The Nuffield Trust

The Maureen Dixon Essay Series on Health Service Organisation

Being a Health Service Manager - Expectations and Experience

A study of four generations of managers in the NHS

Andrew Wall
Visiting Senior Fellow Health Services Management Centre - University of Birmingham
& chief executive of the Bath Health District 1974-92

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The Nuffield Trust for research and policy studies in health services was established by Viscount Nuffield in 1940. Today the Trust acts as an independent commentator on the UK health scene and the National Health Service. It has set out to illuminate the current issues through informed debate, meetings and publications; and has also commissioned research and policy studies aimed at the development of policy and improvement of health services.

Telephone: 020 76318450
Fax: 020 76318451

Email: mail@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

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FOREWORD

Maureen Dixon played a major part in developing systematic approach to organisation design and there continue to be merits in her rigorous approach. The Maureen Dixon Essay Series has been established in order to place her contribution in context and the essays are intended to contribute to informing the debate about the organisation and design of work, whilst at the same time stressing the importance of values in health care organisation and management. The Trust is grateful to Andrew Wall, Series Editor and author of this paper, who conceived the idea for this series of papers.

This fourth essay in the Maureen Dixon series is a further contribution to current issues and a continued acknowledgement of Maureen's contribution to informing the debate about the expectations and experience of health service managers. This fourth essay by Andrew Wall builds on the extensive work done by others in the past, notably Rosemary Stewart. It locates the discussion on experiences and expectations of being a health service manager in the context of four generations of such people. It is based on the assumption that given the changing status of such managers, the experiences that the participants narrate reflect key changes in the nature of the job. Such a discussion is important. Furthermore this essay is part of a much more ambitious project as it is based on a detailed analysis of four interviews recorded on CD-Rom, which we commend as an important resource for those involved in preparing people for management positions.

John Wyn Owen CB
London: October 2001

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Introduction

It is often said that in the early days of the NHS there were no managers, only administrators whose main duties were to provide a conducive environment for clinicians of all kinds to undertake their work of treating and caring for sick people, their patients. These administrators were expected to be relatively unobtrusive and generally speaking had less status than the senior medical and nursing staff with whom they worked or, perhaps, whom they were expected to serve.

By contrast, fifty years later, the manager is in a key position working very much as an equal with clinical colleagues. Those managers who become chief executives are held to be in charge of more or less everything including clinical performance. Whether such a level of responsibility is feasible let alone desirable is arguable. Nevertheless it is important to understand the nature of such responsibility and to assess whether those people holding or aspiring to the role of chief executive have appropriate abilities and personal attributes.

This essay is a modest contribution to the debate, building on more extensive work done by others in the past, notably Professor Rosemary Stewart (Stewart et al 1980, Stewart 1996) and the Essay Series dedicatee, Dr Maureen Dixon (Dixon 1996). The justification for a further study is to locate the discussion in the expectations and experience of four generations of health service managers on the premise that, given the changing status of such managers, the experience that the participants narrate will reflect key changes in the nature of the job. That such a discussion is important is surely undeniable. There is

increasing suspicion of the role of managers in public services tainted, so their critics say, by managerialism based on private sector values on the one hand and, on the other, by being perceived as lackeys of politicians who, as every recent survey shows, are viewed with considerable suspicion by the general public.

This unease contrasts poignantly with the more traditional view of the public servant who was seen as essentially altruistic, happy to work for the common good for relatively little recompense. The job was seen, both by the job holders themselves and by others, as its own reward, perhaps not in a sentimental sense of 'doing good' but more as working towards a fairer and healthier society.

But comparisons between now and then are prone to a mythologizing process whereby in Yannis Gabriel's words 'the past, dressed up and embellished, will triumph over the present' (in Fineman ed. 1993). One way of correcting this process is to juxtapose managers' views across several generations. Accordingly this study is based on interviews with four generations of health service managers. The common link is that they are all graduates of the national management training scheme which, in various guises, has existed since 1956. This scheme has recruited around sixty people a year mostly from new university graduates but also including some in-service applicants. During a period of two years they are given a wide exposure to both the practical and the theoretical aspects of the management of health services. It is probable that those who complete this training will have an accelerated career and many have, over the years, achieved chief executive status by their mid-thirties. Such rapid progress through the ranks may bring its own problems as will be discussed later.

It should be noted that the author was also a national trainee and his career was similar, achieving chief executive status within ten years. Bias or prejudice may have to be allowed for, not least because three out of the four participants are well known to him. The dangers (if that's what they are) of subjectivity may slant the analysis but correspondingly it can be argued that the shared experience will also illuminate the discussion.

The Essay is based on the detailed analysis of four interviews recorded on CD-ROM. Each participant has agreed to releasing the interviews unedited and their generosity is appreciated. This is not surprising. Managers in key public sector jobs are used to saying what they think and are happy to enter into discussion of principles usually lacing their contribution with anecdotes from their own experience. The use of such narratives is now increasingly recognised as giving veracity to research. The so-called objectivity of the disinterested third party researcher, gives way to the vitality of remembered experience.

The participants

Bob Nicholls

1961 BA Geography University College of Wales Aberystwyth
1961 -63 National Trainee (based in North West Region)
1963 Diploma in Social Administration University of Manchester
1963-1965 Senior Administrative Assistant Torbay Hospital Management Committee
1965-67 House Governor St Stephen's Hospital Chelsea London
1967-71 Assistant Clerk to the Governors St Thomas' Hospital London
1971-74 Deputy Group Secretary Southampton Hospital Management Committee
1974-77 District Administrator Southampton & SW Hampshire Health District
1977-81 Area Administrator Newcastle Health Authority
1981-84 Regional Administrator South Western Region Health Authority Bristol
1984-88 District General Manager Southmead District Health Authority
1988-92 Regional General Manager Oxford Region Health Authority
1992- 95 Executive Director London Implementation Group
1995-96 Executive Director and Project Director NHS Executive North Thames Region
1996- date Independent Consultancy

Pamela Charlwood

1974 BA History University of Bristol
1974-76 National Trainee (based in~Wessex Region)
1977-1981 District Service Planner Southampton & SW Hampshire Health District
1981-1983 Service and Capital Planner Wessex Region Health Authority
1983-85 Assistant District Administrator Gloucester Health Authority
1985-87 Director of Planning and Information Gloucester Health Authority
1988-1990 Unit General Manager Mental Health & Mental Handicap Gloucester Health Authority
1990-93 Director of the Institute of Health Services Management London

1993-1994 Regional General Manager South Western Regional Health Authority Bristol
1994 (April - September) Acting Chief Executive NHS Training Division Bristol
1994 -1996 Chief Executive Avon Health Commission Bristol
1996- date Chief Executive Avon Health Authority Bristol

Mike Fry

1978 BA Economics & Social Administration Newcastle University;
1980 MA Health Service Studies Leeds University
1980 -1983 National Trainee (based in Wessex Region)
1983 - 1985 Hospital Administrator St Martin's Hospital Bath Health District
1985-89 Head of Administration and then Deputy Unit General Manager Freeman Hospital Newcastle Health Authority
1989-91 Unit General Manager Christie Hospital, South Manchester Health Authority
1991- 2000 Chief Executive Christie Hospital NHS Trust Manchester
2000- date Chief Executive St John's Street Chambers Manchester

Heather Rice

1991 LLB University of Northumbria, 1996 MA University of Manchester Health Services Management
1994-1996 National Trainee (based in North West Region)
1996- 1998 Business Manager Castlefields Health Centre Runcorn
1998-2000 Executive Development Manager Wirral & West Cheshire Community NHS Trust
2000 - date Director of Service Development Leeds Health Authority

All four participants could be said to have been successful despite setbacks in two cases (Bob and Pamela). Is this success due to their talents, their situation at any given time, the support of other more illustrious people, or just plain good fortune?

Although these four people can scarcely be seen as a representative sample, they still allow us to investigate crucial questions. For instance:

-Can we learn anything about the makings of a good career?

-Is the concept of a career as such now outmoded?

-Are there characteristics of working in the public sector which make such jobs different from those in commerce, industry, private enterprise?

-Is there a tension between the expectations of governments and their own values and how is this managed?

-How has the increase in managers' power affected relationships within the NHS?

-Is there a type of person who is most likely to succeed?

-If they had their time over again, would they make the same career?

choice?

In order to explore these issues each participant was asked the same questions:

1 .Why did you choose health service management as a possible career?

2.Tell me about your time as a management trainee.

3.How was the transition from trainee to first job?

4.Tell me about your subsequent career. How far did you plan it?

5.Looking back, what have been the highlights and what were the worst periods?

6.What are your plans for the future?

7.How would your interpret the rise in the power of the health service manager?

8.Finally, would you recommend a career in health service management today?

If so, what attributes are needed

Reasons for joining

A sense of vocation has always been seen as estimable and might be thought to be universal in those people who choose a career in the public service. Those who choose to enter a profession may well be motivated to do so from an early age but health service management is not a profession in that sense. On a strict definition it does not conform to the rules governing a profession which for instance control entry and exit and require a specific set of qualifications. Anyone can become a health service manager providing they can convince an interviewing panel that they have something to offer.

Nevertheless, the profile of health service managers is increasingly showing that a career is unlikely to succeed without some of evidence of intellectual ability whether this be a first or second degree or a clinical qualification. Dixon's study (Dixon 1996) showed that in 1993 of the 64% of top managers who responded to her survey, 69% held at least a Bachelors degree and in addition 54% held a qualification in management. This shows a

marked increase over twenty years previous when only about 13% of administrators held degrees.

At one time the Institute of Health Services Management (now Institute of Healthcare Management) held their own examinations leading to Associateship but changes in higher education and the increased opportunities to undertake university based Diploma and Masters qualifications has led to the atrophy of this attempt at professionalism. In its place discussions have been continuing over some time to investigate the possibility of accrediting health service managers possibly adopting the Institute of Director's chartered manager approach.

So becoming a member of a profession was not, it appears, a strong motivator although Bob says

> *One of the selling points, which wasn't true for all trainees, was that Teddy Chester who was running Manchester had a post graduate diploma [Diploma in Social Administration] which seemed to convert me from a course which was fun but not vocational [his BA Geography degree] to one which would equip me better to do a job* (BH.OO)

What is more significant is that three of the four participants mentioned that it was through their university studies that they became interested in the health service. Pamela:

> *I chose to do a dissertation on the evolution of the care and provision for people with mental health problems. I took the health services in Portsmouth... working in St James' Hospital... I was tucked quietly in the corner of the office of the hospital secretary, and I observed him working with staff, meeting with patients, relatives, police, press and so on and it struck me that this was a very interesting job to do... and I went for it -in preference to local government* (P03.50)

Mike:

> *While I was doing my first degree I became quite interested in public policy... and I decided to do a second year dissertation on the 1974 reorganisation and as part of that I got to know the sector administrator at Newcastle General and*

went and spent a bit of time there and as a result the health service and hospitals began to get under my skin (M03.ii)

Heather:

In my final year at university I undertook a module on medical law and ethics and I completely fell in love with that subject... I pursued post graduate studies in that sphere... and began to study alongside clinicians ...and at that time also had some personal experience of the health service... and I gradually came to the conclusion that I was spending my personal life and my professional life surrounded by health care and was hugely impressed and while I didn 7 want to be a doctor or a nurse I did want to work in an organisation which was characterised by those people (H02.15)

Until then they had little idea of what hospital (let alone health service) management might entail or that there was indeed any such activity, it often being assumed by lay people, at least in the past, that somehow doctors and nurses ran the organisation. Bob shared this ignorance

I knew nothing about medicine and hospitals, I had been in them and didn't much like them (BU.50)

So how did the participants come to submit their applications for the national training scheme? The answers vary. Two mention that coming from a certain social class seemed to make such a choice more likely. Pamela mentions

I came from a family which tended to have a public sector and particularly local government orientation so I think I always started with quite a strong public sector ethos and assumed from quite an early age that I would teach... (P02.24)

Mike refers to

My background was such that something vaguely middle class, welfare state-ish, ...that was all quite likely..that all fitted (M.04.55)

Early experience suggested to all of them that the job was interesting, varied and worthwhile. Pamela, sitting in the hospital secretary's office, was struck by how interesting the job was. Mike observes

> *It is an interesting, fast moving world, socially worthwhile, useful. Those were some of the initial attractions* (M04.09)

and these factors were more an attraction than the simple desire to 'do good'. As Bob says

> *It wasn 't a great startling flash from the sky or I wanted to do good or something* (B12.06)

The opportunity to be involved with people management was attractive and presumably contrasts at least implicitly with jobs concerned with products and business which in general conversation with health service managers are seen as less estimable and on the whole looked down on. As Heather says

> *I couldn 't get up in the morning and think about going and making toothpaste for a living although some people do* (H41.29)

Over the years the organisation and promotion of the national management training scheme has been the subject of continual redesign and it is interesting that Bob specifically refers to

> *very good presentations by very good people who were senior hospital administrators at that time ...so I was attracted to that* (B12.25)

This compared favourably for him with a particular multinational who recruited graduates widely but offered little idea as to their subsequent opportunities.

For Mike it was more a combination of circumstances

> *Some of the other career options which I have now thought might have been even more suitable - I might have liked to toy with....just didn 't arrive* (M05.12)

First Experiences

A staple part of the national training scheme has always been what is called the 'Cook's Tour' whereby the trainee is attached to a health institution, usually a hospital, and observes the work of the many departments from the wards to the kitchens, from the pathology laboratory to chief executive's office. This is an unique opportunity to understand the complexity of health care provision and to appreciate the necessity for good management. Trainees may never again sit alongside a domestic, a radiographer, even a nurse, never again be involved in processing the payroll or checking the gutters.

The participants all remembered this early experience vividly. Bob had an experience which

> *could have put lesser spirits off... a theatre sister who was certainly in the dragon category and was determined to test me. People don't often die in theatres even then and I was given, with a very young trainee nurse, a body to lay out and move to the mortuary* (BI6.12)

Pamela remembers

> *awful nurses homes with filthy fridges and not being able to sleep* (P05.i5)

from which she fled back to her own cosy bedsit in Southampton but she also appreciated the unique opportunity to have access to all levels of the NHS. She experienced

> *two absolute contrasts; one being the lowest of the low. You had to do as you were told ...and not express too much of an opinion. On the other hand you then had access to parts of the health service that you weren 't going to have for fifteen or twenty years* (P05.36)

Mike found the people he met provided

> *an endless source of fascination... Some people can explain what their job is in five minutes and others couldn't in three weeks* (MC6.21)

He was bemused by having such a good time and even being paid while on holiday in contrast to his lean student years. Heather was impressed by the scale of the enterprise

> *If you go to work in a huge teaching hospital... it's phenomenal how many people*

go to make up that infrastructure ...the incredible diversity (H04.56)

None of the four had bad experiences and were struck by how they were accepted even by those very managers they were likely to leapfrog in their accelerated careers, although Heather noted

people's reaction to me. I think people have this notion that people who work in health care should be older... more responsible perhaps (H.05.39)

Mike was also very conscious of his youth

I was still only in my twenties...it is only recently that I have stopped apologising (M.14.18)

The vividness of their experiences and the opportunities being offered to them, young and inexperienced though they were, removed any doubts about their choice of career.

First substantive job

The trainee lives in a privileged situation having access to the total organisation and allowed to sit in on clinical discussions (with the patient's permission) on the one hand and top level management meetings on the other. There is a potential danger that the day they take up their first substantive appointment, life becomes more mundane. Administrators of the old school tended to discourage trainees entering their first job at too high a level considering that real life in the general office dealing with patients' property and preparing briefing sheets for committees would be a good grounding for the trials of management later on. However all four participants managed to avoid this.

Bob echoed the others in recognising early on that working with good people is requisite for advancement

I think I had a thing about people and trying to find good people to work for (B02.23)

Pamela agrees

It is notable the part individuals play in your career can be quite strong (07.27)

Put bluntly this seems close to nepotism but as Heather points out it is only sensible to manage your own career by making sure that you have a mentor

> *When you start any new job you need immediately to find out where are your allies, where are the people who will support you, help you out of a hole, give you a good piece of advice, a quick tip, whatever* (H09.20)

but she later on notes that there is a difference between *"good people"* and *"people who were good for you"*.

Usually ex trainees are encouraged to move into a large hospital. Interestingly only Mike did this. Bob entered a smallish organisation, Torbay Hospital Management Committee, and found himself already in a third in line post. (An added bonus was that his wife was a junior doctor in the main hospital which facilitated his integration). Pamela confesses

> *that hospitals don't turn me on a great deal and my preference, as can be seen from my career, is for the more planning outwardly orientated work, particularly looking at the relationships with social services, education, the voluntary sector and so on* (P06.50)

In fact she only got involved in operational management some years later.

Mike had attracted attention as a trainee and accordingly was encouraged to apply for a relatively senior post in one of the organisations in which he had trained. This job was mainly concerned with managing the downsizing of a hospital. In retrospect he says

> *It was one of my first attempts at understanding how all those associated aspects of an institution really do have a major impact on how people perceive themselves and their importance* (M08.32)

and that experience manifestly has stayed alive for him in subsequent jobs.

Heather found her first job

> *very scary indeed...the notion of coming into the job on day one and it's you who is responsible, it's you the buck stops with, that's quite an experience* (H05.00)

but quickly got into the swing of things *"you have to"*.

Subsequent Careers

All four participants started well, recognising the importance of being seen as part of the teams of well-respected people. How did they decide to proceed from there? Bob says

> *There was a development path...you got advice... there was a shape... In terms of my own [moves] they were opportunistic. Looking back I think some of [the jobs] were too short... I don't think two years was actually sufficient particularly for the house governor job ... very fast track, perhaps too fast...not long enough to live with your mistakes* (B19.12)

None of them seems to have had difficulties in getting the next job. It might be considered that a more systematic approach would be beneficial both to the candidates themselves and to the NHS. Bob feels that younger managers today have less advice as to how they plan their careers

> *There is far less apparent pattern to careers now and I think in some ways that's a disadvantage both to individuals and for the service in terms of getting good people through the system* (B 18.56)

Theoretically making sure that the early investment in national trainees is capitalised on by placing them in subsequent jobs which widen and deepen their experience and improve their skills might seem to make sense. In fact attempts at career planning through planned movement in the NHS have been relatively unsuccessful. It has tended to be used to redeem a person who, for whatever reason, has fallen by the wayside.

It is therefore of considerable importance how a person manages their own career. Do they have an ultimate goal and how do they achieve it? What are the consequences of such ambition in terms of personal life?

Bob's career shows the importance of getting on with people of assured reputation and his narrative is interspersed with the names of such people: Bryan McSwiney, John Hoare, Len Whitney, all luminaries in their way. In addition he was an early member of The October Club, not a revolutionary body as the name suggests, but a relatively exclusive London based club where administrators, many of them ex national trainees,

met to discuss the issues of the day. It certainly was a place to get noticed particularly if you wanted a career in the more illustrious London hospitals. Indeed the allure of these institutions was considerable thirty years ago, now somewhat diminished by the particular problems of inner city hospitals.

Bob's career also demonstrates how willing he was, even with a young family, to travel the length and breadth of the country to promote his career and amass experience: Torquay to London to Southampton to Newcastle and back to Bristol and then Oxford. Although conditions of service cushioned such moves to a point, they were not particularly generous and certainly changing children's schools and harmonising the career of a partner were not so easily achieved.

Such willingness to move was almost a pre-condition of success thirty years ago but already ten years later Pamela demonstrated far more reluctance to sacrifice personal life to career advancement. It is important to her

> *to work in a part of the world I found attractive because where I live and how happy I am does matter to me and the proximity of family and friends and preferably the sea* (pos. 18)

Accordingly she has remained in the same part of the country for most of her career.

Mike seems to have been less concerned where he worked. A native of Preston in Lancashire he had already, as a student, moved to Newcastle and then to Leeds but seemed equally at home further south. Initially his motivation seemed more to have been the nature of the job. Both his initial job in Bath and the posts of Unit General Manager and then Chief Executive at the Christie Hospital were quite big steps but that suited his desire to do jobs which stretched him. Later where he lives has become more of an issue.

Heather, whose career is still young, has already demonstrated that she is prepared to move if the job is right. She also has the complication of harmonising her career with that of her partner, but as she says, at the moment " *I am still the breadwinner'"* (H1751)

Each person has shown considerable judgement in managing their careers even though the exact route could not be predicted. Indeed in two cases there were hiccups when expected jobs did not materialise. In Bob's case he was passed over for the redesignated post of Regional General Manager even though he was the sitting tenant. Pamela similarly had expected to be promoted in Gloucester to the top job having built up a good reputation there but she was passed over

> *The first rejection I had ever had... it's easy to lead a charmed existence and one needs to learn how to deal with reverses* (P17.02)

Such setbacks in retrospect are seen as character building and provided

> *a chance to look at myself carefully* (B05.30)

but they do also demonstrate that even where careers seem to be progressing well, events can suddenly knock someone off course.

Mike has decided to keep control of his own destiny by changing career in his mid forties in order to avoid

> *becoming grizzled and cynical...I looked around and saw increasing numbers of boring men in grey suits yearning to become fifty when some mystical thing happened with superannuation. I dreaded ever approaching that state of mind* (Ml 8.09)

He is also conscious that long-serving managers can demonstrate the phenomenon when

> *what are personal blind spots become organisational weaknesses* (M16.53)

Heather is still enthused by the prospect of diversifying her experience

> *At the moment I still feel I want to progress...I would like to think of myself as a future chief executive certainly...I wouldn 't be restrictive; I wouldn 't say I [only] want to work in the acute sector, I [only] want to work in primary care* (H12.25)

Highlights

Having chosen this career, the participants needed to ask themselves from time to time how they were doing and whether in retrospect they had made the right decision. The best way of doing this was to look at their achievements; did they make a difference? The nature of the job working closely with others does not make it easy to single out personal successes because so much relies on working within a team. Nevertheless all are able to recall things they are proud of although Mike pauses for some time before answering. He feels that his particular achievement has been to do such high-powered jobs at a young age when as he says he was *"still wet behind the ears "*.

Heather's sense of achievement is a mixture of personal and situational. She is proud to have won a travelling scholarship which took her to Australia. She has also been impressed by the evidence that she works well with people. When she has left jobs she has been touched by the expressions of affection and good wishes.

The ability to work well with people, to inspire respect, is characteristically a key attribute in managers in the NHS which relies so heavily on its staff. And indeed there is great satisfaction in helping people and building relationships across the board at all levels. But equally managers get a kick out of *"getting things moving which perhaps were stuck"* (B22.19) and seeing " *things coming to fruition"* (P10.50). In Pamela's case this was the successful implementation of the government policy to close long-stay mental hospitals and substituting a more flexible regime of care more based in the community. Pamela's three years as the Director of the Institute of Health Services Management propelled her into the public eye with many appearances in the national media. This glimpse of 'stardom' seems not to have diverted her from her main career and she settled back into the NHS without difficulty.

Bob also alludes to the satisfaction of converting government policy into action particularly the prompt implementation of the 1991 Conservative government's

introduction of the NHS internal market. Being a 'good' public servant is a key issue and is discussed in greater detail later.

Bad times

It would be unrealistic to suggest that there have been no bad times for these four people. Heather seems so far to have been largely exempt but that may only be because of her relatively short time as a health service manager. The others are able to be specific. As already mentioned both Bob and Pamela had glitches which in retrospect were temporary but which set them back on their heels. But both faced them with resilience. As Bob acknowledges

I also had very good advice from my then deputy...and he said "who's going to pay the mortgage? " (B43.13)

Pamela recognises the importance of

> *not counting a single reverse as being the death knell. There is life after and it needs the moral courage and the strength of character simply to say "right that's not the route I can go down - that door has been shut - so what other routes shall I look at? "* (Pi8.56)

Mike is more specific. He remembers, *"that my first foray with the press in Bath did not go particularly well"* (M 15.27). Dealing with a theft scam at the Freeman Hospital in Newcastle *"got very messy and the aftermath was unpleasant"* (Ml5.36). He also makes the point that it is not only clinicians who have to deal with patients and he recalls his distress when a heart transplant patient whom he had got to know at the Freeman Hospital did not survive (M 1556). Heather too recalls her distress when a patient died in front of her (H21.36).

The Future

Heather has recently started a new job and, as has already been said, plans to acquire a wide range of experience. It is too soon for her to predict where she will land up but she assumes that the post of chief executive is within her range. Pamela is in an interesting situation in that she is still under fifty but has already undertaken jobs at all levels including national. When asked where she might move to, she says she does not want to run a provider trust nor become a civil servant as she wishes to keep a wider perspective

> *There will come a natural next point for reflection in about two years [from 2000] as primary care trusts become the norm and the role of the health authority must change again* (P21.42)

For her and others in her position, the question must be asked: is it possible in today's climate to remain in one career from start to finish of one's working life?

Bob has naturally progressed to independent consultancy which allows him to capitalise on his wide experience but also permits him to regulate his rate of work. A significant number of his peers find themselves in similar positions.

Mike is particularly interesting in that in his mid forties he has decided to move out of the NHS, at least for a time, because he has not been sufficiently attracted to the sort of posts he might be expected to apply for such as a chief executive of a larger trust or of a health authority. His exit was partly precipitated by what he sees as the increasing interference of government in the day-to-day running of hospitals and a sense that the freedoms promised NHS trusts on their inception in 1991 have not materialised. He would consider returning, providing managers

> *could be allowed to get on with it... I began to despair at the level of party political interference in the health service and the way managers were expected to suddenly discover something because the Secretary of State or minister had happened suddenly to chance on something* (M21.57)

The rise and rise of managers

There is no doubt that the power of health service managers has increased over the last fifty years. It is arguable that this has not been because the managers themselves have sought to improve their position but that the situation has demanded that they take more and more responsibility (Wall 1999). In the 1950s and 1960s nursing management gradually divested itself of the management of the housekeeping functions. At the same time the residual medical superintendents, already dying out in 1948, were finally dispatched by their medical colleagues. The rate of admissions steadily increased, coupled with a marked decline in the length of stay. The implementation of government policy has become ever more demanding and the rate of change has accelerated. Since the original major organisational change in 1974 there have been significant changes in 1982, 1984/5, 1991, 1995, 1997 and currently(2001). Even between these changes there have been continual mergers and reconfigurations of the service.

As a result, a crucial relationship, that with doctors, has changed. Initially administrators had been seen as the people to provide an environment for clinical work to be done. Despite this, many doctors would spend their hospital careers with little appreciation as to what administrators actually did. Their contact would be limited to aggravations about the inadequate supply of white coats and designated car parking. In 2001 the chief executive of a trust is accountable for clinical performance even though in most cases he or she will not be a clinician. Indeed where the chief executive has been - for instance previously in the United Bristol Hospitals - the relationships have not necessarily been better (DoH 2001).

How do the participants view the situation? Bob thinks

> *that the power balance is sometimes still in favour of the professions - and I don't just mean medicine — rather than on behalf of the customer which is actually essentially what it should be about* (B36.12).

This echoes the conclusions of a previous study which claimed that doctors' power was pre-eminent (Harrison et al 1992). Pamela emphasises the need for mutual respect. She

has found that working with general practitioners is rather different presumably because they are more dispersed and less prone to institutionalised reactions

> *There has always been for me an interesting alternative view which is about working with GPs and those in primary care services... I think there is a different atmosphere there* (P32.32)

Mike is more sceptical believing that doctors en masse cannot always be trusted to act in the interests of the patient and that there is a need for the lay voice whether this be at trust board level or through some other channel representing patients' interests. The doctors'relationship with the chief executive has changed and is now

> *a much more equal relationship and in some instances the manager has grown to be the boss... I felt latterly a trust chief executive was a force to be reckoned with...in terms of swapping views or having arguments it was much more equal ...it was not so much riding the medical stallion* (M35.02)

The managers do not see themselves as only the controller of resources and implementer of government policy; they also believe that at times they act as patient advocates whether this is mediating in a clinical complaint or more generally making sure that the traditional power balance within medicine does not disadvantage certain groups of patients

> *I do think you have to be the patient's and the public's advocate* (B37.01)

Acting in fact as a mediator between various forces, is " *a very important role"* he believes.

But it is Pamela who brings the discussion into crisp focus taking us back to those early days of facilitative management, when she says

> *We owe it to our medical and nursing colleagues to be good administrators ...so that*
>
> *we make best use of their time* (P3i.40).

It could be argued that the main reason managers have gained power is because they have increasingly taken on the role of agents of government. All the participants report the importance of their relationship with the government of the day and their perceived duty in implementing that government's policies. This produces strain not only because the managers may not agree with the policies themselves but also because the timescales set by government and the sanctions for not achieving them have become ever more demanding. This development in the relationship with the government will be explored in more detail below.

A job worth doing, a career worth having?

All four participants were in no doubt that choosing this career had been right for them, even Mike, who has now left it for the time being, says that

> *The NHS has done me very, very well. I have had a great life to date earning far, far more than I could have expected. It even served my material needs very well.* (M38.28).

As Bob says, unlike many people he has known, *"I was never bored, never ever"* (B37.44) The others are equally emphatic: would they all recommend such a career? Pamela *"Oh very much so"* (P35.16); Mike *"Certainly"* (M37.12) and Heather *"Absolutely"* (H40.50). The sources of their satisfaction are the intrinsic worthwhileness of the job which links well with their initial impressions that this work is rewarding because *"Outcomes really matter"* (M38.03) They also report the satisfaction of working with a wide range of people and the amazing variety of the work.

But it is hard at times

> *It is tiring and it is relentless - it is hugely difficult* (H 39.03).

Futhermore it can be

> *very frustrating at times... awful, horrible events to deal with, terribly long hours, intransigent colleagues, impossible staff* (M37.30)

So what attributes did the participants feel health services manager should have to meet these challenges?

First they need a set of values. Pamela recalls she said to a young manager recently

> *"You are a person of integrity... Make sure that the medical and nursing staff know you will deal with them straightly and honestly".* (P3L25)

This improves the manager's influence and helps him or her to achieve the increasingly punishing programme of work.

Resilience is also needed to cope with reverses

> *You get a lot of adversity and you just have to have the sense of character to deal with that* (P37.00).

Such resilience helps to temper conflicts arising from tension between personal values and implementing what is needed. Ultimately the managers recognise that if they are to achieve anything at all, as Pamela says, they have to be 'realistic'

> *I think there is a point at which the old analogy " If you don't bend, you break " has to come in so that's a degree of pragmatism or alternatively if you feel you are being asked to bend too far then at that point you have to say "I cut my losses, I leave and do something else... " so a degree of pragmatism and I feel you need political antennae if you are to survive* (P37.16)

There is a danger in this: *"regrettably I would say a thick skin is needed"* says Bob (B41.16).

Finally Pamela stresses the importance of maintaining a sense of self respect. She advocates constantly checking

> *to test that you have not actually crossed a line you didn 't want to cross, and that in retrospect you would regret having crossed because if you have traded too far, your values, your integrity, your personal characteristics, then the time has probably come to say "can I do this particular job any longer? ".* (P38.44)

An analysis of the narratives

What do we learn from these accounts? Has the job of managing the health services changed crucially over the last fifty years or is it still fundamentally the same sort of work albeit now facing greater pressures than before? What are the main themes we can extract from these narratives?

Let us look again at the questions on page 4 and explore through them the people themselves and the setting in which they work. Have the changes in this setting led to different demands and consequently to the need for a new sort of health service manager?

Is a single career desirable or possible?

It used to be the case that a career defined your middle class status and that if this was as a member of one the professions, your social ranking was even higher. Health service managers are interesting in this respect because although it is undoubtedly a career, such managers can only be defined in the loosest sense as being professionals. At the beginning of the NHS the manager was either the gentleman amateur of the voluntary hospital whose principal functions were to raise money and to earn the respect of the local community, or, in local authority hospitals, the manager was more likely to be called the steward and to be primarily responsible for management of resources. As one step up from a storekeeper, his status as a member of the middle classes might have been considered more tenuous.

This interpretation obviously verges on the simplistic. What is clear is that the status of today's managers has changed and, for good or ill, the top managers have high status in their own organisations and are recompensed accordingly. The size of the financial reward has increased considerably in the last fifteen years and can be seen in part as a *quid pro quo* for increased job insecurity. General management, introduced in the mid 1980s, removed the new top general managers from contractual safeguards by introducing fixed term contracts usually no longer than three years, albeit renewable.

This major shift in conditions of service marked a new approach to managerial careers in the NHS. No longer could people expect to continue until their state retirement and indeed very few people in top posts have done so. Although fixed term contracts have largely ceased (mainly on the grounds that they proved unduly costly should someone leave before the end of their contract), the attitudes associated with them remain. Certainly none of the four participants expect to have a sinecure; all realise that change is now a characteristic not only of the environment in which they work but also of their own working lives. As has already been noted Bob and Pamela had faced the situation when they did not got the jobs they were widely tipped for and had indeed expected to get.

Being 'realistic' about the modern world might be considered a necessary attribute of today's senior health service managers. But there is a danger of going too far. The prophets of modernisation, for instance, Handy, Giddens and Hutton, while describing the world as they now see it, are also proselytising. They appear to be saying that if you want to get on you have to share their vision of the world. So portfolio careers (Handy 1991) are seen as inevitable and he suggests, desirable. It is worth challenging this. It is not so much that the basic skills of health service management are difficult to acquire, they are not. It is true however that working within the culture of the health service, managers develop, it is hoped, a sense of judgement and a sense of identity, both essentials for effective management. There is no intrinsic virtue in demonstrating that you can run a hospital and a factory equally well. At a basic level the skills are transferable, but something is lost when the most senior managers do not share the cultural history of the majority of the staff. Such situations also subtly alter the relationship of the manager to the organisation. He or she is seen as a resource that can be traded in the best market. Such commodification removes ideas of shared culture and a sense of belonging that accrue over years of working together.

Notwithstanding this, the four participants demonstrate the difficulties in managing a career. It is a characteristic of effective managers in the NHS that they tend to reach top jobs in their middle thirties leaving them to continue in these roles for at least another

twenty years. Can they continue to be effective, can they keep up with changes, will they become bored? Mike's fear that *"personal idiosyncrasies become organisational failures"* rings in the ears.

To make sense of this dilemma it is perhaps helpful to consider life as a journey, a mixture of travelling and arriving. Levinson, in his seminal work (Levinson 1979) suggested that people's lives are a mixture of stable states and transitional phases, a plateau followed by another choice of direction, a climb up the hill. Some might say such an approach was over schematic, particularly our participants, none of whom describe their own career in such terms. Rather they talk about taking opportunities as they arise. It is true however that their trajectories are unsurprising: their careers advance by status and salary increases. Even faced with unexpected changes they manage to preserve their status. Mike's change in career is on the understanding that he does not lose out financially.

It is interesting to compare them briefly with their doctor colleagues who, having arrived at consultant or GP principal status, are likely to stay in the same place for many years. This broad point may however disguise considerable variety in activity over those years. A consultant may go through stages: first consolidating his or her status within the organisation, then developing private practice. Becoming involved in teaching may follow, then taking on more managerial tasks and perhaps finally acting as representative of his or her colleagues nationally. Long-term top managers may show a similar pattern. In any case organisational changes have been so frequent that they have had to adapt to change continually which has protected them from becoming stale.

Ultimately it would appear that for-the participants, developing a career is more about what Maslow has called 'self actualisation' than external trappings of status. Undoubtedly a top manager is likely to relish 'being in charge', at least most of the time, but even more important is interesting varied work.

The participants are well aware of the pressures of the expectations placed on them by government, by clinical colleagues, by patients, by communities, but they seek to balance these with their own sense of self. If this becomes too difficult or tedious, they, like Mike, will make a decision to do something else. Health service managers, at least these four, are not victims of circumstance, despite the pressures put on them. As Bob and Pamela demonstrate, even when faced with chance events, they quickly adapt and endeavour to make a virtue of the situation. This may single out these four as leaders. A group of other managers, particularly those in the middle grades, might report living a much more beleaguered existence.

Working in the Public Sector

One of the reasons for finding the job stressful is that health service managers are not usually popular, attracting criticism from all sides. Not least their apparent 'boss' the government, all too often have rewarded the determined efforts at implementing government policy with snide comments on the bureaucracy which has been essential for the success of that implementation. However tough the pressures, the managers seem to find the work stimulating and varied enough to continue doing it. (Even Mike does not exclude the possibility of returning in due course). Is this because they are fulfilling some higher ideal, the public service ethic?

This phrase needs some analysis to avoid it being waved around as a sort of talisman to encourage a vague sense of well-being associated with altruism. It is a great deal more complicated than that. Over the last two hundred years it has become more and more obvious that individuals cannot happily live together unless they accept that they have to act collectively. First through the development of charities and then with the state taking on increased responsibility, living conditions have steadily improved. Collectivism reached its zenith in the UK with the advent of the post second world war welfare state. Since that time it has struggled to maintain its ideals particularly in the last twenty years during which consumerist and rights based notions have challenged the universalism of state provision which, in any case, can only be said to be fair in a rather generalised way.

The sensitivity required to match resources to individual needs is now a pre-eminent challenge to managers and clinicians alike.

Despite the reaction against the welfare state and its monolithic, unresponsive tendencies, there is now (late 2001) some sign that the tide is turning towards the re-acceptance that decent living conditions nevertheless rely on some state provided services. The rail transport debacle has been useful to those who promote a return to some of the ideals of the welfare state, particularly public ownership of national utilities. The present government are caught in an ideological trap. On the one hand they want to improve the living conditions of the citizen - more personal wealth, better public services - but on the other and they are troubled by what they see as the intrinsic tendency of the public sector to be financially insatiable and sluggish in responding to consumers' needs.

Public service managers find themselves in a difficult situation here. On the one hand they are encouraged to be pro-active and entrepreneurial finding new ways to solve old problems, reaching out to satisfy consumer demands. On the other, they are expected to regulate and control services to ensure the best use of resources. Having stoked the fires of expectation, they are also required to regulate the heat through limiting the use of fuel.

How far are the four participants prepared to discuss these matters? It has already been noted that they did not come into the NHS with a burning ideal, with missionary zeal. Their entry had been fortuitous having in all cases been exposed to the work that health service management does and been interested enough to pursue it. But equally they all mention that such work has proved to be worthwhile so they clearly accept that there is something about managing in the public sector which differs from managing private enterprises. This is often typified by the wish *"to make a difference"* and stems from a fundamental desire to leave the world a better place than you found it. This aspiration may not stem so much from the desire that your good works should be acknowledged as from a sense that your life must have a meaning. Although manifestly effective in their work, none of the participants showed much worldly ambition or appeared to be in any

way motivated by formal approbation. A few health service managers do receive honours from the state but their peers often regard this somewhat cynically.

The participants are largely uncomplaining about the tensions arising from their work. They accept their accountability to the government, to their communities, to the patients and additionally they also accept that they are expected both to be good controllers of resources. As Pamela says good managers must both administer the more mundane aspects of their organisation's life, while at the same time, being ambitious to improve the health status of the population. They appear to have synthesised reactive and proactive aspects of their work. The skill required to do this is unlikely to be acknowledged by the public who are happy to label all managers as faceless, time-wasting, paper-pushing bureaucrats when it suits them. The participants, while acknowledging that dealing with ignorant attitudes, particularly as voiced in the media, can be tedious, it is not altogether unexpected and is something which has to be managed as well as possible.

Accountability and the relationship with the government

Although most managers would presumably wish to emphasise their prime responsibility to patients, as they become more senior they find that it is the relationship with government which proves to be the most taxing. It is here that the greatest changes have occurred in the nature of their role. Bob's generation were largely allowed to get on with the job and at least until the late 1970s resources were not too much of a problem. Notably NHS authorities did not overspend. In the early 1980s a sense that there was a great deal of waste in the system -started efficiency monitoring and cost improvement programmes which, in one guise or another, have persisted to this day.

In the decade following the scandal of cruel treatment at Ely Hospital in Cardiff in 1969, various other examples of poorly managed hospitals emerged. Remedying these deficiencies in management, required managers to be more directly accountable to

government. The associated failures of clinical care also demonstrated the need for managers to become more involved with what happens to patients.

The 1970s saw an unprecedented number of industrial disputes where nearly every group of staff took industrial action against the government regarding their pay and conditions of service. For the first time health authorities started recruiting personnel specialists to handle these situations. They had to reconcile national conditions of pay with local compliance.

The fourth factor which influenced managers' relationship with government, was the growing antagonism from the Thatcher government to the supposed self-interested and unresponsive nature of public servants, professional or managerial. While attempting to control them, that government also had to endeavour to honour their own libertarian aspiration of 'less government'. That these two were in conflict was scarcely surprising but again it put managers in the paradoxical situation of endeavouring to fulfil government policies with fewer managerial resources. This proved to be impossible particularly with the introduction of the internal market in 1991 and subsequent organisational changes. More management but with lower management costs is a dilemma which persists and is a contributing factor to the long hours culture.

The main characteristic of the government - NHS relationship appears now to be a lack of trust. This has its consequences: as Walsh has said *"The great benefit of trust is that it is efficient"(Walsh* 1995). Consequently the scarcely veiled antagonism which now persists must be considered detrimental to the public interest. Yet health service managers, despite their frustrations, continue to accept that their accountability to the government is fundamental. As Bob says

> *It is only right and proper... if you have a tax funded system. The government of the day should decide its policies, should put them to the electorate... and has the right and the duty to try and implement those policies. I have no problem with that* (B27..26)

Pamela sees the tensions

I have always regarded myself as having accountability in two directions, one to the public...and the other to the government which is after all democratically elected and who make decisions about the taxes which both pay my salary and go to provide the health services within this area... that's inescapable, that dual accountability...it's not comfortable and it is often difficult to reconcile... explains why these jobs are so difficult (P29.42)

Mike has found the situation frustrating and it has been a factor in his career change.

More recently the government has pinned its reputation on the improvement of public services. As Pamela points out

Successive ministers have looked to managers to implement the policies of the day (P28.12)

A lack of trust between them and their agents, the public service managers, may be damaging to the likelihood of success. This puts health service managers in a strong position theoretically but such is the tradition of their duty as public servants that they are unlikely to use the situation in negotiations. Their clinical colleagues in contrast show every sign of exploiting the situation, hence the GPs' recent announcement that they might opt out of the NHS, a threat which has been used before as a negotiating tool.

Although managers accept that the government of the day has a right to expect that their policies will be implemented, the demands have become excessive and this has consequences. 'Earned autonomy', the term promulgated by the 2000 *NHS Plan*, reveals the prevailing attitude of government. Managers are there to fulfil the government's agenda and only when they have done that, can they turn to other issues. This is a grave weakness in that those other issues may well be local issues which have a high degree of priority for the particular community. So in my own experience the national requirement to reduce waiting lists in the early 1990s was considered more important than modernising the community hospitals which were a particular characteristic of local provision. Tensions arose with the then Region who accused local management of "playing politics". It is from situations like this where top-down and bottom-up

management clash that the accusation that there is a fundamental democratic deficit in the NHS arises.

Despite the current talk of 'entrepreneurial management' it would seem that today's NHS top manager has less freedom to choose his or her own priorities. Anecdotal evidence tells of detailed directives being issued from the DoH regarding the more mundane aspects of daily management. Even more irritating was Mike's experience

> *To suddenly be expected to rush along to meetings to hear politicians tell career hospital managers that clean hospitals were a good thing...that stuck in my throat* (M23.21)

Local initiative seems only to be permitted on the manner not the matter; not on what to do but how to do it. For the participants this was recognised as a source of frustration and may be one of the factors in the often-reported desire of some senior managers to retire well before their appointed time. (This is also influenced by the prevailing mood which promotes the assumed joys of early retirement).

Overall we see a crucial difference between the experience of a chief executive in the NHS and his or her counterpart in local government, where, as Baddeley has put it (in Coulson ed.1998)

> *government is... made in conversations between politicians and officers ...(p75)*

Currently in the NHS such conversations seldom take place as politicians prefer to talk to advisors with little or no NHS management experience.

Forty years ago the public servant's accountability was assumed as part of the public service ethos. The components of this ethos included not only serving the state, but also being protected by the state from the uncertainties of the labour market.

Now the situation is more complex, not least because senior managers have multiple accountabilities. Personally they may feel that their immediate accountability is to their immediate senior manager, or in the case of the chief executive, the chairman. Those with

clinical qualifications are more likely to express their accountability primarily to that profession.

Accountability puts the individual manager at risk. Loosing your job due to a random event such as happened when the chief executive of a trust was sacked because bodies had been stored on the floor of the hospital's mortuary chapel, is perhaps seen as something which happens to others. In any case victims of such events are often re-accommodated by sympathetic colleagues. More serious is the loss of a chief executive job through a withdrawal of support from the chairman. But as both Bob and Pamela demonstrated, disturbing though the event was at the time, it was not catastrophic as other opportunities offered themselves. It could well be that a mixture of compassion and organisational guilt helps to restore such people to a suitable post in due course.

Chief executives have to juggle their accountability at one moment to their Board, the next to the Secretary of State, then to their local communities and their patients, and, as leaders, to their own subordinate staff. Each shake of the kaleidoscope makes new patterns, which by their nature are unpredictable. Despite this uncertainty the four participants do not present themselves as victims of circumstance.

The participants accept that the relationship with government is fraught but three of them feel that although the relationship is difficult to manage, it is an intrinsic aspect of their job. Mike, on the other hand, takes a different view feeling that the entrepreneurial spirit is being curbed by excessive central interference and he personally advocates a clearer separation of roles. The government should determine policies and major objectives leaving independent providers to be contracted to fulfil them. Such a system exists in most other countries in the developed world and would remove, he assumes, the major frustrations and inefficiencies which are characteristics of the present over-centralised model. Whatever the preferred model, it is clear that managing the relationship with central government is a major feature of the top management role in the NHS. It was not so forty years ago.

Managers' Power and Influence

The traditional view of the role of health administrators in the early days of the NHS was that they were there to help doctors and other clinicians to do their work by providing a suitable setting. Points of contact were often about routine facilities: secretarial support, offices, car parking and a satisfactory supply of junior doctors. Away from major teaching hospitals this last resource was not always easy to assure and I recall continual conversations with the immigration authorities and with the General Medical Council in an effort to provide suitable doctors at senior house officer and registrar level at a Home Counties hospital where the majority of such doctors were graduates from overseas medical schools.

Such a relationship was inclined to be tense relating directly to the administrators' ability to satisfy the consultant doctors' demands. There was an assumption that the administrator was of lower status than the doctor and essentially carried out a service role.

The situation in 2001 is very different. The chief executive of a trust is not only accountable for the satisfactory financial performance of his or her organisation but also for the clinical performance. Given that the majority of such chief executives are not clinically trained how they fulfil this obligation needs some skill and tact. A problematic aspect of this relationship is that many managers move around relatively rapidly; they have little time to earn the respect of consultant staff.

Despite this change, it is still debateable whether the actual, as opposed to the assumed, power relationship, has shifted fundamentally. Although the patients are becoming more questioning, the majority view their doctors with respect and in many cases with some awe at their ability to make them better. It is unlikely, indeed undesirable, that this reverence for doctors will ever be entirely diminished. It has been suggested (Harrison et al 1992) that NHS managers may always remain suspect because they

will continue to be seen as agents of the government in the way that doctors, nurses and other service providers are not...'Management' is not a fully paid up member of the NHS tribal club - it is seen...as having divided loyalties.

Nevertheless Pamela and Mike certainly believe the relationship is now much more equal. This stems from the authority that managers now have to monitor clinical performance. Detailed audit of doctors' work in hospitals (Yates 1995) has shown that there are many unexplained differences in performance some of which arise undoubtedly from poor working practices. It is however unwise to assume, as government ministers have been tempted to do on occasions, that all doctors will try and get away with less than their contracted work if not monitored closely.

Not all managers work in hospitals. But here again the new primary care organisations, Primary Care Trusts, are inevitably corralling the once rather independent GPs into managed organisations in which the managers are not just the dispenser of fees and expenses to the semi-independent practitioners but managers of them. Recent unrest among GPs partly stems from this change in the relationship.

If the relationship is to remain constructive there is a need for managers to learn the skills of effective but tactful monitoring of clinical performance. Such skills were not needed forty, even twenty, years ago.

Managers' Attributes

So what are the skills and the attributes health service managers need to be effective? Recruiting literature for the Management Training Scheme stresses enthusiasm, energy, interest in others with good communicating and numeracy skills. The danger of such a person specification is that it rapidly develops into a vision of unrealisable perfection. The literature on leadership has demonstrated one thing at least, that the qualities -

certainly more than mere skills - of the leader are extremely difficult to codify; leadership comes in many different guises. And so it seems do successful health service managers.

Nevertheless existing managers are keen to list their own specification at the top of which is the importance of having a set of recognisable values. As has been noted, none of the participants came into the NHS with a strong sense of vocation but three out of four now espouse a belief in some sort of public service ethic if you

> *are to achieve something which is better for people, the public you serve* (P3620)

For Heather

> *You have to have integrity of purpose, integrity with people, but integrity of purpose first and foremost* (H4204)

As we have seen Mike is less sure and proposes that the NHS would be more effective if the providers were allowed to operate outside public ownership of facilities.

They all recognise that their values will be put to the test. A degree of pragmatism is needed. Perhaps 'pragmatism' is the wrong word; more it is the ability to assess what in the end is the main issue at stake. In such situations it is important to demonstrate a sense of commitment which is in itself persuasive.

'Energetic' is a favourite adjective to describe effective managers. Even more than energy, tenacity is needed. As Pamela points out, health service managers require

> *sheer physical and emotional stamina* (P3628)

This may lead to the long hours which all senior managers report and some complain of. Heather has already recognised the importance of remembering that life away from work is important

> *Keeping yourself balanced however you do it...playing tennis...having a group of friends* (H4222)

In the end the effective manager cannot be specified, only the components of successful management. Furthermore it has been suggested (Flanagan and Spurgeon 1996) that the only way to assess effective managerial behaviour is contextual, testing it through the

views of others. Is the manager a 'real 'person to others? This suggests that the personality must be convincing. This does not necessarily require the demeanour of the diplomat. More significantly, it is consistency of values rather than consistency of behaviour which marks out the effective manager in a health service setting.

A Good Career after all?

Would a lay reader of this paper now be asking why anyone would wish to be a manager in the NHS? Daunting complexity, ambiguous targets, demanding colleagues, life and death decisions, insensitive interference from government, unrealistic expectations from patients and their relatives and scant approbation from the public, would hardly seem attractive. Yet all four participants reply enthusiastically that this is a career worth having. This perception seems to be shared by prospective entrants to the Management Training Scheme which in 2001 had the largest number of applicants for six years. Furthermore, a graduate careers survey put general management in the NHS second only to British Airways in popularity.

Variety of activity is clearly attractive and all mention it. No day is ever the same. The constant challenge to achieve improvements also proves seductive. These four, admittedly selected as successful exponents, all enjoy the positive self-esteem that arises from their own sense of purpose and the competency which they are able to demonstrate in their work. This endorses multiple studies on job satisfaction which have relegated remuneration lower in the list of satisfiers than the opportunity to match your own perceived abilities with the tasks to be accomplished.

Complexity is in itself rewarding because it challenges the manager to prove his or her ability to make sense of situations others have found too taxing. The opportunity to solve problems by a mixture of intellect, judgement and influence is an envigorating tonic even if it causes temporary headaches. Our four participants are continually fascinated by the intricacies of the problems presented by their everyday work. Few problems are simple,

most multi-faceted, often a mixture of resources and personalities, short and long-term consequences. Mixing this cocktail to ensure the organisation's thirst is slaked, has endless fascination.

However, these four people cannot be considered a representative sample. Their narratives are revealing and give life to the discussion but they remain in the end four successful people. What of all the others? Undoubtedly there are many who are unhappy, frustrated and longing to get out. But to what? Many of these people are unrealistic about the grass on the other side of the fence. Those who make the change satisfactorily are likely, like Mike, to plan their change carefully, hoping to use their experience effectively in a new environment. Some successful managers have gone on to work in the voluntary sector which arguably has long needed a more sophisticated approach to management. Others have found work in academic institutions using their experience to help their erstwhile colleagues to reflect on the nature of their work and how they are doing it.

But there are still many who find management in the NHS a stressful job, who find the environment unsympathetic, the targets unrealistic. This leaves them with a strong sense of being abused. What we see is that those situations which demoralise the unhappy managers, are meat and drink to the successful. Is this a new situation or was it always so?

The Context over the Last Forty Years

Those deploring the pace of change may well maintain that the continuing process of modernisation is largely spurious as *"we have seen it all before"*. As I have pointed out in an earlier paper for this series (Wall 1999) there is some truth in this. So why do people need to reinvent the wheel particularly when they are well aware that it has already been done? One explanation is that knowledge is transferable but learning is not. It follows therefore that each generation has to accumulate its own experience, in order to develop its own judgement. The type of person choosing a career in health service

management may not change and indeed this study supports that view. If this is so, the interest then shifts to whether and in what way the context in which they work has changed.

Bob became a national trainee in the early 1960s, Heather in the mid 1990s. It is tempting to see the 1960s in a rosy light when the tasks were better defined, when the pressures were containable and when the rewards were commensurately greater if not financially then at least in terms of doing a worthwhile job. Such a view would be sentimental. What has changed is the mood. In the early years of the NHS there was a degree of optimism, or maybe just of relief, that had removed the anxiety that had existed before 1948 as to how and where health care could be provided. Managers were part of a service which was generally accepted as 'a good thing'. Today there is tendency to pessimism that the NHS is on its last legs, that it is facing its last chance and is in imminent danger of collapse. This rhetoric is somewhat questionable given that repeated studies from the 1979 Royal Commission onwards have come to the conclusion that for all its difficulties, a centrally funded, largely free at the point of use service, is still the best bet. Alternatives have not been convincingly worked out and all stumble on the issue of inequality which would get worse under any scheme which promoted a greater mixed economy and more consumer choice.

Managers' influence on these views may be said to be limited because they are preoccupied with making the present system work. Noticeably it is only Mike who makes a suggestion as to how matters might be organised differently by decreasing direct government interference. Significantly such changes would be aimed more at increasing managers' autonomy than improving the patients' experience.

It is arguable that despite the apparent increase in the number of health policy changes, the real change arises from the increasing pressure that government puts on NHS management regarding implementation. As many of these policy changes have been about organisational structure, it has always been in the managers' interest to take them seriously. Noticeably policies regarding patients have been much less successfully

implemented, for instance the shift to primary care and the reform of mental health services.

Crucial has been the changed emphasis on accountability. In the 1960s following the firming up of the chief administrative officers' role suggested by the 1954 Bradbeer report, the group secretary's accountability was expressed in terms of responsibility as the principal officer of his or her committees. Now a chief executive has multiple accountabilities; not only to the board but also to the chief executive of the NHS, the local community, and of course to patients. A significant change came about in the 1980s when, for the first time, chief executives could be called to account in front of a Select Committee. Not many were, but the possibility was there.

At the same time there was a developing dissatisfaction with performance. Various ways of monitoring the NHS performance were introduced and, as has been already mentioned above, these have developed progressively to be more and more specific and consequently more demanding. The consequences of failure are now correspondingly more severe.

These changes arise from various shifts in the spirit of the age, the *Zeitgeist.* It may be convenient, if a little simplistic, to assign these changes to Thatcherism for she as Prime Minister throughout the 1980s seem to embody a new approach, less regarding of traditional communitarian values and more concerned with the individual. Attached to these ideas was a profound suspicion of professionals and other experts echoing a character in Bernard Shaw's 1906 *Doctors' Dilemma* who says that 'professionals are a conspiracy against the laity'. Not exactly professional themselves, managers can be caught in the cross- fire.

As we have seen, there has been a distinct shift in the relationship between managers and doctors; from subordinate to peer. Klein has noted that during the 1980s there was a shift from the management of consensus to the management of conflict.

More recently the conflict has been as likely to be with patients, their relatives and local communities and other agencies concerned with care. In some respects this is a return to one of the key aspects of a pre-1948 voluntary hospital manager's job where getting on with the local community was crucial to the survival of the hospital. But the scale of the task is now quite different as - at the risk of being grandiose - managers are now attempting to represent the government to the electorate; they are acting as intermediaries between the populace and their rulers.

Key to this process is language and health service managers now are required to be far more subtle in managing the message. This puts them in a more exposed position and threatens their integrity, if it is perceived that they are endeavouring to make unacceptable messages palatable and acting as the government's mouthpiece.

The Managers themselves

Given these changes is it likely that the managers themselves will be the same sort of people they were forty years ago? From this very limited study it would appear that they are.

The initial motivation of all four was not rooted in a sense of vocation, rather in a developing fascination with the complexity of the challenges. These four are all well educated in the liberal tradition, that is, not directly vocational. It is less likely that a general manager will succeed today through an apprentice type training such as was the case forty years ago. Brian Edwards, who entered the NHS at its inception and and rose to the most senior jobs in the NHS before turning to academia, offers a prime example of this alternative route. Eight years ago (Edwards 1993) he summed up his career to date as

> *challenging, exciting, immensely worthwhile*

The responses of the four participants echo these sentiments. Indeed the satisfactions and the frustrations remain very similar over the years. Twenty years previously, in a detailed study, thirty two district administrators (Stewart et al 1980) said that the

> *The DAs view of their jobs can be summed up as worthwhile, important,*

satisfying, offering a lot of choice but with many frustrations, some of them to do with structure'

Those respondents also emphasised the variety attached to the job.

It has become somewhat of a cliche to say that there has been a major shift from 'administration' to 'management' and with it, a significant change in what managers do. So for instance a monograph on general management (Eskin 1987) published some three years after the introduction of the 1883 Griffiths report finds several people who graduated from district administrator to district general manager saying that their role had changed:

> *"Is it different to being a district administrator? " This has been the question most frequently asked during my first year as district general manager. My answer has been an unequivocal "Yes". It has felt very different and it has certainly hurt more.* Alan Randall (p24)

Checking this with another view, twenty years earlier (Spencer 1967), a different perspective emerges:

> *'Administration' seems to connote some higher, broader and remoter function than ' managing'.* and that *the 'administrative' family are kept going by the snobbish belief that they are a cut above their 'managerial ' cousins.*

The writer J A Spencer, was himself the manager of a specialist London teaching hospital at the time. He believed that there was no real distinction between the words; they were synonymous. Bob agrees

> *I don't think there is a great deal of difference in the role that some of us tried to perform from the beginning whether we were called administrator or manager* (B26.34)

True or not the range of work changed with the advent of general management, as did the overt authority and accountability. Stewart (Stewart et al 1980) and others have noted that whatever the demands made upon managers at the most senior levels, they still at that time, had considerable choice as to what they would do. Few felt locked in:

Tremendous scope: you can play the game in a whole series of ways
Infinite variety of possible emphases
As wide as one can interpret (p114)

This may not now be as true as it was then. The concept of 'earned autonomy' suggests that managers must complete a list of 'must dos' before they can undertake 'can do or would like to dos'. That the former are directed from above and the latter judged are more likely to be responsive to local needs, must lead to some degree of frustration. In this respect it seems that managers may have less freedom than they did have. Alternatively it could be argued that there have always been constraints and one of the attributes of an effective manager is to find ways of honouring responsibilities without becoming imprisoned by them.

The way these responsibilities are described has changed with the language. The word 'strategy ' emerged in the 1970s and became a shibboleth which every manager worth his or her salt had to utter to gain admission to those who were considered credible. But equally many of today's problems could be said to arise from the need to find solutions to everyday irritants and to coordinate people effectively in the process. This has always been the stuff of health services management which is scarcely helped by too much staring at the distant horizon, a characteristic of some strategic thinkers. The language may change but the nature of the demands do not.

Finally, is a career in health service management as easy to plot as it was? Here there are changes which mirror those in society more generally. The career ladder has been compromised not only by changing ideas about managerial structure which challenge traditional views on the requisite nature of hierarchies, but also by complexity and the diversity of jobs which this offers. The change has been described (Dawson et al 1995) as *'from ladders to climbing frames' an* image Pamela claims to have coined in 1991.

Although various reports (NHS Training Authority 1986; Alban Metcalfe & Nicholson 1995; Dixon 1996; DoH 2000) have suggested that there should be more system in career management, successful managers are adept at plotting their own future. It has been

noted that general managers are more ambitious than those of their clinical colleagues who joined the managerial ranks (Dawson et al 1995).

It seems therefore that the people who do well in health management are those who have high self-esteem, who are reasonably optimistic, who are responsive to others and who are resilient. Our four participants exemplify these characteristics which remain constant whatever the changes in context.

Notes

1. This essay is based on interviews conducted by Andrew Wall in late 2000 and early 2001. Technical and academic support was provided by Simon Baddeley School of Public Policy University of Birmingham.
2. Each quotation is tagged with a time reference (B20.10)

References

Alban-Metcalfe B & Nicholson N (1984) *The Career Development of British Managers.* British Institute of Management: London

Coulson A ed. (1998) *Trust and Contracts - relationships in local government, health and social services.* The Policy Press: Bristol

Dawson S et al (1995) *Managing in the NHS-a study of senior executives.* HMSO : London

DHSS (1983) *The NHS Management Inquiry* (Griffiths report). DHSS: London

Dixon M (1996) *Creative Career Paths in the NHS - Report No 5 Summary of Findings.* IHSM Consultants: London

DoH (2000) *A health service of all the talents: developing the NHS workforce.* Consultation document. DoH: Leeds

DoH (2001) *Learning from Bristol.* Report chaired by Professor Kennedy. Stationery Office: London

Edwards B (1993) *The National Health Service - a manager's tale 1946-1992.* The Nuffield Provincial Hospitals Trust: London

Eskin F ed. (1987) *On Being A General Manager.* Occasional paper No 12. Centre for Professional Development The Medical School University of Manchester

Flanagan H & Spurgeon P (1996) *Public Sector Managerial Effectiveness.* Open University Press: Buckingham

Gabriel Y (chapter 3) in Fineman S ed. (1993) *Emotion in Organizations.* Sage Publications: London

Handy C (2nd ed. 1991) *The Age of Unreason.* Business Books: London

Harrison S et al (1992) *Just Managing: Power and Culture in the National Health Service.* Macmillan: Basingstoke

Levinson D (1979) *The Seasons of Man's Life.* Ballantine Books: New York

NHS Training Authority (1986) *Better Management, Better Health.* (Donne Report) HMSO: London

Parliament (2000) Cm 4818-1 *The NHS Plan.* Stationery Office: London *paragraph 6.29*

Spencer JA (1967) *Management in Hospitals.* Faber & Faber: London

Stewart R (2nd ed. 1996) *Leading in the NHS A Practical Guide.* Macmillan: Basingstoke

Stewart R et al (1980) *The District Administrator in the National Health Service.* King's Fund: London

Wall A (1999) *Icebergs and Deckchairs - Organisational Change in the NHS.* Nuffield Trust: London

Walsh K (1995) *Public services and market mechanisms; competition, contracting and the new public management.* Macmillan: Basingstoke

Yates J (1995) *Private Eye, Heart & Hip.* Churchill Livingstone: Edinburgh