

## ‘I’ve Never Found Doctors to be a Difficult Bunch’: Doctors, Managers and NHS Reorganisations in Manchester and Salford, 1948–2007

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**Abstract:** Since 1974 the National Health Service (NHS) has been subject to successive reorganisations which have shaped and reshaped patterns of administration, clinical care and services. This paper uses two sources of oral evidence: a Witness Seminar with a group of administrators who attended the NHS National Administrators’ Training Scheme in the late 1950s and a collection of interviews with doctors and managers who have played key roles in the health services of Manchester and Salford between 1974 and 2007. It surveys the day-to-day interactions between doctors and administrators/managers in hospital settings and analyses what these reveal about relationships within the broader context of shifting organisational structures and management styles. It suggests that the evidence challenges the historical stereotyping of the two groups and that strong working relationships have been determined as much by the values of respect and association as by changes to structures or management styles.

**Keywords:** Health Services, Medicine, Management, Administration, Doctors

... health organisations cannot survive without the expertise of the clinician, neither can the clinician survive without the supportive structure of the organisation – the two must be brought together in a symbiosis.<sup>1</sup>

Over the past thirty or so years, successive governments have sought to improve healthcare by reorganising the structures and services of the National Health Service (NHS). At the heart of this ‘continuous revolution’ has been a drive to create strong

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This paper evolved out of a pilot study on ‘The Recent History of the NHS in Manchester and Salford, 1980–2007’, which was funded by a Wellcome Trust Strategic Award to the Centre for the History of Science, Technology & Medicine (Grant No. 079984). The author gratefully acknowledges the contribution of her co-investigators John Pickstone, Stephen Harrison and Kath Checkland, and thanks them, Naomi Chambers, Martin Gorsky, David Robson, Rosemary Stevens and the external reviewers for their helpful comments on this paper.

<sup>1</sup> Roger M. Battistella and T.E. Chester, ‘Reorganisation of the National Health Service: Background and Issues in England’s Quest for a Comprehensive-Integrated Planning and Delivery Service’, *The Milbank Memorial Fund Quarterly. Health and Society*, 51 (1973), 489–530: 505.

management, in the hope of making services more cost-effective and efficient.<sup>2</sup> Debates around NHS management began in the early 1950s, partly in response to the conclusions of the Guillebaud Committee (1953) that financial imbalances were the consequences of a failure to anticipate demographic change and inflation and that the Service required more ‘oversight and supervision’.<sup>3</sup> Specialist training programmes for NHS administrators<sup>4</sup> were introduced in 1956 and by the 1970s it was axiomatic that better management could improve the efficiency, economy and quality of services. The 1972 NHS Reorganisation White Paper, as published under Sir Keith Joseph as Secretary of State for Social Services, differed notably from previous drafts in its stress on effective management: ‘the importance of good management in making the best use of resources can hardly be overstated’.<sup>5</sup> Enacted in 1974, the reorganisation introduced consensus management, prescribing multi-disciplinary teams which brought together doctors, other health professionals and administrators. The Thatcher governments of the 1980s undertook significant reforms of the NHS including commissioning the Griffiths NHS Management Inquiry (1983). Martin Gorsky’s article in this volume draws on new evidence from a Witness Seminar to reappraise the Inquiry’s origins, conduct and implementation. He suggests that the subsequent failure to address recommendations including the development of a cadre of clinician-managers has had significant long-term implications for the NHS. The Inquiry was a pivotal moment in the history of doctor–manager relations as it ushered in the ideologies and practices of managerialism which significantly increased perceptions of the legitimacy of managers’ control over clinical services and promoted new management roles for doctors.<sup>6</sup> The implementation of general management was followed by the launch of the internal market in 1991, and over most of the succeeding period a succession of formations has promoted contestability and competition between purchasers and providers. The new NHS Trusts brought together hospitals and other units providing patient care in self-governing organisations managed by executive boards with

<sup>2</sup> See Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002), ch. 3; David J. Hunter, ‘The National Health Service 1980–2005’, Editorial, *Public Money and Management*, 25, 4 (2006), 209.

<sup>3</sup> *Committee of Enquiry into the Cost of the National Health Service*, Cmnd.633 (London: HMSO, 1956), 211. See also Stephen Harrison, *National Health Service Management in the 1980s* (Avebury, 1994), 11–16.

<sup>4</sup> Throughout this paper I use the common term for each period: ‘administrator’ until the introduction of General Management in 1983 and then ‘manager’ from 1983 onwards. It is, however, important to recognise that these semantic shifts, which are often assumed to be evolutionary and associated with changes in practice, are challenged by our witnesses’ testimonies as some described themselves as managers in the earlier period. Stewart has suggested that the terms ‘administration’, ‘management’ and ‘leadership’ operate as a hierarchy, R. Stewart, *Leading in the NHS: A Practical Guide* (London: Macmillan, 1999), but Grey draws attention to the way in which the choice of such terms is highly context-dependent: ‘the ascription of the term “management” to various kinds of activities is not a mere convenience but rather something which has certain effects. The use of words is not innocent, and in the case of management its use carries irrevocable implications and resonances which are associated with industrialism and modern Western forms of rationality and control’, C. Grey, ‘“We are all Managers Now”; “We always were”: On the development and demise of management’, *Journal of Management Studies*, 36 (1999) 561–85: 577.

<sup>5</sup> Quoted in Brian Watkin, *Documents on Health and Social Services: 1834 to the Present Day* (London: Methuen & Co Ltd, 1975), 167.

<sup>6</sup> Christopher Pollitt, *Managerialism and the Public Services. Cuts or Cultural Change in the 1990s?* (Oxford: Wiley-Blackwell, 1990), Stephen Harrison and Ruth McDonald, *The Politics of Healthcare in Britain* (London: SAGE Publications, 2008), 46.

statutory duties.<sup>7</sup> Trusts had direct accountability to the Secretary of State for Health and responsibility for organisational performance was shared by doctors and managers.

Thus from the creation of the NHS in 1948 when doctors generally viewed administrators as ‘operationally and socially inferior’,<sup>8</sup> to the present where managers with greater authority share responsibilities with doctors, their formal relations have been prescribed by the various management structures and coloured by wider service reforms. This paper examines the history of doctor–manager relations against this background, first of administrative stability and then of thirty years of ‘permanent revolution’.<sup>9</sup> My focus is the day-to-day interactions between doctors and administrators/managers in hospital settings and what these reveal about relationships within the broader context of shifting organisational structures and management styles. Many commentators argue that the rise of the lay manager diminished medical autonomy which produced mutual suspicion and adversarial relationships but my analysis is more nuanced.<sup>10</sup> Managerial authority has indeed increased significantly over time especially since the introduction of General Management in 1983 and the expansion and strengthening of the regulatory framework governing clinical services since the 1990s. There is little doubt that doctors now enjoy less individual autonomy over their work than earlier generations.<sup>11</sup> Nevertheless I show that, despite the broad critiques of the early NHS administrative structures, there is evidence of strong and cohesive relations between doctors and administrators in the 1948–83 period, especially in the teaching hospitals which retained pre-NHS administrative arrangements. I also suggest that the post-1983 changes have compelled doctors to engage with management and managers to engage with clinical services in an unprecedented and universal manner that has familiarised the knowledge and understanding of each group’s work and created, in some organisations, a strong culture of mutual enterprise and endeavour.

The paper draws on two sources of oral evidence. First, a Witness Seminar with a cohort of NHS administrators who trained at the University of Manchester in the late 1950s in a health management and policy unit, established in 1956 by Theodore Chester, the University’s first professor of social administration.<sup>12</sup> This oral evidence is supplemented

<sup>7</sup> Chris Ham, *The New National Health Service: Organisation and Management* (Oxford: Radcliffe Medical Press, 1991), 26. Since 2002 Foundation Trusts have been progressively established; they are independently regulated by Monitor. Since 1997, the devolution of political power to Scotland and Wales has resulted in significant divergences in these countries in relation to NHS organisational arrangements and entitlement to services. See Harrison and McDonald, *ibid.*, 156–61.

<sup>8</sup> Rosemary Stevens, ‘Hospital Administration: The Status Quo’, *Medical Care*, 2 (October–December, 1964), 208–13: 209. See also Mark Learmonth, ‘Kindly Technicians: Hospital Administrators Immediately Before the NHS’, *Journal of Management in Medicine*, 12, 6 (1998), 323–30.

<sup>9</sup> Hunter, *op. cit.* (note 2), 209.

<sup>10</sup> On doctor–manager relations see the special themed issue of the *BMJ* (22 March 2003) (Vol 326, Issue 7390) especially: N. Edwards, ‘Doctors and Managers: A Problem Without a Solution?’, 609–10, Huw T.O. Davies and Stephen Harrison, ‘Trends in Doctor–Manager Relationships’, 646–9; Pieter Degeling *et al.*, ‘Medicine, Management and Modernisation: a “Danse Macabre”?’, 649–52; Antony Garelick and Leonard Fagin, ‘The Doctor–Manager Relationship’, *Advances in Psychiatric Treatment*, 11 (2005), 241–52.

<sup>11</sup> See Stephen Harrison, ‘Clinical autonomy and health policy: past and future’, in Mark Exworthy and Susan Halford (eds), *Professionals and the New Managerialism in the Public Sector* (Buckingham: Open University, 1999), 50–64; Stephen Harrison and Waqar I.U. Ahmad, ‘Medical Autonomy and the UK State 1975–2025’, *Sociology* 34 (2000), 129–46.

<sup>12</sup> Witness Seminar: National Administrators’ Training Scheme, 1958 Cohort, held at the University of Manchester, October 2008. Hereafter referred to as NATS WS. David Robson, one of the witnesses, donated his working papers spanning from 1958 to 1997 to the Centre for the History of Science, Technology & Medicine. Hereafter referred to as CHSTM/RA.

by personal documents including reflective diaries written during the training period, and working files spanning the late 1950s to the 1990s. The second source is a set of interviews with doctors and managers who worked in and around Manchester and Salford between 1974 and 2007, undertaken in a collaborative pilot study between the Centre for the History of Science, Technology & Medicine (CHSTM) and the National Primary Care Research and Development Centre (NPCRDC). The participants had a range of academic, clinical and managerial backgrounds and each interview moved systematically through the interviewee's career history.<sup>13</sup> We encouraged interviewees to compare and contrast their experiences against established narratives of the recent history of the NHS and were particularly interested in participants' reflections on key moments of transitions in structures, for example, from hospital to trust.

Oral history was used as a tool to reconstruct the experiences of doctors and managers, partly because it is the most sensitive method of exploring experiences of work<sup>14</sup> and is especially suited to a local study where local networks, relationships and communication pathways underpin policy implementation.<sup>15</sup> It was also chosen because of the difficulties associated with record-keeping during successive reorganisations, caused by the disbanding of offices and archives and the movement of personnel, and compounded by electronic record-keeping and new management cultures for which the past is unknown or seen as a burden.<sup>16</sup> Although largely unintentional, these changes have interacted across public sector organisations to create a condition of institutional amnesia, or the loss of organisational memory, causing a 'declining ability – and willingness – . . . to access and make use of possibly relevant past experience'.<sup>17</sup> In Manchester, and probably elsewhere, successive reorganisations had a severe impact on the archives of the local NHS:

... to be frank ... [The record management] was poor – there was no one responsible and they [the records] were simply dumped in two large rooms, and as people moved on and organisations changed, any sense of ownership was lost.<sup>18</sup>

Oral history then is an invaluable tool for reconstructing the histories of organisations and individuals during this turbulent period of NHS history particularly as there has often been continuity in people, if not in organisations.<sup>19</sup>

What follows is divided into four parts. First, an outline of hospital administration within the new NHS which establishes continuities with the pre-1948 arrangements and shows how new training programmes for administrators produced an elite cadre with distinctive working practices. This leads in to a discussion of doctor and

<sup>13</sup> Our sixteen interviewees were made up of: managers who had worked in the NHS since the 1970s and at different levels – district, area, region and national; and doctors who had worked in hospitals, general practice and public health, and several who had taken up management posts as medical directors, directors of public health and chief executives (local and national).

<sup>14</sup> R. Grele, *Envelopes of Sound: The Art of Oral History* (New York: Greenwood Press, 1991); Paul Thompson, *The Voice of the Past* (Oxford: Oxford University Press, 1990).

<sup>15</sup> Graham Smith and Malcolm Nicholson, 'Re-Expressing the Division of British Medicine Under the NHS: The Importance of Locality in General Practitioners' Oral Histories', *Social Science and Medicine*, 64 (2007), 938–48.

<sup>16</sup> Richard Sennett, *The Culture of the New Capitalism* (Yale: Yale University Press, 2006).

<sup>17</sup> Christopher Pollitt, 'Institutional Amnesia: A Paradox of the "Information Age"?', *Prometheus*, 18 (2000), 5–16, this 6; Christopher Pollitt, *Time, Policy, Management. Governing with the Past* (Oxford: Oxford University Press, 2008).

<sup>18</sup> Personal communication to author, 29 September 2009.

<sup>19</sup> On the use of oral history in the history of policy making and networks of power see Virginia Berridge, 'Hidden from History?: Oral History and the History of Health Policy', *Oral History*, 38 (2010), 91–100.

administrator/manager relations in three main periods: consensus management between 1974 and 1983; general management between 1983 and 1991; and markets and trusts between 1991 and 2007. The conclusion considers how the various structures and philosophies have influenced and shaped relations between the two groups and offers some thoughts on continuities over the period.

### **NHS Administration 1948–74: ‘Professionals Should Always be on Tap, Not on Top’**

On 5 July 1948, the creation of the NHS nationalised voluntary and local authority hospitals and grouped them according to ‘function and character’.<sup>20</sup> The administrative arrangements originated from voluntary hospital structures and comprised tiers of management at hospital, group and regional levels. The Regional Hospital Boards, responsible to the Minister of Health, consisted of a chairman, a lay administrator (secretary) and a medical administrator who was paid a higher salary than their lay equivalent.<sup>21</sup> Hospital Management Committees (HMCs) took day-to-day administrative responsibility for groups of hospitals within a region so as to achieve economies, particularly in relation to joint purchasing arrangements and other ventures.<sup>22</sup> Individual hospitals were managed by a triumvirate: a hospital secretary, a medical administrator and a matron who had day-to-day responsibility and reported to the Group Secretary who was the Chief Administrative Officer for the local HMC. Board and Committee appointments were part-time, honorary and included a significant proportion of doctors who were also represented through Medical Advisory Committees which operated at each level. Teaching hospitals had negotiated special arrangements which allowed them to maintain their Boards of Governors, retain control of their endowment funds and report directly to the Minister of Health.

The single system introduced new stresses and strains as it grouped together hospitals with very different histories and the changes were as ‘potentially fertile in discomfort, as well as in promise’.<sup>23</sup> Unlike the self-governing voluntary hospitals, local authority institutions did have experience of operating within a larger system but they had previously been managed by medical superintendents who were responsible to the local authority and whose medical status facilitated clear authority over lay and nursing administrations. After 1948 the post of medical superintendent declined rapidly in general hospitals across England and Wales: in mid-1951 there was a total of 380 medical superintendents with mixed clinical and administrative duties; by 1953 the number had dropped to fourteen full-

<sup>20</sup> Voluntary hospitals were originally established as charitable enterprises and were managed by boards with members drawn from local subscribers such as doctors, industrialists and philanthropists. Local authority hospitals had their origins in the 1834 Poor Law and from the late nineteenth century were central to state initiatives around public health, especially the spread of epidemic disease. See Brian Abel-Smith, *The Hospitals 1800–1948: A Study in Social Administration in England and Wales* (London, 1964); Martin Gorsky, ‘Hospital governance and community involvement in Britain: evidence from before the National Health Service’. Available online at <http://www.historyandpolicy.org/papers/policy-paper-40.html> (accessed 9 December 2011).

<sup>21</sup> Stevens, *op. cit.* (note 8).

<sup>22</sup> T.E. Chester, *Organisation for Change: The British National Health Service*, Centre for Educational Research and Innovation (Paris: Organisation for Economic Cooperation and Development, 1975), 8. Available online at [http://eric.ed.gov:80/ERICDocs/data/ericdocs2sql/content\\_storage\\_01/0000019b/80/31/58/20.pdf](http://eric.ed.gov:80/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/31/58/20.pdf) (accessed 17 May 2010).

<sup>23</sup> The Acton Society Trust, *Hospitals and the State: Hospital Organisation and Administration under the National Health Service: The Impact of Change* (London: Acton Society Trust, 1956–59) 6 volumes, vol. 1, 43; Stevens, *op. cit.* (note 8), 208.

time and seventeen part-time posts.<sup>24</sup> They were replaced by lay administrators ‘largely untrained in management techniques’ from a variety of backgrounds including the army and navy.<sup>25</sup> For voluntary hospitals, the loss of local independence was a significant factor and in some cases it was claimed that the new arrangements meant that the matron could not buy even a mop without first having approval from the HMC.<sup>26</sup> Historically, in both types of hospital, medical and nursing professionals had viewed administrators as ‘operationally and socially inferior’.<sup>27</sup>

Moreover, the new arrangements exacerbated existing tensions between medical, nursing and administrative staff. The relationship between the secretary and the matron for example was already ‘delicate’ because of the trend towards the specialisation of administrative functions such as catering and management of domestic staff which in practice had begun to diminish nursing authority. In 1945 the Ministry of Health’s booklet, *Staffing the Hospitals*, which was produced to address the acute shortages of domestic labour suggested that the control and supervision of such staff should be allocated to an officer with specialist experience rather than a ‘trained nurse’.<sup>28</sup> The new structures increased such strains and often created a ‘tug of war’ between precedent and new formal powers.<sup>29</sup> The new regime also reinforced existing inequalities between lay, nursing and medical authority as the structures permitted medical and nursing staff to by-pass the hospital secretary and liaise directly with the group secretary. At hospital level the administrator was usually younger and more junior in status than older, established medical staff and this added to the difficulties. In 1954, the Bradbeer Committee, set up to review the internal administration of hospitals, asserted that ‘the normal channel of approach to the group administrator [should be] through the unit administrator’ yet tensions persisted.<sup>30</sup>

Theoretical analyses of occupations and professions focus on the classification of different types of work with special regard to the jurisdiction each has over boundaries

<sup>24</sup> Acton, *ibid.*, vol. 2, 51. The medical superintendent post was retained in Scotland and in mental hospitals. Some commentators have argued that this shift pinpoints the beginning of a weakening of medical control of hospitals and it is worth noting that Greer’s comparative analysis of England, Scotland and Wales shows that in Scotland, where the medical superintendent post was retained, the medical profession retained significant power in the health system. Scott Greer, *Territorial Politics and Health Policy: UK Health Policy in Comparative Perspective* (Manchester: Manchester University Press, 2004).

<sup>25</sup> Stevens, *op. cit.* (note 8).

<sup>26</sup> Acton, *op. cit.* (note 23), vol. 2, 39.

<sup>27</sup> Stevens, *op. cit.* (note 8).

<sup>28</sup> Acton, *op. cit.* (note 23), vol. 2, 17.

<sup>29</sup> Acton, *op. cit.* (note 23), vol. 2, 25.

<sup>30</sup> Central Health Services Council, *Report of the Committee on the Internal Administration of Hospitals* (London: HMSO, 1954), paras 196–7, quoted in Watkin, *op. cit.* (note 5), 184. In 1961 the Department of Social Administration at the University of Manchester undertook an analysis of medical committees, reviewing their functions and working practices. It noted that the different lengths of experience between the hospital administrator and the local medical committee chairman could create tensions: ‘In these days, when the hospital secretary is becoming a sort of administrative registrar, moving on fairly quickly to higher posts, it must be difficult for him to meet on even terms a spokesman of the medical staff who was a senior member of the hospital staff when the hospital secretary was still a schoolboy’. It also noted communication difficulties associated with the hierarchical structures. In one instance, all three officers of a hospital group had been asked to report ‘independently’ to the Group Secretary on a Health Circular on Hospital Catering which created the risk of ‘inconsistent recommendations’ about the services in a particular hospital. In other localities the hospital administrator was by-passed by the Group Secretary liaising directly with the catering officer or matron. CHSTM/RA, *op. cit.* (note 12), file 3.

and contested areas.<sup>31</sup> The key task for administrators during this period was to establish their boundaries of work and define their authority in relation to medicine and nursing. Since the nineteenth century, medicine had been widely regarded as the archetypal profession, characterised by individual and collective autonomy and political and social power.<sup>32</sup> Nursing too, although regarded as a lower status profession than medicine, had developed a clear professional identity and the most senior nurses enjoyed jurisdiction over ward management. Administration then was the messy ‘other’, comprising functions which fell outside of medicine and nursing: finance, supplies, engineering, maintenance, laundry, catering and clerical work.<sup>33</sup>

Administrators’ responsibilities increased in both scale and complexity during the first decade of the NHS as hospital services developed significantly through expanding specialties such as neurosurgery, thoracic surgery and plastic surgery, and new medical technologies in radiography, pathology and blood transfusion services. These improvements were underpinned by an unprecedented increase in the medical and nursing workforces. Between 1949 and 1958 the medical workforce increased by 30 per cent in England and by 50 per cent in Scotland, and the nursing and midwifery workforce increased by 26 per cent across Britain.<sup>34</sup> The drive towards specialisation of administrative functions continued – finance functions, for example, began to be split from general administration, creating new posts of finance officers – and the 1962 Hospital Plan announced a major programme of hospital building, involving new planning and commissioning.<sup>35</sup>

It is not surprising then that during this early period of the NHS, in response to the difficulties around relationships, administrators sought to strengthen and hone their occupational identities and values. Their focus also reflected the wider flourishing of the ‘science of management’ which had begun with the burgeoning of the public sector in the post-war period and was accompanied by the creation of the British Institution of Management (1947), and academic institutions focused on management education and research.<sup>36</sup> The first body of hospital officers, the Hospitals Association, had been founded by Sir Henry Burdett in 1884 and established its journal, *the Hospital*, in 1886. The Diploma in Hospital Administration was created in 1925 and in 1942 the Association formed the Institute of Hospital Administrators (IHA) which had individual councils for voluntary, local authority and mental hospital administrators. An IHA conference held in 1942 resolved that ‘hospital administration is of such importance as to call for special training leading to a recognised qualification’; by 1945 a new examination scheme was in place, and by 1954 some 80 per cent of senior NHS administrative posts were held by members of the IHA.<sup>37</sup>

Writing in 1956, Chester argued that the NHS had created a need for a ‘new type’ of administrator and one of the critical questions was how such staff should be selected,

<sup>31</sup> Eliot Freidson, *Profession of Medicine* (Chicago: University of Chicago Press, 1988).

<sup>32</sup> Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

<sup>33</sup> Stevens, *op. cit.* (note 8), 209.

<sup>34</sup> Charles Webster, *The Health Services since the War Volume II. Government and Health Care: the National Health Service 1958–1979* (London: HMSO, 1996), 17.

<sup>35</sup> Stephen Harrison, ‘Consensus Decision-Making in the National Health Service – A Review’, *Journal of Management Studies*, 19 (1982), 377–94: 379; Webster, *ibid.*, 92–109.

<sup>36</sup> John F. Wilson, *The Manchester Experiment: A History of Manchester Business School, 1965–1990* (London: Paul Chapman Publishing, 1992), 8.

<sup>37</sup> *History of the Institute of Healthcare Management*, [http://www.ihm.org.uk/About\\_Us/history/history](http://www.ihm.org.uk/About_Us/history/history) (accessed 19 October 2011).

trained and promoted.<sup>38</sup> The political debates around NHS management focused on the quality of personnel and issues of training rather than the inherent complexities of the role – because it was both ‘more urgent’ and ‘easier to tackle’ suggested one commentator.<sup>39</sup> The IHA’s response to the Guillebaud Committee which had been set up in 1953 to review the ‘present and prospective’ costs of the NHS, explained that initial assumptions that individual hospitals could be managed by either direct or close supervision from the group secretary or his deputy were misplaced.<sup>40</sup>

This ... far too much ignored the size and geographical dispersion of most groups, and the complexity of the modern hospital and its administration, as well also as the fact that it is at the individual hospital that the care and treatment is actually provided. ... experience has clearly shown that much as services may be planned and co-ordinated at group level and certain administrative functions ... centralized, there necessarily remain important functions of day-to-day management, coordination, and supervision at the individual hospital ... Hospitals, in short, do not run themselves.<sup>41</sup>

Concerns about the need for highly trained staff had led the King Edward’s Hospital Fund for London to establish a bursary training scheme for hospital administrators in 1951, and one or two Regions had organised training, but the majority of the 33,000 NHS clerical and administrative staff had no formal training. In 1956 a National Administrator Training Scheme (NATS) was established, following the Guillebaud Committee’s recommendations for a national recruitment and training plan supported by improved salaries and promotion structures. NATS, initially organised by the King Edward’s Hospital Fund for London and the University of Manchester, was expected to ‘provide the management cadre of the future’.<sup>42</sup> Candidates were selected by a National Selection Committee and there were initially sixteen posts a year. The early NATS consisted of a three-year contract interspersing periods of practical training with study for the postgraduate Diploma in Social Administration and a final period of up to twelve months work experience, although trainees were permitted to apply for posts after six months work experience.<sup>43</sup> The University of Manchester had offered the Diploma in Social Administration for some time but it was now adapted for potential senior hospital administrators.<sup>44</sup> NATS was to prove a significant venture as it established the pathway for the creation of an administrative elite who went on to function as a professional network.

The Manchester NATS was based in the Department of Public Administration under the leadership of Professor Theodore Chester, an Austrian alien who had joined the British Army in the 1930s. Chester’s interest in management began when he was Director of the Acton Society Trust, an apolitical organisation that was set up to promote economic, political and social research and was funded by the Joseph Rowntree Foundation. His research into hospital organisation and administration under the NHS was published as a series of pamphlets between 1955 and 1959, after he had moved to Manchester.<sup>45</sup> The testimonies of our witnesses who entered NATS in 1958 shows that Chester strove to

<sup>38</sup> Acton, *op. cit.* (note 23), vol. 2, 38.

<sup>39</sup> Stevens, *op. cit.* (note 8), 208.

<sup>40</sup> <http://hansard.millbanksystems.com/commons/1956/jan/25/national-health-service-guillebaud-report> (accessed 14 March 2012).

<sup>41</sup> Acton, *op. cit.* (note 23), vol. 2, 46–7.

<sup>42</sup> Stevens, *op. cit.* (note 8), 210.

<sup>43</sup> Note from David Robson to Stephanie Snow, October 2010.

<sup>44</sup> T.E. Chester, ‘A New Recruitment and Training Scheme for Senior Hospital Administrators’, *Public Administration*, Winter (1956), 425–9.

<sup>45</sup> Acton, *op. cit.* (note 23).



create administrators who shared values, identities and behaviours and were equipped with the knowledge and skills that would enable them to function in the most challenging of circumstances.<sup>46</sup> He was ‘an inspiration, made us think about the right things’; his tutorials taught us ‘the essence of management’; he was ‘lively’ and ‘unorthodox’ and known for his Chesterisms, such as ‘you need to produce people whom you can trust to break the rules’. Most importantly, he:

injected a sense of belief in us, a degree of self-confidence and assertiveness, to think things through, look at the options and consult with others. And to have the confidence to make a decision.

Nor did Chester’s influence wane as he maintained contact with trainees after the training period had ended, often visiting them in their workplaces: ‘we had the sense that he would defend us and his ideas’. He encouraged the cohorts to network and share their experiences of working life: ‘whenever I had a difficulty about implementing some circular I’d ring up and ask [another Chester trainee]’.<sup>47</sup> A clear expression of Chester’s philosophies is found in a 1972 article which compares health services management in Britain and the US:

Ultimately what counts is the ability to attract good people who have been trained and are experienced in socially-oriented subjects, as well as management, and who are free to make decisions consistent with local needs. The harmonisation of efficiency with democracy depends more than anything else on enlightened and discerning leadership at the point where people and services meet.<sup>48</sup>

Under the NHS structures, with its undefined responsibilities, administrative power resided less in formal positions than in an individual’s ability to command authority and respect. The boundaries between medical, nursing and lay authority were often contested, and an administrator’s ‘success’ depended heavily on his/her ability to establish strong, collegiate joint-working arrangements. That the Department of Health and Social Security (DHSS) advised Chester to desist from promoting networking amongst his trainees suggests that the new training was empowering administrators to develop more prominent roles than had been the case historically.<sup>49</sup> His insistence that ‘professionals should always be on tap, not on top’ was a strong antidote to the dominance of medical power at the time and one of the most striking examples of the way in which the training embedded a sense of felt power in trainees’ work identities came when all our NATS witnesses responded unequivocally to the question:

*When did you feel yourselves to be managers rather than administrators?*

From day one. Teddy Chester was out to train us to be managers within the health service.<sup>50</sup>

Yet there were concerns that the hospital system was only capable of utilising ‘subservient clerks’, not those who had been highly trained on the NATS and who were equipped to operate in the sort of ‘creative and authoritative administrative system’ which

<sup>46</sup> Our witnesses joined NATS from a variety of backgrounds such as the Civil Service and banking; they were all graduates bar one in-service member. Nicknamed ‘the sobersides’ by contemporaries, they shared a keen belief in the value and purpose of public service and most were practising Christians. Collegiality amongst this cohort may have been exceptional; the group has maintained strong social links including wives and families over the fifty years or so since they first met in Manchester.

<sup>47</sup> NATS WS, *op. cit.* (note 12).

<sup>48</sup> Roger M. Battistella and T.E. Chester, ‘Role of Management in Health Services in Britain and the United States’, *The Lancet* (18 March 1972), 626–30. Note the use of the terms ‘management’ and ‘leadership’, see note 4.

<sup>49</sup> NATS WS, *op. cit.* (note 12).

<sup>50</sup> NATS WS, *op. cit.* (note 12). See note 4.

could be found in some parts of the business world.<sup>51</sup> P.A. Steele and G.S. Evans, ex-NATS trainees, expressed these doubts in a paper on *Recruitment and Training Problems* which was presented at a Nuffield Provincial Hospitals Trust Symposium on Hospital Administrative Training in 1963: ‘What the hospital service needs is leadership. Until this is accepted, the National Training Course will continue to be a stable which breeds race horses to pull milk-carts’.<sup>52</sup>

Further evidence of a strengthening of professional identity can be found in the history of the October Club. Established in July 1964, the Club sought to preserve the association between past members of the NATS, promote lectures and discussions on any topic of general interest to members, and promote and encourage study into aspects of hospital administration.<sup>53</sup> The founding membership consisted of trainees from the first five NATS held between 1956 and 1961 who were mainly based in London and the south east. The Club became particularly active during the late 1960s and by 1971 had a membership of seventy health service administrators with a geographical spread from ‘Carlisle and Durham to Southampton, or from Cambridge to Bristol’.<sup>54</sup> The Club had responded to the second Green Paper on the *Future Structure of the National Health Service*, developed by the Labour Secretary of State for Social Services, Richard Crossman, in 1970, and a year later, to the amended consultative document issued by Sir Keith Joseph, the new Conservative Secretary of State for Social Services. The major cause of concern was that ‘the present proposals still appear to depart in principle from those which will ensure good management’.<sup>55</sup> The Club supported the creation of multi-disciplinary teams and advised that there should be a full debate before a decision was reached as to whether the team should function with a chief executive (as proposed in the 1965 Farquharson–Lang Report<sup>56</sup>) or simply a ‘co-ordinator and spokesman’. It warned that the final solution must ‘avoid the two extremes of creating a potential dictator and leaving the question unresolved as was the case in 1946’.<sup>57</sup>

These representations did not shift the Government’s plans significantly. Nevertheless, they suggest that the NATS had created an elite core of administrators with a common identity and the confidence and skills to work collaboratively and strategically with doctors. Chester’s trainees aspired to being ‘imaginative, farsighted coordinators of all aspects of the service’ and their practices were grounded in the concept of teamwork.<sup>58</sup> For them, the introduction of consensus management in 1974 was not new territory.

<sup>51</sup> Nuffield Trust Symposium in Administrative Training: Paper II, *Management and Training Problems*, P.A. Steele and G.S. Evans, 18 March 1963, CHSTM/RA, *op. cit.* (note 12).

<sup>52</sup> Nuffield Trust Symposium, *ibid.*

<sup>53</sup> The October Club File, CHSTM/RA, *op. cit.* (note 12).

<sup>54</sup> Letter to the Rt. Hon. Sir Keith Joseph, 30 July 1971, CHSTM/RA, *op. cit.* (note 12).

<sup>55</sup> Memorandum on National Health Service Re-organisation, para 1.2, CHSTM/RA, *op. cit.* (note 12).

<sup>56</sup> The Farquharson–Lang Report was published in Scotland in 1965 and recommended that Chief Executives should head regional health boards and local boards but disagreed, albeit ‘reluctantly’ with the British Medical Association’s view that the emphasis should be on medical qualifications: the decisive factor should be the individual’s ‘ability and experience as a manager not his professional qualifications’, quoted in Watkin, *op. cit.* (note 5), 318; see also Webster, *op. cit.* (note 34), 312.

<sup>57</sup> Letter to the Rt. Hon. Sir Keith Joseph, 30 July 1971, CHSTM/RA, *op. cit.* (note 12).

<sup>58</sup> Letter from D.M. Robson to John Sully, 16 October 1972: ‘Integration and improvement is not going to occur by everyone hanging grimly onto what they can. If we as representatives of the age group that will make or break this reorganisation present ourselves to Sir Keith Joseph in the same sort of terms that might be used by the hard core BMA or IHSA council member, I do not think that we will commend ourselves as imaginative, farsighted coordinators of all aspects of the service’, CHSTM/RA, *op. cit.* (note 12).

### NHS Consensus Management, 1974–83: ‘Collective Responsibility Founded on Close Association and Mutual Respect’

The choice of a consensus management model in the 1972 White Paper originated from a Study Group of Department of Health and Social Security and NHS officers working with the consultants McKinsey and Co and the Health Services Organisation Research Unit of Brunel University.<sup>59</sup> In some ways it formalised the pattern of relationships which had worked best in the NHS, given its dependence on a self-regulating and autonomous medical profession.<sup>60</sup> Chester, among other commentators, was broadly supportive of the new arrangements:

... reorganisation can seldom be justified for saving money – the primary contribution is improved management ... multidisciplinary team methods ... may in time create a far stronger environment in support of comprehensive patient care ideals. In the context of collective responsibility founded on close association and mutual respect, consensus need not mean difficult-to-attain unanimity but a more practical sense of the meeting and the accommodation of views, with rare instances of conflict intense enough to invite the exercise of veto powers.<sup>61</sup>

In a few places a consensus style of management had been used prior to 1974 and often produced ‘good results’ although administrators had had ‘to work hard for them’.<sup>62</sup> Our NATS witnesses had been empowered to build strong working relationships and they remembered working closely with medical and nursing staff from the very beginning of their careers in the late 1950s: ‘the only way of working was by consensus management’.<sup>63</sup> David Robson worked at St Thomas’ Hospital, London during the 1960s which as a teaching hospital had retained its governance arrangements through its Board of Governors. He recollected that the Clerk of the Governors, Bryan McSwiney, enjoyed ‘influence’ on the Board and his nursing and medical colleagues. St Thomas’ was being radically developed during this time and this made it an attractive option for NATS trainees who were keen to put their skills into practice.<sup>64</sup> Robson outlined the experience he had gained at St Thomas’ in an application he submitted for one of the new administrative posts created by the 1974 reorganisation:

[My] experience has been applied in a district setting providing for example £80,000 revenue for new developments by reducing the obstetric units from three to two, and developing a new management philosophy for the Board of Governors to assist changes in patient service provision. The latter period has provided considerable practical experience of consensus management.<sup>65</sup>

<sup>59</sup> Harrison, *op. cit.* (note 35).

<sup>60</sup> Harrison, *op. cit.* (note 35), 379–80.

<sup>61</sup> Battistella and Chester, *op. cit.* (note 1), 519.

<sup>62</sup> Letter to the Rt. Hon. Sir Keith Joseph, 30 October 1972, attaching a Memorandum on Management Arrangements from a group of eight NHS administrators, CHSTM/RA, *op. cit.* (note 12).

<sup>63</sup> NATS WS, *op. cit.* (note 12).

<sup>64</sup> Note from David Robson to Stephanie Snow, October 2010. See also Stephanie J. Snow (ed.), *The Recent History of Guy's and St Thomas', 1970s to 2000s*, held 16 June 2011 at Guy's and St Thomas' Foundation Trust (University of Manchester: Centre for the History of Science, Technology & Medicine, 2011), 11. Hereafter referred to as GST WS. Available online at <http://www.chstm.manchester.ac.uk/downloads/guys-thomas-witness-seminar-2011-06.pdf> (accessed 10 December 2012).

<sup>65</sup> Undated draft of letter from David Robson c.1973. Robson was then the Assistant Clerk of Management Services at St Thomas' Hospital, London. Other references in working notes included reference to a planning team at a Regional Health Authority where a multi-disciplinary team was ‘practising consensus without knowing it’ as a means to overcoming differences in opinion between hospital and local authority members, CHSTM/RA, *op. cit.* (note 12).

In contrast to later reorganisations, the transition to the new style of management had been well prepared; recognition had been given to the need to ‘transform officers used to executive and hierarchical management into managers forming a team with co-equal partners making decisions on a consensus basis’.<sup>66</sup> The DHSS commissioned retraining courses at eight educational centres across the country, including the Department of Social Administration at the University of Manchester, where between 1972 and 1974, residential courses were held for around 1000 doctors, managers, nurses, voluntary members and dentists. One of the intentions of the reorganisation was to give doctors management responsibility that equalled the ‘effective control’ they had over resources.<sup>67</sup> Chester led the training at Manchester, which included discussions around service planning. He noted, ‘most clinicians learned by this method how difficult it is for members of such an individualistic profession to arrive at a consensus view’.<sup>68</sup>

Some specialties were more attuned to a consensus management style than others. In 1976 Bill Sang was promoted from his post of general administrator at Salford Area Health Authority to deputy sector administrator at Prestwich, a huge mental health hospital.<sup>69</sup> The 1974 reorganisation had brought Prestwich under Salford Area Health Authority’s jurisdiction and integrating the institution into its area had thrown up considerable challenges. It required, explained Sang,

a kind of culture of alignment between a health authority which is quite thrusting and dynamic and looking at building up its reputation as a teaching centre and grafting on an old asylum which was very . . . backward looking and full of long term problems.

Salford Mental Health Services was one of the largest in the UK and underwent significant transformations during the thirteen years Sang spent at Prestwich. Services were reduced from over 1500 beds on a single site in 1975 to less than 800 beds, dispersed across several sites by 1990. Sang described the way in which in a series of changes in structures and styles of management had combined with the broader developments in psychiatry to positive effect. The 1982 reorganisation brought benefits as Salford AHA became an independent district health authority (DHA) and Prestwich’s status as a relatively new addition to Salford’s portfolio meant that the DHA felt ‘relatively uninformed’ about matters relating to the hospital. Sang found he was free to liaise directly with the region rather than with the district administration:

The District Health Authority . . . were far more confident dealing with local issues . . . that meant I had a great deal of freedom and discretion to plough my furrow and you know, keep people informed but not constantly having to seek agreement or consent to things so in that sense it was very liberating. . . . we had a lot of . . . bilateral negotiations with the [Regional Health Authority (RHA)] rather than through the DHA so again my position was quite central to negotiating with the RHA.

The expansion of psychiatry into sub-specialisms presented new opportunities for investment and growth in services. The Prestwich Hospital site was secured for the development of major regional and national referral services in forensic and adolescent psychiatry, psychiatry for the deaf, psychotherapy and addiction psychiatry which attracted new investment. A land sale was promoted to finance the re-provision of

<sup>66</sup> Chester, *op. cit.* (note 22), 8.

<sup>67</sup> Chester, *op. cit.* (note 22), 19.

<sup>68</sup> Chester, *op. cit.* (note 22), 26.

<sup>69</sup> For a detailed account of mental health services in Salford and Manchester see Valerie Harrington, ‘Voices Beyond the Asylum: A Post-War History of Mental Health Services in Manchester and Salford’ (unpublished PhD thesis: University of Manchester, 2008).

local facilities for the Salford District Mental Health Services; this included partnership arrangements with several housing associations and voluntary organisations. A further enabling factor was Salford's history of integrated mental health services; since the 1960s consultant psychiatrists had been appointed to work across hospital and local authority services and team-working between professionals was an established practice.<sup>70</sup> Most importantly perhaps, the culture of psychiatry proved to be highly receptive to the consensus management approach.

[T]here was much more willingness to share decision making and a willingness to be reflective [especially compared to] surgeons ... [who] regard their decision-making as pre-eminent.

These shifts were enacted in new behaviours at the weekly team meetings:

[T]he chairman of our ... team at the time ... would come in to the sector administrator's office ... sit behind the sector administrator's desk and chair the meeting and my predecessor had deferred, got out of the desk and gone and sat somewhere else and I thought I'm not going to do that. ... the first meeting ... I sat by my own desk and [the chairman] came in and sort of looked and quite happily deferred and sat somewhere else ... eventually ... [we] sat round the table and changed the whole dynamics. ... If I had done that with ... the professor of orthopaedics, oh he'd have thrown a fit and it would have been quite different ... I was actually able to work and build kind of team-thinking and team-working in this setting quite comfortably ... we built up quite interesting management structures and management philosophies from very early on ... that was probably very naïve at first but gradually more significant ... those two things together, the culture of sharing decision-making and the opportunity for growth in the specialisation ... were really quite significant'.<sup>71</sup>

Salford and psychiatry may have been untypical but Sang's experience reveals the positive aspects of consensus management from an administrator's point of view.

In 1979, the Royal Commission on the NHS reported favourably on consensus management.<sup>72</sup> Harrison noted in 1982 that there were few prospects for significantly improving the decision-making process given that members of the team were 'to a significant extent in competition for resources' and that doctors maintained power over resource allocation.<sup>73</sup> In some localities and specialties, consensus management empowered administrators who aspired to be 'imaginative, farsighted coordinators of all aspects of the service', as was the case at Prestwich. In other areas the model was judged to have failed.<sup>74</sup> Importantly, the establishment of strong and cooperative doctor-administrator relations during this period became a critical local determinant of the successful introduction of General Management in 1983.

### General Management, 1983–91: 'Looking at the Organisation from the Outside in'

The introduction of General Management from 1983 was the first serious attempt to shift the 'frontier of control' between doctors and the government.<sup>75</sup> There were wide local variations in the implementation of General Management and good relations seemed to

<sup>70</sup> *Ibid.*, ch. 2.

<sup>71</sup> Interview with Bill Sang, 24 April 2006.

<sup>72</sup> Harrison, *op. cit.* (note 35), 381.

<sup>73</sup> Harrison, *op. cit.* (note 35), 391.

<sup>74</sup> See Gorsky in this volume on the various judgments made on the success or failure of consensus management as a management model.

<sup>75</sup> Harrison, *op. cit.* (note 3); and Stephen Harrison and J. Lim, 'The Frontier of Control: Doctors and Managers in the NHS 1966–1997', *Clinical Governance*, 8, 1 (2003), 13–18. See Gorsky in this volume for the details of the circumstances surrounding the Griffiths' report and its implementation.

rely more on the interpersonal qualities and skills of managers than on their new positional authority.<sup>76</sup> The experiences of our interviewees bear out these findings and we see below how over this period, some doctors and managers began to build knowledge of each other's enterprises in new ways, with managers becoming more deeply involved in clinical services and doctors taking on new management responsibilities.

The new arrangements exhorted managers to think about the organisation in a much broader sense: we were explicitly required to look at the organisation 'from the outside in', noted Lois Willis who joined the NHS as a NATS trainee in the South East Thames Region in 1975. Following the Griffiths reforms she was appointed in Leicester as Unit General Manager of a large and complex acute unit comprising a newly commissioned District General Hospital, a community hospital and a well-established hospital providing tertiary cardiothoracic services, and was one of the youngest post-holders to take on this role. She remembered the chairman encouraging her to speak out in meetings and voice the new 'managerial' views.<sup>77</sup> Some of our NATS witnesses found little change under the new arrangements: 'my experience was a smooth transition; it didn't change relationships'; 'I thought of myself as a manager within a consensus situation'; 'accountability was sharper but practice wasn't'. But others resisted the changes:

I didn't like [General Management] and determined to have nothing to do with it. It felt to me as though I was being given an authority I hadn't earned and shouldn't exercise over people.<sup>78</sup>

That consensus management had enabled some of Chester's trainees to build successful relationships with doctors is illustrated by one NATS witness who recounted being told by a consultant some years later that 'of course, you weren't a manager, what I mean is that you were one of us'.<sup>79</sup> General Management changed the daily working life of managers in many ways and the spouses who were present at our seminar with the NATS trainees had strong recollections of these shifts: 'some things were taken away, other things piled on, the ground was pulled from under his feet, lots more pressures, meetings at 7.30am and staying till 7pm'.<sup>80</sup> Sometimes the new business-focused approaches clashed sharply with the ethos of public service, with instances, for example, where new appointees did not take an 'ethical approach to contracting'.<sup>81</sup> Careers became more unstable as the new appointments were made on short-term contracts of three or five years. You had 'only a little over 1000 days to make your mark, but unlike Anne Boleyn at least you know that from the outset', said one unit general manager.<sup>82</sup>

The new arrangements gave managers increased authority over clinical services and the North Western Regional Health Authority was probably not alone in capitalising on these new powers, appointing managers with the specific task of 'sorting out' the finances at unit level. In Salford, this severely destabilised established relationships at Hope Hospital:

<sup>76</sup> Stephen Harrison *et al.*, *Just Managing: Power and Culture in the NHS* (Basingstoke: Macmillan Press, 1992), 95–117.

<sup>77</sup> Interview with Lois Willis, 17 March 2006. Around fifty-six per cent of the new general managers were appointed from within the same authority or another authority within the same region; just under ten per cent of appointments were from the private sector and the armed forces. Brian Edwards, *The National Health Service: A Manager's Tale, 1946–1992* (Nuffield Provincial Hospitals Trust, 1993), 83.

<sup>78</sup> NATS WS, *op. cit.* (note 12).

<sup>79</sup> NATS WS, *op. cit.* (note 12).

<sup>80</sup> NATS WS, *op. cit.* (note 12).

<sup>81</sup> NATS WS, *op. cit.* (note 12).

<sup>82</sup> Quoted in Edwards, *op. cit.* (note 77), 86.

[He] had been one of the top executive team at the regional health authority. He was brought in as ... unit general manager ... with a very clear remit to get finances under control, [he] was fairly Draconian ... [and] did what he was asked to do but relations with the medics were getting incredibly strained; promises that people thought they had about new services or developments were being revisited and what had been a relatively collaborative organisation was actually getting into some quite difficult territory ... the culture was actually very uncomfortable.<sup>83</sup>

After only a couple of years this unit manager moved on and Bill Sang, by then General Manager for Salford Mental Health Services, was invited to apply for the post in 1990 because he 'worked in a different way'. It took Sang a few 'fairly torrid years' to re-establish a culture of collaboration with doctors and other personnel. Hope Hospital had only gained status as a teaching hospital in 1974 and one of Sang's challenges was to develop corporate thinking:

[I]t took me a while to ... get people thinking corporately because there's a huge amount of, 'well I'm here to make sure orthopaedics is the best orthopaedic department in the world' ... 'I'm here to make sure that the neonatal care is the best neonatal care in the world and to hell with the rest of the organisation', a lot of that thinking was prevalent.

Critical to Sang's success in building this corporate identity was the assertion of unit control over finances. This, however, caused considerable friction with the district health authority as it challenged old patterns of financial accounting where the district prepared the unit's accounts and historically had balanced budgets across the district:

[W]e were still very ... much the child of the district health authority ... it made a big difference in how much were we controlling our own destiny and how much were we being ... directed and influenced by the district health authority; the financial problem was the overwhelming one at the time ... there were some really, really strong issues about how far I could trust the way in which our accounts were prepared for us by the district health authority. They could define funds as being available to the unit or they could define them as being reserves ... the health authority was managing to balance the overall budget and I was arguing that these are actually our funds that they were playing with ... we shared decision making [in the unit] ... and there were things ... as a collective [we had to do] to challenge the health authority.<sup>84</sup>

Liberating 'management to take decisions and do their own thing' had of course, been one of the objectives of the Griffiths' reforms, but the difficulties that this might cause between the tiers had not been anticipated.<sup>85</sup> Nevertheless, unity between doctors and managers in the face of outside forces seemed to strengthen relations:

[W]e had been recognised then as being a management team and a corporate team that could actually handle the situation and take people with us. The health authority was seen as increasingly distant from that, no longer the people that pulled the strings and made things happen at home.<sup>86</sup>

General Management had given managers new jurisdiction over clinical areas but in practice communication between the two groups was 'continually hampered by our lack of common language', said Sophia Christie, General Services Manager at Bolton Health Authority.<sup>87</sup> Medical terminology could be used as a 'blocking mechanism' against managerial reforms and in 1988 the Institute of Health Service Managers established a

<sup>83</sup> Sang, *op. cit.* (note 71).

<sup>84</sup> Sang, *op. cit.* (note 71). The Griffiths Report intended that the role of regional authorities who would hold the districts, hospitals and units to account for performance and achievement should be strengthened. Edwards, *op. cit.* (note 77), 83.

<sup>85</sup> Edwards, *op. cit.* (note 77), 83.

<sup>86</sup> Sang, *op. cit.* (note 71).

<sup>87</sup> Sophia Christie, 'Being on Speaking Terms with Doctors', *Health Services Management*, 84 (1988), 32–3.

seminar series to educate managers in various diseases. The first session on coronary heart disease was not ‘patronising’ and offered a common language which could be used to discuss clinical reasoning and the medical model itself, noted Christie. Increased understanding could inform managerial processes:

... knowledge of the epidemiology of the disease ... will enable us to design services appropriate to its treatment, or perhaps decide that it should be a sub-regional specialty, or realise that lack of service development in the past has stemmed from the unpopularity of the client group. ... An understanding of medical conditions and treatments may raise managerial awareness of when they are taking the politically soft option, at the expense of widespread unmet need.<sup>88</sup>

Whilst managers were grappling with these new areas, the involvement of doctors in management was growing. John Chawner, member of the British Medical Association’s (BMA) Central Committee for Hospital Medical Services had expressed grave doubts about doctors’ suitability and willingness to take on budget responsibilities:

... clinicians should not be expected to branch out into management. Had I wished to take on the role envisaged in the [Griffiths] report I would have enrolled in the packing departments of Sainsbury’s [supermarket chain] and not in a medical school ... limited clinical budgeting gives the clinician all responsibility and no power.<sup>89</sup>

Other doctors were far keener to engage with these areas as revealed by the introduction of clinical directorates to the UK. At Guy’s Hospital in London, some clinicians were familiar with the decentralised operational management structure that Johns Hopkins Hospital in Baltimore had introduced from 1972. In 1984, during a period of intense conflict between doctors and managers over resource allocation, the Guy’s district management team was ‘persuaded’ to visit Johns Hopkins to see at first-hand how such a management structure might work. They were impressed enough to introduce a similar scheme at Guy’s in 1985. The key principles which underwrote the new arrangements were that clinicians would take full responsibility for the operational management of the hospital including financial accountability, in return for the authority to influence the allocation of resources. Within three years total costs had been reduced by fifteen per cent with no detrimental effects on either the quality or quantity of patient care.<sup>90</sup> The significant factor was that clinical directorates gave doctors a new authority over resources and promoted team-working: ‘you do not hear people at Guy’s now referring to “management” as if its members were some separate species, because now everybody is involved’, commented Cyril Chantler, then Professor of Paediatric Nephrology at Guy’s and St Thomas’ Medical and Dental School who played a key role in bringing about the changes.<sup>91</sup>

In Manchester and Salford, some doctors were inspired to engage with management after attending discussion groups organised by Chester with the intention of stimulating junior consultants and registrars to reflect on the macro-dynamics of health services, such as international comparisons of gross national product. Peter Barnes, a cardiologist, attended Chester’s sessions whilst a registrar at the Manchester Royal Infirmary (MRI) and was ‘very much influenced’.<sup>92</sup> He later moved to Hope Hospital and became Chairman of

<sup>88</sup> *Ibid.*, 32–3.

<sup>89</sup> John Chawner, ‘The consultant’s role in NHS management’, *BMJ*, 287 (10 December 1983), 1816–8: 1817.

<sup>90</sup> Cyril Chantler, ‘Historical background: where have clinical directorates come from and what is their purpose?’, *The Role of Hospital Consultants in Clinical Directorates* (London: Royal College of Physicians, 1993), 1–103.

<sup>91</sup> *Ibid.*, 10.

<sup>92</sup> Interview with Peter Barnes, 21 June 2007.



the Medical Advisory Committee in 1984 but because the role had no ‘true representative authority’<sup>93</sup> he described his position as being ‘a kind of go-between’ which was ‘fairly difficult’ to undertake.<sup>94</sup> Nevertheless, Barnes led organisational change at the hospital with two consultant colleagues. The general manager of the time focused on balancing the accounts: he ‘was good in his way but . . . just wanted to sit in his office and get the books sorted’. One of the key innovations was the introduction of clinical directorates:

... by the late ‘80s . . . we’d started to develop a clinical directorate system, and three of us [were] involved in a kind of organisational change, which was very much here medically-led . . . the organisational development was left to myself [and two other consultants] . . . my role then was to try and develop the clinical directorate system.<sup>95</sup>

Doctors taking on new management roles like Barnes found themselves in uncharted waters. None of our medical witnesses had received any training or advice apart from the occasional ‘aspirational statements’ about leadership and managing change.<sup>96</sup> The view that ‘medical management was for weaklings’<sup>97</sup> began to shift during the 1980s and in 1991 a small group of doctors, led by Jenny Simpson, a paediatrician, formed the British Association of Medical Managers (BAMM).<sup>98</sup> Barnes joined BAMM in its very early days; its self-appointed task of improving care for patients by ‘changing the way clinical professionals work with managers’ meshed completely with his endeavours at Hope Hospital.<sup>99</sup> Barnes found that the introduction of clinical directorates had enabled service development across the hospital. He attributed this to the good relations that had been re-established between doctors and managers and the large cohort of young consultants who were responsive to the new arrangements:

I think first and foremost . . . we’ve all got on reasonably well together. The consultant staff . . . have always been very approachable, because of [the hospital’s] newness. . . the professors here were excellent . . . immensely approachable people, and none of the baggage and history that . . . has kept back [older hospitals] . . . there were an awful lot of people being appointed of a similar age, and not much in the way of historical baggage . . . the directorate system got up and running . . . each of the succession of general managers and chief executives that I’ve seen come and go I hope will remember a phrase. . . that I come out with whenever they say, ‘We’ve gotta do this, we’ve gotta save the money’; I say, ‘No, no, you look for quality and the cheapest way of doing anything is to get it right the first time’.<sup>100</sup>

Unsurprisingly, institutions with longer histories and more hierarchical cultures found it much harder to establish collegiate relations between doctors and managers. The MRI where Barnes had worked as a junior doctor was, he said, ‘hugely hierarchical, even consultants who I enormously respected would almost be told to hold their tongue by the professors. . . certainly people at MRI were very snooty about it all, and probably still are’.<sup>101</sup>

<sup>93</sup> Quoted in Philip Strong and Jane Robinson, *The NHS Under New Management* (Buckingham: Open University Press, 1990), 33.

<sup>94</sup> Barnes, *op. cit.* (note 92).

<sup>95</sup> Barnes, *op. cit.* (note 92). On clinical directorates see also Gordon Marnoch, *Doctors and Management in the National Health Service* (Buckingham: Open University Press, 1996), 48; on the inherent tensions of the clinician-manager role see Gorsky’s discussion elsewhere in this volume.

<sup>96</sup> Barnes, *op. cit.* (note 92).

<sup>97</sup> Strong and Robinson, *op. cit.* (note 93), 50.

<sup>98</sup> Jenny Simpson, ‘Whither or wither medical management?’, *BMJ* <http://careers.bmj.com/careers/advice/view-article.html?id=20001287#> (accessed 21 March 2012).

<sup>99</sup> *Ibid.*

<sup>100</sup> Barnes, *op. cit.* (note 92).

<sup>101</sup> Barnes, *op. cit.* (note 92).

In some instances, doctors were provoked to engage with management because they objected to local managerial decisions. During a period of financial difficulties at St Mary's Hospital in the 1980s, managers proposed to balance the budget by closing a ward. David Warrell, an obstetrician and gynaecologist who pioneered urino-gynaecology services in Manchester, viewed this as a 'dotty' idea: 'it causes maximum disruption and minimal financial benefit'. He consequently became involved in resolving the financial problem:

... we formed two little groups, one that kept control of cash by looking at every new post and every request to spend more than a hundred pounds, and another which reviewed all the activities of the hospital, saying, 'Do we need to do it and are we doing it as well as we can do and are we doing it economically?' ... we met at seven o'clock in the morning and I provided coffee and butties of some sort.

Within six months St Mary's had achieved financial equilibrium and two years later Warrell said, we had 'got rid of our ten million pound deficit and we were running on an even keel'. Warrell's engagement with management continued and he became Medical Director and then Chief Executive of the Central Manchester Trust Hospitals (CMTH).

I don't think you need to know much about administration ... I found I could run St. Mary's on about six hours a week so it didn't really interfere with my clinical work. I just got up a bit earlier.<sup>102</sup>

Chawner's concerns thus proved unfounded as our witnesses bear out doctors' competency and willingness to take on both management responsibility and financial accountability.<sup>103</sup>

Throughout the 1980s, the 'value for money' ethos that permeated the Thatcher governments forced managers, both lay and professional, to focus on 'balancing the books', and frequently provoked strong differences of opinion as to the means through which efficiencies could be achieved. Nevertheless, it is notable that in organisations where good relations prevailed between doctors and managers, conflicts over resources were usually resolved without tremendous escalation: 'paradoxically, therefore, General Management probably tended to work better in those places where the previous system of consensus management had itself been relatively successful'.<sup>104</sup> The softening and easing of boundaries between managerial and medical work created new patterns of working that were to prove highly significant in coping with the next wave of reforms.

### **Markets and Trusts, 1991–2007: 'The Synergy between the Consultants and the Managers is Absolutely Fantastic'**

The reforms introduced by *Working for Patients* in 1989 marked a watershed in the history of the NHS, with the introduction of the internal market and further strengthening of management. Several witnesses shared Warrell's view that Trust structures which created self-governing organisations: 'had the advantage of making people responsible for their own patch and their action as opposed to taking orders in a large NHS bureaucracy', and teaching hospitals particularly welcomed the return to independence.<sup>105</sup> Under the new arrangements, trusts were obliged to market their services to the new purchasers and to meet externally-imposed controls like Performance Indicators and national targets.

<sup>102</sup> Interview with David Warrell, 16 May 2007.

<sup>103</sup> A major study comprising more than 300 interviews concluded that most consultants during the 1980s were 'perfectly prepared to acknowledge the need for efficiency and economy'. Christopher Pollitt *et al.*, 'General Management in the NHS: The Initial Impact, 1983–88', *Public Administration*, 69 (1991), 61–83: 74.

<sup>104</sup> *Ibid.*, 69.

<sup>105</sup> Warrell, *op. cit.* (note 102); GST WS, *op. cit.* (note 64), 54.

The contrasting transitions to trust status by Manchester and Salford hospitals give evidence of the way in which managerial, medical, local and political interests collided over the reforms. The CMTH which included the MRI, St Mary's, the Royal Eye Hospital and the Dental Hospital was amongst the 57 new trusts established across England and Wales in 1991, despite local medical and national BMA opposition.<sup>106</sup> The board sought to establish public transparency from the outset; meetings were held in public, four years in advance of government legislation to make this compulsory, and the Community Health Council was invited to attend.<sup>107</sup> The trust gained a Charter Mark in 1996 and won an Investors' in People award in 1998 for excellence in employee communication and training. From the outside, the MRI seemed a highly successful flagship for the new culture but doctors remained highly critical of the management and the Trust rapidly ran into financial difficulties.<sup>108</sup> Sang, who worked in Salford during this period, observed that many of the MRI's difficulties had been created by its lack of corporate focus:

...you didn't have a sense of where's the MRI going, you had a sense of where the renal services are going, or where psychiatry was going ... these things were lots and lots of separate systems.<sup>109</sup>

The Regional Health Authority, keen to ensure the local flagship did not 'go down the tubes' and cause political embarrassment, invited Warrell to take over as Trust Chief Executive. His experience at St Mary's proved invaluable.

I worked ... long days ... I don't think I was popular with the administrators cos' we started at seven in the morning. Some of them worked very hard ... I couldn't have managed without them. They basically took me under their wing and stopped me running into trouble ... what I tried to provide was a simple, pragmatic leadership ... when you work in a bureaucracy you're told what to do ... [that's] one of the difficulties that making Trusts created; ... the people who were running them weren't necessarily the people who were best at individual decision-making. You ... need a different sort of person from a bureaucrat to be a leader of a business.

Much time was spent thrashing out new organisational processes, such as 'How do we do contracts? How do we do this? How do we do that? Until it was absolutely pellucid how the organisation ran and who was responsible for what'.<sup>110</sup>

In Salford, doctors were more enthusiastic about engaging with the new challenges. Sang believed that 'galvanising' the corporate focus of doctors and establishing control over finances during the 1980s had created a 'legacy that encouraged people to say let's ... become an NHS trust'.<sup>111</sup> But the hospital only became a trust in the fourth wave, primarily because of the local opposition by the Labour-run council to the political ideologies that drove the internal market. Once the decision had been taken, the process ran smoothly; several of our Manchester and Salford interviewees commented on the strong cohesion between the council, the local authority and the hospital. Despite the differences between Hope and the MRI there is no evidence that the MRI's early move to trust status had produced service benefits, or indeed that developments at Hope had been hindered

<sup>106</sup> For a detailed account see H.K. Valier and J.V. Pickstone, *Community, Professions and Business: A History of the Central Manchester Teaching Hospitals and the NHS* (Lancaster: Carnegie Press, 2007), 76–93.

<sup>107</sup> Community Health Councils which existed between 1974 and 2003 were statutory bodies to 'represent the public interest in the local provision of health services, and to be the channel for consumer concerns'. There was generally one Council for every District Health Authority. See Ham, *op. cit.* (note 7), 27.

<sup>108</sup> Warrell, *op. cit.* (note 102).

<sup>109</sup> NATS WS, *op. cit.* (note 12).

<sup>110</sup> Warrell, *op. cit.* (note 102).

<sup>111</sup> Sang, *op. cit.* (note 71).

by the delay, a finding which chimes with the Audit and Healthcare Commission's recent report which found little hard evidence of the benefits of system reforms.<sup>112</sup>

During the 1990s, health policy under Conservative and (from 1997) New Labour governments was characterised by a plethora of centrally imposed targets. Most witnesses recollected the challenges of maintaining a strong focus on local priorities in the midst of constant flux. In such circumstances doctors appreciated consistency and 'very clear leadership', said Peter Mount, Chairman of Hope between 1994 and 2001. Mount spent his first few months as Chairman 'meeting the clinicians, meeting the staff, going into theatre to see operations carried out, just getting about'.<sup>113</sup> Sang who was then Chief Executive spoke of the benefits of this approach:

... [the chairman] had visions of how the hospital would work, and I think probably had a degree of scepticism about the health service's changes at the time, that he felt were ridiculous and therefore not worthy of spending too much time and effort on ... I suspect it was a matter of 'let's give the appearance of having complied but let's carry on doing what we know is the right thing to do' ... many doctors take the same attitude.<sup>114</sup>

In 2001 Mount moved to become Chairman of the CMTH and defined his overarching responsibility as the creation of an environment in which doctors could flourish:

I've never found doctors to be a difficult bunch at all, absolutely not. You'll get the ... odd dinosaur ... [but] the majority ... just wanna do a good job for patients, they really do. Just give them the opportunity. ... that's been my overwhelming experience at Hope and here [at the CMHT]. ... there're some very bright people ... they've no wish to be politically difficult. They've got ... professional pride and can be a bit stubborn about changing things ... but that's okay. ... anybody with professional standards isn't gonna be pushed around, behave themselves and be squeezed into the mould. That's not a professional thing.<sup>115</sup>

No locality during this period was immune from the difficult process of reconfiguring services. Yet with effective planning and joint working it was possible for chief executives to manage potentially contentious events, like hospital closures, smoothly. Salford Royal and Ladywell hospitals were closed during the 1990s with obvious financial benefits; the sale of the Ladywell site released over £12 million for investment in new facilities at Hope. Yet the closures were supported by doctors and there was little adverse publicity because, explained Sang, it had been a consensual decision between doctors and managers:

... to get the hospital to decide that it should shut Salford Royal was quite different from the health authority saying ... shut Salford Royal ... the clinicians agreed that, yes ... this wasn't just money, it was safety and standards and all sorts of things.<sup>116</sup>

The four-hour A&E wait was one of the prime targets of this era and initially its implementation 'caused enormous upset and all kinds of silly behaviour'. Barnes, *op. cit.* (note 92). Barnes, who became Medical Director of the new Hope Hospital Trust in 1994, remembers saying to the A&E consultants:

... first of all it's a must do, so tell us how you want to do it and we will help you, but don't say you can't. And it's one of the lines that has made my job a bit easier, I think, that there are some things that I recognise as a 'must do'; we have to do this; we can argue over a pint in the pub afterwards about the rights and wrongs but here we are doing it.<sup>117</sup>

<sup>112</sup> Audit Commission and Healthcare Commission, *Is the Treatment Working? Progress with the NHS System Reform Programme* (London: Audit Commission, 2008).

<sup>113</sup> Interview with Peter Mount, 6 June 2007.

<sup>114</sup> Sang, *op. cit.* (note 71).

<sup>115</sup> Mount, *op. cit.* (note 113).

<sup>116</sup> Sang, *op. cit.* (note 71).

<sup>117</sup> Barnes, *op. cit.* (note 92).

It is notable how Barnes' use of the pronouns 'us' and 'we' positions his identity with the executive team and suggests his ease with this. This is a shift from his experience as chairman of the medical staff committee in the 1980s when he saw himself as 'a kind of go-between' which was 'fairly difficult'. By the 1990s, the executive team, combining medical and managerial inputs, was recognised by doctors and managers alike as 'the main driver of change'.<sup>118</sup>

## Conclusions

Historically, administrators/managers of health service organisations have all too often been invisible and little attention has been paid to the recent rise of the clinician manager. Yet their roles are central to the broader histories of hospitals, health services policy and management. Our witnesses' accounts demonstrate how instrumental the relations between the two groups have been to the delivery of health services over the period and the critical importance of day-to-day working practices in determining these. One small set of interviews cannot offer definitive conclusions about the ways in which structural changes and management styles have influenced and shaped the relations between doctors and administrators/managers over time. Nevertheless, the evidence challenges some of the historical stereotyping of the two groups and provides a more nuanced account of the effects of the successive reforms on our witnesses' day-to-day working lives. From 1948, the new administrative structures exacerbated existing tensions between hospital administration and medicine and nursing and the grouping of hospitals created new difficulties as hospital administrators were frequently bypassed in favour of the group secretary. The establishment of the NATS in the 1950s created an elite group of administrators who shared a strong work identity associated with notions of management and leadership. These administrators aspired to be 'imaginative, farsighted coordinators of all aspects of the service' and their sense of felt power enabled them to forge close relations with doctors, based on mutual respect, as advocated by Chester. We have seen how some of these administrators were able to establish consensual working patterns from the 1950s onwards. Yet it is also clear that because the numbers of NATS trainees constituted only a tiny proportion of the overall NHS administration workforce, the ability of the NATS to effect widespread change was limited. The introduction of consensus management across the NHS in 1974 was intended to establish similar patterns of team-working as promoted by Chester. Retrospective assessments of its success have been mixed but as we saw through Sang's experience of working in mental health services with psychiatrists through the 1970s, in some circumstances consensus management proved a highly effective tool, rebalancing lay and medical powers and proving instrumental in service development. Notably the successful establishment of consensus management became a critical local determinant of the successful introduction of general management in 1983. And yet, as is evident from the case of Hope Hospital in the 1980s, good relations between doctors and managers have been dynamic and sensitive to adverse forces; the appointment of a general manager whose focus was purely on financial matters destabilised relations for several years. The creation of Trusts from 1991 was believed to intensify the onslaught against doctors' professional autonomy.<sup>119</sup> But in some places, rather than fragmenting

<sup>118</sup> Barnes, *op. cit.* (note 92).

<sup>119</sup> Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Oxford University Press, 2006), 105.

doctor–manager relations, the conditions of the market have created new dynamics that prioritised co-operation and collaboration in the executive team.

Gorsky notes in his Preface that one of the most profound problems in healthcare faced by governments across the world is the achievement of optimal health outcomes within a limited budget and the particular challenges this poses for countries with long-established welfare states<sup>120</sup>. Since the 1950s NHS administrative structures and styles of management have been reformed by successive British governments with the aim of improving the efficiency, economy and quality of services. And at the time of writing the NHS is on the brink of unprecedented change with the abolition of Primary Care Trusts and the establishment of consortia of GPs with responsibility for commissioning care from a range of competing public and private providers.<sup>121</sup> Consistent with previous reforms have been the claims that the changes will make services more cost-effective as well as improve quality. It is important then to reflect on the ways in which from the 1950s to the present, strong working relationships between doctors and administrators/managers have been determined as much by universal human values of respect and support as by particular structures or styles. Doctors and managers of the 2000s work in a very different set of structures to those of the 1950s and they engage to a far greater extent with each other's spheres of work. Nevertheless, one of the strongest expressions of Chester's twin aphorisms of 'close association and mutual respect' was found in the words of Margaret Morris, Chairman of Hope Hospital in Salford from 2001 until 2008. Reflecting on the ways in which the executive team prioritised and nurtured doctor–manager relations, she said:

... when people come into the organisation they say the synergy between the consultants and the managers is absolutely fantastic and why can't it be like this everywhere else? It's because we work really hard at it. We have away days as a board where we plan our objectives. ... we have a strategy-setting group which consultants are on ... everybody knows what it is we're planning. ... it's about this mutual respect agenda; we're not enemies in this hospital, we're colleagues working together, and I think that's a real strength.<sup>122</sup>

<sup>120</sup> Martin Gorsky, "'Searching for the People in Charge": Appraising the 1983 Griffiths NHS Management Inquiry', *Medical History*, 57, 1 (2013), 87–107.

<sup>121</sup> Department of Health, *Equity and Excellence* (2010).

<sup>122</sup> Interview with Margaret Morris, 21 February 2008.