current programmes to show that facilities are available with little or no extra cost to meet such requirements if a strategy of support and coordination is adopted.

Sanction for senior managers to take study leave, which is sporadically given by health authorities, should be more openly recognised and organised.

Concept and practice

The universities, polytechnics and other institutions of higher education have the functions of advancing knowledge through research and the development of disciplined intelligence. They can therefore make a major contribution to NHS management training

by providing

a pool of graduates from whom future senior managers might be recruited and developed

postgraduate programmes offering advanced training in skills relevant to management and

teaching based upon research, which university staff in particular have a contractual obligation to undertake, and upon knowledge about vocational fields, which is developed on a scientific basis during the supervision of students' field work.

Graduates and management succession

A general assertion of the value of an academic education in a vocational context has to be balanced by the recognition of its limitations. Nobody can become a good manager through education alone; experience and the ability to benefit from experience are essential. Moreover, effective management requires certain qualities such as energy, ambition, tenacity, initiative and sensitivity which cannot be taught and without which the most gifted intellectual will fail as a manager. High academic ability alone cannot be regarded as a qualification for management. To believe otherwise would be putting the institutions of higher education in the position of dispensing patronage.

Nevertheless, graduates are regarded as possessing management potential and since the 1944 Education Act[48], industry has looked to the universities in particular to provide for management succession. The post-war years witnessed a proliferation of management training programmes in industry aimed at the recruitment, selection and training of graduates. The movement was reflected also in the NHS. Before the NHS, with 3000 independent autonomous hospitals, there was no organised management structure to provide a career in this field and few graduates entered hospital administration. The NHS created large-scale hospital organisation overnight – as in 1974 its reorganisation superimposed health service organisation.

The need for management training, and the need to ensure that the NHS attracted its fair share of graduates were recognised at the outset. After a report by two senior civil servants (one lay and one medical)[9], and once staff interests had been satisfied that legitimate promotion expectations of administrative staff (largely non-graduate) absorbed by the new NHS would not be threatened (which took some years), the NHS emulated industry and launched a management training programme aimed at recruitment and training of graduates. In fact, the first scheme was far in advance of industrial graduate training programmes since it was based on a joint NHS-university venture. With the active help of the late Baron Stopford (then vice-chancellor at Manchester, and a founder member of the Manchester Regional Hospital Board) and following initiatives by the University of Manchester and Ministry of Health officers, a diploma in social administration (hospital administration) was established in the department of social administration, with a newly-created chair taken by Professor T E Chester in 1955. The course was open to new graduates and non-graduates who had shown ability while employed in the hospital service. One year's supervised fieldwork was followed by a full year's academic study of disciplines relevant to management and set in the NHS context. A diploma was awarded after examination. Besides being open to non-graduates already in the service, the scheme protected staff interests further; it restricted intake to one-third of the annual actual requirement and guaranteed trainees nothing more than continued employment on training grade terms. They had to compete for advertised posts. The scheme flourished for a decade and it has been said that those who passed through it subsequently did well. It would have been surprising had they not. The whole venture, by offering what in effect were bursaries, provides a precedent for any official scheme enabling non-graduates to obtain a university qualification.

In the mid-1960s intake to the National Training Scheme was enlarged and the academic year was reduced to three months, thus removing the possibility of awarding a diploma. There were various reasons for the changes, of which the two most important were, firstly, the feeling in the National Staff Committee that young trainees ought not to be kept so long from real responsibility and, secondly, the unease that undoubtedly existed about élitism in a public service.

Since the early initiative at Manchester, an increasing number of social science faculties have offered honours degree courses where the options available can be put together in an approximation to the model indicated in Chapter 3 and are likely therefore to equip the student for NHS management in a very effective manner. Such a syllabus can, for example, give a basic knowledge in the first year of sociology or social anthropology, government, economics, quantitative methods, and accounting; lead on in the second year to optional specialisation in two of these disciplines with a course on social policy and health services as an option; and conclude in the third year with studies of social administration, accountancy or statistics oriented to health services. Graduates with such a background should have a considerable advantage if they enter the NHS, and their contextual knowledge would often be in advance of that at present given during short inservice courses for potential managers. A number of universities would be capable of offering degree courses of this type, including Birmingham, Hull, LSE, Manchester and Nottingham; but the exact combination of options is not often taken as there is no inducement to the student to influence him towards a career in the NHS.

The school of social sciences of Brunel University also offers four-year undergraduate sandwich courses. Although no academic course in health administration is offered, subjects relevant to it, including social policy analysis, are available to students in their third and fourth years. Many students undertake a wide range of work in health authorities as part of their supervised work placement lasting four or five months in the first three years of the four-year course.

Despite these opportunities, few of the 500 graduate administrators who have entered the NHS as a result of the introduction in 1956 of the National Training Scheme or through local recruitment, deliberately studied subjects

relevant to management.

An important development in recent years has been a rapid increase in the opportunities for nurses to obtain degrees. For example, the Manchester degree course is approaching the end of its first decade and now has an intake approaching 50 students a year. Social administration and sociology are among the subjects studied. It may develop into an honours degree, and other degree courses are planned elsewhere. In addition, a significant number of experimental courses is in progress combining the SRN qualification with a social science degree. In all, from 100 to 150 nurses sit for degrees each year already and the number is increasing. Even if much of the content of these courses is not directly related to management, they offer the opportunity for training in disciplined analysis which is much to the advantage of the NHS, and of the student nurses, whether or not they later opt for a career on the management side.

As for those who seek a career in financial administration in the NHS, they originally had to face the same advantages and disadvantages as those interested in general administration. Today recruitment and professional advancement are becoming geared to recognised accountancy qualifications, the teaching for which is for the most part dependent on the polytechnics. In addition, it is understood that preliminary consideration has been given to the establishment of a full university degree in accountancy which would contain sufficient relevance and vocational experience to justify complete exemption from all stages of the examination for the professional qualification.

Vocational use of postgraduate qualifications

Traditionally, graduate courses at academic institutions are based on one or two-year diploma or master's degree programmes. The orthodox use of the master's degree is to fit the student as a master of his discipline for teaching and research in it, but a thesis is not always required and the course can be used as a conversion course, though usually at an intended higher level than that for a diploma.

Diploma courses can provide either advanced study or conversion opportunities for graduates from other disciplines. For non-graduates, diplomas can be used as a short cut to gain some of the benefits and some of the status of a degree.

However, the period of study normally required for postgraduate academic qualifications is longer than many employers may be willing to countenance when considering the release of their staff for such training. Moreover, the educational institutions do not find it easy to provide postgraduate courses for non-graduates. For example, following the withdrawal of the diploma course from the NHS National Training Scheme, trainees were given the opportunity of obtaining a postgraduate qualification in hospital administration at Manchester and an attempt was made to provide a postgraduate course for serving officers aged over 30. The attempt failed because few of the officers at that time were graduates and the university, which for a decade had admitted young non-graduates to its diploma course, could not be expected to offer a postgraduate course exclusively for non-graduates. Diploma courses directly oriented to NHS management were later established and still continue at Leeds and Aston universities, but without support from the DHSS.

Given that the NHS did not expand its graduate intake significantly until the late 1960s, the questions of duration away from work and entry requirements remain major considerations in the future development of academically-based management training for the service. While existing staff organisations have not seriously opposed the recruitment of graduates as such, they might reasonably oppose NHS support for management training programmes to which non-graduates were denied access. We shall return to this point later and suggest a solution designed to ensure that the non-graduate recruit suffers no unjustified disadvantage when competing for senior management posts.

Of the disciplines involved in NHS management, community medicine is distinctive in that it is the only one in which professional and academic education are well integrated. The universities' traditional commitment to vocational training in public health has been extended to community medicine and a specific responsibility has been accepted through the consortia established by groups of universities. Others have established master's degree programmes which carry exemption from part of the Faculty of Community Medicine's membership examination. Moreover, as the DHSS-funded research effort has been based largely on medical schools, there has been some matching of the location of the research and training support. Thus, community medicine comes closest to satisfying our criteria for an education and training strategy for NHS management.

For the other disciplines, the postgraduate provision is far less well developed, although a considerable variety of courses relevant to the NHS is at present on offer. Most emphasis has been placed on master's degrees, and there are reasons for this.

1 For those who entered the service as graduates, though the first degree has probably ensured an acceptable level of intellectual discipline as an initial qualification for a potential top manager, intellectual skills nevertheless need to be steadily sharpened at a higher level and by the demands of 'relevance' as the career develops.

2 Research into management in general, and NHS management in particular, is of prime importance to the NHS and should be a significant academic activity in universities of which higher degrees are a natural concomitant.

3 If in time a postgraduate qualification became more usual as a hallmark of a top administrator, the status of

NHS management as a whole would be enhanced.

4 For many a budding top manager such a qualification would be an assurance of his personal and academic standing and prestige among his working colleagues, especially vis-à-vis doctors with their fellowships and memberships.

5 For those managers who wish and are able to take study leave for as long as nine to twelve months, the master's degree course is the most satisfactory (and economical) method of obtaining an appropriate postgraduate qualification, provided that their purpose is to continue in management afterwards rather than take up teaching or research.

A further argument is that, as long as there is a relatively large proportion of non-graduates amongst potential and actual top managers, there is a need for a qualification which gives an intellectual training equivalent to that of an initial good honours degree.

Postgraduate education

Postgraduate education in management subjects has been actively encouraged by the Social Science Research Council. It is notable that in 1971-1972 nearly a quarter of the council's expenditure on postgraduate training was allocated to management courses with the avowed aim of improving the quality of management. SSRC support is usually for master's degrees, and a good honours degree is the normal prerequisite both for support and access to courses. Although the UGC also supports postgraduate education, the financial mechanism is such that universities are usually forced to fund postgraduate courses from other sources. These considerations and the problem of duration away from work, suggest that this stimulus to management training will have little impact on NHS managers seeking post-experience training, unless there is a definite policy of NHS support for recognised courses.

In the absence of a professional management qualification at a level recognisably comparable to that of the medical specialties, there will be a persistent if small demand from the NHS for long courses to provide administrators with a qualification of some acknowledged status. Since on average 15 members of each discipline (that is, administrators, community physicians, nurses and treasurers) enter the ranks of top management each year, potential candidates for master's degree courses oriented to management will not be very numerous. Most community physicians and treasurers will not see this sort of course as appropriate to their discipline, and anyway only those under 35 years of age or thereabouts are likely, as a general rule, to apply.

The number of hypothetical applications for a master's course per year can be estimated in a variety of ways, but Mr Don White's suggestion of 20 to 30 seems on the high side.[78] Ten seems to us a more realistic planning figure, bearing in mind that some of those eligible will refuse an opportunity for study leave for personal reasons, and others will wish to use it in another way. On the other hand, any one course might attract students from among those providing specialised services, such as supplies, personnel management and computing, and from fields other than the NHS, and thus show a cost-benefit greater than that implied in the NHS intake suggested above.

However, although a demand for master's courses as a means of education for teaching and research is likely to remain, there is less certainty that this will be so in the long term, as far as those seeking the degree as professional management qualification are concerned. Experience with professional education of the kind instituted by the Faculty of Community Medicine or favoured by the Association of Health Service Treasurers may show whether, once professional education at specialty level is established as an essential qualification, the demand for master's courses is reduced. Alternatively, the universities may devise other methods to meet demand once this is defined and constant over a longer term; and in this connection it should be noted that postgraduate diploma courses can be of as high a standard as truncated courses for master's degrees.

There is a clear need to compare the likely demand with the substantial resources – from UGC funds, independent foundations and the DHSS, among others – presently going to existing academic departments which offer master's degrees. A detailed compilation of these considerable and available resources, and of current plans for future development, needs to be made, to provide a factual basis for future policies: and to this end we recommend a survey. In the absence of such information, the compilation of which was beyond the means and time at the working party's disposal, we either visited or corresponded with a number of university centres and the following case studies are indications of the present position and of the advisable direction of development.

Community medicine

At the London School of Hygiene and Tropical Medicine the course for MSc social medicine, open to those medically qualified, is of two years' duration and includes an attachment to gain practical experience. It was initially supported by the DHSS grant of fellowships. The continuance of these and the pattern of courses in the future are under discussion. The subjects covered include epidemiology, statistics, sociology and social administration, health economics and miscellaneous others. It carries exemption from Part I of the membership examination of the FCM.

At Manchester the MSc course is open to candidates with degrees in medicine, nursing, dentistry, physiology, social sciences and statistics. It is of two years' duration but can be taken in sandwich form by students in the NHS. Subjects covered include epidemiology, behavioural sciences, principles of health service management, and environmental studies; and the degree provides exemption from Part I of the MFCM examination.

At Nottingham the MMedSci course is for medical graduates and graduates in other approved subjects such as dentistry, nursing, education and social science. The duration is two years and the degree is accepted for exemption from the MFCM Part I examination. Topics include epidemiology and research methods, the history of medical care and its evaluation, decision-making, health education and the behavioural sciences. The course is strongly supported by the Health Education Council.

Administration

At Birmingham the MSocSci is open to those with a good honours degree, or equivalent, and includes policy-making and organisation theory, with environmental health, personnel management, finance and other optional subjects. The degree can be obtained by thesis only in approved cases. The DHSS supports this course to prepare future NHS management educators.

Brunel University offers an MA in public and social administration, in which full or part-time students, who are either working in the NHS or who teach health service administration subjects at further and higher education levels, are able to concentrate on health policy and organisation. The course offers a wide range of appropriate subjects including operations research, organisation analysis, techniques of corporate planning, theories and methods of social enquiry. The main part of the course, however, is concerned with a systematic analysis of social policies and their institutional frameworks and with a special area of study in one of four subjects: health, education, housing, or social services policies and organisation. Students also undertake a supervised field dissertation which is related to their area of specialisation. About half of the course is, therefore, directed to a special study of health policies and structure in the case of those students who opt for health as their special subject.

The LSE and Manchester faculties of social science offer an MSc in social administration and social work studies of one year's duration. They cover social planning and social policy, and offer among other options health service planning. It is noteworthy that the LSE course is regarded as normally the fourth year of a first degree (as in the case with several master's courses in social work), but the other courses are expected to be taken by more mature students.

Information

The University of Exeter has for some years offered an MSc course (information processing in the health services) of one year's duration. The entry requirement is a good honours degree in a subject involving a substantial numerical content. The course was originally supported financially by the Nuffield Provincial Hospitals Trust but is now in difficulty due to lack of permanent support from elsewhere.

Business management

London and Manchester business schools offer MSc degree courses, and although occasionally taken by those who enter the NHS, they seem unlikely to meet much demand until more directly oriented to public service.

In all, it is estimated that less than 20 NHS managers (non-medical) have so far taken MSc degree courses, which may not be surprising if it is remembered that these courses are designed primarily for those interested in teaching and research positions. The value of such courses to the NHS is not wholly indicated, however, by the number of NHS staff taking them, since those who provide the courses must necessarily pursue research and the value of this may be made available to the NHS in other ways.

Professional education and the polytechnics

While courses of less than one year may not lead to academic qualifications, they are often used as the teaching base for professional qualifications. It is not unusual for professional bodies to act as examining, but not educational, agencies and the adult education and extramural activities of the universities and polytechnics meet the needs of those seeking professional qualifications.

The polytechnics are, in fact, extensively used in connection with professional training. Six (and two correspondence colleges) are currently offering courses adapted to the IHSA examinations; 27 (and nine technical colleges) are listed in connection with the CIPFA exams; and three in connection with degree courses for nurses (South Bank, Leeds and Newcastle). Their services are also extensively in use for short courses and the teaching of particular skills.

One reason for the large role the polytechnics play is their willingness to design courses to meet vocational requirements and their ability to provide teaching on a day release or night class basis. As long as such teaching coupled with 'distance teaching' (for example, by correspondence) is the only access to education available to the inservice student, they will have a major role to play.

Ultimately, an assessment of their role in regard to senior management will depend on how they contribute to the fundamental purposes of advancing knowledge, and training and disciplining the intelligence. A resolution of the current debate about the division of responsibilities between polytechnics and universities would help such an assessment, but is beyond the scope of this working party. We can but note that despite the disadvantages of a lower quality student entry and of a lack of opportunity for research, the polytechnics meet a need by offering vocationally oriented programmes on a part-time basis, and that they are subject to central monitoring under the responsibility of the CNAA. If a review of existing educational programmes is carried out (as we will suggest), it should extend to the polytechnics and should

be a significant step towards making their role clearer. Until then, doubt about this must remain because of the complexity of the education and training needed to equip a senior manager, and because of the lack of opportunity which exists in the polytechnics for research.

Short courses

Short courses in the interests of the NHS are more often than not organised at the universities, and range from management courses of different levels and of four to eight weeks' duration, through short instructional courses in particular skills (such as planning) of one or two weeks, to weekend or one-day seminars. Because of their short duration, these courses (except for those imparting specialised skills) can only be appreciation courses and their effectiveness depends on their relevance and on how well the demand for them has been assessed by the centres and the staff committees. Such courses, however, often produce other less tangible benefits than the appreciation or technical instruction they are designed to provide. One such is the creation of a social centre where NHS staff, whether of the same or other discipline, can exchange notes and news. Another, close to this, is to improve morale by refreshing the outlook, cultivating *esprit de corps*, and satisfying the wish for status. The value of this should not be underestimated, provided that it is so done that 'course euphoria' is not brusquely dispelled on return to the service post. In the final analysis, the effectiveness and reputation of short courses will depend on whether they stem from up-to-date or advanced knowledge springing from research, and whether the theory and practice taught transfer to the real problems of the NHS.

Ideally, serving officers should be recalled for months at a time to teaching units in order to keep the units in touch with practical issues. In practice, this is not feasible and resort has to be made to other devices.

One solution is for the teaching to be done by full-time staff already engaged in relevant degree courses and, therefore, in touch with current problems through research and feedback from under- and postgraduate students. Most departments, however, find it very difficult to fit short, intermittent courses into their timetable and are inclined, if they take up the challenge at all, to pass the burden to temporary staff who lack proper career opportunities and the capability to carry out research and, therefore, parity of esteem with departmental colleagues.

A second option is to follow the methodology of adult education departments which act as jobbing brokers to put together (not necessarily only in the home university) a suitable package to meet a particular demand. To carry out this method, it is necessary to find a director of courses who will be satisfied to spend most of his time in administration.

A third method is to establish an independent unit, in or outside a university, which can successfully finance itself by offering for sale to service units both consultancy and teaching, extracting material from the former to develop the latter. A major difficulty of this method is the achievement of a marketable reputation. Problems arise, as they do for commercial consultants, from the need to balance obligations to established clients with the pressure to cultivate new ones. Charges for courses are likely to be high as overheads will need to be covered.

Those familiar with the history of the centres which offer short courses will recognise that, at different times, some or all of these methods have been tried with varying success. It has been persuasively said that, where there has been lack of success, this has often been due to short-term demands by the DHSS and NHS for courses which could not be successfully staged by any of these methods and have consequently lacked a solid base of research, knowledge and practical experience. Another cause of failure, which can also be seen as a symptom of short-term policies, has been the lack of control over admission to the courses.

The research connection

Unless and until independent units have successfully established themselves on the base of consultancy services, neither short nor long courses will successfully cover a field as dynamic as health services management without a firm research base. To achieve this, a long-term strategy is required which will discourage teaching based on temporary staff who lack the opportunity to undertake research. So far, there has been no attempt to link in a comprehensive plan the teaching and research programmes of the DHSS. In the disciplines allied to health service management, there has in the last decade been created out of research funds a well-developed framework of health service research institutions which, however, have no part in the main stream of management strategy. Even allowing for the fact that not all those of distinction in research are competent or willing to teach, the best use of resources does not seem to be achieved, with the result that some of the major research units have little or no part in teaching, and the teaching units no part in research except where this has been financed independently. If it is accepted that the benefits of university involvement are two inseparables, the advancement of knowledge and the education of future managers, the necessity for a single strategy covering research and education is obvious. Financially, the linking of resources from both fields in a long-term policy ought to create benefits for both fields without additional expense. It is noteworthy that in community medicine both undergraduate and postgraduate education are most usually based in institutions already deeply engaged in research, which are able to carry through teaching programmes with credibility and at the minimum of expense because these have grown up 'on the back' of research.

A policy towards higher education

Assuming that the universities accept and effectively

discharge a responsibility for advancing knowledge in health service management, and for educating those who aspire to practise it, this should be the pivot of any long-term plan not only on the educational front but for the whole strategy of the NHS. Those who dispute this have to show that there are other sources available to meet these objectives. The activities of the professional associations and of NHS management itself are essential parts of the system for education and training, but are dependent to a significant degree on the universities. 'What can be taught within the public service depends in the last resort on the contributions academics make to the administrative sciences.' In broad terms we agree with this verdict of Ridley and Steel.[71] Moreover, academic qualifications are often recognised for exemption from all or part of professional examinations and – less frequently – professional qualifications are sometimes accepted as pre-entry requirements for degree courses. The two systems – professional and academic education – can therefore be complementary, and the strategy of the NHS management training might be judged on two counts: first, upon the degree to which the various factors are integrated – undergraduate, postgraduate, and professional education, including short courses in education centres or sponsored by the DHSS at universities and polytechnics; and, second, given the emphasis in higher education on research, upon the extent to which the location of DHSS-funded research coincides with the location of DHSS-supported management training.

In line with these general criteria, it is important to ask whether the universities in particular, within the limits of the resources at their disposal, are doing as much as they might to prepare students for a senior management career and to advance knowledge about NHS management. The question also arises: are the DHSS and NHS, within the limits of their resources and their capacity to influence, following the right policy and giving appropriate support to the universities?

Need for a commissioned study of existing programmes

Unfortunately, it is not possible to answer this question without a detailed study of the present degree and other teaching programmes which might be followed by those who wish to enter, or who are already within, the ranks of senior management. We therefore suggest the commissioning of a thorough study of what is at present on offer. Indeed, it is surprising that no one has filled this void in the past. Without such a review, it must be difficult for those who have to consider appointments to and within the NHS to assess the value of particular qualifications. Such a study would find that between them the DES, DHSS, NHS, UGC, and individual students who pay fees, are contributing significant sums to vocational and professional education in universities and polytechnics. But without a descriptive analysis and an estimate of cost and effectiveness, it is impossible to quantify the value of such education to the enhancement of management.

A successful strategy will be founded upon interaction of the NHS and the universities based on an understanding of the need of the NHS for a combination of management research and vocational education, and of the need of the universities for a base in the community for research.

The whole system of medical education, despite certain failings, may be a precedent for a successful interaction. There are two essential features of it which are not present in management education; a policy that the NHS makes plans for a comprehensive research and education system on a long-term basis, and an acceptance by universities that, as with medical schools, they must be ready for corporate dealings with the NHS instead of a *laissez-faire* for individual academics. Solo displays by brilliantly innovative entrepreneurs should be the exception rather than the rule.

Another reason for our recommendation that there should be a review of all research units and academic departments which have possible connection with management education in order to analyse their relevance and depth, is that such an exercise could be a useful forerunner to the changes mentioned in the above paragraph.

Basic assumptions

In discussing possible policies for degree and other courses at the universities, there are four assumptions which are suggested by previous sections of this chapter.

1 The number of those who, on average, annually enter senior management (excluding community physicians and treasurers) is about 30. It therefore looks likely, from the number of graduates becoming available to compete for this career, that a university honours degree will soon become recognised as a qualification to which considerable importance is to be given in selection for the post of the senior manager.

2 Since no professional administrative qualification is accessible which is truly equivalent to an honours degree, the non-graduate working his way up in the service should have a fair opportunity to qualify himself for admission to an honours or postgraduate degree and to compete for a limited number of awards at select universities. There are precedents for this in other public services.

3 The NHS tradition that administrative staff cannot be spared to educate themselves by secondment or study leave is indefensible.

4 Any policy for courses must take account of the fact that the advancement of knowledge is an objective as important as the education of the student.

The summarised review below is based on these assumptions.

Honours degree courses

An honours degree course, through a systematic training of the intellect, confers on the recruit to NHS management who has undertaken it a long-standing advantage over colleagues of equal character and ability. We would, therefore, recommend that, at least on an experimental basis, staff who have entered the service without a degree, but who early in their career have or acquire by their own efforts university entry qualifications, should be able to compete for a limited number of awards enabling them to take up suitable honours degree courses, after selection by a specially appointed board. Such a scheme would also provide the long-term encouragement to the universities to undertake the investment in research and teaching which is a necessity in this field. It is not to be forgotten that all the disciplines relevant to management (discussed in Chapter 3) ought to be attracted to research and study in the NHS; and it is not easy for universities to achieve progress with some of them. The strong incentive provided by an honours degree course is needed.

It is also becoming necessary to pose the question whether it is wasteful of resources to make no distinction in recruitment between graduates on account of the relevance of their degrees and their possible need for supplementary education. The traditional view of the Civil Service, and presumably of those responsible for NHS recruitment, has been that to recognise certain degrees as of greater relevance than others would be to deprive the service of some of the most able recruits, and that it would put undesirable pressures on school leavers to choose between university programmes when not fully aware of the implications of their decisions. The merits of this view have been the subject of argument for a considerable time, but it is not necessary to reject it in order to believe that it would be valuable for students to be offered a more definite and attractive programme of education oriented towards NHS administration, and for those concerned with appointments and promotion to have available an objective assessment of such programmes when they may have to discriminate between applicants of much the same apparent character and ability. We have, therefore, already recommended a review of the work of research units and academic institutions concerned with NHS management. It would be of value not only to policy formation and personal management but, if suitably presented, as a guide and incentive to the student with a potential vocational interest in the NHS.

Postgraduate courses

Courses undertaken for a master's or PhD award are required by those who wish to engage in research and teaching, and who are usually selected by the academic institution and financed from research or other funds found by the institution. This procedure appears satisfactory, and one to be followed by those who wish to undertake research or to teach in this field.

But the question whether a programme should be instituted for the support of master's courses as an extension of the professional education of those likely to be senior managers in the NHS is a separate issue, and one which has recently been raised by the Business Graduates Association as well as by the DHSS itself. It is assumed that such courses would be specifically aimed at the needs and problems of corporate and consensus management as now practised in the NHS.

We believe that undertaking such a degree course involves at least a year's absence from duty and therefore must be linked with the grant of study leave. If the master's degree is viewed as an extension of professional education, it will not be equally required by all in senior management. In particular, those who already possess a good honours degree in relevant subjects might be better involved in research or teaching during the period of study leave. A master's degree course will be of the clearest benefit to those who are without a degree but have gained another entry qualification and are older than the usual undergraduate student, and to those who are likely to convert or add to a previous degree with profit. Although we believe that pressure may eventually emerge for the creation of a higher qualification of a professional administrative nature parallel to the qualifications recognised by the FCM or CIPFA, we believe there is a good case, until that happens, for carrying out a programme of awards of study leave and financial support towards master's degree courses for the purposes indicated. As there is already a number of courses available which are in principle suitable if they received official encouragement, we would not recommend that there should be any direct financing of teaching staff.

The better option would be to encourage applications for the award of leave and fellowships from those who are able to obtain a certificate from a recognised university that they will be admitted to the course if chosen. Such courses should not be exclusively geared to the NHS because there is already enough capacity with only small additional support to cover the small numbers of students, and there is no need, therefore, for special institutions with their disadvantage of restricted vision. Although it might be necessary to monitor the quality of courses, at this stage we believe that the only criterion necessary for course recognition should be an undertaking by the institutions concerned that the student's studies and thesis will be related to NHS problems, and that tutorial staff are themselves committed for part of their time to research in this field. For reasons already explained – the creation of a useful interaction between NHS management and the universities – the selection of courses and the grant of fellowships would be usefully made by a joint NHS/university board.

Courses now available in departments of community medicine and social administration are most likely to meet the proposed criteria. Courses in the business schools, and departments of statistics, economics and law, would be of value if their content were oriented to NHS problems. There is a need, however, for effort not

to be dissipated in too many penny packets, but focused on select departments where there is a genuine commitment to NHS studies, and appropriate resources of academic staff and nearby departments with associated interests. There is a precedent for the implied relationship with the universities in the mechanism for course recognition used by the Central Council for Education and Training in Social Work.

Accepting that various arguments advanced in this chapter carry differing degrees of cogency, we are of the opinion that there is scope for master's courses within a complete scheme of management education and training within the NHS, and that the value of such courses would be increased if they were not specific to the NHS but suitable also for middle-rank managers from all types of large organisations, provided that individual students can carry out projects related to their own profession.

We have no doubt that master's courses of this kind will enhance the quality of top management in the NHS; and, with a harmonisation of funding of university activities aimed at the NHS, we see no financial problems in the way of the modest operation which we envisage. Some may feel that we underestimate the demand and make over-modest proposals; but we think it wise to err in that direction than risk disillusionment from over-ambitious programmes. It needs to be emphasised that, whereas the various arguments we have reviewed reflect real problems, their importance and relevance depend crucially on the scale of the total operation. In particular, if our estimate of the demand – say, ten a year – is near the truth, some of these problems diminish and need not be viewed as obstacles to early initiative.

Short courses

Apart from its own specialist staff college, the main weight of DHSS management training investment lies in support of courses at the Administrative Staff College at Henley (and to a lesser extent at the business schools) and to direct financing of short management courses at the education centres; the King's Fund College, the universities of Birmingham, Leeds, and Manchester, and Leicester Polytechnic. As this section is dealing with the role of the university, it is not the place to comment on the first of these approaches except to note that there is an absence of a close link with health services research, and that in the second approach, with the exception of the King's Fund which is independently financed, there are difficulties over providing attractive conditions of service to the staff at the education centres.

We see no reason to take issue with two fundamental points of policy announced by the DHSS.[24] First, that the responsibility for education and training should be devolved to the health authorities except where it is undertaken in the national interest or is of a highly specialist nature; and second, that the health authorities should be responsible for identifying training needs and priorities and that a strategy for the whole field should be built upon this work.

With responsibility devolved to health authorities, they will be able to meet much of the demand internally or in consultation with existing bodies. Where university aid is required, the right kind of base will be created and the NHS will be able to exercise persuasive power of an informed kind if, as already proposed, it has become a sponsor of undergraduate and postgraduate awards.

There remains for the next chapter the important question of seminars and other education methods for the assistance of top management. But here too, whatever method is adopted, a secure base for teaching and research in the universities which may be drawn upon for advice and conceptual knowledge, is essential.

7 The role of the DHSS and NHS authorities: past and future strategy

Each of the bodies closely concerned with the recruitment, selection and development of senior managers in the NHS has its own particular perspective, but there is a need to attempt the difficult task of looking at the needs, problems and opportunities as a whole. Even the DHSS seems to have taken a less than comprehensive view, limited as it is by the tradition that its own direct role should be small. The National Training Council has the opportunity to set a new standard of comprehensive vision in the future. In any event, none of the main protagonists should pursue its own ends without awareness of the whole.

In this chapter, building upon previous chapters, our purpose is to see how the web of interconnected problems and activities fit together. First, we summarise briefly the characteristics implicit in the history of this field as described in detail in Chapter 4, and note that there is now widespread dissatisfaction with the idea of merely perpetuating past policies. Next, we state what in our view was wrong with these past policies in the light of the nature of management and management training (Chapter 3), the needs and policies of the professions (Chapter 5), and the skills and activities of the universities (Chapter 6).

We then turn to the more important and creative question of how a better strategy can be developed. We suggest an overall strategic framework, and propose seven specific steps as the selective measures most urgently required. The progress and success of these measures should themselves be reviewed regularly, and the overall strategy should be revised from time to time.

What is the role of the DHSS and the employing authorities in preparing and developing people for senior management positions in the NHS? What strategy are they following against the background of professional and academic activity described in the last two chapters in order to fulfil their role? And how, if at all, would we like to see this strategy altered? Chapter 4 gave the historical background up to the 1974 reorganisation and described the increasing national concern with personnel matters. Not surprisingly, the periods immediately before and after reorganisation have seen the publication of an unprecedented number of circulars and memoranda on personnel management, including senior management selection and development.* Distinct patterns of a strategy can be found in these papers, though there is the difficulty inherent in the DHSS-NHS relationship: a DHSS circular can legitimately (if not always correctly) be taken to be part of a political or departmental strategy; the NHS on the other hand has no single voice, yet must also carry a major part of the responsibility. The actual strategy being followed in senior management recruitment, selection and training must, therefore, be deduced from a variety of sources, rather than from a single coherent statement. The following paragraphs represent our interpretation.

*Of which the two key ones are listed in the bibliography.[25,26]

Inherited roles and strategy

Responsibility for recruitment, selection and development of staff is decentralised and widely diffused in the NHS, with the DHSS taking only very selective initiatives. Each authority recruits its own people and provides a wide variety of training programmes. Each manager is supposed to be responsible for the assessment and development of his own staff. Each individual plans (or does not plan) his own career. When the DHSS intervenes in an attempt to set policy guidelines, it only goes beyond circulars containing enlightened generalities in the case of development that cannot be undertaken at area or region, such as the national schemes for graduate and A-level entry.* In such cases, support from the DHSS can be in the form of either central finance or of centrally

*See Appendix C.

organised provision, but either way the policy is to act centrally only where devolution is impractical. Indeed, devolution is usually carried past the regions to the areas, though there is considerable variety among regions in the extent of direct regional involvement in needs such as training. In principle, we support this national strategy of maximum devolution with selective national and regional involvement, though, as will be clear later, we are less happy about some of its results.

The professions the main initiators

Each profession and occupational group has watched over its own members' basic competence, personal aspirations and continuing developments. The drive to raise standards or change methods of training comes primarily from the profession or occupational group concerned. Normally, the DHSS has preferred to react to these initiatives rather than itself setting the pace. Thus, the NHS finance officers currently aim, as they have told us in their evidence, to transform the NHS finance function from one often led by professionally unqualified people to one in which a professional accounting qualification will be mandatory for any top post. Similarly, the training and qualifications of community physicians have been strongly taken in hand by the Faculty of Community Medicine. Currently, however, the nurses and the administrators are less clear about the qualifications and training required for top posts. Less clear still are the chairmen and members of health authorities – who are a crucial part of the leadership – since they belong to no single professional group and have no historical tradition. It seems to us therefore that the DHSS needs to develop and explain its own ideas about professional competence especially in these cases where the impetus from within the profession concerned is less than overwhelming.

DHSS involvement strictly limited

DHSS direct involvement in senior management recruitment, selection and development is little different from what it was before 1974, and is still mainly restricted to the national schemes for graduate and A-level entry; control over numbers, types and pay levels of senior posts, with some influence on methods of selection; and support of five national education centres. The first of these involvements was broadly successful in attracting bright young people into health administration, most of whom have stayed, without creating a privileged, fast-promotion stream. The second, although it caused anxiety and delays in appointments during the reorganisation period, is desirable in a national service. The third involves an expenditure of some £500 000 a year at present (less than 0.01 per cent of the NHS budget) on paying course fees at Leicester Polytechnic and the King's Fund College*, and on providing the main financial support for the centres at Manchester, Leeds and Birmingham. Most of the resources of these centres are used for development courses of four to six weeks for those who have recently entered senior management; shorter courses for those who have held senior or top posts over three years; seminars providing in-depth training on specific subjects, and courses for the national trainees.

In addition, the regions spend an amount which we estimate at £500 000 to £750 000 a year on management education, but hardly any of this is applied to the senior levels. Total NHS expenditure on training at all levels from national to local was estimated in NTC 75/4 as £30m to £40m, or around 1½ per cent of the total salary bill.[24]

Cautious approach to long courses

The possibility of longer senior management courses, based either at a new staff college or universities, has often been discussed, and is under discussion again. So far, the number of NHS staff who have attended such courses is small. The proposal for a staff college was intensively canvassed in 1970 and 1971. The reasons for its rejection by the DHSS at that time have never been revealed, though it is clear that the traditional staff college concept is more suited to a homogeneous service like the police than to a diffusely organised multiprofessional one like the NHS. Also, a health service staff college might be too isolated and inward-looking. The university-based management centre is meeting some success for those who plan a career as teachers and researchers in management subjects in health care, but so far has evidently not been a practical training base for most of those who are, or hope to be, senior managers. Between 50 and 100 NHS staff have attended the three-month course at Henley or similar courses at the business schools. A much smaller number has attended full MBS or MSc courses. At present, the DHSS is again actively investigating the potential contribution, viability and form of longer courses, including the possibility of one or more master's level courses (on which subject we have submitted specific evidence to the Standing Committee on Management Training and Education).

Dissatisfaction with the past

These seem to us to be the main features of the strategy implicit in departmental initiatives and actions so far. But we detect a higher level of concern at the DHSS, if only because of the unprecedented flow of personnel circulars; and the time seems ripe for major advances. In the NHS, and in each of the professional and staff bodies, there is a readiness to consider new approaches, and an awareness that nobody should be complacent about the past record in the personnel field. In the education centres with an NHS link there is a sharply questioning attitude albeit coupled with a natural wish to see new initiatives taken through these institutions rather than elsewhere. While in the broader field of further education, as Chapter 6 suggests, the financial situation is such that anyone prepared to pay for research and

*The King's Fund and, to a lesser extent, the Nuffield Trust have invested substantial sums themselves in management education.

educational programmes is likely to get a sympathetic hearing.

Weaknesses in past strategy

In the development of new strategies aimed at the current and future needs of the service, it is helpful to identify the weaknesses of the past strategy. Our findings are inevitably based on limited evidence; but though we would have liked to research more exhaustively into certain aspects of the present system, we believe that there would be general agreement with the following analysis.

Little support for individual self-development

Support to individuals in their self-development efforts has been weak almost everywhere, and is now even weaker than before reorganisation. It is the exception for the individual officer to be able constructively to discuss his managerial strengths and weaknesses, and his aims and ambitions with a senior officer in a structured way. As mentioned in Chapter 4, staff reports never covered more than about half the administrative staff of the service, and specifically excluded the chief officers. Moreover, the emphasis was seldom as it needs to be, on appraisal as a basis for confidential counselling, and there was rarely any assessment of the training needs of individuals. With a few notable exceptions, personnel development has received little attention and the matching of people to training opportunities has been largely random. Relatively little as the NHS spends on management training, much of what it spends is, we believe, poorly invested because it is not closely enough matched to the individual nor integrated with his working experience before and after the training received. The arrangements for selecting people for courses are unsatisfactory – influenced too much by who can be spared and by the need to make up course lists on the Noah's Ark principle of two members of each species. Furthermore, a part of the price of NHS reorganisation has been the disruption, or even destruction, of the information base and advisory system which were being built up in many regions to support management development. Thus, although individuals should retain prime responsibility for planning their own careers, and senior officers should develop those they lead, both need support and that support is now lacking.

Weaknesses in management training of administrators and nurses

In nursing and in administration, the present arrangements to prepare senior managers in one of their key roles – that of leadership within their own profession – are inadequate. In particular, individuals in both groups reach senior positions with inadequate preparation in numeracy and in the analysis of health and social policy. Present proposals for change under discussion within the nursing and administrative professions do not, in our view, go far enough in concentrating on skills that can be taught and in aiming for a professional level of attainment. It is in this area that new master's level and diploma courses are needed – not for the finance officers and community physicians, but to create concepts of excellence for the administrators and for those nurses who move into administration.

Lack of preparation for senior management posts

For all the main professional disciplines there is an urgent need before reaching senior management posts for a broadening and intellectually challenging exposure to health policy and to the skills of other professions. For potential senior managers it is at this stage that multiprofessional courses on management subjects have most relevance, particularly those concerned with what in Chapter 3 have been called the conceptual skills. At present the undoubted need for a multiprofessional approach has been recognised too unspecifically, leading to far too many courses being multiprofessional in attendance when the real need varies by profession. But by this stage each profession should have mastered its own essential professional skills, and its members should be ready to study the broader aspects of making health policy and to learn in depth about the contributions that other professions make at the management level. Present arrangements are weak in this area. Although attempts have been made to establish courses in which senior managers would think about their role and prepare themselves for it, the initial concept of these attempts has been eroded. They have tended to become middle management courses in fact if not in name. And in general neither the teachers on them, nor the participants, nor the senior managers whom they originally set out to attract, are happy about them.

Lack of development opportunities for those already in top posts

There is no planned provision for the varying needs of those already in top posts during the remainder of their careers. Because reorganisation is so recent, the absence is understandable, but is being felt increasingly acutely by senior managers in the ever more complex service. Some senior officers have specific, individual gaps in their preparedness; for example, in industrial relations, handling publicity media or computer appreciation, which can be filled by short courses. All must keep their own professional skills up to date. Many teams welcome outside counselling on organisational development lines. An example of a welcome attempt to fill part of the vacuum is Professor Chester's seminars, supported by the DHSS, for interchange of ideas among those in top posts.* But this is only one of a broad range of activities needed. Study and sabbatical leave of various kinds will be required to reopen people's horizons, encouraging them to undertake whatever project or activity will help them to grow in knowledge and experience and thereby increase their contribution to the NHS.

*At the University of Manchester.

FIGURE 12 Professional Training Needs of Senior Managers

Skill and qualification needs	Administrators A	Finance Officers F	Nurse Administrators N	Community Medicine Specialty CM
Corporate management training needs (see Figure 13)				
Professional training needs	**1** Management and social administration (sound theoretical grounding)	**1** Accountancy (must reach full qualification CIPFA or equivalent)	**1** Nursing management and administration in broader setting of management theory	**1** Epidemiology and medical statistics
Technical	**2** Economics with statistics **3** *Either* specialist option (personnel, works, supplies) *or* running of hotel and other supporting services	**2** Economics, statistics and public finance (at least as required by CIPFA)	**2** Basic analytic skills including logic and statistics	**3** Management administration (basic grounding)
Human	**4** Behavioural sciences		**3** Behavioural sciences	**4** Behavioural sciences
Contextual	**5** NHS in setting of its history, international comparisons and public administration	**3** As A5, plus broader awareness of public finance (see 2 above)	**4** Health and social problems and services **5** History of nursing	**5** As N4
Entry qualifications	Good 'A' level results and suitability (degree desirable)	Good 'A' level results and suitability (degree optional)	SRN (degree optional)	Medical degree

Lack of training for chairmen and members

There is a serious vacuum in the training of chairmen and members of authorities and in the training of clinicians joining the DMTs. As a once-for-all emergency measure, the NHS reorganisation courses went some way to meeting this need, but nothing yet exists for the longer term. Chairmen and members certainly need preparation, rather as magistrates do, to understand what their role is and how to discharge it properly. Clinicians need a different preparation for their period of office in DMTs, since they know some parts of the health service very well indeed, but not others, and require insight into the unique representative role that they are asked to fill. The King's Fund and others have taken the initiative in trying to help both members and clinicians, but there is scope to sharpen the focus of what is done.

Lack of integration between research and education

The education centres are not yet the centres of excellence they should be. They are too much engaged in the treadmill of short courses, many of them at an appreciation level. Little research is undertaken in them – nor are they financed for research – and the DHSS should seek to integrate research and education centres. It is anomalous that, on the one hand, none of the leading British centres of health systems research has a major education function in the NHS and that, on the other, none of the training centres undertakes research on any scale. Other problems facing the education centres include the difficulty of attracting and retaining high calibre staff (since they can neither give tenure nor – in most cases – university status); of drawing effectively on the strength of other faculties; and of expanding their role in counselling and consultancy, to increase their practical knowledge and take training to the senior NHS officers who do not come on courses. All the education centres are making brave attempts, but in our judgment none of them has yet achieved excellence as an education and research institution. Much has been achieved in establishing a series of education resource groups: the question now is how to build upon this base and use it to best effect in the future.

Towards a future strategy

The establishment of the National Training Council and the national staff advisory committees should provide the stimulus and channel that have until now been lacking for developing an explicit and innovative strategy rather than an implicit and reactive one. We hope that the council will use its influence to have some of the matters studied which we were unable to take further, and will use the conclusions we have reached, and that the DHSS and the NHS authorities will support it in this. On what principles, then, should future plans be based?

We emphasise first the need for a conceptual framework. No single step, such as establishing a staff college for the NHS or starting master's degrees in health policy, by itself defines a useful strategy. The needs are too heterogeneous for any single action of that kind to meet them all. As we describe in Chapters 1 and 5, we believe that each of the four professional groups with which we are primarily concerned has development needs that can be analysed in two dimensions.*

The needs vary profession by profession, but each group must go through a sequence of preparation for qualification in its own profession, and then become increasingly concerned with developing a broader corporate perspective and competence.

If we now interpret the basic pattern profession by profession, we have a scheme somewhat as shown in Figure 12.

It should be noted that, where the same subject headings appear for more than one professional group, the depth of study or the perspective usually varies greatly. Only in contextual knowledge is there substantial coincidence in what is needed across all four groups. It is this that leads us to sound a note of warning on interprofessional or multiprofessional training being introduced on any scale at this first stage of professional education.

At the more senior level, however, (that is, when officers are becoming leaders in their own profession) the position changes. Now the prime need is to prepare people for their corporate role, and the natural way for them to do this is to train *together*. But even at this level there will be variation in the training needed among the professional groups, since each must learn something of the unique contributions of the other three. We picture the training needs at this stage in Figure 13.

Identification of weaknesses in existing arrangements

Given this analysis, it is possible to see more clearly where the main weaknesses lie in existing arrangements. Our assessment is summarised in Figure 14.

Our assessment, therefore, identifies five areas of major weakness in current arrangements; the first three have been discussed in Chapter 5 but are repeated here since they form part of the broader whole. The last two are added here, and affect all the professions.

1 Recruitment of community physicians

2 Development of a professional foundation in administration which should cover the band of administrative specialties, besides general administration

3 Development of a professional foundation in nursing administration, (despite the enormous growth of degree and other educational programmes)

4 Preparation of all disciplines for the corporate, senior management role

*See Figure 2, page 39.

FIGURE 13 Further Training Needs of Senior Managers

Skill and qualification needs	Administrators A	Finance Officers F	Nurse Administrators N	Community Medicine Specialty CM
Shared needs	**1** Understanding of corporate and individual roles (theoretical and role-playing, including role of members with officers, and of each NHS level with the others) **2** Health policy-making including issue analysis, decisions on priorities, operational and strategic planning and resource allocation (theoretical and case study applications) **3** Social policy and government, and health policy and services in relation to them **4** Public communication — how to listen and how to communicate with patients, the public, the staff and professions and unions (theoretical and role-playing) **5** Use of time — one's own and other people's — including planning one's own activities, preparing for meetings, obtaining completed staff work and conducting meetings.			
Special needs	Insight into F, N and CM Epidemiology and medical statistics Nursing and nurse administration NHS finance accounting	Insight into A, N and CM Epidemiology and medical statistics Nursing and nurse administration NHS organisation and administration	Insight into A, F and CM Epidemiology and medical statistics NHS organisation and administration NHS finance and accounting	Insight into A, F and N NHS organisation and administration NHS finance and accounting Nursing and nurse administration
Entry requirements	Qualification for leadership in own profession (see Figure 12) and selection for corporate role			

FIGURE 14 Assessment of Current Arrangements against Blueprint

Stages	Administrators A	Finance Officers F	Nurse Administrators N	Community Medicine Specialty CM
Entry	Reasonably good past records of attracting recruits from wide range of backgrounds	**Some weakness** Schemes to attract able recruits to specialise in finance rather unsuccessful so far	**Some weakness** Because of the lack of other career paths some nurses enter administration who are not suited to it	**Major weakness** Attracting the right calibre of entrants into the specialty
Foundation for leadership in own profession	**Major weakness** IHSA examinations represent only a threshold level across a broad field. A higher standard of qualification is required to set the pace in administration and command the respect of the other professions	Present plans represent a substantial, and needed, raising of standards **Some weakness** at advanced part of this stage. (For those who have attained full professional qualification there is a need to develop broader health service perspectives)	**Major weakness** Wide range of degree, diploma and short courses but no agreed standards of qualification	Relatively new, but potentially strong arrangements
Foundation for corporate management	**Major weakness** No serious attempt to meet needs in this area other than in the special, crisis situation of reorganisation			
Continuing development and renewal at chief officer level	**Major weakness** Little is done to help people identify their needs or enable them to meet them. In the professional dimension, F and CM have active plans for continuing education			

5 Continuing development and renewal of these in the senior management role

Recommendations

We would contrast the need for a comprehensive approach and strategy with the need for selectivity in recommending specific changes in the short term. Without a comprehensive approach, there is a grave danger (indeed a certainty) of selecting changes on a random basis, or on the basis of what is popular. Any proposal should, therefore, be assessed in relation to a picture of the whole. On the other hand, it would be unrealistic, and probably stupid, to try to make a great number of assorted changes at once.

We have therefore restricted ourselves to recommending seven specific steps.

1 Establish new standards of qualification for administrators

The IHSA examinations provide a threshold level of preparation across a broad field for all who aspire to middle or senior management positions in health administration. Building upon this, we see the need for a range of postgraduate education provision, which is at the moment lacking. The IHSA aims to obtain recognition for its final exams as an entry qualification for postgraduate courses, and this would be very helpful in ensuring, as suggested in Chapter 6, that non-graduates with high potential and suitable experience are not barred from postgraduate study. Within the range of postgraduate provision we would like to see

entry for suitable NHS officers to a wide variety of existing master's and diploma courses, in subjects such as operational research, statistics, computing science, economics and social administration

recognition of, say, two master's degree courses of high quality in health policy and administration.

We have given written evidence on this subject to the Standing Committee on Management Training and Education. Arrangements should be made to enable officers who meet the relevant university entry requirements, and who have proved their value to the NHS, to be paid while attending such courses. Arrangements are also needed, as indicated in Chapter 6, to assess the quality and characteristics of all university courses to which NHS officers are seconded.

2 Establish in the nursing profession a body to monitor the wide range of activities in nursing administration and to set standards of excellence

Whether this should be organised by the Royal College of Nursing, the General Nursing Council, or some other statutory or professional body, is a matter for the profession. What we have in mind is some body parallel to the Faculty of Community Medicine. In addition to an administrative faculty in nursing there should probably also be clinical faculties and a nursing education faculty to avoid over-emphasising administration which is only one of the natural career paths for nurses.

3 Develop new arrangements to prepare those selected for chief officer posts from all disciplines for their new responsibilities

What we have in mind ultimately is a mandatory requirement that within, say, six months of appointment all officers appointed to DMTs, ATOs and RTOs should attend a residential course aimed at meeting the needs identified previously. The course length might be about two months and must not be allowed to become so short as to involve merely a token appreciation level. Course content would make extensive use of the case study approach. While the arrangements would have something in common with the staff college approach of the armed forces, the police and the Administrative Staff College at Henley, it should not be based on a separate, free-standing institution, since this would lack an adequate research and education base. The best solution would be, we believe, a consortium approach using the joint resources of several academic institutions with a strong health service interest and a broad research base.

4 Develop, possibly in association with recommendation 3, separate, much shorter courses for clinician members elected to teams and for members and chairmen of health authorities

Each of these three groups requires separate provision. Courses might be about one week in length. Again, they might best be provided by the consortium approach, and experiments in how to provide them should be encouraged. Whether they should be obligatory is a matter for later decision, in light of experience. On some of these courses it would be beneficial to include senior members of the DHSS staff, to help bridge the gulf between the NHS and the department. It might also be appropriate to plan some courses specifically for senior civil servants working in health and related policy areas, but this is not a matter we have felt competent to examine.

5 Formally recognise the need for continuing education (professional and corporate) for senior managers

All long-established senior managers should be encouraged to take planned leave of absence for educational purposes. Since the best use of this will vary by individual, no standard provision should be made. Rather, individuals should work out their own proposals, to be approved by the authority concerned, within national and regional guidelines. Standard arrangements should, however, be instituted for making and processing study leave applications. In addition to study leave, on-the-job training should also be encouraged, such as consultancy to management and officer teams by members of academic health policy faculties, and organisational development. More meetings and short

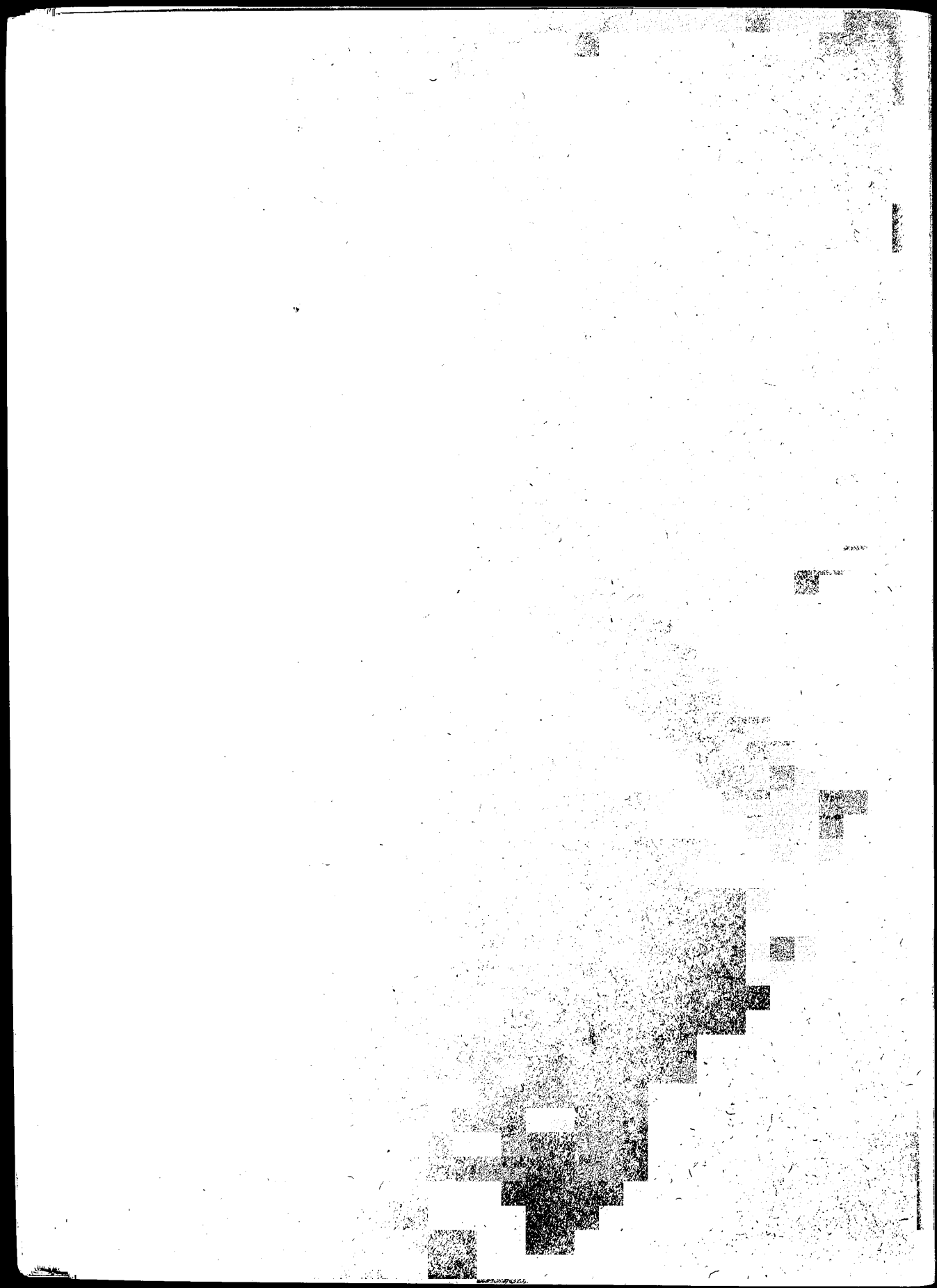
courses, of the type run by Professor Chester, are needed and some of them should be extended across professional boundaries.

6 Establish better personnel appraisal and counselling in the NHS including collaborative arrangements among authorities

These arrangements should include regional information centres (formed with the support of areas, not by regional fiat) to exchange information on posts available, and experience of courses, and to advise individuals and personnel officers on the options available for self-development.

7 Encourage, in association with the National Training Council's standing committee, a close, continuing interest by senior NHS managers of all disciplines and by senior DHSS staff in the quality of health administration and methods of improving it

As Chapter 4 indicated, the late 1960s saw for the first time an emerging interest in management and management education in the NHS. Today, the pendulum has swung back from management being in fashion with the DHSS and NHS, to a definite 'anti-management' bias. We believe that the swing has gone too far. Running the health service today is probably more difficult than ever, and the financial limits are very clearly demonstrating the need to use the available resources well. The reallocation of resources from some parts of the country to others creates major problems and opportunities in both the districts that receive reduced allocations and in those where resources are increased. The need to draw the best out of people is the most important task of all: without a high standard of leadership the future of the NHS is gloomy. The preparation and development of senior health service managers is, therefore, not an élitist preoccupation but a matter of major concern to the whole service and to the country. It deserves and requires action in the context of a carefully conceived strategy which cannot be static and must itself be regularly reviewed and revised.



8 Implementation

Our detailed conclusions and recommendations are left within the context and summaries of the appropriate chapters, rather than being collected into a single list in this final chapter. As indicated in the introduction, our hope is that this is the form of report which will be of most use to the King's Fund in its continuing examination of the issues we have raised with the DHSS, the health authorities, the professions, and other institutions involved in health care. We hope, too, that some of our conclusions will be of value to the Royal Commission on the National Health Service in its deliberations about the best use of NHS resources.

In this last chapter we face the final and critical question: given a comprehensive set of proposals relating to senior management in the NHS (whether or not they follow the lines of our report), how best can decisions be taken on them and implementation carried through? The working party has given much thought to this question and its conclusions are briefly as follows.

First, while it cannot be doubted that highly trained senior managers are essential to the quality of the NHS as a whole and to the care given to each patient, ministerial and public recognition of this basic fact may have become blunted in recent times by political and professional discontents, particularly with the present organisational structure of the service. But this must not be allowed to defer decisions upon training policies which are an imperative need for those who face the complexities of managing the NHS, no matter what its structure. Firm leadership is vital if progress is to be made towards the more difficult of the targets mentioned in this report, and it must come, in part, from government ministers.

Leadership is less easily given by civil servants for, despite their thorough and devoted work which has led to innovation and progress in management training, they are inevitably restricted by the immediacy and spread of their central government responsibilities and also by the mobility inherent in their own careers. Instead, it would be easier for the employing authorities of the NHS themselves to take initiatives.

Next, we have concluded that there are indissoluble connections between sound initial selection, early career guidance, selection and training for first appointment to senior management, and subsequent continuing education; that, in these contexts, the health district, areas and regions cannot be treated separately; and that, therefore, the NHS requires a unified policy for the development of its senior management.

It follows, in our view, that the evolution of policy and its continuing implementation should be the responsibility of a group specifically established for the task and possessing executive powers to act. Such a group with its secretariat would be of modest size since the scale of the whole operation, as indicated in the final paragraph in Chapter 1, is itself modest. As to the group's constitution and administrative position, several possibilities have been carefully considered: among them, a section of civil servants within the DHSS given unified responsibility over all the professions involved, a sub-committee of the National Training Council, or a consortium of health authorities.

We have concluded, in part for reasons already given, that the last possibility has a clear advantage over the others. We also consider that the early history of management education organised under the national staff committees shows the benefits accruing from the degree of independence of central government departments which they enjoyed. Also, we believe it to be right that the major responsibility should lie with those who have the most direct knowledge of, and self-interest in, good management, namely the regional and area health authorities. However, no one authority by itself has the status, size or expertise to establish a viable system of education for senior management.

Our proposal, therefore, is that, following precedents successfully established in other national spheres (such as local government authorities), a consortium of health authorities should be established for the purposes we have outlined. Initially, such a consortium might be formed voluntarily. In this way, for example, action could be taken more immediately and without a formal commitment from central government; and the earliest action on training schemes could be treated in a quasi-experimental manner. But we would expect that, within a period of only a few years, the significance and importance of the work of such a consortium would be recognised to the extent of pooled funding on a statutory basis.

In the event of this sequence of events being accepted, the working party expressed the hope that the first initiatives would be taken by authority chairmen.

That, then, represents our major recommendation for the mechanism whereby sound policies can be formulated and implemented. Parallel to it, two further actions need, in our view, to be taken.

First, we feel that the training in management which is at present on offer to NHS personnel by a relatively large number of organisations (most of them within, or attached to, universities or polytechnics), whether or not funded by the DHSS, should be studied in depth with a view to qualitative assessments and judgments being made. As a working party, we have necessarily touched the edges of such a study and have profited greatly from visits and discussions at a number of centres; but a much more thorough knowledge of what is at present available is necessary as a precursor of any global strategy for senior management. It would be appropriate for this study to be commissioned by the National Training Council and the results, together with the NTC's advice, passed to the proposed consortium of health authorities.

At the same time, we feel that no time should be lost in the provisional establishment – either under departmental sponsorship or by an independent body, such as a university or a charitable foundation, or in collaboration – of, firstly, prototype courses for selected staff who have gained professional qualifications and are considered eligible for appointment to team posts, and secondly, an experimental range of provision for senior managers already with substantial experience in the management teams. If this were done without commitments, the consortium would have at once a basis for further development.

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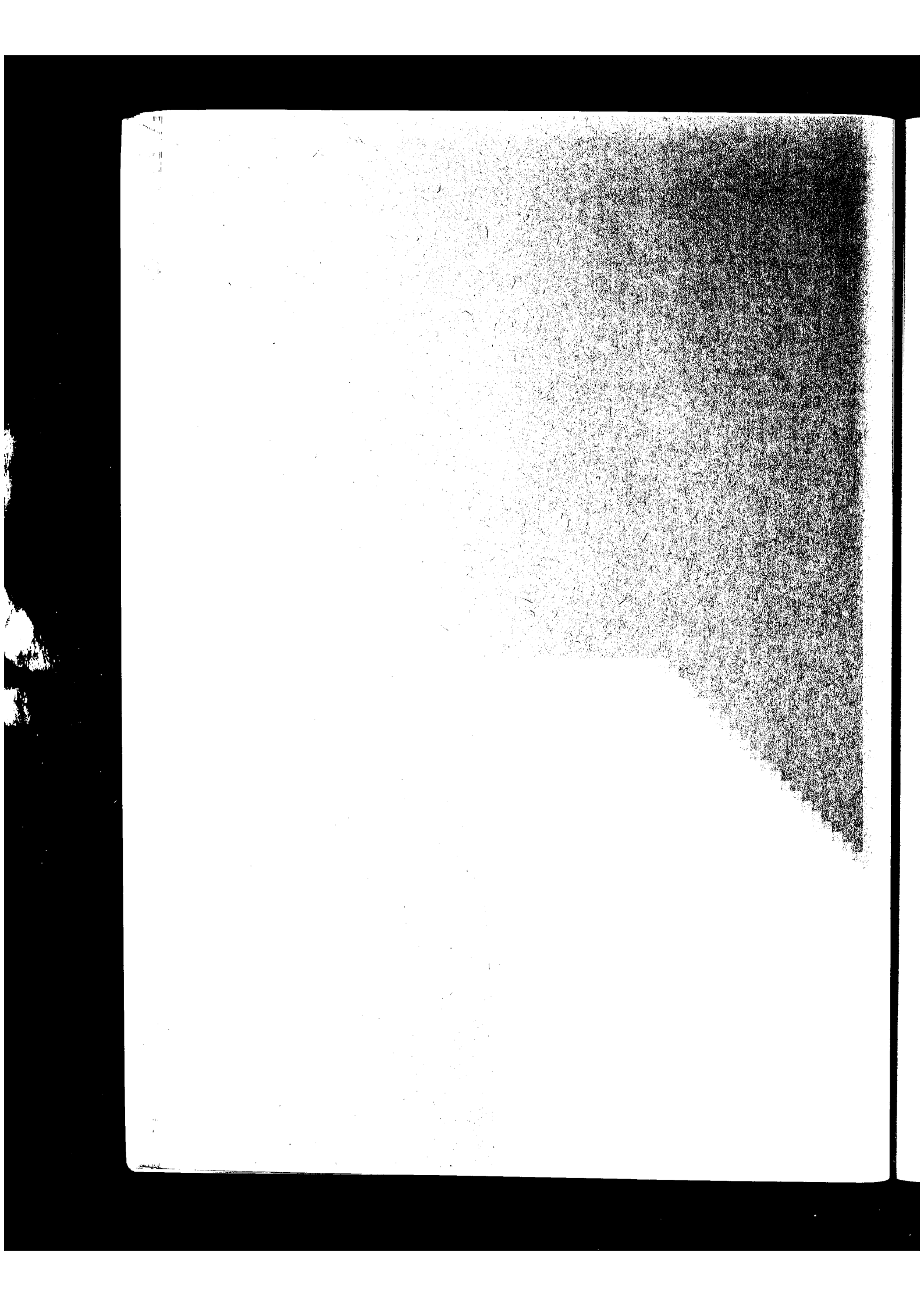

Appendix A
Abbreviations

AA	area administrator
AHA	area health authority
AHST	Association of Health Service Treasurers
AMO	area medical officer
ANO	area nursing officer
AT	administration trainee (Civil Service)
AT	area treasurer
ATO	area team of officers
CIPFA	Chartered Institute of Public Finance and Accountancy
CHC	community health council
CNAA	Council for National Academic Awards
COI	Central Office of Information
DA	district administrator
DCP	district community physician
DES	Department of Education and Science
DFO	district finance officer
DHSS	Department of Health and Social Security
DMT	district management team
DN	diploma in nursing
DNO	district nursing officer
DPH	diploma in public health
FCM	Faculty of Community Medicine
GAA	general administrative assistant
HCO	higher clerical officer
HEC	Health Education Council
HMC	hospital management committee (until 1974)
HV	health visitor
IHSA	Institute of Health Service Administrators
IPM	Institute of Personnel Management
LGTB	Local Government Training Board
LSE	London School of Economics and Political Science
LSH	London School of Hygiene and Tropical Medicine
MFCM	Membership of the Faculty of Community Medicine
NDC	National Defence College
NHS	National Health Service
NNSC	National Nursing Staff Committee (until 1974)
NSC	National Staff Committee (until 1974)
NTC	National Training Council
QMC	Queen Mary's College
RA	regional administrator
RCDS	Royal College of Defence Studies
RGN	registered general nurse (Scotland)
RHA	regional health authority
RHB	regional hospital board (until 1974)
RMN	registered mental nurse
RMO	regional medical officer
RNO	regional nursing officer
RSC	regional staff committee (until 1974)
RT	regional treasurer
RTO	regional team of officers
SCM	specialist in community medicine
SCM	state certified midwife
SRN	state registered nurse (England, Wales and Northern Ireland)
SSRC	Social Science Research Council
UCCA	Universities Central Council on Admissions
UGC	University Grants Committee

Appendix B

Notes on the structure and organisation of the National Health Service*

The National Health Service Act 1946 made the Minister of Health responsible to Parliament for ensuring that health services were available to everyone throughout the country.[51] The services are free at the time of need, except for token charges for some items, and are financed from central government funds through taxation and national insurance.

Until 1974, the NHS was organised in three parts: hospitals, general practitioners and local authority services. The hospital services were run by regional hospital boards and hospital management committees. Under the National Health Service Reorganisation Act 1973[52], these were replaced by regional and area health authorities with statutory responsibilities for all health services.

Central authority

The Ministry of Health and the Ministry of Social Security amalgamated in 1968 to become the Department of Health and Social Security, with the Secretary of State for Social Services at its head. This is a political appointment, as are those of Minister of State (Health) and Minister of State (Social Services). The permanent officials of the DHSS are members of the Civil Service.

Regional health authorities

A regional health authority is responsible to the DHSS for strategic plans and priorities for its region and for allocating resources to, and monitoring the performance of, the area health authorities in the region. It is also responsible for identifying and providing services which need regional rather than area bases.

The chairman and members of an RHA are appointed by the Secretary of State after consultation with appropriate organisations, universities, local authorities, professional organisations and trades unions. The chairman is paid part-time; the members are unpaid but may claim expenses.

The senior permanent officials of a region are an administrator, medical officer, nursing officer, treasurer and works officer; they form the regional team of officers (RTO) and are responsible to the authority. Each region is divided into areas.

Area health authorities

An area health authority is responsible to the RHA for assessing needs and for planning and organising services in its area.

The chairman is appointed by the Secretary of State after consultation with the chairman of the RHA. Of the members, four are appointed to represent the local authority, the remainder are selected by the RHA. The chairman is paid part-time; the members are unpaid but may claim expenses.

The senior permanent officials of an area are an administrator, medical officer, nursing officer and treasurer; they form the area team of officers (ATO) and are responsible to the authority.

Health districts

There may be up to six health districts in an area depending upon the size and population of the area. The day-to-day operation of health services in a district is the responsibility of the district management team (DMT) which comprises an administrator, community physician, finance officer, hospital consultant, general practitioner and nursing officer.

The district also has health care planning teams whose functions are to determine the health care needs of the district – for example, services for the elderly, mentally ill – and to study particular problems, such as reorganisation of outpatient departments or development of primary care services.

Social services

Social services are planned and controlled by local government authorities, in consultation with area health authorities, and are financed mainly by local government funds.

*These notes give only a very brief description of the NHS. Readers may wish to consult the bibliography for further information.
[2, 4, 17, 18, 23, 51, 52, 65]

Community health councils*

Each health district has a community health council (CHC) which represents the 'consumer'. Its members are appointed by the local authority, locally active voluntary bodies and the RHA. The members are unpaid and appoint their own chairman. A CHC has powers to secure information, to visit hospitals and other institutions, and has access to the AHA and its team of officers. The AHA is required to consult CHCs on its plans.

*Further information may be obtained from *CHC News*, 126 Albert Street, London NW1 7NF.

Appendix C

Notes on school examinations and educational requirements for entrance to the three main professions

School examinations in England and Wales*

The public examinations recognised by the Department of Education and Science are the Certificate of Secondary Education (CSE) and the General Certificate of Education (GCE). The CSE, normally taken by pupils of 16 years of age, is administered by 14 regional examining boards. The GCE is conducted at ordinary (O) level, normally taken by pupils of 16 years, and advanced (A) level, normally for pupils of 18 years. It is administered by nine national examining boards. The GCE O level is aimed at about the top 25 per cent of the pupil population and the CSE at about the top 60 per cent. GCE A level caters for roughly the top 15 per cent.

Two or more GCE A levels are required for entry to a first degree course at university. GCE O levels or CSE equivalents are required for courses of further education and for professional training courses other than those taken at university.

Educational requirements for entrance to health professions†

Medicine

Medical schools are part of the university system and candidates for entry must have university entrance qualifications in science subjects. The Government delegates to the General Medical Council statutory responsibility to maintain a register of all those qualified to be medical practitioners. Primary qualification, which confers a title to provisional registration, is obtained by examination; full registration may be applied for after a year as resident house officer in approved hospitals. Medical practitioners who hope to become consultants and specialists require experience in the chosen specialty and additional qualifications – a higher degree, or membership or fellowship of one of the royal colleges, or equivalent qualifications.

Nursing

Minimum requirements for general and mental nurses are set by the General Nursing Council for England and Wales and, for midwives, by the Central Midwives Board. These are statutory bodies with responsibility to the Government for maintaining registers of nurses and midwives qualified to practise. GNC minimum requirements for state registration courses are five years' full time education with two GCE O levels or CSE grade 1, or three GCE O levels or CSE grade 1, or a pass in the GNC educational test. Most training schools require higher standards than the minimum, some offer degree courses linked to universities or polytechnics (see Appendix D).

Administrative and financial

A good level of general education is required on entry, though formal qualifications are not specified. University graduates and those with equivalent qualifications compete for places in junior administrative training schemes. Some places are available to those with university entrance qualifications. Professional qualifications in administration are conferred after examinations by the Institute of Health Service Administrators, a professional association with no statutory responsibility. Other professional qualifications, for example in accountancy, are conferred by the appropriate association.

*Information for these notes is taken from *Britain 1977*[19], and *British Qualifications*.[69]

†Information for these notes is taken from *British Qualifications*, and from leaflets on careers in the health service prepared by the Department of Health and Social Security and Central Office of Information.

Appendix D
Nursing degree courses

Number of courses	13	
University-linked courses	10	Places 148
Polytechnic-linked courses	3	Places 78
		Total Places 226
Courses linked to UCCA scheme for processing applications	9	

Qualifications and degrees offered

SRN	1
RGN	1
RMN	1
HV option	4
DN Certificate	3
BSc(Hons) Social Science and Administration	2
BSc(Hons) Nursing Studies	3
BSc(Hons) Economics	1
BA(Hons) Social Science and Administration	1
BSc Social Science	1
BSc Life Sciences	1
BSc Social Science – Nursing	1
BA Nursing	3
BSc Nursing	1
BTech(Hons) Social Science	1

Finance

local authority grant only	5
student nurse training allowance and local authority grant	8

Numbers qualified

Between 1966 and 1976, 162 students have started and completed courses; 136 have obtained nursing qualifications and a degree (wastage 26). More students have started courses but have not yet completed.

Degree and Registration

1971	7
1972	7
1973	25
1974	35
1975	46
1976	16 (so far – this includes Liverpool)

		Started	Degree	Registration	Degree and Registration
St George's – Surrey	1966-71	7			7
	1967-72	4			4
	1968-73	7			7
	1969-74	11			10
	1970-75	15			15
St Thomas' – Southampton	1969-74	8			6
	1970-75	6			4
	1971-76	7			7
	1972-77	7		4	
	1973-78	10		6	
St Bartholomew – City	1968-72	4			3
	1969-73	6			4
	1970-74	6			6
	1971-75	6			6
Liverpool	1971-76	5	4		*
Middlesex – Bedford – LSE	1969-74	4			3
	1970-75	9			5
	1971-76	5			4
London – QMC – Goldsmiths	1968-73	3			2
	1969-74	6			1
	1970-75	5			3
	1971-76	2			(1)
Manchester	1969-73	12			12
	1970-74	13			9
	1971-75	16			13
Cardiff	1972-77	10			
Newcastle	1973-78	15			
Leeds	1974-79	16			
Westminster – South Bank	1974-79	11			

*awaiting results

Note: The course at St George's Hospital and University of Surrey has now been discontinued and not included in any of the figures except of those who had qualified by 1976.

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Index


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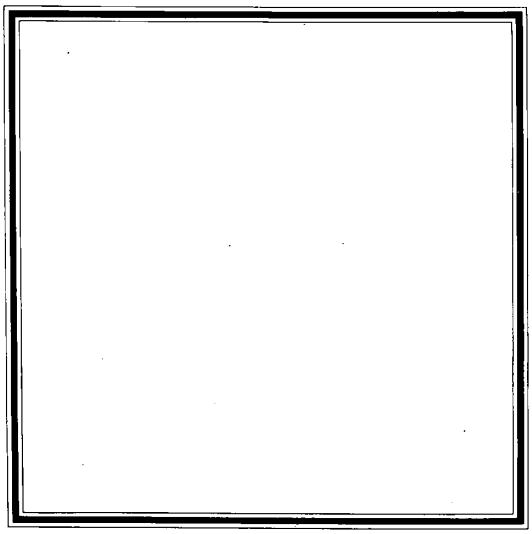
The education and training of senior managers in the National Health Service – a contribution to debate

This report of a King's Fund working party discusses the special problems of managing health services, compares the development of management training in the NHS with that of other public services, with an analysis of the role of universities, the Department of Health and Social Security and the NHS authorities, and outlines a future strategy. In a foreword, the Secretary of the King's Fund writes 'In setting up the working party, the King's Fund held the belief that a sufficient period had elapsed since the reorganisation of the NHS to ensure the relevance and effectiveness of a study of the education and training needs of those responsible directly to the health authorities for the working of the new service . . . there is throughout the study a firm belief in the value of good management from the point of view of the patient. There is too a conviction that, suitably handled, resources already exist for the achievement of an appropriately high standard of management education for this purpose. Within this context, there are three aspects of the educational process which are emphasised as needing special consideration.

'First, there is the role of the separate professions, each with its own high level of professional qualification, which must adjust to new responsibility for corporate advice and decision. Second is the need for a policy for the use of universities and other institutions of higher education as the source of conceptual development and research. And third, the evidence is reviewed and a case argued with conviction for the establishment of a system of continuing education and preparation for change.'



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