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Report of a Working Party on
Education and Training of
Managers in the National
Health Service.

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F I N A L D R A F T

INVITATION TO INITIATIVE

Report of a Working Party on the
Education and Training of Senior
Managers in the National Health
Service

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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 800,000 people in a complex enterprise of the greatest importance to the national well-being. The cost annually to the tax-payer is of the order of £3,000m. representing some 11.4% of total public expenditure and approximately 4.8% 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 are 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:
 - (i) 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 multi-disciplinary management practice at senior level,

- (ii) the need for a continuing and imaginative system of educational support for those already holding senior managerial appointments in the health service,
- (iii) 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,
- (iv) 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.

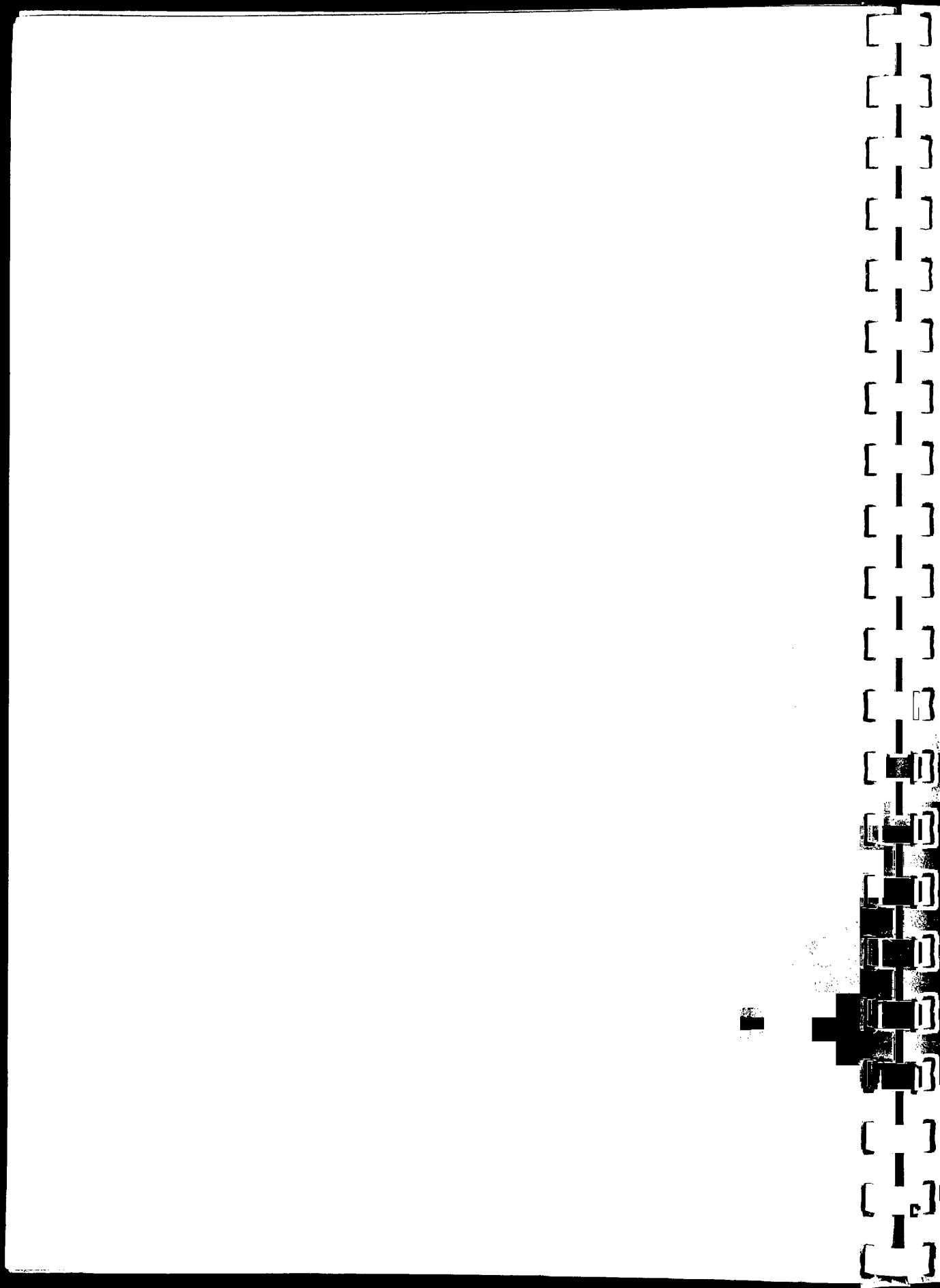
REVIEW OF SENIOR MANAGEMENT TRAINING IN THE NHSMembership of the Working Party

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PREFACE

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, a year 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 National Health Service 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 see 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 specialisms 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 even 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 the Preface, Chapter 1 and Chapter 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.

We are greatly indebted to all those individuals and organisations, listed on page ____, who have helped and advised us, orally and in writing. Attention is also drawn to the bibliography on page ____ which we hope other students of the NHS 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 Mr. Richard F. A. Shogog has made to our work. His assistant, Mrs. Elizabeth Haynes, also has earned our deep gratitude, as has Miss Judith Pottinger of the King's Fund for her organisation of our affairs.

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 in-service training. The Working Party has therefore excluded the civil servants from the scope of this Report.

Nevertheless, the intimate managerial relationship between the Department 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 of those involved in the running of the National Health Service 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 AHA was (in the words of the 'Grey Book') "a small body selected for its capability". Only two years later, an AHA is

as often as not much larger than convention and experience would suggest a managing body should be, and its composition and outlook may 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 do 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, the nurses, the treasurers and the doctors (who at all levels include the specialists in community medicine, and at district level representative clinicians and general practitioners in addition). These officers form the core of senior managers within 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

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

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 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, while there are 205 district administrators there are only 99 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 (even 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 enough be dealing with problems in a multi-disciplinary 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 of 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 consensus agreements on general issues of policy-making, of priorities, or of resource allocations. 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:

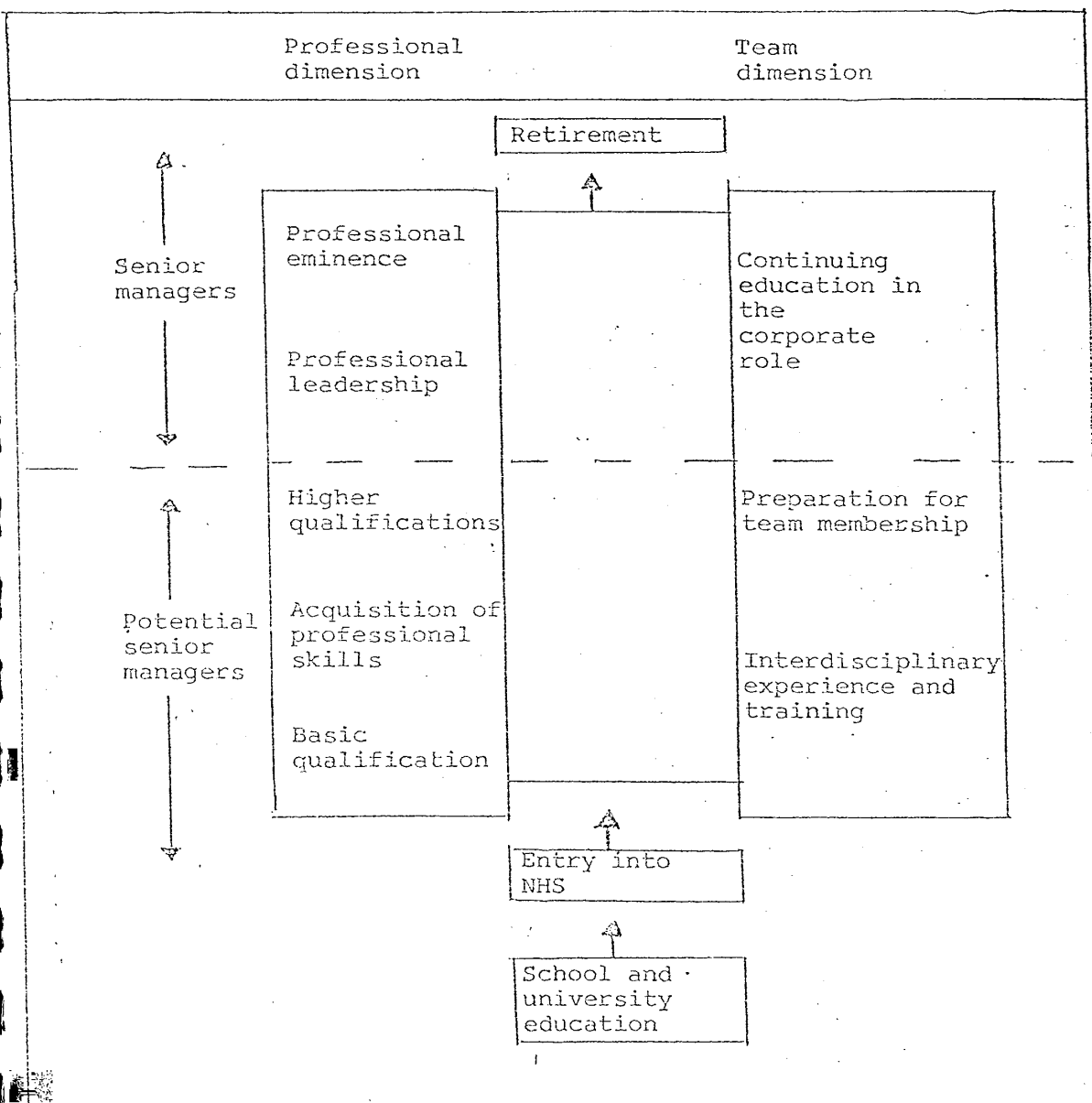
(i) Corporate Training

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.

(ii) Continuing Education

This refers to the need for senior managers to undertake periodical training. Such training will include, though not necessarily simultaneously, inter-disciplinary 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 this:



This diagram, 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 eighteen for the student nurse or junior administrator up to twenty-four 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 inter-disciplinary training groups from officers at these levels. However, at around the age of thirty-five, good officers in any of the professions should be coming up to team membership 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 elitism 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

in this sphere. 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, 308 administrators in the three sorts of teams, which implies according to our definition, 1236 senior managers excluding the clinicians. If the average senior officer spends up to twenty years as a team member, then the total annual throughput over the whole country will certainly be less than 100 per year. In addition, if we assume that provision is made every four to five years for the continuing education of each senior manager, some 300 or so will be involved each year in some kind of organised training of a short duration. In sum, then, the selection, development and subsequent continuing education of senior managers represents an operation whose scale is so small that the cost of implementing our recommendations would be utterly negligible in comparison with that of the Service as a whole.

PRECIS OF CHAPTER 2

The chapter assesses the extent and importance of the 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 sensitivity of the NHS this is very evident if one considers the emotion and physical pain involved for the patient or the value judgements 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 co-ordination, 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.

SPECIAL ASPECTS OF THE NATIONAL HEALTH SERVICE

We have already indicated that, in comparison with other forms of public administration, the National Health Service 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 that 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 National Health Service 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 visually 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 the general hospitals are only one specialist part of a service which provides hospitals of other kinds including those which offer long-stay care for many 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, even 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 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 thus 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 know what they want and expect only the highest quality of service.

COMPLEX STRUCTURES

If, then, the tasks of the manager encompass a wide range of services and social and political values, so do the institutions and the organisational structures which they manage. The totality of health authorities represent an extraordinary 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. Or again the professional administrators simultaneously belong both to their own hierarchy and are part of 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 scientist or para-medicals, 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. 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 that 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 health service work 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 Health 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 within hospitals is now an outposting from the local authority social services department. Who will link social work in hospitals to social work within 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-tray 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 of that, and helped to make the system of patient 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.

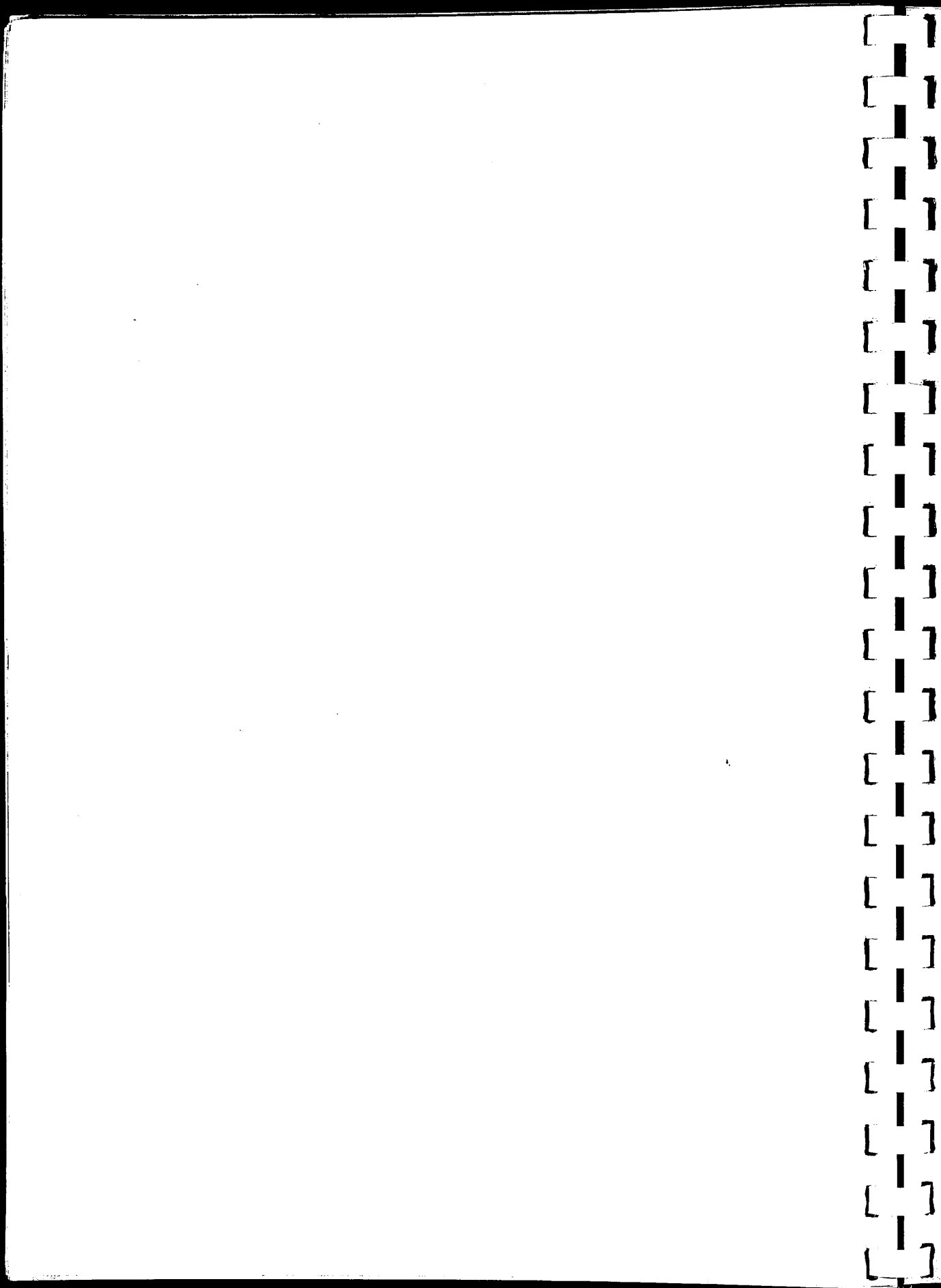
So, the health service requires managers trained to be both

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.

PRECIS OF CHAPTER 3

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.



3 THE NATURE OF MANAGEMENT AND A COMMENTARY ON MANAGEMENT TRAINING.

INTRODUCTION

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 National Health Service.

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 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 of 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 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 this attempted answer to the question 'who are the managers?' 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 as follows:

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 policy-implementation as 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 task allocation 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 co-ordinating 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 (as 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? We turn to these questions in the next section.

3 How do 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 (1967) was an influential analysis based upon the self-recorded activities of a sample of business managers. A more recent study is Henry Mintzberg's The Nature of Managerial Work (1974) and it is mainly on his findings that the following is based.

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 manager 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 cutbacks 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, or carrying out negotiations, or 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 judgements may be to deny the contributions which can be made by specialists and experts.

4 What is different about senior 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 (1972), Desmond Keeling suggests that 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. 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. 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 are the skills of management?

We have already touched on this topic 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 on 'Skills of an Effective Administrator' (Harvard Business Review, 1974).

Katz argues that there are three basic skill-categories: technical skill, human skill, and conceptual skill. 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 cooperative 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 decision-making 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 are managerial skills 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 the 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 and 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 decision-making exercises relating to problems of a sort which the manager can expect to encounter following promotion.

The aspect of training which produces most controversy is with regard to the human skills. Is "inter-personal 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, change-management, group behaviour, and what used to be called 'man-management' or 'working with people'.

7 What are the purposes of training?

The need for this question may not be obvious at first sight: surely we all know what management training is and the purposes

it serves? In fact, training can mean different things to different people. For example:

A Training as induction or re-orientation

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 "re-orientation".

B 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 talk about "motivation" or "socialisation".

C 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 situations).

D 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: (1) they help managers to

understand what is involved in their craft and may deepen their commitment to it; (2) they help non-managers to understand the contribution of management and managers; (3) they create a framework for subsequent instruction in particular aspects of management.

E 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 as to 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 re-orient them to the demands and circumstances of their new posts. The motivation and socialisation element 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 stage 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 training needs on the one hand and particular needs on the other. 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 in management curricula. 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 or economics or law or sociology or psychology or statistics or accountancy. But managers - especially at senior levels - do not want or require

training in academic disciplines. The academic inputs must be re-assembled around managerial activities and problems.

One such problem-area is decision-making and decision-implementation or what is often called planning and control. The most useful academic approach to this area 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 matters as: (1) is the clientele for such courses likely to be homogeneous or heterogeneous? and (2) what appear to be the most ^{important} problem-areas and managerial activities of the clientele(s)? 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 follows:

- A a hierarchy of training, with the possibility of progression from one level of training to the next;
- B an emphasis upon selectivity and elitism, so that staff are selected for higher training courses and to be chosen for the highest level courses is to join an elite within the service;
- C linkages 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 is used as a method of deciding whether or not candidates for promotion have certain necessary qualities or qualifications;
- E training is seen as serving an integrating function and, at the highest levels, trainees are 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 is 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 promotions - 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% of officers of relevant ranks will be selected for NDS and only 2% - who will "hold key posts in the direction of defence" - go on to RCDS. Career-linkages exist 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 do 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 in, say, Army or Navy terms 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, etc.) as well as 'foreground' professional studies. The National Defence College and Royal College of Defence Studies are staffed by a mixture of permanent academic staff and career officers on secondment to the colleges and the 'broadening' elements of the curricula involve a wide range of outside speakers.

In sharp contrast to the training situation in the Armed Services 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 training which now exists on a national scale is provided for younger administrators. The main qualification sought by the latter 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 it 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. INLOGOV is recognised for certain purposes by the LGTB 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 Master's courses elsewhere contribute to the training available). Indeed most of the necessary conditions (hierarchy, selectivity, career-linkages, etc) for the creation of a staff college system are lacking in Local Government. The decentralised, pluralistic, pragmatic approach to administrative 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% of Civil Service training and the levels of training range from "Mechanics Institute to All Souls" (to quote the recent Heaton-Williams Report). 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 Department 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 came closest 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 clearly 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, or money, or information; while others are general managers. There are quite different types of management jobs, including supervisory, executive, planning and many other types. 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 between, say, a laboratory setting and a 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 some at least of the 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 skill-mixes. 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.

PRECIS OF CHAPTER 4

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 thirty 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 national service, that is, of administrators and finance officers, and of community physicians and nurses, though excluding in the latter case, recruitment and professional training.

The experience of the 1960's 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.

THE HISTORY OF RECRUITMENT TRAINING AND MANAGEMENT

When it became accepted that management development has a contribution to make to the quality of senior management, the main emphasis in the early years was on the management development of administrators and treasurers. In this Chapter this early period has been divided into three historical divisions (1948-55; 1955/65; 1965/72), the first being marked out from the second by the Guillebaud Report, and the second from the third by the Lycett Green Report and the establishment of the National Staff Committee. In 1967 with the setting up of the National Nursing Staff Committee, the nursing profession was included on equal terms with the other two and a special section is given to this development. There follows a second special section on the link between management training and community medicine. Finally, there are brief summaries of the situation arising after the reorganisation of 1974.

1948-1955

Section 12(2) and (3) of the NHS Act 1946 said that it was the duty of Hospital Management Committees and Boards of Governors to control and manage their hospitals. This included the appointment and dismissal of staff except senior doctors and dentists. All staff however were subject to nationally determined scales of remuneration and other conditions of service, although apart from this authorities were able to determine the numbers and grades of staff to be appointed and the nature of their employment.

In 1948 the authorities set out within this framework to exercise the "lively independence" which Aneurin Bevan had promised them. The total number of people employed was about 400,000 and there were well over 400 independent employing authorities. Recruitment was a continuing activity and although in the name of the authority, was largely in the hands of heads of departments. Many such staff - doctors, dentists, nurses, midwives and para-medical staff - were either already professionally qualified or were joining the organisation with a view to obtaining professional qualifications. The responsibility for the training of these professional qualifications was vested in

statutory or other independent bodies although administrative staff were a notable exception. Significant parts of the training required the use of NHS facilities.

Although staff recruitment, training and promotion were almost entirely in the hands of the authorities themselves, general guidance was issued by the Ministry of Health about the pattern, duties and desirable qualifications of senior staff. These patterns varied considerably according to the nature and size of the hospital group, its geographical unity, the past history of individual hospitals, and the advice of the chief executive officer, the group secretary. There were group posts and individual hospital posts with the range of duties of hospital secretaries depending on whether other heads of departments, (eg. the group engineer) had direct access to the authority, or whether, the matron was also in charge of catering and/or domestic services.

Some, but by no means all, senior administrative officers saw the importance of attracting promising recruits or pupil administrators and giving them experience in various aspects of hospital administration. A pupil administrator who had received his early training with such a senior administrator had a distinct advantage when seeking hospital posts elsewhere.

From 1950 onwards steps were taken by the Ministry of Health to control manpower numbers with the specific aim of restraining the growth of hospital expenditure. Reviews of local administrative establishments were undertaken by teams appointed by the Ministry of Health. Increases in numbers beyond those endorsed by these teams required the approval of the Regional Hospital Board or the Ministry of Health. These measures, to some extent, inhibited recruitment and movement of staff between one department and another and between one hospital authority and another. "Tight establishments" was a frequent excuse for non-participation in otherwise desirable schemes for broadening experience, and for developing individual careers to the best advantage.

There was, nevertheless, a growing awareness of the importance of training those who might occupy senior posts and of providing career structures which would attract and retain staff of adequate quality and ability. The King Edward's Hospital Fund for London took the initiative in 1951 in setting up staff colleges which provided not only a variety of courses but also a meeting ground for all interested in studying the problems of hospital administration.

1955 to 1965

The previous period was characterised by acute financial problems. There was doubt too, about the permanence of the structure; some feared and some hoped that Regional Hospital Boards would be abolished. However, in 1951 a Select Committee on Estimates drew attention to the lack of authority of Regional Hospital Boards to control the establishments of Hospital Management Committees, to the incursions of the Ministry of Health in this field and to the resulting uncertainty in the minds of Hospital Management Committees as to where control really rested. They recommended that the whole question of staffing should be reviewed on a national basis by the Ministry of Health and that individual Regional Hospital Boards should be given more extensive powers of establishment control. The Guillebaud Committee reporting in 1956 on the cost of the NHS went further in concluding "that Regional Hospital Boards should be told and Hospital Managements Committees should accept that Regional Boards are responsible for exercising a general oversight and supervision over the administration of hospital services in their regions'. All this helped the service to settle down.

Another factor which may have helped to steady the hospital service in 1955/56 was a forecast increase in the amount of money available for capital building, which held out the prospect of a long delayed new building programme on an altogether larger scale than before. Energies could therefore be concentrated more constructively on specific new projects, and this among other things had implications for the quantity and quality of senior staff.

The Guillebaud Committee also stressed the importance of having sufficient people of the right calibre at all levels of

hospital administration, and saw the need for an improved staffing and salary structure with sound recruitment, training and promotion policies.

In 1956, stimulated no doubt by discussions in the Guillebaud Committee, the Ministry of Health issued a comprehensive circular (HM(56)32) based on recommendations made by the Whitley Council for administrative and clerical staffs, which laid firm foundations for recruitment, training and appointments of this group of staff. The circular said that the schemes if promulgated depended for their success on the gradual building up of a corps of administrators trained under national, regional or group arrangements forming a pool of talent available to hospital authorities throughout the country. It referred to the need for the organisation of mobility and selection arrangements to take full advantage of the benefits of improved recruitment and the advantages which would accrue from more mobility.

The provisions of HM(56)32 included the recruitment of school leavers as well as university graduates and others professionally qualified. In regard to school leavers, the more progressive regions responded by arranging for the voluntary collaboration of hospital authorities so as to provide combined recruitment activity, induction programmes and guidance on study for careers and also for financial assistance towards educational expenses.

The scheme for the recruitment of university graduates and others professionally qualified was designed to ensure that the hospital service got its fair share of this pool of the country's talent. This scheme, the National Selective Recruitment and Training Scheme, which was to make a major impact, began in 1956 with 16 trainees, some of whom were already employed within the NHS. It was assumed that those so recruited would be capable in time of promotion to the most senior appointments.

The initial training posts were held for three years, after which trainees competed for suitable appointments in the

the hospital service in the normal way. Counselling was provided by tutorial staff of the Hospital Administrative Staff College of the King Edward's Hospital Fund for London and the Department of Social Administration in the University of Manchester, who had agreed with the Ministry of Health to provide and share in the training. The training was both practical and theoretical, and in Manchester included an academic year for the Diploma in Social Administration. The practical training involved working in a variety of hospital jobs under the guidance of the training institution and in collaboration with senior hospital administrators. Trainees had very little difficulty in securing posts in competition at the end of the training period - in fact it quickly became a seller's market.

This National Scheme was extended to 22 trainees in 1961 but reduced to 16 in 1963 when a parallel scheme was introduced with recruitment conducted nationally on the same basis as the original scheme but with the induction and training in the hands of regional authorities. Each region was allowed up to 3 trainees and an annual intake in England and Wales of up to 45. This development gave the regions an additional training role and a senior officer was either allocated or specifically appointed by the Regional Hospital Board for the purpose of liaising with training institutions, for the administration and supervision of the training, and for counselling the trainees.

The pattern of training for the regional schemes provided for periods of practical experience in hospitals, and in the offices of the Hospital Management Committees and regional hospital board, together with periods of theoretical instruction. The Hospital Administrative Staff College and the Department of Social Administration in the University of Manchester agreed to share in this theoretical instruction. The Nuffield Centre for Health Services Studies in the University of Leeds where experimental post-experience courses for hospital staff had been built up since 1958, also agreed to share in the training. As with the original scheme the trainees emerging from these regional schemes had no difficulty in securing suitable posts in competition.

In 1957, after an enquiry which stemmed from the Guillebaud Report, Sir Noel Hall reported on the grading structure of administrative and clerical staff in the hospital service, and referred to "that strong initiative" taken by the Ministry of Health (the issue of HM(56)32). He drew attention to various difficulties which tended to inhibit effective career development in the hospital service, such as an imbalance in the age structure of administrator's and "the great gulf fixed" not only between different types of hospital authority but also between the staff of the secretary's, finance, supplies and other departments. He saw as his central problem "that of devising the means of securing the advantages of a national service for the existing multi-unit hospital service". And in order to overcome the problem he recommended a simplification of the grading structure, and the introduction of a regional information and advisory service designed to help appointing authorities find the right candidates and officers the right posts; to keep factual records of staff and to assist in the development of training schemes. He also proposed that senior members of regional hospital boards should participate in senior appointments by hospital management committees.

After consultation with hospital authorities the Ministry of Health issued in 1958 a revised promotion and appointment procedure and other guidance based on Sir Noel Hall's recommendations. It provided for the establishment of staff advisory committees in each region to maintain registers of all officers in the administrative grades, to advise on availability of staff and on career prospects and to organise and supervise training schemes within the regions. These committees were also asked to provide a system of outside assessors who would be available to sit on appointments committees of hospital authorities.

A review by the Ministry of Health in 1960 revealed uneven progress on these recommendations, though most regions had established links with the further education service and some had established training centres of their own to provide courses for many types of staff and particularly for those

with supervisory and managerial responsibilities. These training centres performed regionally a function similar to that so ably performed nationally by the Hospital Administrative Staff College previously mentioned.

The second half of the period, 1955 to 1965, was characterised by a quickening pace in the hospital building programme. The publication of the Hospital Plan in 1962 set the pattern for the next decade. It produced an even greater demand for specialised skills necessary to achieve capital building programmes. There was also a move to larger units of administration by the amalgamation of two or more HMCs and a development of the concept of functional management, ie of discreet parts of the whole such as supplies and personnel. Hospital Management Committees themselves increasingly felt the need for specialist advice at their meetings and this increased the demand for functional heads and particularly for advice from the nursing profession. The 'Group' matron concept grew in popularity and usefulness and senior nursing staff found themselves in need of wider management skills in order to meet the responsibilities of this emerging role.

Changes at the top of the Ministry of Health also brought new initiatives. Bodies such as the Advisory Council for Management Efficiency were set up and the need to continue to improve the quality of senior general and nursing administrators was clearly seen. As a result the Lycett Green Committee was set up in 1962 and requested - "having regard to the need for maintaining a high standard of efficiency in the administration of the NHS hospitals, to enquire into the present arrangements for recruitment, training and promotion of administrative and clerical staffs in the hospital service, and to make recommendations". In 1963 this was followed by the Salmon Committee which 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".

1965 to 1972

The Lycett Green Committee reported in 1963 and in 1964 the then Minister of Health accepted generally their main recommendations, which were designed to ensure more effective co-ordination, in the making of appointments and of staff training and movement. The National Staff Committee (NSC) was established by the Minister with the intention of considering with him the detailed recommendations of the Lycett Green Committee and their implications. NSC recommended that regional staff committees be appointed (a Lycett Green Committee recommendation) to take over the work of existing regional staff advisory committees and to be ready to assume wider responsibilities pending the fuller consideration of all the recommendations. The RSCs were set up in 1965.

A comprehensive account of the NSC's approach to and recommendation on their remit is given in their report published in 1967. They saw their task as the production of a recruitment and management development policy which would have regard to (i) an estimate of future manpower needs, (ii) recruitment to maintain and where necessary to develop the manpower force, (iii) training, and (iv) a procedure for assessment and advancement.

Manpower Information

A valuable part of the Lycett Green Committee Report contained statistical information on the number, grades, ages and main descriptions of administrative staff in the hospital service, based on a survey taken on 30 June 1962. Building on this the NSC used later Ministry of Health data which did not go into such great detail, to bring up to date the 1962 statistics, and to help formulate their recommendations on recruitment in 1965/67. They instituted a comprehensive survey based on staff records, which all administrative staff had to complete on 1 January 1969. Each administrative officer was asked to send the completed record form to the NSC via regional staff officers, whose first task it was to check the information thoroughly and eradicate errors before passing the material on. The collection, checking and collation of the completed forms proved to be very laborious;

it was not until 1971 that the NSC was in a position to publish analyses similar to those in Lycett Green Committee's Report. The decision to ask each individual to complete his own record, (which was designed to establish confidence in the exercise) undoubtedly contributed substantially to the delay. It had also been intended regularly to keep the information up-to-date, by regional staff officers forwarding corrections and additions to the Department's statistical division. Although, partly because of the onset of the reorganisation of the National Health Service, there was insufficient time to do this thoroughly; the Committee nevertheless made full use of the information based on the position at 1 January 1969 in making recommendations on recruitment in 1971 and 1972.

Recruitment - Administrators

In 1965 the NSC reported on recruitment to the clerical grades of school leavers with requisite qualifications, who sought career opportunities in the hospital services. Guidance was given on upper limits of recruitment (150-200 a year) based on Lycett Green's statistics. RSCs were asked to organise inter-authority recruitment, training, job-rotation and to ask employing authorities to provide for one of their senior officers to be made responsible for this work and for career counselling. The upper limit of 120-150 recruits per annum was increased to 200-250 in 1967 after taking into account the growth of administrative staff between 1962 and 1967. These arrangements proved reasonably successful.

In 1968 the Committee recommended that 40 of the total should be recruited for training in accountancy and that they be required to study for a professional accountancy qualification.

In regard to the schemes for recruitment of graduates and others professionally qualified, the NSC assumed responsibility from the Ministry of Health reducing the intake to 45 a year and the period of training to 2 years. Local arrangements were placed in the hands of the RSCs. In fixing the limit at 45, subject to review, the Committee had regard to the estimate of retirements (at age 63) and deaths in the designated

grades taken from the Lycett Green statistics. For the years 1968-1977 the forecast was an average of 90 a year. It was therefore considered that there was ample opportunity for promotion to the designated grades* for the graduate entry and all others.

Latterly, however, the statistics derived from the 1969 staff records showed that, because of the continued growth in the total number of administrative staff, the figure of 90 needed to be increased to over 100 on age grounds alone.

The annual graduate intake was therefore increased from 45 to 60 in 1971 and remains at this level in 1976.

In 1971 the Whitley Council for Administrative and Clerical Staff extended downwards the Junior Administrative Grade (the Training Grade for the graduate entry) to permit the recruitment of school leavers with two or more 'A' levels at competitive rates. A new junior administrative grade training scheme was introduced in 1971 providing for an annual intake (England and Wales) of up to 80 recruits. The RSCs handled the recruitment. The training programme was designed to last for 4 years to ensure that trainees obtained as wide as possible experience while still in training.

Recruitment - Finance Staff

The NSC constantly stressed the importance of including among recruits to the clerical grades a number sufficient for the manning of finance departments. Of the total of 200-250, 40 were to be recruited for this purpose who would be required for study for professional accountancy qualifications. It was also said that up to 10 of the 45 graduates recruited might be from those interested in a career in financial administration, although they were not required to study for a professional accountancy qualification.

* About $\frac{1}{4}$ of all officers in the administrative grades.

This let recruits who had earlier chosen financial administration keep their options open and a number changed their minds and sought their careers in general administration. The number of places taken up by those interested in finance in 1967 and in subsequent years was disappointing.

The NSC introduced for the first time in 1974 a Specialist Finance National Training Scheme for graduates and others with approved qualifications, running alongside but separate from the main scheme in general administration. This scheme offers 15 places a year; it lasts just under 4 years and is geared to the training requirements of the Chartered Institute of Public Finance and Accountancy. The training consists partly of working attachments and partly of professional instruction at selected polytechnics - the Trent Polytechnic, Nottingham, for the first two years of the scheme being used. The response to this scheme has however been disappointing so far with the number of trainees being only 3 in 1974 and 11 in 1975.

Training - Professional Qualifications

The NSC saw training comprehensively as including a study for professional qualifications; the acquisition of a variety of working experience in the Service, particularly during the earlier years; attendance at management courses and, for some, secondments to outside bodies with close links with the NHS, such as the Department of Health and universities.

For administrators, the qualification most regularly sought was the Diploma of the Institute of Health Service Administrators and the NSC established close links with the Institute. The NSC chairman and principal officer were members of the Education Committee of the Institute and the principal officer was also a member of its examination sub-committee. In this way there were able to make a contribution to the education of administrative officers in the NHS.

Training - Planned Movement

In regard to the acquisition of a variety of working experience, the Committee were aware that movement from post to post within employing authorities was already taking place on a small scale.

It depended very much however on the attitude of senior officers to the development of their juniors, on the size of the authority and on the availability of staff. In any case, a movement within an authority could never provide a promising officer with all the increasingly varied experience available in a growing and complex service.

Planned movement was designed to remedy this. Authorities having posts, particularly in the lower administrative grades, which they were prepared to earmark for the purpose when they became vacant, were asked to advise RSCs and discuss their suitability for planned movement purposes with them. It was for RSCs to identify officers who wished to take advantage of the opportunities offered after providing them with advice on their careers. Many officers took advantage of this counselling service. If an authority was prepared to accept on their staff an officer recommended by the RSC, he was appointed to the post. Ideally, it was hoped that he might occupy two or three different posts in this way in about six years.

The NSC recognised that over such a period of time increased responsibility might be appropriate for some officers as well as varied experience and therefore promotion might be considered. When promotion was involved the National Staff Committee insisted that appointments should be made only after competition among officers recommended for the post in question.

Between 1965 and 1970 the NSC's records showed that 365 administrative officers had secured posts through planned movement, but the annual numbers had fallen steadily throughout the period. One of the main reasons for this was that promotion opportunity was so readily available that promising officers sought advancement in the open market rather than seeking a variety of experience through planned movement which might mean remaining in the same grade.

Discussing planned movement in their report to the end of 1968, the NSC referred to a fear by some officers occupying posts which their authorities were prepared to earmark for planned movement that they might be moved away or persuaded to move to free the post. Others contemplating planned

movement felt that at the end of the understood duration of tenure there might not be another post immediately available and they would be stuck. In a further report on recruitment and management development issued in 1971, the NSC reviewed the subject at length. In particular it referred to discussions with the staff side of the Administrative and Clerical Whitley Council on some of the misgivings of their members about the working of the planned movement schemes. These included variations in practice between one region and another, the need for more flexibility particularly in regard to 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 as to whether the system was for all officers or only for those who had been through a process of selection. Many of these points had been regularly discussed between the NSC and RSCs and over the years the operation of the scheme had been adjusted to meet some of the criticisms.

By 1971, planned movement was operating on the basis of a much smaller number of earmarked posts, and it had become the custom for RSCs, on being notified of a vacancy, to ask an authority whether they would consider an officer known to the staff committee who needed the type of experience which the post offered. The post might be occupied on a secondment basis for an agreed period or substantively. The part played by RSCs and the Staff Officer developed into a career counselling service. However the NSC remained convinced that with the growing complexity of the Service, the increasing number of administrative specialists and the prospect of reorganisation, officers should obtain the widest working experience if they were to succeed to the most senior posts.

Management Courses

The Lycett Green Committee recommended that a three months' residential management course at a staff college should be organised nationally for selected officers. They made this recommendation before the Franks Committee recommended the establishment of business schools and before the great surge forward in management education which followed in the country as a whole. (In 1964 three British universities were offering

Master's degrees or equivalent awards in business studies with an output of about 20 graduates in that year. By 1973 23 university business schools were members of the Conference of University Management Schools and a further 8 were offering Master's degree programmes with an output of over 800 a year. In the further education sector there were over 500 centres offering courses leading to the Diploma in Management Studies).

The NSC had before them in 1965 offers from the Hospital Administrative Staff College and the Nuffield (Health) Centre for Hospital and Health Services Studies to provide the courses recommended in the Lycett Green Committee's Report. The Committee saw an opportunity for experimentation and accepted these offers. Courses of 8 weeks duration were agreed upon and the proposed teaching programmes accepted. It was a criterion for nomination to these courses that an officer should have already demonstrated his competence and potential in posts of some seniority. The selection was made jointly by representatives of the NSC and of the two centres.

An endeavour was made to balance the membership of the courses to make them as representative as possible of the various types of experience and discipline. The courses at the Hospital Administrative Staff College also included medical and nursing officers selected by the College.

The National Staff Committee were aware of the need to provide courses in management for younger promising officers in the administrative grades who had not had the benefit of the theoretical part of the two year training programme for graduate and equivalent entry. They therefore asked regional staff committees and the education centres to provide what they called a first management course of a month's duration for such people. These first management courses concentrated on management subjects. They later became multi-disciplinary with the institution of middle management courses for nurses on the recommendation of the National Nursing Staff Committee in 1968. They were provided in the main at regional training centres but also in association

with the further education service.

The Administrators Development Course was instituted in 1974 by the NSC to provide an early management course for all promising administrative staff officers whatever their method of entry into the Service. This took the place of eight weeks of the three month theoretical course previously included within the graduate training programme.

Procedures for Assessment and Advancement

In 1965 the NSC instituted a system of confidential staff reports on administrative officers. The system was voluntary, following the line taken by the Lycett Green Committee. The purpose was to assess an officer's performance in his grade, to help plan career development and to assist in assessment of training needs. By 1970 the position was as follows:

| Administrative Grade | Total Number | Subject to staff reporting | |
|----------------------|--------------|----------------------------|------|
| | | Number | % |
| General | 3617 | 1959 | 54 |
| Senior | 2425 | 1640 | 67.6 |
| Designated | 2875 | 1420 | 50 |

Chief Officers were not subject to staff reporting.

In 1967 the Ministry of Health announced the introduction of new procedures for the appointment of administrative staff in the hospital service, as recommended by the NSC. These procedures provided for the notification of a vacancy either to the RSC or to the NSC depending on the seniority of the post together with a job description and a draft advertisement.

They also provided for the setting up of a short-listing panel, consisting of representatives of the Authority, the RSC (or the NSC) plus one or two assessors appointed by the latter, to consider all those who had applied for the post.

The material available to the Panel included the applications of the candidates, their staff reports and references; and there was also provision for interview of the short-listed applicants by the Authority with the assistance of the assessors

with a view to making a suitable appointment.

These arrangements were welcomed by the majority but viewed with some suspicion by some staff and some authorities who resented any outside involvement in the exercise of their "hiring and firing" powers though the procedures in no way detracted from these. It was significant that when the NHS Staff Commission was taking evidence on how the appointment in the reorganised service should be made, these procedures were widely commended to them as the pattern to be followed.

The staff reporting system became subject to criticism, particularly by the staff side of the Whitley Council in 1970/71. They were dubious about the use made of confidential staff reports at short-listing and at interviewing committees, and wished to see the introduction of an 'open' system of staff reporting. In this way an officer seeking promotion would be aware of the general tenor of the reports which had been made on him when his application was under consideration, and it is likely that the pattern of staff reporting for the future will be in this form.

MANAGEMENT DEVELOPMENT OF SENIOR NURSING STAFF

Parallel action to that for general administrators was taken by the Secretary of State for Social Services after receiving the report of the Salmon Committee. The National Nursing Staff Committee (NNSC) was appointed in 1967, but that Committee did not recommend the establishment of regional nursing staff committees. The Committee's recommendation on the management development of senior nursing staff, as set out comprehensively in DHSS circular HM (69)2, endorsed on-the-job training for nurses having management duties and stressed the responsibilities of more senior nursing staff in this matter. They saw the priorities in the provision of training as being for senior, middle and first line levels of management as defined in the Salmon Report and in that order. They stressed purposive selection of course membership as likely to give increased benefits. They considered that inter-disciplinary courses at middle-management level were desirable and recommended outline programmes.

For the senior level, the NNSC endorsed the content and duration of the existing inter-disciplinary courses which had been instituted by the NSC for administrative staff in 1965. Jointly, the two Committees supervised these courses and to meet the growing demand for places, invited the Department of Administration at the University of Manchester and the respective departments at the Universities of York, Cardiff and Birmingham to take part.

Selection and Appointment of Senior Nurses

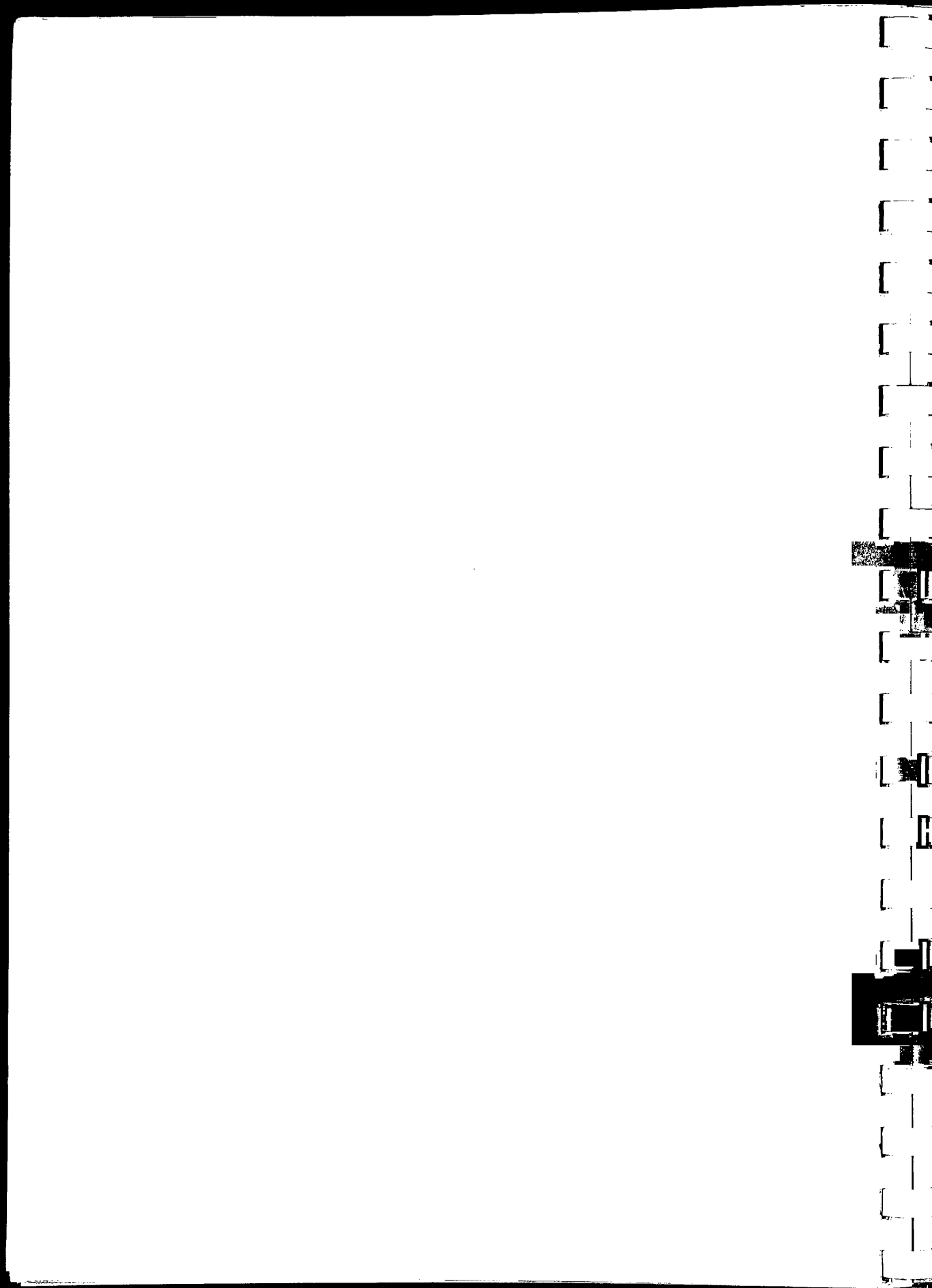
In 1969 the NNSC's recommendations on procedures for the appointment of senior nurses were accepted by the Secretary of State, namely a nationally-oriented approach to the selection and training of staff without encroaching on any individual authority's powers of appointment. Standard application and reference forms were introduced and the value of the service provided by independent assessors in assisting authorities when making appointments was stressed. Detailed procedures appropriate to various levels of nurse management were recommended and the value of small interviewing committees stressed.

The Secretary of State commended a Report on Staff Appraisal in the Nursing Service issued by the NNSC in 1971. Unlike the staff reporting scheme for Administrative Staff, it was compulsory. It was to be introduced group by group and only after careful preparation. The NNSC arranged a publicity programme with the aid of strip films (specially made for this purpose), leaflets and courses of instruction for all. This process was still under way when reorganisation became a major issue in 1972.

Further Management Training

The NNSC endorsed a recommendation of the Salmon Committee that some nurses of exceptional promise should undertake a one year university course for a diploma in social sciences of nursing administration. They also endorsed the Salmon Committee's recommendation that some younger chief nursing officers be given the opportunity to attend the Administrative Staff College at Henley, and possibly appropriate courses at the new Business Schools. The NSC had also proposed similar kinds of experience

for promising administrative staff. The Committees therefore joined in exploring the possibility of putting their respective recommendations into effect. After discussions with the academic authorities concerned, the Committees were able to put definite proposals to the DHSS, and since 1971 a few officers, provisionally selected by the respective committees, have attended annually at Henley and the London and Manchester Business Schools.



COMMUNITY MEDICINE SPECIALISTS

Historical Background and Evolution

The origin of this professional group can be traced to the Public Health Act of 1848 which authorised the appointment of medical officers of health, the predecessors of the community physicians of today. London was the second city to make such an appointment and chose Dr. John Simon, a pathologist and a meticulous and skilful administrator. In 1855 Simon became Medical Officer to the Government and three years later Chief Medical Officer at the Privy Council and his influence was considerable. By his systematic investigation of a wide range of health problems, Simon really changed the practice of public health into a scientific discipline.

Medical officers of health were subsequently appointed in many of the towns and counties of the United Kingdom. Their main responsibilities were in sanitary reform and in the control and prevention of infectious disease, and they set in train many of the changes in the environment on which the present health of the country rests.

With the changes in the health problems in the United Kingdom in the early part of the twentieth century, however, the position of public health medical officers began and continued to change. The importance of environmental health measures was increasingly taken for granted. And the role that these doctors played came to be regarded as of lesser importance than those of their colleagues working in clinical medicine and surgery who, with the discovery of potent and effective drugs and treatment, were able to show tangible benefits to many of their patients.

Between 1918 and 1948 many local authorities developed hospital and welfare services which were managed by the medical officers of health, and in 1948 when the hospital services were placed within the newly formed National Health Service medical management of these (anyway in England) largely lapsed. Medically qualified administrators were appointed to Regional Hospital Boards but their main functions were in personnel matters, capital building programmes and in providing medical advice to their Board.

The medical officers of health retained their function in environmental health, welfare and social services and had responsibilities (which they used widely in many parts of the country) for community health and nursing services such as those for babies, school-children, the elderly and the mentally handicapped. However, following the acceptance of the Seebohm Report in 1968-69, responsibility for welfare and social services passed to the local authority social service departments.

Training of Medical Officers of Health

In order to become a medical officer of health, doctors had to obtain a statutory diploma in public health, the DPH. Training for this was provided full-time by the London School of Hygiene and Tropical Medicine in London and by a number of University Departments of Public Health in England, Wales, Scotland and Northern Ireland. Part-time instruction for this diploma was also available at the Royal Institute of Public Health and some University Departments. The curricula for the DPH included instruction in public health, medical statistics, law, environmental hygiene, maternal and child health and so on. In more recent years some courses have included aspects of management.

Community Medicine

The Royal Commission on Medical Education* (1968) emphasised the importance of the changes in the role of public health and suggested that community medicine would be a more appropriate title for the specialty. They also suggested the establishment of a Faculty of Community Medicine to control education in and furtherance of the subject. This faculty was established jointly by the three College of Physicians in 1972 after discussion with the various societies responsible for or representing medical officers of health, administrative medical officers, and academics in the field of social or community medicine.

Training of Community Medicine Specialists

In the development of plans for the Faculty of Community Medicine

* Bibliography

the education and training of future community medicine specialists was central to many of the deliberations. Clinical training for hospital specialties had never involved any specific period at university. In public health, by contrast, the statutory necessity for public health medical officers to obtain a DPH involved, in most cases, at least nine months full-time academic study. There was increasing dissatisfaction with the candidates for these courses and with the output of doctors they produced, due partly to the changing rôle of the medical officer of health and the consequent difficulty of defining training needs.

The creation of the Faculty of Community Medicine brought together three groups of people principally concerned in the development of the specialty:

- (i) public health medical officers;
- (ii) administrative medical officers in regional hospital boards and hospital medical superintendents, as well as medical officers in central health departments;
- (ii) academic and research workers in university or other departments of public health and social, community or preventive medicine.

The Faculty recognised that the future training of community medicine specialists, in whatever setting they aspired to work, would have to change. Some of these changes were already foreshadowed in the development of an MSc course in Social Medicine at the London School of Hygiene which began in 1968. This is a two-year academic course. The first year is concerned with instruction in the basic disciplines of epidemiology, the behavioural sciences, medical statistics and management. In the second year, students are attached to academic units or service authorities and undertake an original project.

The Emergence of Consortium Training

In the consideration of training needs for community medicine it was accepted that such a two-year course was extremely taxing and very different to the model used in other branches of medicine. For an experimental period, therefore, a new course has been developed based on the model of clinical training. In this trainees are appointed to a service post for a two-year period. During this time they receive instruction in the four basic

subjects of community medicine - epidemiology, medical statistics, behavioural sciences and management as applied to health services. The instruction is provided in modules, usually lasting two weeks, by consortia of universities in different parts of the country. Over the two-year period students are expected to spend about six months of their time in academic work. This includes one day off a week of study time under the supervision of an appropriate tutor.

The first consortium, the Midlands and South-Western Consortium, began in 1973 and consisted of the Oxford, West Midland, Wessex, and South-Western Regions and Wales. The second consortium, made up of the four Thames and the East Anglian Regions, started work in 1974. The third consortium consists of the Northern, Yorkshire, Trent and North-Western Regions and began in 1975.

Up to now the MSc courses and the consortium training have been restricted to basic instruction in the core subjects. Continuing education is being developed by some University Departments, in particular through the two Centres for Extension Training in Community Medicine in London and Manchester. It should be noted that the secondment of community medicine specialists to these centres is in the tradition of many local authorities who seconded their medical officers for further training in both community medicine topics (for example, child health development) and management training, particularly following the Mallaby Report (1967)*.

THE REORGANISED SERVICE

Although recruitment and management development activity continued during the reorganisation period, attention was inevitably sharply focused on the nature of the new Service. Officers wanted to know what the new posts were likely to be and what would be arrangements for securing them. A full account of this period is given in the report of the NHS Staff Commission. The senior management courses provided for senior nurses and administrative officers continued at a reduced tempo, and the duration was reduced to six weeks. They were renamed General Management Development Courses. The energies of the teaching centres providing them were diverted to a considerable extent to provide

* Bibliography.

programmes of courses of preparation of senior officers for the impending reorganisation and well over 1500 officers attended such courses.

Reorganisation of the DHSS was taking place more or less simultaneously with the reorganisation of the Health Service, including the emergence of the personnel divisions. At the same time, the personnel function was firmly established at Region, Area and District. The objective was to provide for the exercise of recruitment, training and management development aspect of the personnel function in an entirely new national framework. The National Staff Committees were replaced in 1974 with new bodies as part of the reorganisation of the personnel function.

Four national staff advisory committees and a national training council were established. The four staff committees, which cover administrative and clerical; nurses and midwives; ambulance; catering; accommodation and other support staff, have as their terms of reference to advise Secretaries of State on policies and procedures for various aspects of recruitment and development of the particular staff groups concerned. The National Training Council, which has set up a Standing Committee on Management Education and Training, is to advise on general strategy, development and coordination of training for the NHS and on training needs common to different groups.

Training Policies in 1974/75

Arrangements for the management training of NHS officers since reorganisation have been made in accordance with a policy statement issued by the DHSS (HSC(IS47)). This circular has attempted to consolidate the experience gained from training undertaken under the aegis of the former National Staff Committee and sets out a number of principles constituting a framework for further developments. One of the later features consequent upon this policy has been an increase in the variety of management courses on offer with the intention of matching individual needs more precisely. The DHSS are financing training programmes for senior NHS managers which have included six-week senior management

development courses limited to those who are relatively new to senior management and 2½ week experienced senior management courses for officers who have worked at this level for some years. Others are five day specialised seminars for concentrated attention on a single management activity, (eg industrial relations, resource allocation, staff development), and a variety of courses and seminars tailored to the current problems of a particular occupational group, eg, catering managers, and functions, eg planning. There is an expanded use of ten-week and four-week courses which are provided at the Administrative Staff College at Henley and the Business Schools at London and at Manchester.

Another feature of the new policy has been to place complementary emphasis on forms of management development which meet the needs and objectives of organisations more directly (for example, participative management, team training, organisational development). A more selective approach to these off-the-job courses is encouraged in the recent review of guide-lines issued by the DHSS (HSC(ISI89)) which urges in particular that managers be helped to develop their ability to train their own staff at the place of work by coaching and counselling, the systematic acquisition of varied experiences and participation in special projects of problem-solving groups.

EPILOGUE

In 1948, in the early days of the NHS, recruitment, training and promotion rested almost entirely in the hands of the employing authorities which could (even though they by no means always did) exercise the "lively independence" Aneurin Bevan had offered them. The climate was therefore not right for national initiatives in the personnel field. The need for such initiatives became clearer some seven years later following reports by the Guillebaud Committee and by Select Committees which had looked at costs and management efficiency. By 1958, the need for national initiatives was more acceptable and they were taken by the Ministry of Health. Even so, they were generally phased in terms which led to the question whether they were mandatory or not. However one national initiative was positive. The Department launched the National Training Scheme in 1956 which was immediately successful and has had a major impact.

The 1960's saw reports leading to the establishment of the National Staff Committees. Their job was to formalise, after consultation with staff interests, earlier initiatives in the personnel field which had erred, if at all, because they had been too permissive in character. Significant developments took place in the methods of advertising, short-listing (with the help of independent assessors) and interviewing applicants for posts. Staff appraisal systems were introduced for both nursing and administrative staff designed to assist career development. Whilst the system for nurses was getting under way when NHS organisation came along, early experience of the system for administrators suggested that much more preparation was required if an essentially sensitive technique was to become an acceptable part of staff development.

The introduction of the National Training Scheme in 1956 brought a university into the management training field for what was probably the first time, when (as discussed in chapter 6) the University of Manchester provided for an academic year leading to a Diploma in Social Administration. The syllabus was in sharp contrast with that of the Institute of Hospital Administrators which required students to learn a lot of detail about the NHS. It was also in contrast with the approach of the HASC which had tended to concentrate on the details rather than the principles. The precedent of the Manchester syllabus was followed in subsequent developments of the National Training Scheme though by reducing the course from a year to three months the opportunity to study the subjects in depth was lost.

It was only during the 1960's that interest in management education became at all common in Britain. In some respects the NHS was ahead and the institution of "senior" management courses for administrators in 1965 and for senior nurses in 1967 was a major development, with an eight week programme following broadly the content of the administrative trainees course. They were popular, probably because they were seen by some as a passport to promotion. The courses proved difficult to run. Course members, unlike trainees, were very different in age, experience and profession. By 1970, the Department of Health and Social Security began to ask the

the National Staff Committees for an evaluation of the courses. A number of studies were undertaken by independent researchers and the main findings recommended a much closer examination of the needs not only of the individual but also of the institution to which he belonged before he was sent on a course. Another problem which was identified was the "re-entry syndrome". These findings were similar to the opinion of others who had been involved in post-experience courses and have led to experiments in a much more intimate involvement by the management teacher in the problems of the organisation and the needs of its personnel, to which management courses are not necessarily the only solution.

PRECIS OF CHAPTER 5

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 the nursing profession, 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 involved 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 needs 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.

5. RECRUITMENT AND PROFESSIONAL DEVELOPMENT

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 the '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 skills as the ability to conceptualise unless the

ground has been laid during his professional development.

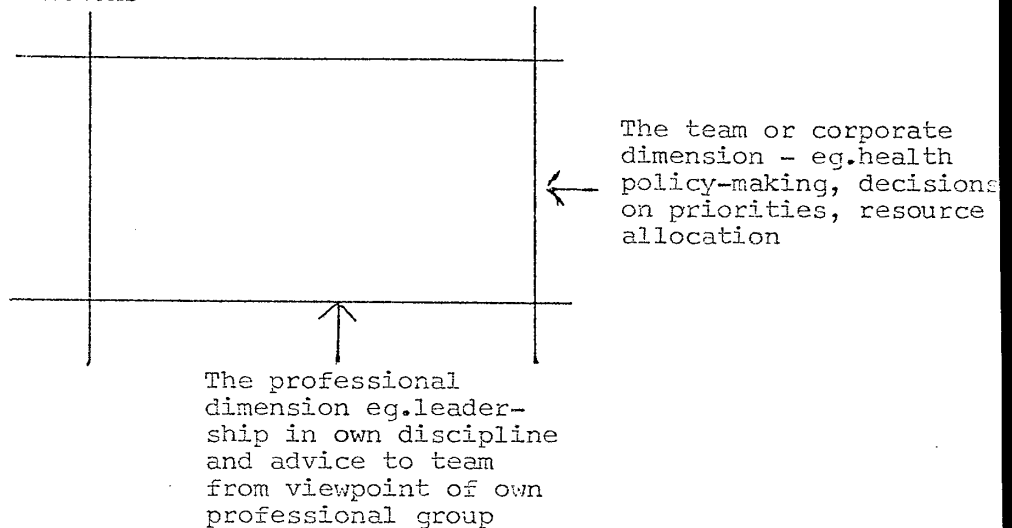
Although at certain levels the administrator requires some specialised skills such as in personnel management or supplies, there is no single body of knowledge which can be taught and applied as 'management'. The implication is that in looking ahead we cannot depend on professional groups (nor indeed 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.

OUR APPROACH

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.

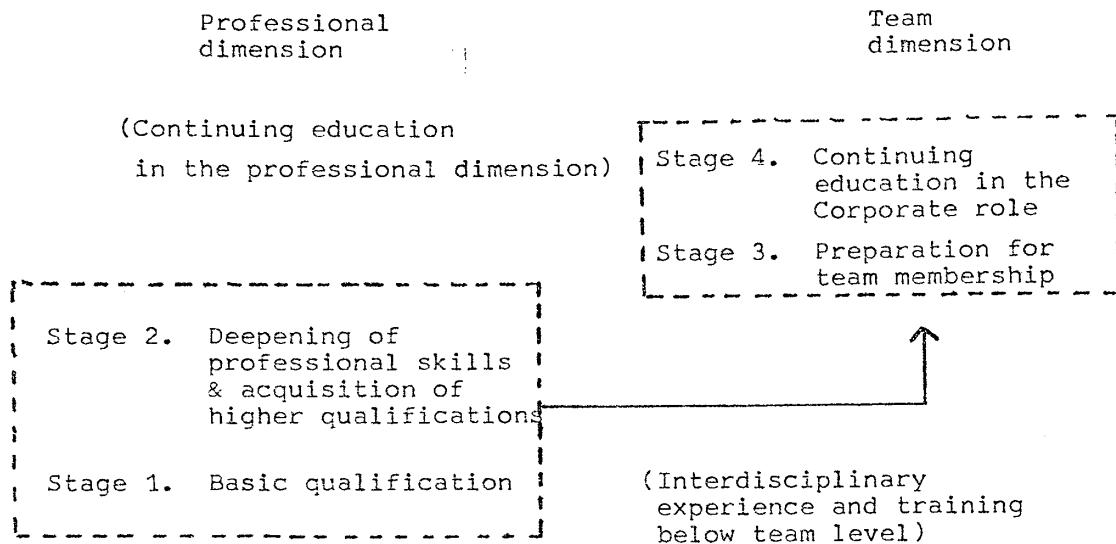
The background and training of these groups are of course profoundly different, but each passes through a number of stages of preparation from basic qualification onwards until they converge as senior managers. Clearly the levels of training required at each stage are not equivalent in each group - thus 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 (ie DMT, AMT, ATO, RTO AND DHSS), everyone is concerned with management in two dimensions



In the team dimension the task is shared and multi-professional, 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 Chapter 1, and picks out four stages as crucial for our purposes:-



In the following sections we deal separately with these stages in each of the four professional groups and assess how far the existing arrangements for professional development meet the NHS needs for senior managers, in terms of numbers and skills.

ADMINISTRATION

The information available* on administrators now in middle and senior management posts is summarized in Figure 1. It shows clearly that a substantial proportion of administrators in senior posts, particularly District Administrators, have the possibility of over 15 years further service at team level. Only 54% of administrators who have currently achieved team membership are over 50, and for District Administrators the figure is 46%. Of those in "second in line" administrative posts (Grades 23 to 29) only some 40% are over 50.

These figures highlight two main problems in management development - firstly, the need for special attention ^{to be given} to continuing education and revitalising of administrators who are already operating at team level secondly, the promotion blocks which exist for second in line officers and other junior and middle grade officers who have both aspirations and the potential for, senior posts.

*The information in this Chapter has been specially collected by the Working Party, supplied by the Association of Health Service Treasurers or derived from official sources.

On the other hand the situation thus revealed does provide 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 1 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 (IHSA, IPM, etc) are apparently 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 2 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 in the remainder of this section. 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.

Fig. 1 ADMINISTRATORS

A. AGE DISTRIBUTION AT OCTOBER 16, 1975

Number of People

| 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, 23 | 20 | 93 | 118 | 162 | 15 | | 408 |
| Grades 23 and 27 | 28 | 72 | 99 | 108 | 12 | | 319 |
| Total | | 48 | 209 | 297 | 382 | 52 | 938 |

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 | 33.9 | 3.8 | |
| 4.8 | 21.1 | 30.1 | 38.7 | 5.3 | |

C. NOTES

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

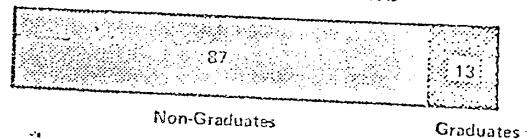
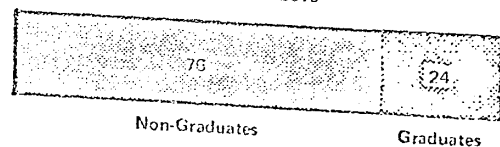
2. Administrators include a range of specialist functions but the general administrators are predominant at all grades*

Percentage Distribution by Function

| | | | | |
|------------------------|-----------|-------------------------------|----------|---|
| 62 | 12 | 11 | 9 | 6 |
| General Administrators | Personnel | Family Practitioner Committee | Supplies | Management Services (including computers OR/and statistics) |

3. Graduates ^{from} a relatively small proportion of the total even in senior posts*

Percentage of Holders of All Posts

Percentage of Holders of Posts of
33M and Above

* England and Wales data, scale 9 posts and above

Figure 2

Preparation and Development of Administrators

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

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 eg. 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 has been 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 judgements. 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.

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. In broad terms they are:

- (1) To manage an extensive variety of hotel and support services, ranging from domestic to personnel and public relation 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.
- (2) To provide administrative support to the authority (at Regional and Area level only), to his colleagues on 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") - a task demanding special skills if it is to be done well.
- (3) To coordinate the work of the team, and provide 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, as 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 been or not done.

These 3 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 (and even their proposed revision) 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, in their present form, 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 2 and in our basic model.

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 3/4 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 and promotion in a specialist or generalist field. The multi-unit nature of the NHS and the fact 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 (4/5 years) would include responsibility for managing specific functions together with general administrative posts and specialist work. The use of semi-structured "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 (eg. managers of support services like catering, work study etc.). 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 Preparation for team membership and continuing education
and 4 thereafter.

Before or shortly after selection for a senior management (team) post we feel there is a need for multi-disciplinary corporate training possibly in the form of a workshop or seminar. This is discussed in a later chapter. Following his selection for a team post, it is important for the administrator to continue his education and training so as 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 his own sphere 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

Figure 3 provides 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. DCPs, 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 at SCM and above in the next 15 years.

In figure 4 we illustrate the career plan that has developed for this professional group in recent years, as a result of the Hunter Report and the efforts of the Faculty of Community Medicine.

FIG.3. COMMUNITY MEDICINE SPECIALISTS**A. AGE DISTRIBUTION AT APRIL 1, 1975**

| GRADE \ AGE | Number of People | | | | | ALL AGES |
|----------------------------|------------------|----------|----------|----------|-----|----------|
| | 20 to 29 | 30 to 39 | 40 to 49 | 50 to 59 | 60+ | |
| 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 | 252 |
| 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+ |
|----------------------------|----------|----------|----------|----------|------|
| RMO/AMO | | 3.9 | 48.1 | 35.6 | 12.5 |
| DCP | | 6.7 | 38.4 | 43.3 | 11.6 |
| SCM | | 9.1 | 39.0 | 40.8 | 11.1 |
| Latched on/ transferred | 2.4 | 11.9 | 26.6 | 37.3 | 21.8 |
| Training | 22.2 | 40.0 | 37.8 | | |
| Total | 1.9 | 10.4 | 36.3 | 37.4 | 14.0 |

C. NOTES

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

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

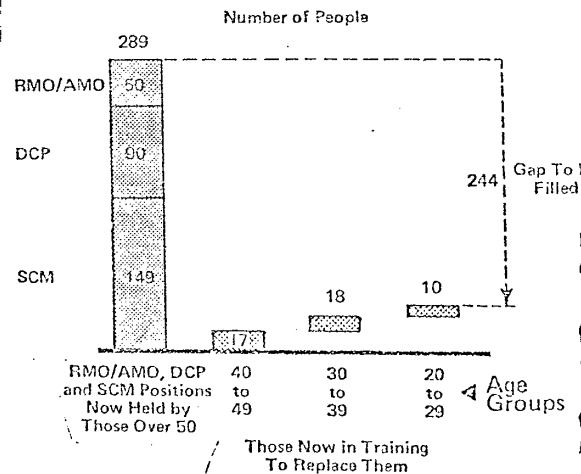
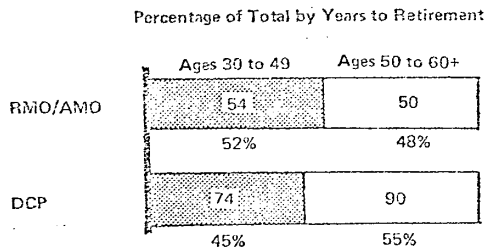


Figure 4

Preparation and Development of Community Medicine Specialists.

| <u>Stage</u> | <u>Type of post held & experience gained</u> | <u>Formal professional training currently provided</u> |
|--|---|---|
| 4. Continuing education in the corporate and professional dimensions | <u>DGP, AMO, RMO</u> Learning and discharging the team role while continuing to maintain professional skills and responsibility. | Continuing education programme. |
| 3. Preparation for team membership | <u>Specialist in Community Medicine</u> 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 | <u>Senior Registrar</u> Increasing responsibility for part of the service, and for a contribution to research. | Part 2 of Membership of FCM |
| 1. Basic professional qualification | <u>Trainee in Community Medicine</u> Basic training in epidemiology, medical statistics etc, 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 | |

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 19th century tend to be forgotten, and the preventive aspects of medicine in the 20th 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 the field of 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.

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 fulfillment at stages 1, 2 and 3, 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 teams 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 Councils 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 it applies 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. Other courses, not recognised by the Faculty exist in Liverpool, Bristol and the Royal Institute of Public Health.

Following the Part 1 examination for Membership of the Faculty of Community Medicine, 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 the management process 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 'proper 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, even 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 resource allocation.

The difficulties in the development of community medicine training at the moment are 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 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 summarized on Figure 5. 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 promotion opportunities for 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 6 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.

FIG. 5 NURSES AND MIDWIVES*

A. AGE DISTRIBUTION AT JUNE 30, 1975

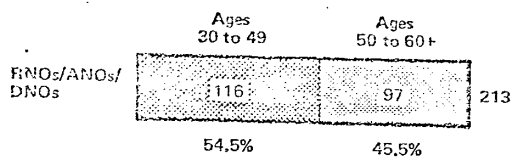
| AGE GRADE | Number of People | | | | | ALL AGES |
|--------------------------------------|------------------|----------------|----------------|----------------|-----|-------------|
| | 20 to 29 | 30 to 39 | 40 to 49 | 50 to 59 | 60+ | |
| RNO/ANO | | 2 | 36 | 40 | 1 | 79 |
| DNO | | 11 | 67 | 54 | 2 | 134 |
| Second in line region and area | | 44 | 100 | 57 | 3 | 204 |
| Second in line district | 1 | 78 | 233 | 215 | 9 | 541 |
| Total | 1 | 135 | 441 | 366 | 15 | 958 |

B. PERCENTAGE DISTRIBUTION BY AGE
WITHIN GRADES

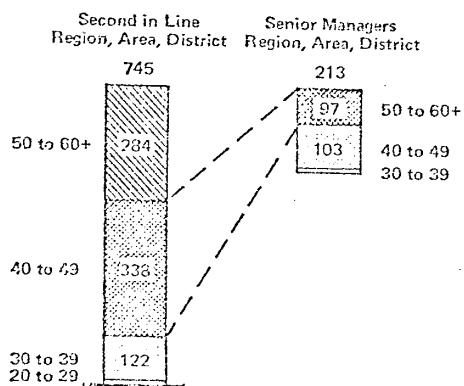
| | 20 to 29 | 30 to 39 | 40 to 49 | 50 to 59 | 60+ |
|-----|----------------|----------------|----------------|----------------|-----|
| | | 2.5 | 45.6 | 50.6 | 1.3 |
| | | 8.2 | 50.0 | 40.3 | 1.5 |
| | | 21.6 | 49.0 | 27.9 | 1.5 |
| 0.2 | 14.4 | 44.0 | 39.8 | | 1.6 |
| 0.1 | 14.1 | 46.0 | 38.2 | |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

C. NOTES

1. Over half the nurse senior managers have more than 10 years till retirement



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



3. There is substantial variation in age structure by region

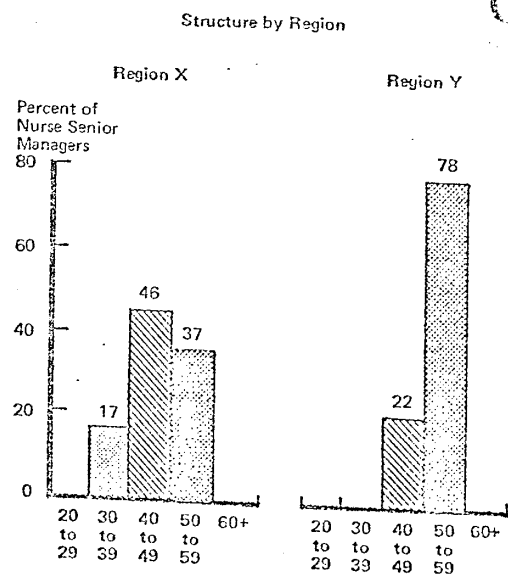
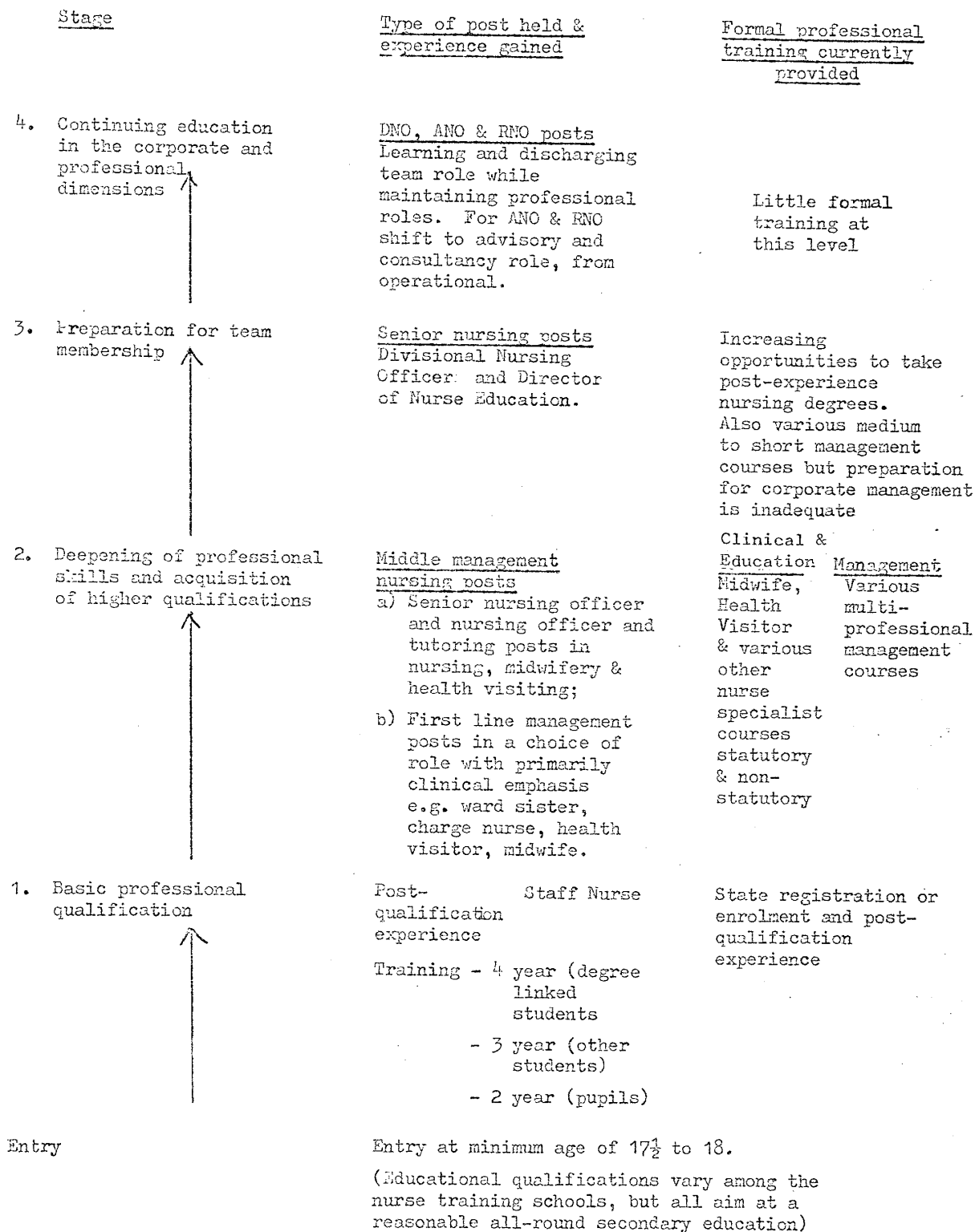


FIGURE 6

PREPARATION AND TRAINING OF SENIOR NURSING MANAGERS

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 and later those of the Mayston Working Party, 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 management structure established the Chief Nursing Officer as a member of the management in her own right and required from all the disciplines concerned a true understanding of (as distinct from the payment of lip-service to) 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 the working situation.

At the middle and upper middle levels of nursing management emphasis is now increasingly being placed upon the professional/clinical as well as the managerial content of the work since in some situations the former yields the highest satisfaction and may be the dominant element in the job. The nursing officer and certain senior nursing officer posts (as commended by Salmon et al)* 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 occurred 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

*Committee on Nursing Staff Structure Page 51, 5.40.

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 the training process 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 within it. This balancing and reconciling of organisational, occupational, service and educational demands with individual aspirations and expectations, is delicate but essential if all available resources are to be optimally deployed. Success in the latter marks out an effective manager although 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 8 - 10 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, clinical and management to proceed together, until the point at which managerial development becomes the dominant element and it is necessary for the individual to expand and increase their 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/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: Salmon* and later Briggs+ both draw attention to the numbers involved. The backlog is being reduced and the numbers requiring first line management courses are presumably known to AHAs and RHAs through their Personnel and Manpower Planning Divisions. However the extreme mobility and wide age/experience range of 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 (ie nursing officers and senior nursing officers). One of the constraints on senior nursing managers is the criteria of grade for acceptance on courses at middle and senior management level: the post held rather than ability and potential are considered. 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 with the other disciplines) for the in-service 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

*Report of the Committee on Senior Nursing Staff Structure (Salmon)

+Report of the Committee on Nursing (Briggs) Cmd.5115 HMSO 1972.

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 (ie 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. As with others they are probably weakest in the numeracy, analytical and conceptual skills. These are essential for participation in the corporate planning process to which the senior nurse manager must make her own particular contribution equal to that of her team colleagues. They 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 judgement, be prepared to take decisions, and be able to explain them.

In a later chapter we make proposals for multi-disciplinary 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 summary of the present situation is given in the Appendix to this Chapter.

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, PhD, etc. are steadily increasing. Financial support for these individuals 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.

In conclusion

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 specific suggestions but the point needs further consideration.

No single model can take into account the multiplicity of professional choices which present themselves to nurses and 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 may be wasteful of skills.

We also 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 permit them to do so.

SUMMARY OF U.K. NURSING DEGREE COURSES

| | | | | | | |
|-----|----------------------------|-----|-----|-----|--------------|--|
| I. | Number of Courses | ... | ... | ... | 13 | |
| II. | University linked courses | ... | ... | 10 | Places = 148 | |
| | Polytechnic linked courses | ... | ... | 3 | Places = 78 | |
| | Total | | | | Places = 226 | |

| | | | | | | |
|------|---|-----|-----|-----|---|--|
| III. | Courses linked to U.C.C.A. Scheme for processing applications.. | ... | ... | ... | 9 | |
|------|---|-----|-----|-----|---|--|

IV. Variety of qualifications and degrees offered :

| | | | | | | |
|--|-----|-----|-----|-----|-----|---|
| S.R.N. | ... | ... | ... | ... | ... | 1 |
| R.G.N. | ... | ... | ... | ... | ... | 1 |
| R.M.N. | ... | ... | ... | ... | ... | 1 |
| H.V. option. | ... | ... | ... | ... | ... | 4 |
| D.N. Certificate | ... | ... | ... | ... | ... | 3 |
| B.Sc. (Hons) Social Science and Administration | ... | ... | ... | ... | ... | 2 |
| B.Sc. (Hons) Nursing Studies | ... | ... | ... | ... | ... | 3 |
| B.Sc. (Hons) Economics | ... | ... | ... | ... | ... | 1 |
| B.A. (Hons) Social Science and Administration | ... | ... | ... | ... | ... | 1 |
| B.Sc. Social Science | ... | ... | ... | ... | ... | 1 |
| B.Sc. Life Sciences | ... | ... | ... | ... | ... | 1 |
| B.Sc. Social Science - Nursing | ... | ... | ... | ... | ... | 1 |
| B.A. Nursing | ... | ... | ... | ... | ... | 3 |
| B.Sc. Nursing | ... | ... | ... | ... | ... | 1 |
| B. Tech. (Hons) Social Science | ... | ... | ... | ... | ... | 1 |

V. Finance

Courses whose students are financed by a Local Authority grant only 5

Courses whose students receive a Student Nurse training allowance for part of the course and a Local Authority grant for the remainder 8

VI. Numbers who have qualified

162 students have started and completed their courses since 1966 and by 1976. 136 of these have been successful in obtaining Nursing qualifications and a degree (wastage = 26 students).

Please note that more students than this have started their courses but have not yet completed.

Degree & Registration

| | | |
|------|-----|---|
| 1971 | ... | 7 |
| 1972 | ... | 7 |
| 1973 | ... | 25 |
| 1974 | ... | 35 |
| 1975 | ... | 46 |
| 1976 | ... | 16 (so far this year - this figure includes Liverpool). |

N.B. The course at St. George's Hospital and Surrey University has now been discontinued and it is not included in any of the figures of Section I - V but those who had qualified so far are included in Section VI.

DEGREE COURSES 1970-75

Appendix 1A.

QUALIFICATIONS OBTAINED

| | | <u>No.</u> <u>Started</u> | <u>Degree</u> | <u>Registration</u> | <u>Degree and</u> <u>Registration</u> |
|-------------------------|-----------|------------------------------|---------------|---------------------|--|
| St. George's/Surrey | 1965/1971 | 7 | | | 7 |
| | 1967/1972 | 4 | | | 4 |
| | 1968/1973 | 7 | | | 7 |
| | 1969/1974 | 11 | | | 10 |
| | 1970/1975 | 15 | | | 15 |
| St. Thomas'/Southampton | 1969/1974 | 8 | | | 6 |
| | 1970/1975 | 6 | | | 4 |
| | 1971/1976 | 7 | | | 7 |
| | 1972/1977 | 7 | | 4 | |
| | 1973/1978 | 10 | | 6 | |
| St. Bartholomew/City | 1968/1972 | 4 | | | 3 |
| | 1969/1973 | 6 | | | 4 |
| | 1970/1974 | 6 | | | 6 |
| | 1971/1975 | 6 | | | 6 |
| Liverpool | 1971/1976 | 5 | 4 | | awaiting results |
| Middlesex/Bedford/LSE | 1969/1974 | 4 | | | 3 |
| | 1970/1975 | 9 | | | 5 |
| | 1971/1976 | 5 | | | 4 |
| London/GMC/Goldsmiths | 1968/1973 | 3 | | | 2 |
| | 1969/1974 | 6 | | | 1 |
| | 1970/1975 | 5 | | | 3 |
| | 1971/1976 | 2 | | | (1) |
| Manchester | 1969/1973 | 12 | | | 12 |
| | 1970/1974 | 13 | | | 9 |
| | 1971/1975 | 16 | | | 13 |
| Cardiff | 1972/1977 | 10 | | | |
| Newcastle | 1973/1978 | 15 | | | |
| Leeds | 1974/1979 | 16 | | | |
| Westminster/South Bank | 1974/1979 | 11 | | | |

FINANCE

Information about the ages and qualifications of finance officers is summarized in Figure 7. The problem highlighted by these figures is the shortage of professionally qualified accountants. A quarter of those in top posts lack a full accountancy qualification, while more than half those in the service who have such a qualification are already in a top post.

In figure 8 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 co-ordination. 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. The recruitment of persons to senior posts of Treasurers has been made difficult because of the relatively small number of senior finance staff with a professional accountancy qualification (Figure 7). The finance departments are manned in the same way as administrative departments and 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 service the majority of 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 fifteen 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. An appropriate qualification is deemed to be that recognised by either:-

- (a) The Chartered Institute of Public Finance and Accounting; or
- (b) The Institute of Chartered Accountants (all British Institutions) or
- (c) 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:-
Stage 1.

The first stage should include a foundation course followed by sandwich courses and in-post 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 in-service training will eliminate the problem of Finance Officers with wholly technical training being frequently out of touch with the practical requirements of the NHS. Stages 2 and 3.

At 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 multi-disciplinary 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, Treasurer 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).

- (a) Multidisciplinary courses of substantial length which give 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 such courses should probably be selected by a special panel, who would assess their suitability objectively,
- (b) Postgraduate Finance courses 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 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 Service or of independent institutions.

Fig. 7 FINANCE OFFICERS

A. AGE DISTRIBUTION** AT JUNE 30, 1975

Number of People

| 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 | 1,096 |

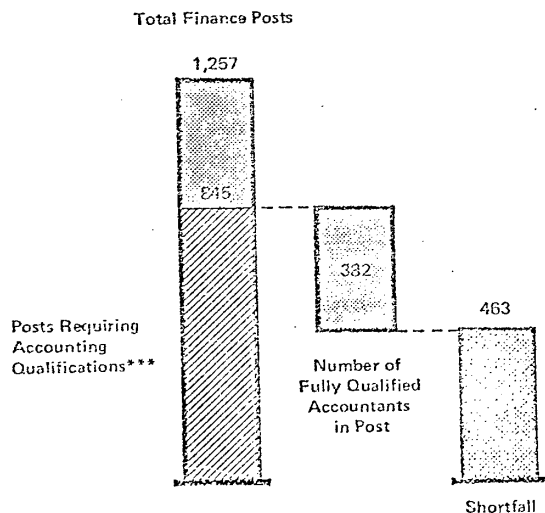
plus vacancies 161
total posts 1,257

B. PERCENTAGE DISTRIBUTION BY AGE** WITHIN GRADES

| | <35 | 35 to 44 | 45 to 54 | 55 to 59 | 60+ |
|----------------------------|------|----------|----------|----------|------|
| Senior managers | 14.2 | 21.4 | 34.6 | 18.0 | 11.8 |
| Senior finance staff | 40.5 | 19.2 | 24.5 | 11.8 | 4.0 |
| Middle level finance staff | 29.1 | 16.7 | 32.9 | 16.5 | 4.8 |
| Total | 28.6 | 18.7 | 30.8 | 15.5 | 6.4 |

C. NOTES

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



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

3. And of the 382 fully qualified Accountants in the NHS more than half are already in senior management posts

* - Includes Regional Treasurers, Area Treasurers, District Finance Officers and some second in line posts in larger regions

Figure 8

Preparation and development of Treasurers and Finance Officers

| Stage | Type of post held and experience gained | Formal professional training currently provided |
|--|--|--|
| 4. Continuing education in the corporate & professional dimensions | <u>DFO, AT and RT posts</u> 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 that is specific to the NHS or has a corporate management emphasis. |
| 3. Preparation for team membership | <u>Senior finance posts</u> Consolidation of leadership and management experience in the Finance Department at 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 | <u>Middle management finance posts</u> Continuing experience, with increasing responsibility for a finance function. | |
| 1. Basic professional qualification | <u>Trainee and junior finance posts</u> | 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. | |

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 Health Service, though inevitably he knows his own specialty much better than any other part of it. During his undergraduate and graduate 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 available resources are used, through their clinical decisions.

An increasing number of attempts are 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. 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 eg. 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 - and a recent American count reached a total of over 200 such groups - 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 lend 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 of the other disciplines.

MEMBERS OF HEALTH AUTHORITIES AND COMMUNITY HEALTH COUNCILS

We are aware that members of health authorities and of their 'consciencess' 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 as are 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 existing 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 totally insufficient numbers as yet 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 will 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 shall 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 is as important as their continuing education in their own professions.

PRECIS OF CHAPTER 6

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.

6 THE ROLE OF HIGHER EDUCATION

PART I

CONCEPT AND PRACTICE

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

- 1 providing a pool of graduates from whom future senior managers might be recruited and developed,
- 2 providing postgraduate programmes offering advanced training in skills relevant to management, and
- 3 providing 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 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 National Health Service. Before the war, with 3,000 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 was recognised at the outset. After a report by two senior civil servants (one lay and one medical) 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 and Ministry 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 field work 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 by restricting intake to one-third of the annual actuarial 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-1960's intake to the National Training Scheme was enlarged and the academic year was reduced to 3 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 elitism 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 orientated 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 in-service courses for potential managers. There are a number of Universities 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 Brunel University School of Social Sciences also offers four year undergraduate sandwich courses. Although no academic course in health administration is offered, many 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 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 are 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 (as has previously been described) 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 as to justify complete exemption from all stages of the examination for the professional qualification.

The 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 orientated 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 1960's 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 unjustifiable 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 the reasons for this are:-

- 1) that 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) that 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; and

- 4) that 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 a vis doctors with their fellowships and membership; and
- 5) that, for those managers who wish and are able to take study leave for as long as 9-12 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, so 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.

The Present Situation in 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 support postgraduate education, the financial mechanism is such as usually to force universities 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 specialities 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 below 35 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. 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 for example supplies, personnel management and computing, and from fields other than the NHS and thus show a cost-benefit greater than that implied in the National Health Service 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 Treasurers may show whether, once professional education at specialty level is established as an essential qualification, the demand for Masters 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

* Bibliography.

and the DHSS, among others - presently going into 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, so as to provide a factual basis for future policies: and to this end we will 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 2 years duration and includes an attachment to gain practical experience. It was initially supported by the DHSS grant of fellowships. At present the continuance of these and the pattern of courses in the future is 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 memberships exam 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 2 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 exam.

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 exam, Part I. Topics included are 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 National Health Service 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, social enquiry theories and methods. 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 special 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 a 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 a MSc in Social Administration and Social Work Studies of one year 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 Masters courses in social work) but the other courses are expected to be taken by more mature students.

Information

Exeter University has for some years offered a 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 course, 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 extra-mural 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 9 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" (eg. by correspondence) is the only access to education available to the in-service 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 purpose 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 CNAAB. 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 under-estimated, 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 "transfers" 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 feed-back 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 from existing resources (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

the shadow of 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 existing 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-term courses will recognise that at different times some of 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/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 course.

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 have been created in the last decade 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 in this field 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 within 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.

PART II

A POLICY TOWARDS HIGHER EDUCATION

Assuming that the universities accept and effectively discharge a responsibility for advancing knowledge in the area of health service management and for educating those who aspire to practice it, this should be the pivot of any long-term plans not only on the educational front but for the whole strategy of the NHS. Any 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 the verdict of Ridley and Steel*. 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

*Bibliography

counts. First upon the degree to which the various factors involved 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 these questions without a detailed study of the existing 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 do not exist at present on the management side - 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. Sole 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 existing 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 last paragraph.

Basic Assumptions

In discussing possible policies for degree and other courses at the universities, there are certain 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 & teaching which is a necessity in this field. It is not to be forgotten that all the disciplines relevant to management (as 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 that 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 Department 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. Viewing the Master's degree as an extension of professional education, it will not be equally required by all in senior management. In particular those who

are already possessed of a good honour's degree in relevant subjects might be better involved in research or teaching during the period of study leave involved. 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 the carrying out of a programme of awards of study leave and financial support towards Master's Degree courses for the purpose indicated. As there are 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 inter-action 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.

Existing courses 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 focussed in 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 Health Service but suitable also for middle-rank managers from all types of large organisations, provided that individual students can carry out projects relative to their own profession.

We have no doubt that the existence of Master's courses of this kind will enhance the quality of top management in the NHS; and with a harmonisation of existing 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 rather 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 depends crucially on the scale of the total operation. In particular, if our estimate of the demand, - say, ten a year - is near the truth, then 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 Henley Staff College (and to a lesser extent at the Business Schools) and to direct financing of short management courses at the education centres, at the King's Fund College,

Birmingham, Leeds, and Manchester, and at Leicester Polytechnic. As this section is dealing with the university role, 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 recently announced by the Department. 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 is essential which may be drawn upon for advice and conceptual knowledge.

Precis of Chapter 7

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 fits 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 then 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.

7 THE ROLE OF THE DHSS AND THE NHS AUTHORITIES: PAST AND FUTURE STRATEGY

What is the role of the Department of Health 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 prior to and following 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.

INHERITED ROLES AND STRATEGY

Responsibility for recruitment, selection and manpower development are 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 does intervene in an attempt to set policy guidelines, it only goes beyond circulars containing enlightened generalities in the case of development that cannot be

*Bibliography.

undertaken at area or region, such as the national schemes for graduate and A-level entry. In such cases, support from the DHSS can either be in the form of central finance or of centrally 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 (a) the national schemes for graduate

and A-level entry; (b) control over numbers, types and pay levels of senior posts, with some influence on methods of selection, and (c) support of five national education centres. The first of these department 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 (or less than 0.01% 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 4-6 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% of the total salary bill.

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 personnel who have attended such courses is small. The staff college proposal 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 multi-professional 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 the health field, but so far has evidently not been a

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

practical training base for most of those who are, or hope to be, senior managers. Between 50 and 100 NHS personnel have attended the 3-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 Department, if only because of the recent 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 a 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 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 even 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 was 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 does spend 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 previously 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 multi-professional 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 multi-professional approach has been recognised too unspecifically, leading to far too many courses being multi-professional 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 health policy making and to learn in depth about the contributions that other professions make at the management level. Existing 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, eg. in industrial relations, handling the 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 in 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.

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 DMT's. As a one-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 on 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

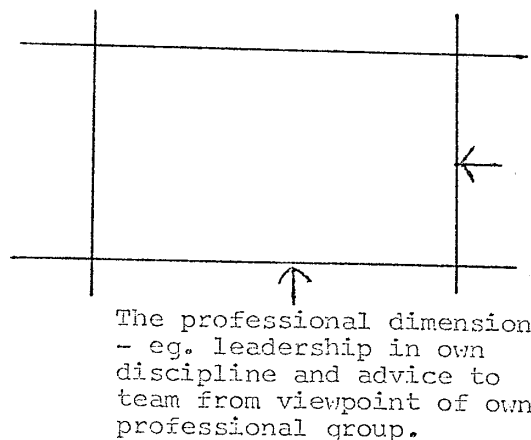
The educational centres are not yet the centres of excellence they should be. They are too much engaged in the treadmill of short courses, many of them at an appreciation level. Little research is undertaken in them - nor are they financed for research - and the DHSS should seek to integrate research 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 educational centres include the difficulty of (a) attracting and retaining high calibre staff, since they can neither give tenure nor - in most cases - university status; (b) drawing effectively on the strength of other faculties and (c) 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 educational centres are making brave

attempts, but in our judgement none of them has yet achieved excellence as an educational and research institution. Much has been achieved in establishing a series of educational 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 alongside the National Staff 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 emphasize first the need for a conceptual framework. No single steps such as establishing a National Health Service Staff College or starting Master Degrees in health policy by themselves define a useful strategy. The needs are too heterogeneous for any single action of that kind to meet them all. As already described 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 team or corporate
dimension - eg. health
policy-making, decisions
on priorities, resource
allocation

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 follows:

PROFESSIONAL TRAINING NEEDS OF SENIOR MANAGERS

| Professional Group Skill / qualification needs | Administrators (A) | Finance Officers (F) | Nurse Administrators (N) | Community Medicine Specialty (VM) |
|---|---|--|---|---|
| Corporate management training needs | S E E L A T E R | | | |
| 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 |
| 145. - Technical | 2 Economics with statistics 3 Either specialist option (eg. personnel works, supplies) or running of hotel & other supporting services | 2 Economics, statis- tics and public finance (at least as required by CIPFA) | 2. Basic analytic skills including logic and statistics | 3. Management administration (basic groundi |
| - Human | 4 Behavioural sciences | | 3. Behavioural sciences. | 4. Behavioural sciences |
| - Contextual | 5 NHS in setting of its history, international comparisons & public administration | 3 As in A5 plus broader awareness of public finance (see 2 above) | 4 Health and social problems & services 5 History of nursing | 5 As in N4 |
| Entry qualifications | Good 'A' level results & suitability (degree desirable) | Good 'A' level results & suitability (degree optional) | SRN (degree optional) | Medical degree |

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 their 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 multi-professional training being introduced on any scale at this first stage of professional education.

At the more senior level, however, (ie. 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 like this:

FURTHER TRAINING NEEDS OF SENIOR MANAGERS

| <div>Professional Group</div> <div>Skill / qualification needs</div> | Administrators (A) | Finance Officers (F) | Nurse Administrators (N) | Community Medicine Specialists (CM) |
|--|--|--|--|--|
| Shared needs | <ol style="list-style-type: none"> 1 Understanding of corporate and individual roles (theoretical and role-playing, including role of members v. officers and of each NHS level v. 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. | | | |
| <div>147.</div> <div>Special needs</div> | Insight into F, N & CM Epidemiology & medical statistics Nursing and nurse administration NHS finance accounting | Insight into A, N & CM Epidemiology & medical statistics Nursing and nurse administration NHS organisation & administration | Insight into A, F & CM Epidemiology & medical statistics NHS organisation & administration NHS finance and accounting | Insight into A, F & N NHS organisation and administration NHS finance and accounting Nursing and nurse administration |
| Entry requirements | Qualification for leadership in own profession as in table 1 and selection for corporate role. | | | |

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 the following diagram:

ASSESSMENT OF CURRENT ARRANGEMENTS AGAINST BLUEPRINT

| Professional Group Stages | Administrators (A) | Finance Officers (F) | Nurse Administrators (N) | Community Medicine Specialists (CM) |
|---|---|--|---|--|
| Entry | Reasonably good past records of attracting recruits from wide range of backgrounds | <u>Some weakness</u> Schemes to attract able recruits to specialise in finance have been rather unsuccessful so far | <u>Some weakness</u> Because of the lack of other career paths some nurses enter administration who are not suited to it | <u>Major weakness</u> Attracting the right calibre of entrants into the specialty |
| 149. Foundation for leadership in own profession | <u>Major weakness</u> 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, & needed, raising of standards <u>Some weakness</u> at advanced part of this stage. For those who have attained full professional qualification there is a need to develop broader health service perspectives | <u>Major weakness</u> Wide range of degree, diploma and short courses but no agreed standards of qualification | Relatively new, but potentially strong arrangements |
| Foundation for corporate management | <u>Major weakness</u> 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 | <u>Major weakness</u> 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 | | | |

Our assessment therefore identifies five areas of major weakness in current arrangements. The first three of which have already been discussed in Chapter 5 but are nevertheless 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 specialities, 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.
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, namely:

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 (a) 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 and (b) 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 also 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 the set standards of excellence.

Whether this should be organised by the Royal College of Nursing or by the GNC or by 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 of the order of 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 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 (3) separate, much shorter courses for clinician members elected to teams and for members and chairmen of health authorities.

Each of these three groups require separate provision. Courses might be of the order of 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 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 time 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 recently run by Professor Chester, are needed and some of them should be extended

across professional boundaries.

- 6 Establish better personal 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 before 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 whose 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 elitist 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.

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 Preface, 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 Department, 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 in their 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 individually 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 is. 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 Ministers.

Leadership is less easily given by civil servants, for despite their thorough and devoted work which has led to innovation and progress in the field of 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 districts, areas and regions cannot be treated separately; and that therefore the National Health Service 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 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 or 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 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 judgements 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 National Training Council'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 (i) prototype courses for selected staff who have gained professional qualifications

and are considered eligible for appointment to team posts, and
(ii) 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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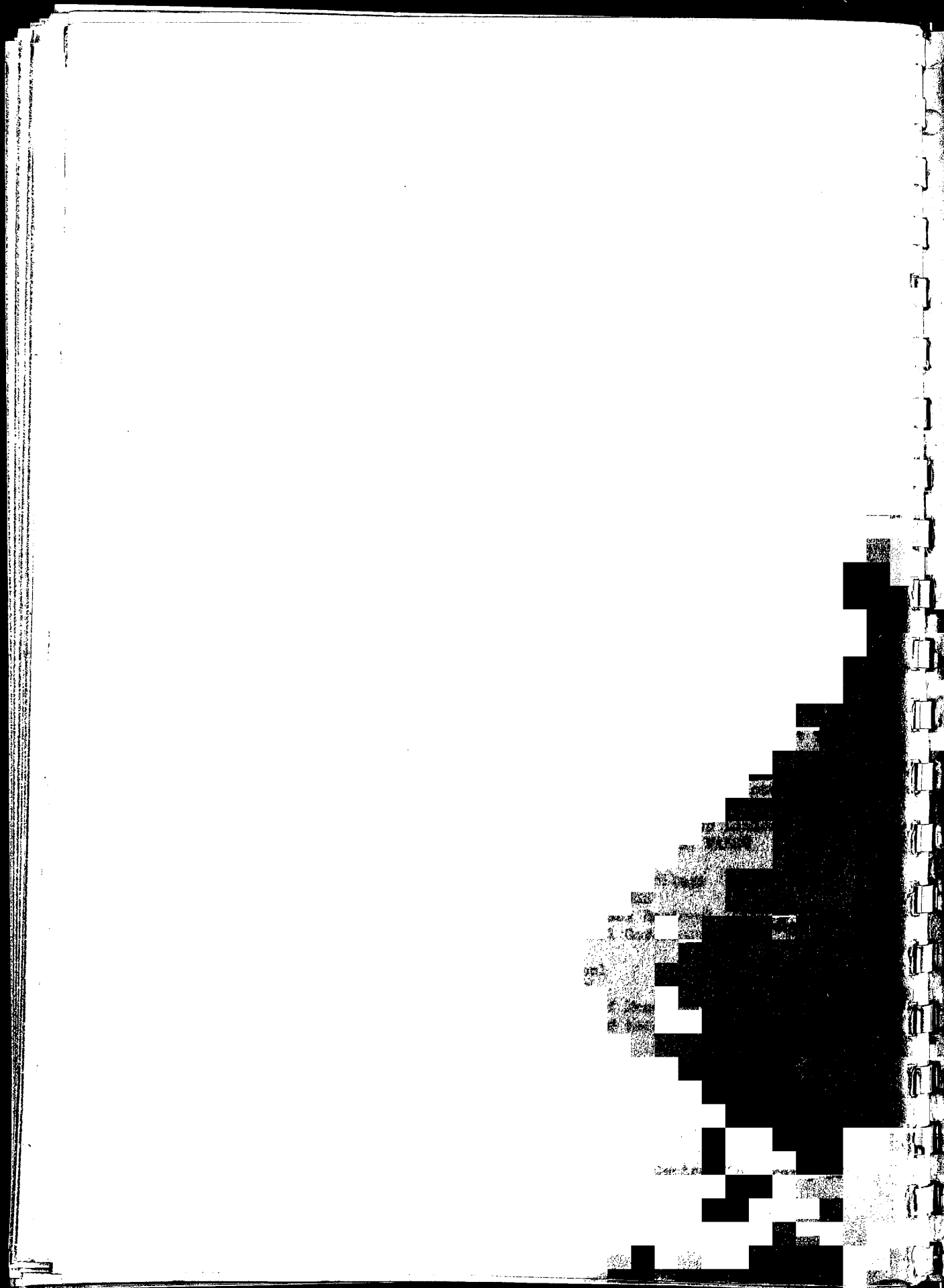
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