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DECISION MAKING IN THE NEW NHS

CONSENSUS OR CONSTIPATION ?

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Hay

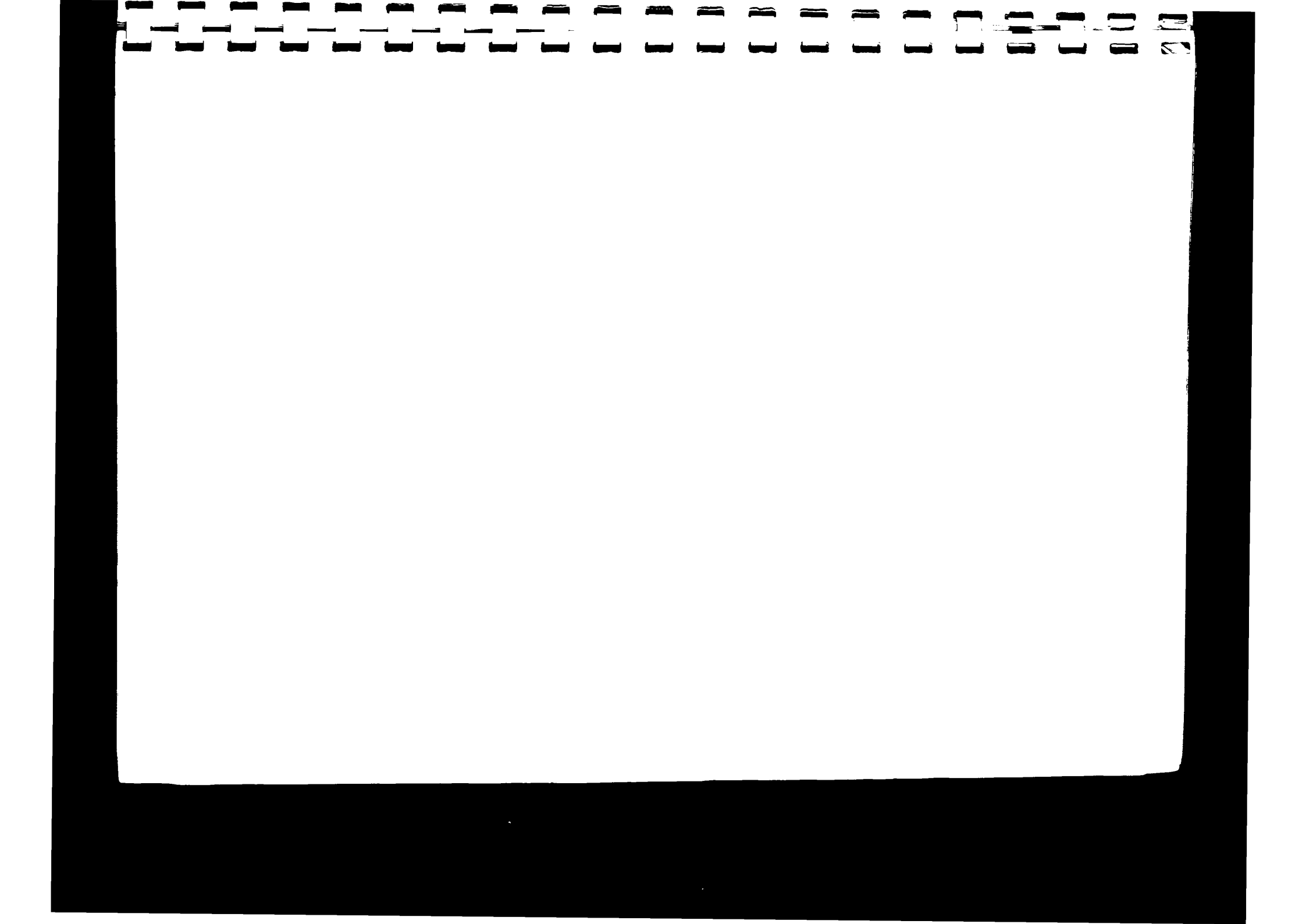
CONTENTS

SUMMARY

The process of decision making in area health authorities in often slower than it was in the pre-reorganisation hospital management committees and local health authorities. This is not merely a transitional problem which will go away as the service settles down: there are features in the formal management arrangements which threaten to slow decision making down, without commensurate gains in quality, in the long term. The absence of convincing interdisciplinary machinery below the district management teams, particularly in multi-district areas, is the major problem because it has accentuated the trend towards centralisation of decision making at team level. The complexity of the consultative machinery within the area health authorities and the frequent equation within management teams of consensus decision making with 'no offence' also add to the difficulties.

The analysis is based on a number of sources of information, of which the chief one is a three year project into the impact of reorganisation on a four district area health authority. This is supplemented by information gained from officers in all parts of the country, other research projects, official reports, articles in professional journals and experience of membership of a health authority.

The case for speedy decision making in the NHS is discussed in the introduction and this is followed by a discussion of the expected impact of the new formal arrangements on this feature of management. The comparison of expectations and reality and the reasons for the dissonance between the two are discussed in the second section; the possible remedies are considered in the concluding section. While accepting that other factors such as training and availability of adequate information are important in determining the quality of management in the NHS, the case is made in the conclusion for some changes to the formal management arrangements to streamline the decision making process.



INTRODUCTION

The reorganisation of the NHS was not, we were assured, motivated by notions of 'administrative tidiness': it was sold by the Government of the day as the prerequisite of better services.[1] The benefits were not, however, expected to flow automatically from the unification of the three, previously separate, arms of the service; a new approach to its management was also thought to be necessary.

> 'As the document's brief statement of the Government's proposals for a new health service structure makes clear, their essence ... is the emphasis they place on effective management. The importance of good management in making the best use of resources can hardly be overstated. It underlies the document's proposals for strengthening the regional organisation ... and in drawing clear lines of responsibility and accountability throughout the levels of authority.'[2]

The most tangible manifestation of this approach was a blueprint for the new management arrangements prepared by a study group assisted by the management consultants, McKinsey and Co, and the Health Services Organisation Research Unit of Brunel University, and known as the 'Grey Book'.[3]

In this paper we examine the impact of the new arrangements (which owe much to the Grey Book in spite of changes in detail) on one important aspect of management - speed of decision making - to see whether they have produced any improvements in this direction. Speed of decision (and action) is often held to be a sign of managerial competence by those in the NHS, and thus constitutes a relevant and significant test of the appropriateness of the new arrangements and the philosophies which gave rise to them. This is not to suggest that the speed is always the most important consideration in decision making: there are occasions when a measured approach is more appropriate. Planning decisions - where the quality is as, and possibly more, important than decisiveness - are a case in point.

Yet speed of decision is important in a service like the NHS. Managers responsible for back-up services to field staff must be able to respond quickly to operational problems if patient services are not to be affected. A surgeon, for example, who finds that his

operating sessions are being held up by defective supplies from the central sterile supply, wants something doing about it quickly: long term consideration of alternative sources of supply is no answer to an immediate problem.

There is another reason why it is important to dispose of some issues in the shortest possible time. The manager has a limited amount of time at his disposal. If he is to deploy it to full advantage, issues of limited importance must be dealt with as expeditiously as possible to allow him to concentrate his energies on those with more long term implications.

The case for speedy decision making is not, however, confined to issues of lesser importance and crises. Naylor and Willcocks, writing before the changeover, argued for local discretion 'to ensure freedom of action and speed of decision' for what they described as the 'general management' of the total enterprise. At the operational level, this responsibility encompassed 'the co-ordination of the entire local organisation, the determination of policies and the setting of objectives, and the management of resources taking into account medical and social priorities'.[4] Clearly this definition encompasses issues which have substantial implications for the long term development of the service, and for which we have already suggested a measured approach may be more appropriate, in the interests of a higher quality of decisions.

The reasons for their commendation of speed in these circumstances are not clear, and perhaps like many others, particularly managers, they take the case for it for granted. In one important respect it is, however, possible to see a strong case for limiting the time spent on finding solutions to long term and major problems. Herbert Simon long ago demonstrated the 'bounded rationality' of administrative man and the impossibility of finding the optimal solution to any problem.[5] There is thus little profit in continued consideration of alternative courses of action beyond the point at which the enhanced quality of the decision will not compensate for the disadvantages involved in additional delay.

These, then, are some of the reasons for the importance attached to speed of decision making in any organisation. The most familiar prescription for its realisation is decentralisation of authority since this shortens lines of communication from the field stage to a manager who can take action on problems. Delegation of authority in itself is not a guarantee of quick decisions: local management arrangements themselves have to be conducive to speed. An analysis of whether the formal management structure for area health authorities meets these requirements is the specific focus of this paper.

One basic assumption underlying the analysis is the significance of the formal arrangements for management behaviour. In recent years it has been a fashionable sport in the academic world to deride the prescriptions of the classical school of management, who set great store by the formal structure of the organisation. And indeed it is easy to point in that body of theory to contradictions and prescriptions which, in the event, mean nothing very specific in practice. The sport of the academic has not caught on with successive governments, which have subjected the public sector to an avalanche of administrative reforms in the last decade. Unless one has sunk into irredeemable cynicism about the motives of those who govern, we must accept that they were convinced that changes in the formal structure of organisations produce better services. In other words, they thought changes in formal structure were closely associated with changes in managerial performance.

Those who take this view do not have to deny the influence of many other factors on the behaviour of managers. Clearly, factors such as selection, training, quality of information are important, but like the formal structure they only give us part of the picture. What is at issue is really the relative significance of each of the many influences on managers. In this paper we have done no more than assume that formal arrangements do have some significance and trace the relationship between them and the process of decision making in the NHS.

The analysis begins with a look at those features of the formal management arrangements which could have been expected to streamline the decision making process, or at least make a contribution to that end. This is followed in the second section by an assessment of their impact to date, and their likely impact in the long term. This assessment is based on material from a number of sources of which the main one is a three year research project into the effect of reorganisation on one multi-district area health authority.[6] Information gleaned from this source (identifiable by a reference to the 'research area') is supplemented by that from other locally based research projects, observations by senior personnel on our material, and reported experiences and assessments of staff within the service. The final section examines the possible contribution of modifications to the formal arrangements to streamlining the decision making process in the reorganised NHS.

Speed of decision making and the formal management arrangements

One of the basic facts of life in the NHS is the interdependency of the various occupational groups in it. The increased size of health authorities (budgets, staff employed, etc) has

given another twist to the scale of differentiation of function and thus made provision for effective coordination even more essential. There are not only more management levels but also, within the authorities themselves, the bigger workload has led to the creation of separate departments and specialist posts. Any analysis of the new management system is well advised to start at this point, since inadequate or over-elaborate machinery for integrating the many departments, tiers and specialists will have a significant impact on the process of decision making.

We describe below the formal provisions for coordination as they appeared in the Grey Book, which, after all, was the basis for a common management framework. It must be remembered, however, that there were local variations, particularly in the machinery for bringing together the views of medical staff.

a MECHANISMS FOR INTER-PROFESSIONAL COORDINATION

Management teams

The senior members of the major occupational groups (administrators, community physicians, finance and nursing officers) come together at district, area and regional level to constitute management teams. The four district officers are joined by the two representatives of the district medical committee (a consultant and a general practitioner). The integrative function of the teams is reinforced by their collective responsibility to the health authority and by the requirement that their decisions must be by consensus. Each member of the team has the power of veto, making this particular definition of consensus the equivalent of unanimous agreement.

Health care planning teams

Health care planning teams were designed to look at the future development of particular services rather than everyday problems of coordination. Nevertheless, they were designed to promote interdisciplinary cooperation and, indeed, embrace a wider spectrum of professional groups than do the management teams.

> '... there will probably have to be representation of general practitioners, consultants, hospital and community nurses, health visitors, relevant para-medical staff and representatives of local authority services, particularly social services.'[7]

The administrators

The responsibility for general coordination - defined as 'helping all branches of the service to work effectively together to meet patient needs' - falls to the administrator. His authority in no way, however, undermines the concept of equality between team members since it is confined to persuasion. Administrators who are not team members are also expected to play a similar role at other levels of the organisation. [8]

Community physicians

Community physicians also have responsibilities for coordination of activities within specific functions.

> 'A specialist in community medicine must stimulate the process of integration. He will provide a service to clinicians, acting as a link with the local authority services.' [9]

The attendent responsibilities for planning, information, and evaluation of services makes the role of community physician somewhat reminiscent of that of the senior administrative medical officers of the pre-reform regional hospital boards. In these authorities too the medical officers and administrators had responsibilities for coordination - a fact which will make the 'new' situation rather familiar to many managers from the hospital service.

b MECHANISMS FOR INTRA-PROFESSIONAL COORDINATION

Hierarchies

For all occupational groups, except doctors, there are familiar pyramidical management structures. At each organisational level, managerial authority is thus the main instrument of coordination.

Collegiate systems

The uniqueness of the medical profession is well recognised in the new management arrangements. A hierarchical arrangement would, given the professional independence of general practitioners and consultants, be inappropriate as a means of coordinating their activities. Nevertheless, since their decisions have resource implications for other groups of staff at all levels of the service, and for each other, machinery to coordinate their own activities and to tie them into the general process of decision making is necessary.

The new structure builds on to the collegiate system which had developed in general practice (local medical committees) and in the hospital service (divisional and medical executive committees). Those committees consisted of all the relevant doctors (eg, all surgeons in the division of surgery) or their representatives. In the new set-up there is, in addition, a medical committee at district level with representatives of general practitioners, consultants and other branches of medicine: an area advisory committee which is similarly constituted: an area committee for representatives of hospital staff to match the one for general practitioners: and links between this machinery and that at regional level. The doctors are also linked directly to the general decision making processes by their representatives on the district management teams.

c INTEGRATIVE DEVICES IN THE NEW MANAGEMENT STRUCTURE: GENERAL

We have only discussed the most important formal mechanisms for integrating the activities of the different groups within the NHS. There are, of course, other features such as the new planning system, which will also facilitate this process and thus make the course of decision making run smoothly.

The benefits to the decision making processes were not confined to better machinery for coordination. The restrictions on the role of authority members, for example, to broad policy issues and general supervision, were designed to leave officers freer than their predecessors had been on matters of detail. This has obvious implications for speed of decision, as have some other features of the new arrangements, which are discussed briefly below.

Delegation downwards

Maximum delegation downwards was a much trumpeted feature of the new service. There are a number of rationalisations for this strategy (one of which may be that there is no alternative in the health service), of which one is directly related to speed of decision making. The longer the chain through which information has to go, the longer it takes to get action: the nearer the decision point to the place where the service is offered, the greater the capacity for a speedy response.

Definitions of management roles

Another facet of the new structure which was expected to benefit the decision making process was the emphasis on clear and precise role definitions for managers. Great store

was placed on this particular development, which has been the theme of other contemporary reorganisations (eg, Salmon). 'It is important that organisation structures, functions and procedures should be clearly laid down to a greater extent than in the past.'[10]

Again the rationale for specification of management roles, relationships and responsibilities is not necessarily speed of decision making. Jaques, for example, links it with accountability and, through that, with a higher level of performance from managers.[11] In the context of this paper though, role specification is a relevant consideration because the route to the appropriate decision point should thus be clearer, and it provides the basis for the decentralisation of authority because accountability of officers and authorities is more easily established.

Participation in management decisions

The new service is designed to be more participative than the old one. Sir Keith Joseph, in his introduction to the White Paper on Reorganisation, picked out this feature for particular mention as far as the staff (essentially the professionals) themselves were concerned:

> 'He, or she, will have the opportunity of organising his or her work better and of playing a much greater part than hitherto in the management decisions that are taken in each area.'[12]

The wider 'net' of consultation was not confined to the staff employed in the service. Joint consultative committees, involving members and staff, have been established with local authorities; and community health councils, as representatives of the consumers, have to be consulted on plans for the development (or cutbacks) of the service locally.

It may be thought that the main benefits of this approach will be better rather than quicker decisions. Indeed, many would go further and assert that consultation and speed are mutually antipathetic: more of one means less of the other. Anyone taking this view would have expected decision making to be slower in the new service precisely because of the more elaborate provisions for consultation.

But this is too simple. There are ways in which more consultation could paradoxically 'smooth' the processes of decision making. The commitment of doctors, for example, to the outcomes of these consultative procedures could make life easier for managers. They would have a clear brief and hopefully would not be so susceptible to pressure to do something inconsistent with those decisions.

Nevertheless, the balance of advantage, as far as increased participation is concerned, is most probably with the outcome rather than the speed of decision making. The Grey Book, when discussing the case for more medical involvement, justified it in those kinds of terms. It pointed out that 'clinicians are important innovators', and it was important for management to be aware of their new ideas because of their impact on administration. Consultation was also to be a means of enabling doctors to 'carry out their clinical duties with an understanding of the effects on other parts of the service' and committing them to 'proposed changes and developments'.[13]

Wherever the balance of advantage lies, it is clear that the policy of maximum consultation was going to have some effect on the process of decision making. In the context of speed, it was important that the consultative machinery did not slow down decisions on day-to-day affairs and delay 'longer term' decisions past the point where the benefit, in terms of better outcomes, became marginal.

d THE NEW MANAGEMENT STRUCTURE AND THE PROCESS OF DECISION MAKING: COMMENT

It would be unrealistic to have expected all the features of the new management structure to streamline decision making in the NHS. The outcome was, after all, the product of a bargaining process in which professional groups tried - quite naturally - to protect the interests of their members. Nevertheless, it is still valid to argue that one test of the appropriateness of the management arrangements (particularly those features that we have just highlighted) is their impact on speed of decision making since reorganisation was sold on the basis that it would improve management. And, in important respects, speedy decisions are an integral part of good management.

In the next section we examine the decision making process in action to see whether the management arrangements do, in fact, pass this particular test.

THE MACHINERY IN ACTION

a FIRST IMPRESSIONS

One ex-hospital administrator who kept a close watch on events in the first year of the new service commented on 'the unreasonable delays in getting action' and the separation of 'management' from the 'service'.[14] It is not clear from his article whom precisely the writer has in mind when he refers to 'management', but whoever it is, the two phenomena - a slowdown in the response to problems and the distance of the managers from other staff - would, in his opinion, seem to be linked.

A growing gap between the administrators and the consultants has been the subject of comment elsewhere. For example, a consultant at a conference organised by the British Medical Journal to review the progress of reorganisation said that, compared with the pre-reorganisation situation access to the administrator had become more difficult. He felt administrators were now 'so busy with paperwork and discussions that they were never seen about the place', and it now took longer to get decisions.[15] Similar comments were made by consultants in the research area.

The research project also produced evidence of a slowdown in the dispatch of routine business. A substantial minority (a third) of a sample of middle grade managers who completed a questionnaire, some seven to eight months after the appointed day, agreed that decision making on day-to-day issues had slowed down as a result of reorganisation. Very few (less than a sixth), in contrast, felt it had improved, while the majority felt reorganisation had made no difference.[16] In follow-up interviews there were complaints that suppliers were not receiving payments as promptly as hitherto, of wages not being paid on time on two occasions, and the whole process of decision making being slowed down by the delays in making budget allocations.

This would seem to have been a general (and not unexpected) phenomenon and few senior officers - in or out of the research area - dispute the adverse impact of the transition from the old to the new on the speed of day-to-day decision making. What is perhaps more surprising is the length of the period in which these disadvantages have manifested themselves. As late as March 1976 Pethybridge, reviewing the national scene, refers to what 'appears to be a growing volume of criticism about delays in obtaining decisions ...' and blamed - partially - the inevitable difficulties associated with reorganisations for this state of affairs.

This is not, however, the whole story. Pethybridge, by arguing for better management to streamline decision making, accepts that the management arrangements themselves have contributed to the malaise.

> 'After all, most professions have, over the years, developed ways of circumventing the more outrageous extravagances of politicians and Parliamentary draftsmen; the added difficulties imposed by McKinsey should not be allowed to drive us to conceding defeat.' [18]

The possibility that particular features of the management arrangements are partially responsible for the slowdown in decision making on day-to-day issues is strengthened by the persistence of the difficulties into the second year of the new service, when some of the immediate problems had been overcome. In the research area some officers related delays not to the strangeness of the new arrangements but to essential parts of them. One nursing officer, who had had experience of a top post in the pre-reorganisation service, put it this way:

> 'What is generally complained about (by colleagues) is the abundance of meetings. Every day you are at a meeting, and what is generally complained about is that from these meetings come no decisions, and I think this is because there are so many committees that have to be consulted before any decision can be made. It's got to go to the community health council, the local medical committee, the district medical committee, the nurses' advisory committee ... '

The basis for her comparisons - as far as speed of decision making was concerned - was clearly her previous experience in the old service. And compared with that, the process of decision making seemed slower and promised to remain so in the long term for similar types of issues. We look at why this is so in the next section.

b LONGER TERM PROSPECTS

Three features, in particular, promise to be a continuing source of difficulty, even when the transitional difficulties have been fully overcome. One is the absence of convincing machinery, below district management team (DMT) level, to coordinate the activities of different professional groups. This has been a factor in the rather unexpected degree of centralisation of authority in the districts in the DMTs, which has slowed down the process

of decision making. Another is the machinery for medical involvement in management. It has - so far - added little to the quality of decisions and lengthened the process through which they have to go. This again has bogged the machine down. The third feature which has contributed to the constipation of the administrative machine is the relationship between the area and district officers. The 'monitoring' role of the former has proved a source of confusion in the allocation of responsibility and this too has injected difficulties into the decision making process.

All three problems have been exacerbated by the requirement that management teams proceed only by consensus. As a general proposition the idea sounds fine, and in this democratic day and age any other course would, to say the least, be hazardous. Yet its effect, as we shall see later, has been to make it more difficult for top management to tackle deep-rooted problems, because of the emphasis on not offending colleagues - or indeed powerful interest groups.

Before we look at each of these stress points in some detail to substantiate the view that they have promoted the constipation of the decision making process, we need to be somewhat more precise about the kind of decisions we are talking about. Essentially, they are the small-scale executive decisions which give expression to agreed policies or keep the machine ticking over. An example of the former is the detailed preparation of schemes to attach community nursing staff to general practices after a general policy has been agreed. It is worth noting that the criticisms of the slowness of the decision making process voiced by the senior nursing officer and quoted above referred to just such an exercise. The multitude of decisions,on such issues as the replacement and renewal of equipment, stocks, maintenance programmes, appointments and related staffing matters, interpretation of incentive bonus schemes, supply problems and training, also fall within this definition. Together they constitute the bare bones of what the Working Party on Devolution within the NHS called the operational role of area health authorities (AHAs) and for which they were to have 'maximum freedom'.[19] While it is this class of decisions which has been particularly hard-hit by reorganisation, the 'stress points' in the management arrangements could have the same effect on the preparation of plans, once the planning system is fully operational.

Decision making in the health districts

The DMT is the basic operational unit of the NHS. As such, the district organisation has to have the capacity to deal with those issues which need prompt treatment from management. Note that it is the organisation and not the DMT itself which needs this capacity; the health

district is a large-scale enterprise in its own right with some providing services for populations of half a million.

Two features of the management arrangements outlined above are particularly relevant in this context. First, the integrative devices, like the responsibility of the administrator for coordination, designed to facilitate decision making on issues involving more than one discipline; and, second, the policy of maximum delegation downwards (matched by accountability upwards) within the context of agreed plans to meet the needs for consistency. The Grey Book and ministerial pronouncements have been less than 100 per cent clear about exactly who would benefit from this policy, but we assume for our purposes that factors like size and clinical freedom would require it to extend to managers within the health districts.

Centralisation of authority within DMTs

In fact authority seems to have drained from the levels below the DMTs. In the research area, for example, this was at least implied in the feeling of consultants that they were now farther away from the centre of decision making. A number of them too felt that the new managers (in terms of equivalent points of contact) had not the authority to act that their predecessors had had. We have already quoted the view of one senior nurse who felt similarly: her colleagues gave us specific examples. One example was that the go-ahead to get a replacement for the damaged car of a member of the community health staff in a rural area took much longer than under the old system. Part of the problem was uncertainty about the appropriate decision point, but the organisational distance between the divisional officers making the request and the decision maker (when found) was also a factor.

Another test of the centralisation hypothesis is the autonomy of officers who had had experience of top positions in both services. While the nursing and finance officers on the teams have gained in this direction, some administrators do feel that they have lost some freedom of action - as do some community physicians. Four of the senior officers in our research area fell into this second category (two ex-group secretaries and two community physicians) and three felt this was so. Another administrator (not a team member) felt that he too, although he had been promoted, had less scope for independent action than he had had as a hospital secretary.

Clearly promotion would imply that promotees should be dealing with issues of a different order, if those at the periphery of the organisation were to retain the same kind of authority as their predecessors had had. It was reasonable to assume too that the additional

responsibilities of team members, in particular, for planning would absorb their energies, thus leaving room for the delegation of authority to managers farther down the line. Yet the kind of business transacted at DMT level (and sometimes at area level) has often been reminiscent of the hospital management committees, suggesting that the planning function (possibly because of the delay in introducing the new system) has not absorbed the energies of all district officers. They are still often involved in the kinds of decision (though in a wider geographical context) that demanded their attention before promotion. This is not confined to the research area. A contributor to a British Medical Journal conference on reorganisation acknowledged too that 'our DMT has dealt with too many residual problems which could have been tackled at a lower level'.[20]

Centralisation within DMTs: a temporary phenomenon ?

It is tempting to dismiss the centralisation of decision making in the DMT as another temporary phenomenon. After all, team management was new to most senior officers in spite of experiments on these lines before the appointed day, particularly in the hospital service. It did involve, too, a quite different set of relationships between the heads of the various professional groups. Before reorganisation the medical officer of health had been the boss of the directors of nursing services: the group secretary had been the de facto chief officer to the hospital management committee, and, as such, senior to both the chief nursing officer and the treasurer. Now all were supposed to be equal.

It has not always been easy in this new situation, either, to decide which issues should be left to the professional manager most concerned or referred to the team for consideration. It is therefore not too surprising to discover that, at a time when officers were conscious of the need to establish good relationships with each other, they often erred on the side of caution and sent too much to the team for decision. So much so in one case that one team member in the research area said that the DMT was spending time haggling over things which he decided himself before reorganisation 'with my eyes closed'.

It might also be argued that a centralisation of authority is to be expected in the early stages of reorganisation. This certainly was a feature of NHS reorganisation, particularly in the planning stage. We should therefore not be too surprised to find that the national picture has been repeated locally. In the case of the districts, there were additional factors to explain the centralisation of what authority there was in the DMTs. Since team members were the first senior officers to be appointed in the districts, it was natural that they would do things which they would subsequently delegate to others. For a long time there was no one to whom they could delegate - at least, officially.

Yet this is not the complete answer. There are institutional as well as transitional factors which explain the centralisation of authority within the districts. Of these, the most important is the absence of convincing machinery for interdisciplinary decisions below DMT level.

Machinery for interdisciplinary decision making below DMT level

Rowbottom has identified five areas in 'any sizeable health organisation' requiring some coordinating machinery

1 the treatment of the individual case ('co-ordination of the individual case')
2 services for a particular patient group ('co-ordination of the patient group')
3 the work, training and development of particular occupational or professional groups ('occupational co-ordination')
4 the activities at one particular institutional site ('institutional co-ordination')
5 the development and provision of services as a whole ('overall operational co-ordination').

At least four of these areas (1 to 4) call for some provision below DMT level, although, like Rowbottom, we feel there is 'little scope for any extension of stronger, hierarchical, mechanisms of integration' as far as the 'co-ordination of the individual case' is concerned. We therefore confine the examination of the adequacy of the formal management arrangements for inter-professional coordination within the health districts to the other three areas of activity (2, 3 and 4).

The most extensive formal provision is for those activities which Rowbottom said required 'occupational co-ordination'. The hierarchical system for integrating the work, training and development of particular groups of staff has been underlined in the new NHS, and the 'professional pyramids' provide a familiar context for coordination. This may have produced some early gains for the reorganised service. Over a third of the sample of middle managers referred to earlier felt that communications between hospital and community nurses had already improved as a result of reorganisation, while for activities where there was no common hierarchy (eg, between hospital departments and the ambulance service) a much smaller proportion thought there had been any improvements. It is worth noting in passing that there are groups of staff (eg, paramedical, scientific) for which satisfactory hierarchies have not been established, and problems of occupational coordination thus require (if Rowbottom's premises are accepted) different mechanisms for their management.

The formal arrangements for coordinating the services to particular patient groups and within institutions have received less attention in the blueprints for the brave new management world. The most relevant features are the health care planning team and the responsibility of the administrator for coordination. The former, however, as its name implies, is more concerned with setting the context for long term decisions and, as such, is not the obvious vehicle for bringing together the relevant disciplines to settle operational problems.

The role of the administrator is much more central to the need for coordination. If there has been a centralisation of decision making at DMT level because of the absence of convincing machinery for interdisciplinary coordination, it follows that it may have been because the 'official' role of the administrators - or the way it has been perceived - was inadequate for this particular task. If so, this raises the question of whether their persuasive authority is sufficient to provide a firm base for interdisciplinary decision making below DMT level.

The annual report of the Hospital Advisory Service for 1974 would suggest that this is so.

> 'One of the problems which has emerged following the re-organisation of the National Health Service is connected with the day-to-day management of hospitals. With the introduction of multi-disciplinary management there now appears to be a lack of co-ordination of effort and there is no one person who represents the individual hospitals 24 hours a day seven days a week. Previously the hospital secretary was regarded as co-ordinator of management, but this position is changing with the appointment of sector officers who may be responsible for several hospitals and who are frequently away from the hospitals which they serve. An additional factor which makes this position more serious is that many senior officers from the hospital have been appointed to posts at Regional, Area and District level, and with the lack of senior posts at hospital level the sector officer and his subordinates are not always of sufficient seniority to enable them to co-ordinate the psychiatric, nursing and paramedical staff. The problem is further complicated by functional management, where functional managers deal directly with their subordinate managers and frequently do not keep the hospital secretary informed of developments.' [22]

The authors of the Grey Book did acknowledge the need for 'liaison' - either informal or formal - in the health districts. They did not specify any particular machinery for this purpose, however, though it was accepted that 'there may be multi-disciplinary teams established within institutions or sectors'. [23] The rather uncertain position of the sector was further reinforced by early guidance from the DHSS which said it was not a multi-disciplinary management tier. [24]

The absence of a specific prescription has strengthened the perception of the DMT as the 'natural' place to settle interdisciplinary issues and the team consequently acts as a 'lightning conductor' for issues requiring consideration by more than one discipline. The emphasis below the DMT is thus on vertical rather than horizontal communication. This tendency is, in turn, reinforced by considerations of status. The professional head at DMT level can feel his own position vis à vis other team members threatened if accommodations and agreements across professional boundaries are reached too freely down the line: it would circumscribe his freedom of action.

The ability of lower tiers of management to take responsibility (reinforced by the comparative inexperience of officers at this level compared with many of their immediate predecessors) on interdisciplinary issues is consequently clearly weakened and the absence of matching management structures for the different occupational groups further inhibits the growth of horizontal relationships. This is a pity because the increased differentiation of function, facilitated by the increased size of health authorities, means that interdisciplinary integrative machinery has become correspondingly more essential. This is a point made by a working party of senior administrators on the role of unit and sector administrators. They argue for an administrator of status for units and sectors. 'If there is no local manager of any status then the unit fragments and trivial problems are taken to a higher level for determination.'[25] The fact that the working party felt the need to talk in these terms reinforces the contention here that this is exactly what has happened in many places.

The connection between increased size and administrative constipation is strengthened by the prevailing view that single district areas have had fewer problems than multi-district ones[26], though a review of the management of the reorganised NHS by a working party of chief administrators reported most dissatisfaction with two district areas.[27] Smaller areas may well have been more aware of the need - and organisational room - for integrative machinery below DMT level, because the area team of officers doubled up as the management team. One administrator, for example, in such an authority, in commenting on the first year of the new service, chose to underline the importance of the sector, which he described as 'the essential forum for effective co-ordination'.[28] In his area, multidisciplinary teams (including, incidentally, paramedical staff) have been established at sector level.

Lawrence and Lorsch have pointed to the tendency of an 'integrating unit ... to push influence further down the structure'[29], which suggests that the creation of such machinery is an essential part of any move to decentralise decision making in the health districts. Good intentions are not enough, and some amendments or additions to the formal arrangements for the management of health districts are required if the decision making process is to be

relieved of its constipation.

Doctors and management

Another feature of the new structure which has had an adverse effect on the decision making process is the establishment of machinery to promote closer links between doctors and management. Although similar provision has been made for other groups of staff, it is not as extensive as that for the medical profession and thus has less impact on events so far. Interest is therefore confined here to the machinery for doctors. There has been an increase in the number of committees in which doctors have to participate. A consultant, for example, could now find himself on the divisional medical committee for his specialty, the district medical committee (DMC) as the representative of the division, the district management team as the representative of the DMC, a health care planning team, and a member of the area medical committee (AMC). Even this does not exhaust all the possibilities; there are places for consultants on the local medical committee (LMC) of the general practitioners, the area committee for consultants, the area health authority and regional committees.

Immediately prior to reorganisation, the number of equivalent 'opportunities' to participate was four committees less (AMC, area committee for hospital consultants, health care planning team, membership of the DMT). Even this comparison does not adequately portray the different dimension of involvement, because some of the new commitments - such as the DMT - are far more demanding than any of the pre-reform committees and in their turn generate additional work. In the research area, for example, members of the DMT represent the team at meetings of the community health council and the area health authority, and the two DMCs have established joint committees.

The potential of the new machinery for delay is well illustrated by taking a hypothetical example of a decision to attach community nurses to general practice in the light of a general policy to introduce such schemes. In the old service, the local health authority (essentially, the medical officer of health and the director of nursing services) had to obtain the agreement of the LMC and the executive council. Once obtained, detailed schemes could be prepared and the approval of particular doctors sought. If extra resources were required, the treasurer and the finance committee of the local authority would have to be convinced by the medical officer that this project deserved some priority. The initiative clearly lay with the officers of the local health authority, to whom fell the responsibility of negotiating with the three main interests - the executive council, the general practitioners and those who held the purse strings.

This took long enough. In the new service, however, the number of groups who have to be consulted has increased. The initiative rests with the district community physician and the district nursing officer, though in the new set-up there is no line relationship between the two. The other fairly familiar aspects of the consultative landscape are the LMC; the successor to the executive council; the family practitioner committee (FPC); and the finance officer. They have now been joined by the DMCs, the DMT, the area officers and the area nursing advisory committee, all of whom can legitimately expect a piece of the action.

It is hard to see the distinctive contribution of all the different interests which could be expected to be consulted in such a case. As far as the involvement of doctors is concerned, it is hard to see what the FPC and the LMC can add to the contribution of the general practitioners on the DMC. At best they represent another formal stage through which a proposal has to go, and at worst yet another interest to be bought off. The chain has thus lengthened without any obvious advantage to the quality of the decision making process.

The combination of a greater investment of time and absence of improvement in decision making occasioned comment at the British Medical Journal conference on the reorganised service. 'Clinicians spend more rather than less time on committees, most of which are acknowledged round the luncheon table to be useless,' was the comment of one consultant.[30] This is not, of course, the evidence on which grand theories are based but it is a commonly held view among clinicians. In the same vein, another contributor quoted the example of the 18 committees in one region which 'now had to consider a new registrar's post'.[31]

We leave a fuller discussion of possible remedies until later, but it is pertinent to note at this point that the extent of professional participation and the form it took was primarily determined by bargaining between the DHSS and professional associations who, quite naturally, wanted to maximise their fields of influence. The result may satisfy no one. Some, for example, would shrink from the emphasis on formal committees as the main vehicle for participation: nor does it seem to command the enthusiasm of doctors, perhaps because, according to the chief administrators, 'the new medical advisory machinery has yet to win credibility'.[32]

Clearly the machinery offers many opportunities to bog or water down a particular proposal. Though these may be familiar enough features of organisational life, the consultative machinery in the NHS has made these processes somewhat easier to initiate and the emphasis on consensus clothes the ploys with legitimacy. Yet, having been sanctified by legislation or departmental edict, due deference has to be paid to it even if decisions are delayed unprofitably as a result.

DMTs and the area team of officers (ATO)

It was suggested earlier (pages 12/13) that one feature of the new arrangements, the specification of management roles, relationships and responsibilities, had two advantages for the decision making process in the NHS. First, it provided clear routes to the appropriate decision makers; and second, it paved the way for the decentralisation of authority since the principle of accountability can be upheld.

One particular aspect of the specifications - those relating to the area officers and members of DMTs - has proved to be somewhat difficult to put into practice in multi-district area health authorities (AHAs). It was an issue on which the working party on devolution felt it necessary to comment, though it did also say that it did not know 'how widespread these problems may be, or how temporary'. The problems they mentioned were two-way ones. On the one hand, it was ATOs 'acting almost as if there was a line-management relationship between themselves and DMTs' and, on the other, a reluctance by DMTs to use the 'expertise which is available to them at area ... because they wish to preserve their "independence"'.[33] The working party of chief administrators, in their view of the reorganised NHS, felt, 'It must be a matter of concern that, after eighteen months of reorganisation, there should be so much doubt on this subject (i.e. relationship of DMTs to AHAs) and that some of the anxieties should be so strongly expressed.'[34]

The DMTs are - at least in theory - responsible directly to the AHA itself, with area officers' roles confined to 'monitoring' their performance. It was made clear from the outset that 'monitoring' was not a clever way of saying that there was a line relationship between the district officers and their area counterparts, either as teams or individuals.

> 'A monitoring relationship is not managerial. The person who monitors has the authority to require to be kept informed about the activities of the persons monitored and has the authority to persuade them to change but, in the final analysis, he cannot order them to do anything and, if not satisfied, must refer the matter to higher authority ...'[35]

This may be more workable where the 'monitors' are responsible to a different authority from the 'monitored' (as is the case with area and regional officers), since no question of a line relationship can then arise. Within AHAs, the area officers have responsibilities which make this a difficult system to operate. They are expected, for example, to advise on area-wide policies, which at times will involve arbitrating between the competing claims of the districts. In the research area one district officer was quite open about the effect

of this. It was vital for him to be on good terms with his area colleagues because the latter would inevitably have much more influence with the authority than he ever could have. Unless he got on well with them, his district might suffer. The corollary was equally plain. Everything for the authority must be routed through the area officer, whose informal agreement would be sought. A de facto line relationship was thereby always a possibility. In two of the specialties this was already happening by the end of the first year of the new service, though the staff in the situation did not always realise it.

The devolution working party saw the direct access of the DMTs to the AHA as a crucial element in a successful policy for decentralisation of decision making. They stressed the need for papers prepared for the authority by area officers to be circulated to DMTs before the meeting to allow representations to the authority if this was necessary.[36] In fact about two-thirds of DMTs are represented at meetings of their AHA, though this visible presence seems unlikely to offset the inevitably closer relationship the area officers will have with the AHA because of their role as its secretariat. It is the closer relationship, rather than the right of access, which will (and does) bestow an informal authority on the area officers which, in its turn, will (and does) encourage the development of a line relationship mentality in both area and district officers.

Another responsibility of the area officers - to assist the AHA to control the performance of DMTs - merely reinforces this tendency. The assessment of management performance will always contain a large helping of subjectivity, given the difficulty of establishing objective measures. This will be so even when the planning system is in operation and performance can be measured against implementation of agreed plans. Approval of the way problems are handled, avoided, and the priority given to various demands on the time of district officers, will always involve questions of judgment. It will be, inevitably, the judgments of the area officers which will be crucial rather than those of the members, and, human nature being what it is, those who assess are going to be regarded as the senior partner by those who are assessed.

The difficulties many have had in putting this subtle relationship into practice have affected the on-going decision making process in a number of ways. For example, Maxwell (then of McKinsey and Co) feels that the uncertainties about roles have been a factor in the tendency towards centralisation, which, as we have already suggested, has slowed down decision making in the service.[38] The working party of chief administrators agree on the fact of centralisation, though they see the absence of the new planning system as the main cause of the difficulties in getting the area/district relationship on a sound footing.

> ' ... in the absence of the planning system there has been little or no reason for members and their Regional and Area Teams of Officers to embark on such conceptually difficult and demanding activities. The resultant vacuum has been filled by Authority members and their officers feeling the need to retain control of executive tasks.' [39]

The uncertainty surrounding the respective roles of area and district officers has, in some cases, produced another response which again has not been to the benefit of speedy decisions. Lewis and Weiner, pointing to the difficulties of making the concept of monitoring acceptable without the implementation of the planning system because oversight then looked like interference, report attempts by area officers 'to monitor' being 'fiercely resisted' by DMTs - with a certain amount of success in some areas. [40]

Conflict is not, of course, always a bad thing: it is an integral part of change which, in our kind of society, is usually regarded as a sign of progress. In the NHS however, the emphasis on consensus would suggest that it is not regarded as a desirable state of affairs, and there has been a preoccupation with getting the structure right, rather than producing the right decisions.

The new, formal structure has consequently not provided the clear routes to the decision points and the remaining doubts about the relative positions of the area and district officers add to the problem. Doctors in particular find it difficult to find their way around the complex new machinery and one group of consultants in the research area discovered 11 different routes for ordering supplies of screws for orthopaedic work !

Consensus decision making

Cynics who saw the notion of consensus as a compromise, necessitated by the unwillingness of the main professional groups to concede the chief executive role to a rival, will not have been unduly surprised by our earlier assertion that it has made for additional difficulties in the decision making process. Nevertheless, there were some (for example, Gourlay) who thought the concept had much to commend it, precisely because it would lead to improvements.

> 'Decisions made by consensus are characterised by their innovativeness and the commitment which the team feel to them ... A person party to a consensus decision will feel that he has had the opportunity of influencing the decision. All the alternatives available will have been thrashed through so that the group have a sound understanding of the problem and possible implications of each decision ...' [41]

In the event, the definition of consensus adopted for management team working was somewhat different. The Health Services Organisation Research Unit at Brunel University, in their gloss on the new management arrangements, portrayed it as 'equivalent . . . to unanimous agreement', in which acceptance 'can mean anything from strong backing to a just minimum amount of support'.[42] Nevertheless, it was clear that the practicability of the concept would have a considerable influence on the decision making process.

It was essential, for example, for this relatively time-consuming process to be confined to issues which merited such an approach. This has obvious implications for the agendas of management teams. Unless they were confined to issues which could not be settled elsewhere (and thus usually more expeditiously), the machinewould get bogged down. Our earlier comments on the centralisation of authority suggest, of course, that this has not happened and team agendas have contained items which should have been settled farther down the line. Pethybridge's plea for more decision making outside formal meetings and less attention to consultation suggests that this is also his view. '... It is almost invariably more important to make progress - including mistakes - than to over consult and stagnate.'[43]

It was equally important for the teams to use the consensus notion constructively so that a better quality of decision emerged than had been possible in the pre-reorganisation NHS when managers were more autonomous. There is some doubt about whether this has happened either, in spite of a feeling among the chief administrators (less pronounced among area administrators) that the concept of consensus decision making was working pretty well.[44] Lewis and Weiner give a somewhat less hopeful picture in which 'controversial issues tend to be put off to await resolution and are therefore delayed rather than referred for decision elsewhere ... '.[45] One reason for this phenomenon in the research area has been the determination not to offend colleagues; establishing relationships has, for many, implied the avoidance of challenge. Indeed, in one team where there has been a challenge, particularly from the medical representatives, it has not been welcomed. After one particular encounter, one of the permanent team members commented that the general practitioner 'must consider himself an expert on everything'.

Comments from senior officers in other parts of the country would suggest that this is not an unique phenomenon and, if so, the avoidance of solutions which might threaten personal relationships between team members is another obstacle to better management of the NHS. Most, if not all, of the problems we have so far identified need fairly radical remedies if they are to be tackled locally, and this view of consensus would make such an approach an unlikely prospect - at least for some time to come.

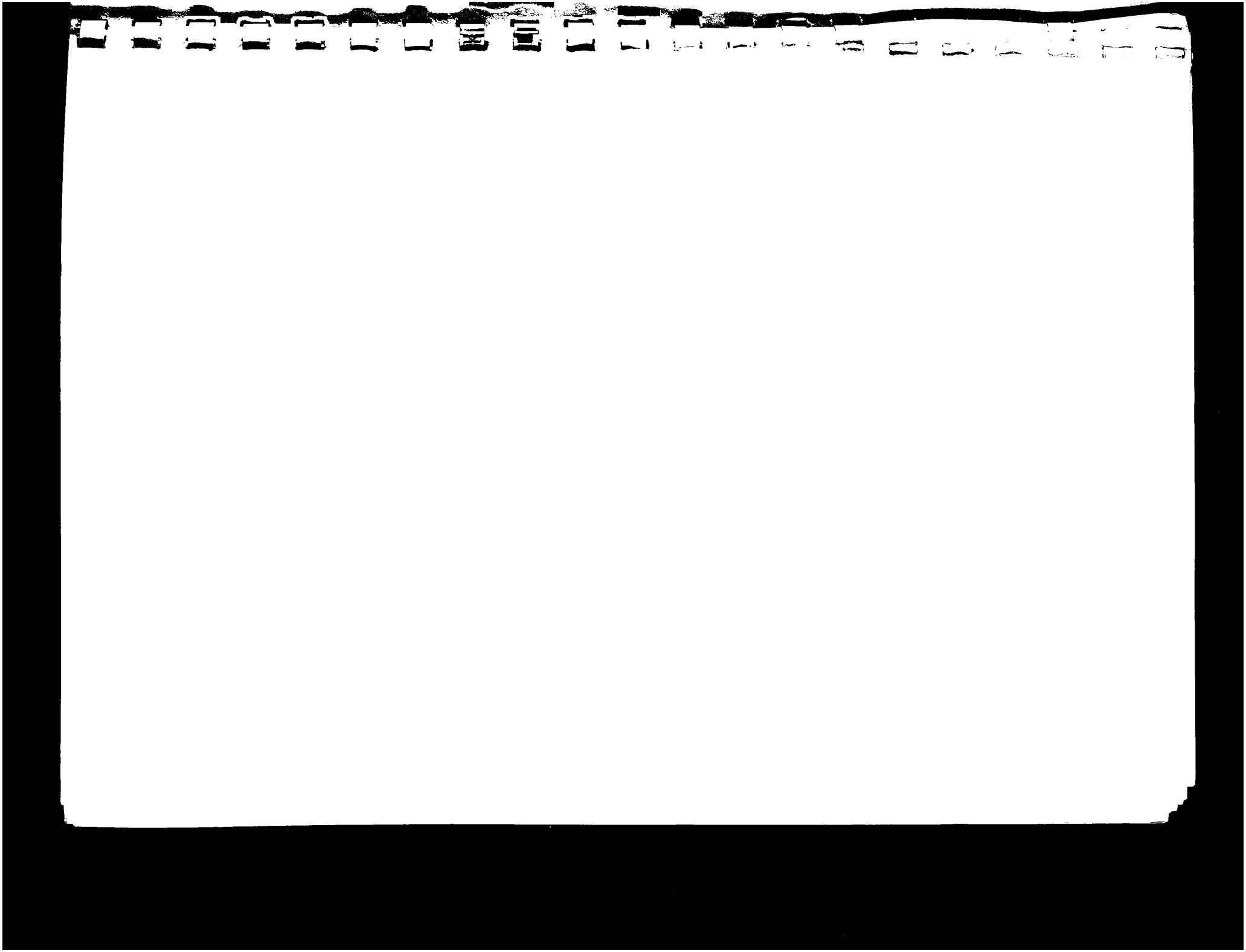
The machinery in action: final comment

In the previous section we identified features in the management arrangements which could have been expected to produce a decision making process which met the following requirements

1 an organisational capacity to decide a course of action very quickly when the occasion demands
2 the extent of consultation to be proportionate to the gains in the quality of outcome
3 the procedures designed to produce better as distinct from quick decisions should be reserved for those issues which have the most important consequences for the organisation.

In this section we have identified four features which have not matched those specifications. This does not, however, invalidate them totally. The design of the structure was determined by many considerations, and not merely speed of decision. For example, the notion of consensus decision making in teams owes much to the politics of the NHS. If the DHSS had taken a strong line at the inception of the new service, and insisted on a chief executive officer, the cost in hard feelings, difficult negotiations with the 'disadvantaged' professional groups, and the subsequent vying for position could have been very heavy.

Nevertheless, it remains true that the rationale of reorganisation was improved management - and any constipation of the decision making machinery is hardly compatible with this. Although some of the difficulties may have been temporary ones, the analysis in this section of the paper suggests that something needed to be done about the machinery for interdisciplinary activity below DMT level, the relationships between area and district officers and the prevailing definition of consensus within the management teams, if that objective is to be achieved.



THE FORMAL MANAGEMENT ARRANGEMENTS: POSSIBLE MODIFICATIONS

INTRODUCTION

The starting point for the analysis thus far is the significance of the formal management arrangements for management behaviour. If the premise that there is a strong link between the two phenomena is accepted, it follows that some of the problems which beset the decision making process in the NHS can be (partially) explained by defects in the design of those arrangements and there might therefore be some advantage in amending them. Some might argue that the incomplete implementation of the Grey Book prescriptions is a cause of the problems we have described. This explanation has not been accepted here because the management structures of the health authorities did follow these prescriptions fairly closely for management staff. On that test a tightening-up process would not seem to be the answer.

Others would put more stress, say, on a programme for management development in the NHS. There is, after all, a voluminous literature on the dissonance in organisations between what is supposed to happen - the formal structure - and what actually happens, to remind us of the limited influence of formal prescriptions on management performance. The quality of managers - irrespective of their immediate situation - is clearly a crucial factor and there is still much to be gained from a strategy aimed to improve the performance of individual members of staff.

The purport of the argument in this paper, however, is that such a strategy would not, in itself, be enough and the creation of a streamlined decision making process requires more than better selection and training programmes. Indeed, one can go further and argue that the potential gains from such a programme need a slightly different working environment for their realisation, and amendments to the formal structure are one way of trying to produce that different environment.

Another very real objection to any amendments to the formal arrangements is that of timing. It can be argued - and indeed has been very forcibly by the working party of chief administrators among others - that it is far too early to be thinking of more changes, particularly as the service is still recovering from the 1974 reorganisation. Again, it is fair to add that the trauma of the reorganisation may have prevented the parts of the management structure which we have criticised from working as they were intended to, and given time all will be well.

There is much to be said for this line of argument, particularly if radical changes were contemplated. The costs of doing nothing - and we have outlined what these are in the previous section - may, nevertheless, outweigh those arising out of technical adjustments to the machinery, designed to remove some of the obstacles to speedy decision making. In this final section we look at possible modifications to the formal structure which would pass this particular test.

A CHIEF EXECUTIVE OFFICER ?

Wherever two or three NHS managers gather together, there is a good chance that the case for a chief executive officer will come up in course of conversation. To some extent, this reflects a basic yearning for simplicity: an organisation with a 'bossman' is easier to identify with than one in which authority is vested in groups. It also suggests, however, a realisation that the chairmen of the health authorities do not fill this particular gap. However able and dedicated they are, they cannot perform a chief executive type role in the two days per week the job is officially expected to take.

We have already made it clear that the decision not to create a chief executive post did not mean that machinery to pull the constituent parts of the organisation together was ignored. In addition to the responsibilities of administrators for general coordination and of community physicians (as yet largely unrealised) for planning, each senior officer was made responsible for coordinating 'the team on matters of particular relevance to his own discipline' and management teams were expected to have a chairman 'to ensure that no team becomes ineffective through failure to initiate ideas or lack of drive to carry them through'.[46] In the event, not all teams have appointed chairmen, preferring a more informal arrangement for team meetings.

In spite of this veritable battery of provision we have, nevertheless, argued that there are deficiencies which are linked with the slowdown of decisoon making on day-to-day issues. In particular, we have pointed to the absence of convincing machinery for coordination of the activities of managers from different disciplines in the health districts, which has led to centralisation within the DMTs themselves and the problems some teams have had with the notion of consensus decision making. In the light of these difficulties (and others), it is perhaps not surprising that the case for a chief executive officer should remain on the agenda.

In what way, however, would such an appointment help ? Before we try to answer this question, we have to be a little clearer about the kind of animal we have in mind. Broadly speaking there are two alternative species. The first is a chief executive officer without department responsibilities, as recommended in the Bains Report on local government.[47] The second is the designation of one (or perhaps two) of the occupation groups as the general managers throughout the service, with more than the persuasive authority than is accorded at present to administrators and community physicians.

A CHIEF EXECUTIVE OFFICER WITHOUT DEPARTMENTAL RESPONSIBILITY

The Bains Committee envisaged - as the title of the post suggests - but one chief executive per authority. If this model was adopted uncritically in the NHS, there would thus be one such appointment in each area and regional health authority. Nor would one professional group, at least in theory, automatically provide the incumbents for the post: all chief officers would be eligible. The chief executive officer would be chairman of the management team.

It is possible to see such an officer making an impact in some of the problem areas we have identified. It would fall to his lot, for example, to ensure that when issues require interdisciplinary discussion they get it: and, conversely, to stop the teams wasting their time on issues which could just as easily be decided elsewhere. It would also be his responsibility to coordinate the work of the specialists; draw up the agendas for the team; initiate studies of the overall effectiveness of district area management; and interpret team policy to 'outsiders'. An officer with the special responsibility too for effective team working might thus find it easier than the team itself to break the log-jam caused by overcentralisation at DMT level.

The important change would be the accountability of the chief executive officer, rather than of the team itself, for the work of the team to the health authority. If there were difficulties he could be asked why they were occurring and what he intended to do about them. At the moment these questions, particularly when a chairman has not been appointed, can only be addressed to the team as a collective body, and the responsibility for action is difficult to pin down. Accountability shared may diminish its effectiveness as a motivating factor when the task is a comparatively nebulous (but nevertheless vital) one and outside the sphere of competence of the functional specialist.

It is obvious that such an appointment would change the relationships between the senior officers, and this immediately poses the question of the authority of the chief executive officer vis à vis his colleagues. The Bains Report counselled caution in this issue.

> 'We do not suggest that there should be no formal definitions of his position vis à vis the Chief Officers, but it is, we believe, important to recognise both the difficulties and the limitations of spelling it out, particularly in any detail.' [48]

Some years before reorganisation a working party set up by the King Edward's Hospital Fund for London and the Institute of Hospital Administrators to consider the future pattern of administration in hospitals had had to face up to this problem, because they too had decided that 'one person should be given management responsibility for the whole hospital'. [49] Although the authority of the general manager was not spelt out in any detail, it was clear that the working party had in mind more than the coordinating authority conceded (probably just the right word) to the administrator in the reorganised service.

> 'Thus we envisage that the other senior officers concerned with the management of specific services (i.e. medical and paramedical services: nursing: finance and statistical services: general services) would hold appointments as Service Directors who would assist and advise the General Manager to manage the District Hospital ... Nevertheless it is of fundamental importance that one person should retain the final authority to take decisions.' [50]

In contrast, three types of relationships between managers in the NHS have been defined: 'managerial', where the manager is responsible for the work of his subordinates; 'monitoring', to which we referred earlier in the context of area/district relationships; and 'coordinating', which arises when 'a person is responsible for relating the work of two or more people who are not his subordinates ...'. The difference between a monitoring and coordinating relationship is not in degree of authority - both rest on persuasion - but in the focus of activity. Monitoring is concerned with checking performance, ideally against agreed standards, while coordinating focuses on 'assisting a group of people to carry out a task which affects some aspect of their total activity'. [51]

None of these formulations really encompasses the kind of authority envisaged in the King's Fund proposals for a general manager or for a Bains type of chief executive officer. If the framework for managerial relationships in the NHS is accepted, it then becomes difficult to

find a distinctive role for a chief executive. There are two possible reactions. The first is to allocate specific functions to the chief executive, make it clear for which aspects of interdisciplinary activity he is responsible, and leave the situation to sort itself out. The second is to develop alternative notions of authority, drawing on other types of organisation, and try to apply them in the NHS. Just because something is difficult to define (eg, the informal authority of many group secretaries in the old hospital services), its existence should not be denied.

There are, nevertheless, serious drawbacks with this strategy. If, for example, it is thought desirable to retain the direct line of responsibility from DMTs to the AHAs (and the devolution working party felt this to be a pre-requisite for effective decentralisation[52]) it would be logical to have a chief executive officer for every management team. Since these would be additional appointments, they would run counter to the current concern to contain and possibly reduce administrative costs. More specifically, such an appointment would not be immediately relevant to the other obstacles in the path of the decision making process in the NHS. It would do nothing directly, for example, to improve coordination across professional boundaries below DMT level, streamline the consultative machinery for doctors, or sort out the district/area relationship. All it could offer are more decisive management teams, which might or might not do something about these problems.

A LINE MANAGEMENT FOR THE NHS ?

The second alternative is to designate an occupational group as general managers throughout the service. If, for example, the administrators were the 'chosen race', this would mean that unit, sector, district, area and regional administrators would be so designated and they would assume a more 'forceful' - for the want of a better word - posture vis à vis managers in other disciplines at their level of activity. The unit and/or sector administrators would remain in a line relationship with the district administrator and there would be no obvious reason to change the direct responsibility of the latter to the AHA. All would retain departmental responsibilities.

A variant on this theme would be a 'duarchy', like the one frequently found in many regional hospital boards before reorganisation, where the administrators and medical officers were accepted as the senior officers. This in no way implied a line relationship with the other disciplines but there was a general recognition that they carried a greater weight of responsibility for the general performance of the board than did the other officers.

In the preparations for the new service in the various areas, this informal ranking was evident too. Many of the joint liaison committees appointed a medical officer of health and a group secretary as their two senior officers, and it was from these two groups that most of the leadership came in this period. In the old service both had, of course, been recognised as the senior officers (de facto rather than de jure in the case of the group secretary) by their committees, and this, as in the regional hospital boards, had given their counterparts further down the line some 'pull' in interdisciplinary matters.

A duarchy would have an advantage over the obvious alternative of building on the administrators' existing responsibility for coordination and labelling them as the general managers. The real objection to this course of action is the peripheral role, comparatively speaking, of the administrators in the delivery of health services, which in turn limits their authority vis à vis other groups.

Hickson has suggested that the power of a group in an organisation is dependent on the existence at the same time of three main factors. These are the substitutability of skills; the centrality of function (in the sense that the organisation would soon cease to operate if the particular group withdrew its services and the pervasiveness of its activities); and the ability to cope with uncertainty.[53] While a group which scores highly on, say, two of the dimensions would be influential, it would not necessarily be the most powerful. This is the position of the administrators. They have an important part to play in reducing some types of uncertainty for other groups in the organisation and their function is a pervasive one. They are not, however, central to the organisation's function in the other sense, and their skills (particularly those associated with clerical routines) are eminently substitutable. The designation of administrators as 'general manager' would thus create a gap between the formal designation and the realities of power, and counsel caution about their ability to provide the coordinative impetus necessary to overcome the defects in the decision making process.

Much the same objection can, however, be made to any other occupational group other than the clinicians - and even they have not the expertise to cope with all the uncertainties which beset health organisations. The development of a duarcy of, say, administrators and community physicians, on the other hand, would diminish the gap between actual power and formal authority for the general development of the authority's services, because together they would be more central to the organisation's activities. It would have the advantage too of not being too radical a change in direction. It would on the one hand build on the experience of the old regional hospital boards (which are perhaps a close parallel to the new AHAs in scale of operation) and, on the other, recognise the primacy of medical and lay

administrators with which many were familiar in the joint liaison committees which did the preparatory work for reorganisation.

There still remains the objection that the designation of one or two groups of staff as general managers would, in itself, do little to remove all the obstacles to speedy decision making in the new service. And that after all was our starting point. Such a change would have some impact on team working, and we did identify some problems at this level. Since, too, management teams are required to proceed on the basis of unanimous agreement with, perhaps, only a minimal amount of support in some quarters (see page 28) rather than search for optimal solutions to which each member will feel very committed, little should be lost by designating two officers who could short-circuit the whole process and proceed, if need be, without agreement. Again, Pethybridge's remedy of fewer decisions being taken in team meetings and more action based on informal and more selective contacts between officers seems more likely to materialise from a situation where team members are not formally equal in status.

Nevertheless, the changes would need to be more extensive than the designation - or reincarnation ?- of administrators and medical officers (throughout the service) as general managers. Although such a move might help unit and sector administrators, together with their counterparts in community medicine, to improve interdisciplinary coordination at these lower levels of management, some additional impetus is also necessary to tackle that particular problem.

INTERDISCIPLINARY DECISION MAKING IN THE HEALTH DISTRICTS

The problem in the districts stems from the centralisation of decision making on day-to-day issues in the DMTs. The need is for convincing machinery for interdisciplinary coordination, particularly at institutional and/or patient group level, to permit decentralisation. Two developments may meet this need. The first is to set up permanent, formal mechanisms for coordination; the second is to establish ad hoc committees or groups as and when they are required. The two are not, of course, mutually exclusive: the first is more suited to activities with a continuing need for coordination, and the second to planning particular projects.

The need for mechanisms for institutional and/or patient group coordination would seem to be ongoing and thus requires formal and continuing machinery in addition to the health care planning teams, whose terms of reference are designed to direct their energies to longer term

issues. Clearly, in some districts (perhaps many), formal machinery for both patient group and institutional coordination would be too much. Services in many areas, for example, span district boundaries; with units spread between different hospitals too, it would be difficult to construct an intelligible system for both areas of activity. The resulting complexity would be worse than the disease. The sector level between the institution and the district would seem to be the appropriate level for additional coordinating machinery for both purposes, though it may not be ideal for either. We have noted earlier the plea of the Hospital (now Health) Advisory Service for multidisciplinary teams at unit level.

The minimum requirement for more effective coordination (at sector or institutional level) would be matching hierarchical structures for the major occupational groups: at the moment, even the divisional structures for nurses do not always coincide with the sector organisation of administrators. This would involve a re-examination of management structures with the health district and incidentally give the opportunity for another look at the claims of groups of staff, such as paramedical personnel, who are not represented directly on DMTs. The sector (or unit) administrator together with his immediate colleague in community medicine would of course be the general managers to whom the functional managers would report.

If a multidisciplinary team were thought appropriate, the membership other than the core provided by, say, the administrator, the community physician and nursing officer, could be flexible to allow specialists with particular interests to attend for the issues which concerned them. What is more important than the composition of teams and places at the top table, however, is the parallelism between management structures, because - at the very least - it would reduce the number of lateral contacts for each officer.

The designation too of the sector or unit as the budget centre, with limited powers to switch funds between services, would reinforce its position because it would help to build up a sense of identity for the officers concerned. It would become a more obvious point of contact with management for clinicians and other groups and would thus, hopefully, simplify the decision making routes for them. They would be relieved of the need, for example, to decide which of the professional hierarchies one should galvanise into action on issues which might concern more than one of them. The issue, in this alternative set-up, would be referred to the general managers for disposal.

STRATEGIES FOR CHANGE: WHOSE RESPONSIBILITY ?

A twin strategy of designating general managers and developing sector and/or unit management would go some way to streamlining the decision making process on day-to-day issues in the NHS. In particular they would provide an organisational base for decentralisation and, if this happened, the management process would be speeded up. It would leave highly paid officers and management teams with more time for those issues which require a more considered approach to problem solving.

The changes, if adopted, would leave the overall shape of the management arrangements more or less intact, though they would nevertheless generate considerable opposition. The nursing and finance officers, having fought so long for their place in the sun, would hardly view the elevation of their colleagues in administration and community medicine with equanimity. It would also have the incidental (and marginal) advantage of relative cheapness compared, for example, with the strategy of appointing chief executive officers.

The proposed changes would do nothing, on the other hand, to mitigate the adverse effects on the decision making process of the two other features of the management arrangements. The machinery designed to increase the involvement of clinicians in management remains Byzantine and unloved: the uncertainties surrounding the relationships between district and area officers persist and are, perhaps, too much loved by those who see the answer to problems in 'getting the structure right'. The answers to these problems - or, more accurately, dilemmas - lie in the resolution of the much broader issues of clinical freedom and effective use of resources, and the respective merits of drawing health service boundaries to match those of local authorities or determining them by reference to health service considerations only. There is some consolation, however, in the fact that the biggest problem - the lack of convincing multidisciplinary machinery below the DMTs - is the most amenable to organisational engineering in the near future.

The final consideration concerns the locus of responsibility for promoting this type of change. The formal arrangements for the management of the NHS have been handed down by the DHSS in a way that not only establishes their legitimacy but also gives them a theological quality: the structure, with its own language (and 'bible'), is thus unassailable. This is all the more so when some generally applicable change, such as the recognition of some groups of managers as more equal than others, is required. Having got into the business of designing (or merely

legitimising) management structures in some detail, the Department has to stay in it when some re-examination is clearly required.

There is another consequence of this central enunciation of management arrangements for the NHS which has a bearing on the likely response of health authorities to opportunities to use their initiative. The very fact of central involvement in a particular area of activity is a disincentive to initiative, because any local arrangement may well be superceded by later guidance. This is what the working party of chief administrators seemed to have in mind when they referred to centralised attitudes in their report. This may be one reason why the opening left for health authorities to develop appropriate machinery for interdisciplinary decision making below DMT level does not seem to have been fully exploited. Another reason, of course, is that its development in the direction suggested here would not always be welcomed by team members, and the prevailing notion of consensus in some teams would not encourage senior officers to broach the subject in those circumstances.

In the short term, then, our suggestions for speeding up the decision making process imply some action from the centre because of the situation created by central involvement in the shape of the management structure. In the longer term, the value of the additional machinery for integration below the DMT level will be largely determined by the way the DHSS and health authorities come to terms with the conflict between the pressures for centralisation (essentially, via accountability) and the need to delegate authority to match the needs of the situation in the NHS.

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