The Nuffield Trust

The Maureen Dixon Essay Series on Health Service Organisation

Icebergs and Deckchairs
organisational change in the National Health Service

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Published by
The Nuffield Trust
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London W1M 7RD

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

ISBN: 1 902089 23 5

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FOREWORD

Maureen Dixon played a major part in developing a 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.

There is no doubt that management can make a difference to health and health care. Achieving health gain - adding years to life and quality life to years - requires services that are sensitive to community and patient interests. Outstanding managers are characterised by the way they think and behave and, when effective, add value throughout the whole organisation.

This first essay in the series, *Icebergs and Deckchairs*, written by Andrew Wall, examines why, after several reorganisations, the structure of the NHS remains confused and although the public have never been better informed, there continues to be dissatisfaction with many of its organisational aspects.

John Wyn Owen, CB
June 1999

Icebergs and Deckchairs

- organisational change in the National Health Service

Introduction

The National Health Service reached its fiftieth anniversary in 1998 but how successful is it in meeting the health needs of the UK? On the one hand the NHS appears, from relatively crude comparisons with other countries, to provide health care at a reasonable cost. The population have prompt access to health care in an emergency even if they have to wait longer for treatment for less urgent conditions. Technological and scientific advances have led to major changes in clinical practice generally for the good. Patients and their relatives are now better informed than ever before.

On the other hand, there has been continual dissatisfaction with aspects of the NHS and in particular its organisation. This series of monographs will discuss aspects of the organisation of Britain's health services and make comparisons with other countries.

As a nation we have explored various organisational solutions with major changes in 1974, 1984/5, 1991 and now in 1999. For all but the most cynical, these reorganisations have been attempts to find, if not a perfect model, at least one which satisfies the needs of patients, the needs of staff, and the needs of the population generally. It might be assumed that by now we would have developed **a** clear idea how health services should be run but despite an acceleration in the number and pace of reorganisations, the structure of the NHS remains confused and often dysfunctional. This paper examines why this might be and suggests a way forward - an acknowledgement that hierarchy is the most effective organisational model.

The Design of the National Health Service

The purpose of the NHS was memorably set out in the opening paragraphs of the 1946 Act:

> ..to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness and for that purpose to provide or secure the effective provision of services..'

Lost in the resounding grandeur of these aspirations is that word 'designed'. And yet the design of the NHS has been one of its main preoccupations over the last fifty years. This is scarcely surprising; all social policy needs to be designed so that it can then be implemented. What is to be done relies on how it is to be done.

The history of organisational change in the NHS seems to suggest that there is a belief that there is a perfect design for the NHS somewhere if only we could find it. Consequently an enormous amount of time and money has been spent - and continues to be spent - on restructuring. Having been involved, both as a manager and as an academic, with much of this activity, I have come to the reluctant conclusion that the perpetual tampering with the organisation of the NHS has meant that management has had little time to implement the NHS' original purpose. Furthermore management has failed to handle appropriately the perennial problems which face health care systems world-wide: the demand for health care outstripping supply and the fluent management of patient care which should ensure that patients are in the right place for the right purpose at the right time. It is no wonder that clinicians and public alike are critical of management. The following paper neither seeks to demonise managers any further nor indeed to exonerate them; it aims to analyse what has happened and to suggest that progress is only possible if some of the habitual ways of thinking are challenged.

Myths and Illusions

A major difficulty in making sense of what has been happening in the NHS (or indeed in any large organisation) is that what is said is often not what is done. This has been described, somewhat cynically, as a process whereby the 'formal' organisation is subverted by the 'informal'. In the 1970s The Health Service Organisational Research Unit at Brunei University under Elliot Jaques developed a more subtle taxonomy when they suggested that organisations can be seen in different lights - the assumed, the manifest, the extant and the requisite:

The MANIFEST - the situation as it appears in charts and policy statements

The ASSUMED -the situation as each individual assumes it to be

The EXTANT -the situation as it is found to be after objective analysis

The REQUISITE - the situation which appears to best meet the needs of organisation

see: Rowbottom R et al(1973) Hospital Organization Heinemann p267

My argument is that much of the reorganisation to the structure of the NHS has been based on a faulty reading of the situation and has been unduly influenced by fads and fancies. This being the case the search for a requisite organisation - to use the Brunei term - has been haphazard and seems to have been unattainable. At least four phenomena can be observed: the reverse Peter principle: devolving to

the level of incompetence; restructuring to solve yesterday's problems; restructuring according to some doubtful but fashionable ideologies; blaming and shaming illusory villains; all of which has meant that restructuring has failed to address the NHS' main purposes.

Organ grinders and monkeys

The principle of devolution has acquired hallowed status. Bosses who do not delegate are criticised. Authority and tasks alike are therefore to be passed down the line. If this is done indiscriminately the consequences are dire. Tasks are given to those who do not have the necessary competence and experience and authority is given only to be rescinded when things go wrong.

It has become a truism that delegation is not abdication. So passing tasks down the line should only be done if competence has been checked and with the safeguard that if things get difficult the boss will offer support. Too often this does not happen; the subordinate is dumped on and left stranded.

One of the enduring features of organisations is that the boss figure is seen by others as the person they most want to speak to because it is believed that it is with this person that the most authority resides. It seems unreasonable therefore to attempt to work against this expectation by creating difficulties in communication. But there is a problem: the boss cannot speak to everyone. This has led to the division of labour, a fundamental characteristic of hierarchies, and to the devolution of responsibility. But it has also led to a degree of complaint. People do not want to waste their time with people who either do not have the necessary competence for the job or who are unable to make a decision. Why speak to the monkey when it is the organ grinder who is making the decisions?

This is not an easy issue to resolve but it might have been better done if there had been a more subtle analysis in particular an appraisal of *how often and for how long* the dialogue with the boss was required. We have all learnt from our managerial textbooks that span of control should not exceed six or at the most twelve people. But in many parts of the NHS this is impracticable; indeed if implemented would lead to monstrous hierarchies. As district general manager of the Bath Health District prior to 1991, I had (on paper at least) 7000 subordinates. Subdividing those into groups of twelve people would have been ludicrous. The solution is to assess the frequency and duration of contacts. So for instance, I learnt that providing I saw each GP practice - there were sixty - once a year over a sandwich lunch in the surgery, I did not get complaints that "We never see the boss". Sending a second or third in line person on their own did not satisfy the GPs even though in my office those people were doing much of the associated work.

Similarly in a more public setting it is the boss figure who is required to be shown if only for ceremonial purposes. Public accountability is not satisfied by a 'hospital spokesman'; it is the named chief executive or chairman the public want. False modesty about being the boss is mistaken; leadership requires visibility. The boss is a symbol as well as a person.

Horses and stable doors

Controlling expenditure, controlling doctors, and being responsive to consumers' interests were animals which had been around a long time but were a long way down the road by the time the 1991 changes came about. It is arguable that that reorganisation did little to entice them back home. Still less likely are the 1999 changes to resolve these issues. Putting the stable lads - the GPs - in charge rather than the trainers may well compound the difficulties.

Indeed the relative status of members of primary care groups is likely to be a problem which appeals to the principle of partnership cannot resolve overnight. For instance the group of executives and non executives, NHS and local authority staff, together with a somewhat token member of the public have to overcome their inherently different ways of viewing the world. The failure in the government's guidance to deal with the intrinsic differences between the centrally governed NHS and the locally governed social services departments has stymied joint working ever since a spate of reports appeared in the 1980s. To date government wraps up the parcel labelled 'partnership' in the apparent belief that the problem is secured; that the slogan has resolved the problem.

Emperors and new clothes

Managers and politicians are slaves to fashion, managerial fashions. Consensus, matrix management, quality management and risk management have all been espoused as providing salvation. In some cases they have been merely the sensible acknowledgement of what is central to good management such as quality and a reasonable assessment of risk. In other cases such as consensus, the nature of the idea has been misunderstood and misapplied.

Health organisations are typified by the range and number of experts working in them and many of those claim to be autonomous professionals whose professionalism would be compromised by a strict command structure. But if doctors are principally concerned with their patient in front of them, there also needs to be someone who is concerned not only for the generality of patients but for the viability of the organisation at large, its internal structures, its relationships with others externally. So there are at least two broad categories of staff, the specialists and the generalists. Was consensus management, the hallmark of the 1974 reorganisation, a better way of managing the relationships between the two?

Consensual teams were introduced by the 1974 reorganisation but even at the time it could have been argued that consensus was not as crucial a change as was made out. In so far as it represented a way of working together it manifested a humanising of the organisation, but it did not fundamentally remove the hierarchy. Managers holding or aspiring to the title of district or area administrator, continued their journey up the status ladder and indeed under the cover of consensus might be said to have accelerated their progress. Doctors remained both in and out of the system, getting involved when it suited them and assuming independence when it didn't.

As has often been perceived from close analysis of organisations, the broad hypothesis proved to be misleading; in this case the teams of equals - the area team of officers and the district management team - were in fact anything but. The so-called consensus team was a rather more subtle micro-organisation where there was a clear understanding of roles and of relative power. It was not politic to emphasise the point, but the district administrator (DA) was in effect the *primes inter pares* by the very nature of his or her job. It was the DA who tended to select the majority of items for discussion at the weekly meetings who, in so doing, was defining the main issues facing the organisation. The problem definer is a powerful role not least because the significance of problem definition is not always readily perceived by others, a phenomenon described memorably by Stephen Lukes in his monograph *Power - a Radical View,* as the third face of power. Once matters are discussed, resulting decisions have to be enacted. This was usually in the hands of the DA's administrative team.

Apart from the management of the business, the DA was also the main co-ordinator in the organisation. This powerful role allowed considerable scope for interfering in the working areas of other people, even those whose expertise was not readily understood by the administrator. From 1974 - 1984 the more able administrators led their organisations without insisting that their leadership be publicly acknowledged. The transition into the post Griffiths general management arrangements was therefore a journey from implicit to explicit power, not in fact such a very big step.

Another reason consensus teams weren't as united as the rhetoric suggested was because of the different status of two of its members, the consultant and the GP, both of whom were nominated by their peers and in some cases or over some issues, chose to take this nomination as meaning that they were representatives or delegates of their constituents. This limited their ability to make independent judgements and reduced the ability of the team overall to resolve contentious issues, particularly those which had direct implications for patients.

Consensus became openly discredited as encapsulated in Griffiths' much reported remark that if Florence Nightingale were walking the corridors of a hospital in 1983, she would be hard put to it to

find anyone in charge. The situation was more complex than this. An underlying tension existed because in many ways the DA was in charge but the rhetoric of consensus did not allow this to be acknowledged openly. At least the introduction of general management provided the new general managers with visible authority.

The experiment in a more apparently egalitarian organisational structure had failed, criticised as much from within as from outside. But there is difficulty with my argument. I have said that consensus was never real and so how could it have 'failed'? My rejoinder is that consensus management is a case of *style not structure.* Of course it makes sense to harness the talents and enthusiasm of people within an organisation but that does not require a different structure. There were many examples where consensus teams made working at that level of management more pleasurable but this was still within the context of a traditional, if for the time-being covert, hierarchy.

The 1991 changes have proceeded on the basis of another contestably doubtful concept, the purchaser/provider split. It was assumed - on what evidence is not clear - that people who plan should not be in charge of providing as providers always act in their own interest. Furthermore planners are a different animal from providers. This essentially rational and consistent, and indeed male way of thinking, has a major disadvantage which had been one of the principal reasons for the collapse of a similarly split organisation in 1982: it separates planning from doing so that those who plan do not live with the consequences of their actions.

The first lesson in psychology will demonstrate that we learn by experience; remove the experience and learning is impaired. Despite this it remains true that the majority of practitioners and politicians still espouse the split even though the study of NHS organisation will show numerous examples of the conflict which the split engenders. And in any case in that crucial area of public policy, primary care, the split is entirely artificial: GPs are both providers and purchasers.

This classification also has an unfortunate effect on the training of managers. It is apparent that an effective manager should be able to deal with issues of a different order at the same time. So for instance, the person in managerial charge of a hospital should be able to walk down the corridor acknowledging members of staff he or she passes, note the blood on the floor from yesterday not yet wiped up and at the same time discuss the long-term strategic development of the Trust with the chairman. If managers can only do one thing at a time, (a characteristic more likely to be true of males than females we learn from research) they will never get through what needs doing and in any case single jobs can be processed much quicker by computers.

Men and grey suits

The new clothes which politicians deplore are grey. 'The men in grey suits' are often not men and the suits often not grey but with such images is political popularity sought. In a similar vein is the denigration of bureaucracy which is the very process of management. Bureaucracy is not bad in itself; indeed its progenitors, in particular Weber, said that bureaucracy determined the morality of an organisation. It is true however that the manner in which bureaucracy operates may be bad. It is not helpful to confuse the matter with the manner as is repeatedly done to elicit applause.

The problem is that symbolic language has tainted not only the NHS' relationship with the people it serves but also the thinking of the people who do the serving. The reasons for this are muddled. First it has to be accepted that many of the public whether they currently have patient status or not, feel that the NHS is a monolith; by that they mean it is something large which obstructs the path to resolving their health problems. But at the same time the NHS is seen as a mass of ill-relating fragments scarcely held together because communication is poor and a sense of accountability too delicate for any one person to take absolute responsibility for resolving patients' problems.

Certainly the clinicians, particularly the doctors, are regarded relatively favourably (despite recent attempts to cut them down to size by the government). These clinicians are also seen as facing impossible odds because of' the management'. This in turn may lead managers to expect their boss to defend them against this unpopularity.

The danger in all this is that whatever the reality of the situation, there is persistent inclination to use imagery which clouds the issue. "Putting doctors in the driving seat" of the new primary care groups is a woefully unhelpful metaphor suggesting that commissioning health care for a given population in the future is somehow associated with the joys of racing down a country road in a nice little coupe with a girl friend (the nurse?) in the passenger seat! From men in grey suits to Mr Toad in goggles. Such language does nothing to sort out the organisational complexities of PCGs other than to reassert the idea of someone being in charge.

The more the managers and the organisation are described in symbolic terms the more their responses are likely to be ritualistic. If this is true, the NHS never really faces that challenge so resoundingly set out in the original Act. Its managers are always busy, often under stress, always on the point of resolving problems but never quite doing so and always susceptible to the latest organisational fashion, led astray by slogans and symbols. It may have to be faced that they are happily waylaid; that while they are otherwise engaged , they have no time to sort out the real problems.

Fiddling and burning

The current vogue for achieving 'health gain' is in part an acknowledgement that managers have failed to address the original purposes of the NHS. In turn they can claim that they have been victims of successive governments' desire to reorganise. Each of those reorganisations have had some sort of rationale however poor the diagnosis of what had been wrong. A characteristic of each reorganisation has been that, generally speaking, managers have improved their status and their salaries in the process. Managers may well have covertly welcomed continual change because it has justified their existence and dramatised their work, rescuing them from the tedium of managing day-to-day situations in a consistent and rational manner.

The criticism of fiddling while Rome burns is hard to refute. For instance the management of patients through the system is as fraught as it ever has been. To look at Muriel Skeet's 1970 report *Home from Hospital* today is to see that the management of patient discharges is still often extremely unsatisfactory. The excuse will be that the patient's progress through the system has been accelerated and that every agency is under pressure financially. These reasons are true enough but what are managers doing to resolve them? This is the crux; they are often otherwise engaged in setting up new organisations under increasingly punitive time limits. The establishing of primary care groups is a case in point. Failure to meet the deadline of April 1999 is likely to lead to personal sanctions against key managers. In such a climate is it any wonder that patient discharges take second place?

The NHS notoriously has been unable to make good use of IT for patients. Payment systems, stock controls have benefited but patients' records have not. There have been attempts, usually ending in allegations of financial impropriety, but computers' potential to track and assist a patient's progress through the system so that everyone knows what has been done and what it is planned to do, has yet to be exploited.

From all these myths and illusions, it seems that reorganisation is about jam tomorrow for which managers are picking the fruit. For many patients there is still yet to be bread today.

A Brief History of NHS Organisational Change

How has this state of affairs come about? Can we make sense of the history of organisational change in the NHS? The 1946 National Health Service Act which initiated the NHS on 5th July 1948, united what had been very disparate health services. Voluntary hospitals, local authority hospitals, mental illness asylums, mental subnormality hospitals and colonies, TB sanatoria, infectious diseases hospitals and community health services, had all been run in different ways according to different

traditions. It is easy now to underestimate the challenge that 1948 represented. Fifty years on, it might be supposed that the view in 1948 was that the NHS was going to be a 'good thing', but for many doctors this was not the case. The BMA's vociferous opposition to many of the proposals forced compromises which are still with us; for instance the independent status of GPs and the inclusion of private beds within the NHS. The challenge from doctors arose not only from practical issues such as payment systems, but from more atavistic feelings regarding the place of the doctor in society. The medical profession has traditionally taken a view that their expertise is available to the rest of society under certain conditions. Even today it is possible to detect the assumption that doctors are somehow giving a service from a position outwith the society in which the rest of us live in. This view is bolstered by the continuing high status of doctors accorded them by society. And it is fundamental to the question as to how health services should be organised; no other group has such influence, not even the managers.

The organisation within the NHS was traditional, where status mirrored class structure. There was a clear line of accountability within hospitals and then upwards through Hospital Management Committees (HMCs) to Regional Hospital Boards (RHBs) and thence to the Ministry of Health and its Minister. In local authorities the accountability was focused on the Medical Officer of Health (MoH) whose authority was pre-eminent. He was accountable to the local authority's health committee and upwards through the local authority to the Ministry of Health. The Executive Council's chief officer had less status than his counterparts in hospitals or local authorities because his authority was much more limited dealing largely with the regulation of independent contractors rather than managing large numbers of staff and services. This provided a model which has some resonance today with the separation of commissioning and regulating of services from their provision. But significantly the Executive Council chief officer post was seen as less powerful than the MOH or the group secretary of a HMC. Power is a recurring theme in the analysis of organisations.

Essentially the relationships between each branch of the NHS and between each level were simple and easy to understand. These organisational arrangements continued until 1974 but were put under increasing pressure by a number of forces, some internal, some external. Internally the fragmentation between the three branches of the NHS was becoming more problematic as were the shifting relationships between professions, many of whom were seeking more independent status. Externally the climate of society was changing in favour of more liberalism which challenged traditional models of behaviour and of organisation. Schumacher's influential book *Small is Beautiful*, published in 1968, attacked the idea of large organisations.

The 1974 reorganisation marked a watershed between evolutionary change, adaptive and flexible and a more purposeful and designed process of change. Who were the designers and what were their assumptions? Undoubtedly politicians and their servants, the managers, were at the heart of the changes and it is their propensity to make faulty diagnoses and to prescribe questionable remedies which I have already described in the earlier part of this paper. One thing is clear, the history of the NHS, particularly since 1974, is a story of ambition and presumption; ambition that there is very little which cannot be improved providing the right people do the right things, and presumption that such ambition is justified.

Without doubt by 1974 circumstances were changing. Within the NHS increased functional specialisation was leading to increased organisational complexity. Specialisation began to erode broad categories of medicine. The terms general surgeon and general physician became less and less appropriate with the development of sub specialties. With this specialisation came pressures to be more exclusive so that GPs, even those with a higher degree such as FRCS (Fellow of the Royal College of Surgeons), found that they were being squeezed out of surgical work by their consultant colleagues. The development of geriatric medicine was a significant advance in the care of the elderly. With specialisation came higher standards. These standards were also enhanced by a much more equitable allocation of consultant staff across the country so that some communities who had only had visiting consultants now had there own. The rules for the allocation of GPs (which still apply) meant that the natural flow of GPs to the more affluent areas was controlled.

During the 1950s there was a significant development in the professional role of nurses. In had been habitual for nurses to manage all the housekeeping functions in hospitals, domestic work, catering, linen and laundry and staff residences. One by one these functions were handed over to the hospital administrator and, in the process, each of these functions increased their own status by adopting quasi-professional approaches such as formal training schemes and national associations. The model of a hospital as a big household presided over by the housekeeper - the matron - changed into something less traditional and more federal needing greater co-ordination to ensure its effectiveness.

Once nurses were free of the peripheral housekeeping role they were able to concentrate on their own core responsibilities and there was a rapid development in the professionalism of nurses. In the 1960s and 70s not only were there reports on extending their professional scope, there was also recognition that nurses, as the largest occupational group, needed more sophisticated management. This was at the heart of the - much derided - 1966 Salmon report which set out ten levels of nursing from the relatively unskilled nursing auxiliary to the chief nursing officer. This development had a

considerable impact on the administrators, making the institution more difficult to manage but also enhancing the administrators' status.

Other professional groups gradually emerged from being ancillary to medicine to a more independent status. So a physiotherapist who in the early days would have expected to have given treatment as prescribed by the doctor, later expected to be given the diagnosis and the symptoms and to then make her or his own assessment as to the most suitable treatment. These professions' journey to more independence was interrupted by the 1991 changes which by fragmenting them into smaller groupings self-contained within over 400 Trusts, effectively dis-empowered them.

Up to 1991, as each profession found its own feet, the need for co-ordination by a lay - i.e. non professional - manager, became more necessary. A single clinical hierarchy headed by doctors gave way to parallel hierarchies which required bridging if they were to work effectively. The administrator/ manager was the bridge builder, at least until the time when self co-ordinated teams were tried in some areas such as mental illness. After 1991 the crucial relationship was that of doctors and managers with a determined attempt by the latter to incorporate doctors into the processes of management and into the managerial hierarchy. This continues.

Externally, the NHS as one corporate state institution, is a political organisation as never before. Politicians are expected to give answers about what is going on in the NHS and managers are required to provide them with the necessary information. This developing politicisation has been a major factor in the increasing significance of the managerial role.

The history of organisational ideas

By 1974 increasing complexity, developing professionalism, the need for cost control, increased politicisation and the inherent difficulties arising from the tri-partite structure, led to the view that all these issues could be mastered if the overall organisation could be run in a more modern manner based less on traditional lines of authority - chains of command - and more on mobilising motivation through smaller group working. Concurrent with this was a developing belief that rational planning could reduce uncertainty. Both these views carried considerable moral weight: treating people in a more egalitarian manner and using our capacity for rational thinking and action, both were superior to the dis-empowering attributes of traditional organisations.

So, for instance, organisational theories which had usually originated in the USA, were espoused (at least on management courses if not always at work). What was called the Human Relations School had developed 19th century paternalistic ideas based on organisations as human enterprises. The tone

was optimistic based on the essentially good nature of people and in this respect was critical of the mechanical approach to organisations manifested early in this century by Taylor and was also suspicious of the rigidity of the bureaucratic ideas stemming from Henri Fayol and Max Weber.

But parallel to these ideas was the development of rational planning which relied for its success on clearly defined organisational relationships. This was an attempt to modernise the more traditional ideas of hierarchy using on the one hand the experience of the world-wide management consultancy McKinseys and on the other, the detailed analysis of how the NHS worked provided by the Health Services Organization Research Unit (HSORU) at Brunei University headed by Elliot Jaques*. Underpinning both approaches was the view that the NHS was old fashioned and in urgent need of an organisational refit.

Given the care and thought underpinning the 1974 changes it might have been assumed that something like a requisite organisation had been established. Area Health Authorities (AHAs) were in place to plan health services for given populations and District Management Teams (DMTs) based on recognisable groups of health care providers, were bidden to run services effectively within the AHA's plans. Yet a mere eight years later this model was agreed not to be working. The reasons for this failure are confused and subject to different interpretations. For some, the economic climate induced by the oil crisis of the early 1970s had a profound effect on all public services putting them under a strain not really felt before. Others felt that the problems were largely political with a failing Labour government increasingly ensnared in the dissatisfaction of workers across the public sector. This culminated in the 'winter of discontent' where ancillary workers took action within the NHS which threatened patient care. Almost all groups of staff on the NHS had taken industrial action at some point in the 1970s. In addition to these problems, the relationship between the AHAs and DMTs was often antagonistic as each competed for a supremacy which the organisation had not given them in 1974, it being assumed that they would work better as peers both equally and directly accountable to the AHA.

The next organisational fix was the introduction of general management in 1984/85 following the Griffiths inquiry which had roundly criticised the NHS for having no-one 'in charge'. This assessment was meat and drink to the Conservative government keen not only to be able to introduce the NHS to what they saw as the reality of business management but also because it supported their view of accountability; someone must be in charge so that they can be judged by their performance and if

**The importance and subsequent relevance of this work is explored by David Hands in the second essay in this series.*

found wanting, got rid of. These changes were unpopular with clinical staff who feared an increasing authoritarianism, although at the same time they were also likely to be the most vociferous critics of the slowness of decision making under the old consensus model.

Clinicians' reservations regarding general management were nothing compared to their wholesale objection to the proposals in the 1989 *Working For Patients* white paper. These objections had very little effect on the government and the changes were duly implemented from 1991 onwards.

Both general management and the purchaser- provider split concepts had old and new elements. The general manager epitomised the traditional idea of one boss, the apex of a hierarchy but was also modern in that it suggested that the traditional autonomy of the professional could now be challenged. The 1991 changes with the development of market ideas, aimed to improve organisational focus, but to do this revamped the separation of planning - now called commissioning - and providing, which had been a relatively unsuccessful model in the 1970s. The 1999 changes scarcely improve the situation introducing primary care groups, effectively another level of management, and increasing the complexity of relationships, not least by introducing a line of accountability which for the first time has a non executive chairman being accountable not to his or her own kind, but to an executive: the chairman of a primary care group is accountable to the health authority's chief executive.

As I have said the organisational structure favoured in 1948 was largely traditional and as such reflected the current views on how best to organise work. Hierarchies are about the division of labour and the allocating of responsibility. But the climate was beginning to change. The experience of the second world war had tended to endorse the traditional line of accountability with clear, even rigid, allocations of work. This rigidity was increasingly unacceptable in a peace time environment. The overriding task of winning the war was now fragmented into a more diffuse set of societal aims and objectives, relying much more heavily on a spirit of voluntary partnership rather than coercion. The Labour victory in 1945 heralded a new approach which, at least in spirit, recognised a more egalitarian approach to the way things should be managed.

With this came new ideas as to how organisations could be run. Probably the most influential was the Human Relations School, referred to above, which developed earlier work before the war - notably that of Elton Mayo and the Hawthorne experiments - on the behaviour of workers. There was now much more concern for creating an environment which allowed the worker to be fulfilled in the belief that a satisfied worker is more effective. In the NHS work undertaken by Reg Revans went further, deducing from research in several hospitals, that where staff were happy, patients got better quicker.

These ideas were relatively slow to be absorbed into the NHS. But for those of us taking part in management courses in the 1970s, the work of Maslow, Herzberg, Macgregor and Argyris was an inspiration leading us to feel that the old traditional hierarchical models of organisation were no longer appropriate. We only had to treat people well or be treated well ourselves, to enter a new world where everyone at whateyer level in the organisation was happy and 'self-actualised' (one of the more compelling concepts).

And yet the influence of these ideas had little effect on industrial relations with the 1970s experiencing the worst ever period of industrial disputes. In the NHS nearly every group of staff, clinical or other, took industrial action during this period and managing strife and its influence on patient care became the daily work of managers.

Nevertheless at the same time the experience of team working was growing. At the top level of Areas and Districts a team was in charge. In clinical areas, especially in mental illness and mental subnormality, which were emerging from the primitive conditions prior to the 1959 Mental Health Act, team working influenced by the Tavistock research institute approach was becoming customary. Experiments, such as at Singleton Hospital Melrose, in creating a total therapeutic community seemed to be suggesting that the traditional hierarchical structure was becoming outmoded.

This period of apparent enlightenment based as it was on an essentially optimistic view of human nature, crumbled rapidly at the end of the 1970s and was replaced by a neo-classical approach to organisation where the concept of one person in charge was reasserted. So in the NHS the recommendations by Griffiths in October 1983 endorsed the conservative government's view that although teamwork might be a suitable way of allocating tasks, team accountability was an anathema. Performance management nailed responsibility to individuals and failure to achieve was punished.

The justification for this harsher approach was that the developed world would not stay developed if the economy started to deteriorate; only the fruits of booming trade could support the life we had all began to accept as a right. Competition therefore was a natural way of ensuring efficiency and fear of sanctions the most obvious way of stimulating individuals to meet objectives. People who failed were dispensed with, often in a summary manner. This ethos has remained in a modified manner even though the assumed rigour of the market i.e. that competition gets the best results, has now been questioned.

Another major influence has been the explosion in information technology and this, it is assumed, will have a profound effect on organisations. Not only does it accelerate the rate of work, it also

undermines the power which it has always been assumed is attached to the control of information. If the most junior member of staff has access to much the same information as the boss, surely the old style hierarchy is no longer appropriate? This has led to attempts to describe organisations in a more sophisticated way as a complicated set of networks, or as ever changing groups of people clustered around tasks.

The problem with these organisational theories, even though many of them have been derived from the close analysis of organisations at work, is that being at work in an organisation continues to feel much as it ever did. It is an experience often characterised by conflict. To listen in on hospital staff gossip in the coffee lounge is to hear time honoured narratives of interpersonal relationships often dramatised for effect by who won and who lost a particular battle. It could be said therefore that organisations are only interesting if we study the power relationships within them.

The history of power relationships

There is a view that essentially the power relationships within the NHS have remained relatively constant with the doctors in the pre-eminent position. This is not necessarily because of their own self interest but it is the result of the status given them by society generally: our primitive instincts are to expect the doctor to work his or her magic on us and make us better. But the history of the doctors' influence on the way the NHS has been designed is rather more sophisticated than this as is shown by the ebb and flow of their involvement in managerial matters.

The early days saw an elaborate structure of medical committees both for hospital doctors and for GPs, some of which arrangements, the medical executive committee, the local medical committee, still remain. These processes could be said to be the result of not having a hierarchy at least at consultant or GP principal level; the alternative is a relatively complicated bureaucracy. A distinction has to be made between what the doctor is doing in a committee and what he or she is doing in a clinic. Increasingly this distinction has been more difficult to draw as doctors have found that managerial considerations, for instance living within a budget, have impinged on their clinical decisions.

Claiming clinical autonomy has always helped doctors to avoid some of the more difficult decisions while at the same time maintaining an exclusiveness which has exempted them from the more mundane aspects of management. The first attempt to organise hospital doctors so that they would play their part in management were the 'Cogwheel' reports in the late 1960s leading to the setting up of clinical divisions. These have lasted in one form or another and today are seen as a necessary part of the structure of hospitals. What has been interesting is the way that an apparently equal team in fact

recognises the usual pecking order with the clinical director virtually in charge of his of her nursing and administrative colleagues. But the power of these directors is somewhat mitigated by the degree of support given them by their medical colleagues which at times can be limited.

Arguably, only in the current reorganisation have GPs been similarly corralled into the managerial camp. It remains to be seen whether the setting up of primary care groups with a GP chairman and a GP majority on the PCG board, will manage GPs in a different way than before. To pursue my argument I would say that the desire by government and managers to incorporate doctors into managerial arrangements is evidence that, for good or ill, hierarchical control is seen as requisite for an effective organisation; top dogs should be in charge.

What of the other professions? Nurses have traditionally displayed the most obvious examples of hierarchical organisation with structures not far removed from the formality of the armed services. This is for obvious enough reasons as there needs to be a clear division of labour based on graduated levels of knowledge and expertise. Indeed when matrons gave up their housekeeping roles, if anything, they expanded their hierarchies and this was confirmed by the elaborate arrangements following the Salmon report, when nursing was organised into a supposed ten levels of responsibility. This experience is often used to denigrate hierarchy but it is rather more an example of a mindless implementation of a structure which has failed to analyse with any discrimination what needs to be done where and by whom. Subsidiarity was not then a word in common use but its principle of never allowing work to be passed up the line unless it is absolutely essential, was often not observed in 1969 when the new structures were implemented.

Managers, while not able to claim professional status, nevertheless have attained the most dramatic increase in status. It is tempting to see the history of power in the NHS as centred on a struggle for supremacy between doctors, representing in many ways traditional values, and the new breed of managers changing, chameleon-like, their colour to every new managerial fad and every new government.

Where did these managers come from? In order to fulfil the NHS' original objective there needed to be not only a new design but new designers and it is the enhancing of the status of the these new designers - health service managers - which has been one of the more remarkable developments. Remarkable in that these managers had relatively humble beginnings and were in many ways ill-equipped to undertake their rapidly expanding responsibilities but also remarkable in that in the UK most of these managers, at least at senior levels in the organisation, did not have a clinical training.

A characteristic of each organisational change has been the boost it has given to these managers. This steady - and seemingly irresistible - rise in the power of managers is not a phenomenon exclusive to the NHS but much of the criticism surrounding the NHS stems from a belief that the increase in the number of managers and their authority has not brought in its wake an improvement in the running of the NHS. But if the managers are so unpopular, how have they thrived? Is it because they have proved to be adept in the business of self-promotion or is it because the circumstances have made them more and more indispensable?

In my view the latter is truer then the former. Today's health service managers - the custodians of the NHS as an organisation - have a curious history stemming from two rather different set of ancestors. In 1948 voluntary hospitals were largely financed by public subscription and the Secretary to the board, also called House Governor, was among other duties, in charge of fund raising. This crucial role required what we might call a gentlemanly approach where social respectability and credibility were of prime importance.

A rather different type of person was likely to be found in local authority hospitals. The title Steward was often used and indicated that the manager was the custodian of facilities and consumables necessary for the professionals to undertake their work. From 1948 onwards both functions were united in the developing role of the administrator, the preferred generic title until the mid 1980s.

Progressively providing health services has required more complex organisational structures. The organisation provides the framework for care. This in turn requires criteria which authorise who is eligible for treatment. To treat all comers with no system would be to abuse principles of fairness and equitable use of public resources. The organisation, at its most fundamental, is therefore a system designed to manage care and treatment.

Why not allow those who are providing that care and treatment, the clinical professionals, to run the organisation? In a simpler environment, for instance in the developing world, this would be the case. But in a sophisticated western society, it is clearly not possible' in that the managerial tasks would require too much time and the patient would lose the benefit of the clinicians' expertise. Someone else is required to provide, at the very least, the environment for the clinicians to practise.

The various attempts to design Britain's health services have been about how best to provide the environment of care within an overall public service ethos. This ethos has not been constant. The grand all-enveloping universality of the 1946 National Health Service Act has, in the late nineties, given way to a less generous approach to welfare. Discussions on eligibility are now less likely to be

from a point of principle and more likely to be empirical: who must have what, based, not on rights, but on economic sense. This tension is not new: the history of poor relief from which our welfare systems have developed, depicts a continual conflict between rights and available resources. This grand debate is mirrored within health organisations by the roles, often also in conflict, of clinician and manager. Clinicians attempt to do the best for each of their patients and indeed are professionally committed to do so. Managers have to mediate these demands with the overall policies of the nation, with the resources available and with a concern for the general needs of the community.

Health service organisations are therefore forums for debate where clinicians and managers negotiate the appropriate responses to patients' needs. They are partners if at times uneasy ones.

There is another source of power, the patients themselves. Indeed the discussion so far could be criticised for being unduly concerned for the people working within the NHS and in particular the managers. Some would say this illustrates all too well the problem with hierarchies and the way they work: they are to be self-regarding and unresponsive to the people they are meant to be serving. All that many patients ever know is that the NHS, how ever it is designed and organised, does not adequately fulfil their needs. They might be expected to feel that the NHS was set up for them and that its workers should in effect be their servants. The more informed and vocal members of the public feel that many of the state organisations cannot be relied upon to keep their interests always in view; that such organisations very quickly hide themselves behind a veneer of consumer sensitivity which is quickly found wanting. The polish on the veneer has taken on a higher sheen in the last ten years as a result of the quality management movement but fundamentally many NHS organisations are still locked in their own affairs with the patients, customers, stakeholders (however they are designated) outside.

Such criticism has at least had an effect on the proposals for organisational change but has too often continued to concentrated on the wrappings rather then the goods themselves. The challenge is that the NHS should be designed in such a way that responds automatically to patients' needs. If it did, concern for presentation would not be needed. Because so many members of the public feel that it fails to meet this crucial test, they are cynical about any attempts to present the organisation as being 'customer friendly', a concept which the NHS has been ill-advised to adopt from the retail trade. The NHS is not selling goods, nor does it need to attract buyers.

The problem with stimulating consumerism is that when tested the consumers have as yet to show much stomach for resolving some of the more intractable issues such as priority setting. Their power

is the power of disaffection rather than support and this may well drive NHS staff back in on themselves, particularly if that disaffection is taken to the law courts as is increasingly the case.

The history of random incidents

Those with power are either overturned by random events or, if more politically adept, are able to use them for their own purposes. What effect do such events have on the structure; do they tend to consolidate it or make it unstable?

Some world events have obviously had a fundamental effect on the state of the nation and its organisations. A great deal of tension arose from the world oil crisis in the early 1970s and it is arguable that from then developed the idea that the welfare state could not fulfil its original aims. If this was the case then the need to control such state organisations became even more important.

Within the NHS several key incidents have also had a resounding effect. On being returned to government for the third term in 1987, Margaret Thatcher found that far from reaping the rewards of electoral success, she was put under considerable pressure regarding the funding of the NHS. This was encapsulated in the case of David Barber, a baby of a few weeks old with a heart defect requiring advanced surgery. The cost of the operation exceeded the budget available and the operation was refused by the health authority. After much publicity, they released resources, the operation was undertaken but the baby died. It is said, and substantiated by some research, that these bruising and unsatisfactory incidents set Mrs Thatcher on the path which resulted in the white paper *Working for Patients* in 1989 the ideas of which had been developed largely behind closed doors.

Many years earlier, in 1969, a report on ill treatment of patients at Ely hospital in Cardiff had led the then Secretary of State Richard Crossman to ponder where the line of accountability stopped, with him or lower down? This dilemma has remained and at the very least cannot be resolved unless there are clear levels of responsibility, what we now call corporate and individual governance.

In 1998 the unsatisfactory outcomes of children's cardiac surgery at Bristol Royal Infirmary gave the Secretary of State the lever he needed to put pressure on clinicians to implement medical audit and clinical governance procedures which to date they had been slow to do in most places. These scandals have had considerable organisational implications which are difficult to work through except within a hierarchical framework.

The history of political interventions

The incidents just described show how sensitive is political action to untoward incidents. Does this mean that politics and management are synonymous? Scarcely. Management in the NHS owes its origins to the need to resolve uncertainty and to reduce instability. At least that was management's original aim as it took over from the professionals the major task of co-ordinating the organisation towards the common aim of patient care. Essentially such a process was rational in intent and reached its zenith in the 1974 reorganisation which was designed in a painstaking manner notwithstanding a change of government at the last minute. This rationality went hand-in-hand with the belief that through state intervention a better society could be achieved. But as we have seen, other events in the 1970s fatally corrupted this ideal and the political interventions by the incoming 1979 Conservative government largely ignored the results of the Royal Commission which had just reported and, two years later, attempted to suppress the Black report with its unacceptable but obvious conclusion that poverty and ill health are unhappy bedfellows.

The next decade was typified by increasing emphasis on efficiency justified by populist sloganeering which denigrated bureaucracy - the process of management - and with ever more simplistic ideas about what management was for. *Patients First* in 1980 was a slim and largely content free pamphlet made much of because it was such a contrast to the papers that had inaugurated the 1974 reorganisation and the 491-page Royal Commission. The Griffiths report was commissioned on the basis that if Sainsbury's can be well run so can the NHS and it was only a question of putting someone in charge.

Such slogans were of course popular in that they spoke to almost everyone's innate belief in how organisations should be. The sophistication of the Brunei and McKinsey analysis ten years previously was seen as so much obscurantism. Given this popular support the government went further both with the 1990 National Health Service and Community Care Act and with the new GP contract and pressed on regardless of professional opposition. They were duly rewarded at the ballot box in 1992.

Four years later the political tide had turned but the incoming Labour government had some difficulty in capitalising on the 1991 reorganisation while at the at time appearing to offer something different, and better. In their white paper *The New NHS - Modern. Dependable* (also with a high slogan quotient), they endeavour to have their cake and eat it. The resulting organisational changes mirror this ambiguity and it remains to be seen whether they can be resolved. It is certain that further reorganisation will be necessary. Both Conservative and Labour governments alike have shown a considerable resistance to taking advice on organisational design, suspicious that those inside the NHS will always organise things to suit themselves rather than their patients, clients, customers,

stakeholders. Notwithstanding, all parties seem, despite what they may say, to accept a basic hierarchical structure as being the way the NHS should be run. But perhaps this assertion needs more analysis before suggesting how the NHS might become more effective.

Why is Hierarchy Unpopular?

In this paper so far I have been concerned to re-examine the factors which led to a more or less continual state of reorganisation in the NHS. Much of my comment has been critical suggesting that successive reorganisations attempting to remedy dysfunctional aspects of the NHS often failed due to a misdiagnosis of what was wrong. Even those reorganisations sympathetic to the idea of hierarchy managed to pervert its principles. Before suggesting how matters might be improved it is worth also noting that people in general have an innate distrust of hierarchical structures and this alone may make it almost impossible to design an organisation which meets approval either from its participants or from onlookers.

There are two main reasons why hierarchy (structure) and bureaucracy (process) have a bad name in the NHS. The first is that the current culture is antipathetic to the idea of what is called a command and control structure and secondly this is justified by people's experience.

I have already discussed the perverting influence of myths and illusions about organisation and the pejorative spin given to 'command and control' is yet another example. The associations of the words are those of the parade ground. A more subtle analysis of the need of people to fulfil the purposes of an organisation demonstrates that order, clear instructions, as well as sensitivity to people's abilities and desires will make organisations effective. This process will involve some commanding and some controlling - both basic attributes of management - but without necessarily proving abusive.

Nevertheless antipathy to the idea of hierarchy is widespread. Why should this be? Our first experience of hierarchy is in the family where the parents are our 'bosses'. Some parents may protest but in simple terms their role is to direct and control as well as to nurture and develop - all functions of a boss. From the very start the child challenges the parent and that fundamental kicking against the pricks stays with us always but it is regulated and moderated by both circumstance and by our growing awareness that having someone to look after you is, after all, in our interests not only to keep us safe but also to provide affection. The next step is into school where we learn that out teachers - if they are good - bring similar attributes to our lives. So is going out to work a threshold into a hostile world which once crossed allows no return, a world characterised by oppression from those with more power than ourselves? If this is a universal experience then it is not surprising that people complain.

However this scenario is, to my mind, far too crude. Childhood is just one end of the continuum of life and it is sentimental to assume some sort of Blakeian innocence which is shattered on entry to working life. The child-parent relationship is a workshop where the child learns but so does the parent. And once out of that particular workshop we enter a series of others, also places of potential learning. In other words all our experience is valid, even if some is pleasant, some unpleasant, some helpful, some not.

How does this relate to our feelings about hierarchy? I suggest that it begins to explain why most of us see hierarchy as an obstacle because it places us in a particular relationship to others which, even if it gives security and the opportunity to develop, we tend to want to challenge. This desire stems from a variety of causes. First we may resent the degree of supervision. The child says "Don't look at me while I am playing" seeking a private place all of their own, the adult at work resents his or her overseer - to use an old but telling term. This need to work things out without someone looking over our shoulder seems to be a fundamental emotion.

There is another reason we do not like being supervised all the time - it lessens the impact of our achievement. Far more dramatic to retire into a corner and then to come out with the finished object, the solution to the problem. All languages have a word for this moment "Look what I've done".. "Voila..", "Ecco..". But it has to be pointed out such moments of triumph may be short-lived if the solution is wrong, the workmanship faulty, the result of inadequate instruction.

In any case there is some ambivalence in our reactions. We are as likely to complain of lack of support as we are of being over-supported. How are we to interpret this? Are we denying hierarchy as an organisational principle or are we just being critical of the manner in which the hierarchy works, its bureaucracy? If we deny hierarchy are there any true alternatives or are the more modern organisational systems actually only amendments of the traditional hierarchies? Certainly it is possible to run small groups in a consensual mode but even here the evidence needs careful analysis.

I have suggested that the concept of the traditional hierarchy which both reflects and enhances power relationships, was the idea underpinning NHS organisation up to 1974. But during the same period managerial theories had been developing which suggested that organisations would not maximise their potential unless they acknowledged the creativity which is inherent in everyone. Rigid structures, it was said, lead to a dysfunctional organisation because they fail to allow for human flexibility. But again we see the confusion between the structure and the way it works: having an unambiguous place in an organisation can enhance the satisfaction of participants.

A different perspective suggests that it is only managers who are hierarchical and the struggle has been between their ideas as to how organisation should be run and those of doctors. If this reading of events is true, then the study of the internal organisation of the NHS demonstrates a continual battle for supremacy between doctors and managers.

Doctors have hierarchies in training. When they reach the top whether as consultants or GP principals, how are those different chains of command to be joined with the managerial hierarchy? Are they doomed to operate for ever in parallel? Does this matter? In the 1980s the Conservative government with a record already of limiting professional autonomy, felt that it did matter. The doctors having been vociferous in criticising consensus, now got landed with general management. With this came a more determined attempt to incorporate doctors in the managerial agenda, making them more accountable for the use of resources.

There are two ways of attempting to assure compliance, by direct control or by contract. Before 1991 performance management could be operated through the chain of command down to the district general manager. With the 1991 changes, the line of accountability bi-focated at regional level with trusts and health authorities both accountable to the NHS Executive through the regional office. But there was now a second accountability relationship, the trusts' compliance with the contracts agreed between them and the health authorities. Either way hierarchy remained intact - the pervading organisational principle. As we saw in the 1980s clinical staff were very suspicious of the new general managers while at the same time being the greatest critics of consensus management which general management replaced. It is not uncommon to find these conflicting responses. It follows therefore that people who criticise the supposed authoritarianism of hierarchical structures may also be the greatest supporters of the clear allocation of responsibilities which are the characteristic of such hierarchies.

A persistent criticism of hierarchy is that it is inherently oppressive. It provides the opportunity for people's natural talents to be circumscribed, it reduces their access to information, it requires them to act as servants of their seniors, it fails to honour individual rights. But this is where there is confusion between the attributes of hierarchy and the manner in which people work within its structures. To be in a scalar structure is not itself intrinsically oppressive, indeed the principle underlying it allows people to be good at what they are good at. It promotes expertise and allows people to shine, contributing unique skills for the benefit of the organisation a whole. The NHS provides many examples of this. At ward level many skills are at the service of the patient, the doctor, the nurse, the physiotherapist but also the domestic, the porter and the medical records clerk. Some of these people

have spent many years acquiring their expertise and it makes sense to ensure that the structure allows them to use their skills and capitalise on their knowledge.

Away from the patient's environment, the principle is the same. Managers, often as we have seen, are generalists with little if any clinical training. Nevertheless they bring skills to their jobs not least in their attempt to bring the clinician's ethic of providing the optimum care for their patient into harmony with the common good. This cannot easily happen in a loose structure or indeed where there is ambiguity as to who is in charge of what.

A Way Forward

Is the organisation of health services intrinsically intractable? The institutions are large and complex; professional relationships are often in conflict; the aims of the NHS are both paradoxical and ambiguous; the political and economic setting is unstable. Can the NHS ever be designed to meet its aims? Is this the responsibility of management and if so how do the clinical staff fit in? The first obligation is to set up an organisation which will allow patient care and all its attendant work to be effective.

A frequent complaint from staff in the NHS is that " we have been here before" or " how many more times are we going to sail round this buoy?" A cursory look at the managerial literature over the last thirty years would show that some issues are always with us: today's quality management was yesterday's management audit; the importance of continuing education is constantly being reiterated if not carried out.

This phenomenon may be deplored but it is more helpful to find an explanation. I would suggest that it stems from the fact that *knowledge is transferable but learning is not.* This means that we can be told about the history of the NHS and be able to recite the necessary key policy changes but our own behaviour is only altered once we have experienced the meaning of those changes and this we habitually do by enacting them. If this process is true it would seem to compromise the hierarchical idea that the boss knows best and it is sufficient for him or her to say " believe me I know this is the best way forward". But this is to simplify their role; the wise boss uses his or her experience to help the subordinate to learn, not just to tell them the answer. They can do that because they have themselves learnt through experience. Crucial to this process is the ability to reflect on experience. Arguably this is what many NHS managers are unable or unwilling to do, faced with the barrage of performance imperatives; reflection is seen as an expendable luxury. Even so, what might such reflection teach us?

Structure and style

Large groups of people cannot function effectively within an organisation without the allocation or assumption of roles and an understanding of the relationship between those roles. The connections between people - the mortar - is what keeps the organisational building intact. Without this formality the organisation will find it difficult to fulfil its functions, usually described as planning, programming, co-ordinating, controlling and evaluating. The traditional way of preparing the organisation to undertake this work is through the setting up of a hierarchy which allows for specialisation or functionalism but keeps all these experts within a single line of accountability.

There has been considerable confusion in the NHS and elsewhere, because of a failure to differentiate between hierarchy and bureaucracy. Hierarchy describes the structure, bureaucracy describes the manner in which that structure is made to work. The two words are not synonymous. The alleged evils of one do not necessarily arise from the other. Formal hierarchies with relatively long chains of command can be made to work given an appropriate style of management. Equally, flat organisations do not necessarily facilitate better staff relationships: I have known such organisations where the method of communication was almost entirely through memos and e-mails! Peer groups are not always known for good communications.

Roles

In the NHS as in other social organisations there is a natural order which allocates tasks to people according to their ability and to the status which is attached to that ability. To recognise this is not to support some Victorian concept of rich lords in castles and poor men at the gate, nor is it a justification for supremacist behaviour. It is instead a sensible way of organising work. Despite the attention given to describing roles by functions, as seen in every job description, there seems to be a process by which these roles become confused and the job description rapidly becomes a meaningless bit of paper.

One of the reasons for this is our natural desire to enhance our experience, to dramatise our lives. We all construct narratives of our experience - that is how we attempt to make sense of it - but in the process we are often inclined to observe the traditions of a good narrative rather more than giving an accurate account of what happened (which of course is always open to some level of disagreement). In narratives there are traditional goodies (doctors in this case) and baddies (managers/ bureaucrats) and stories are based on their contests. The NHS is a particularly fertile field for such stories.

These narratives have another function in tidying up the past to present a coherence which was not apparent at the time. From this process myths develop. Take the perennial assertion that if we brought back the matron all inefficiencies would be solved. This imposes order on the past but more importantly suggests that such order can be replicated today. The facts of the matter scarcely support the hypothesis. To begin with the old-time matrons varied in effectiveness and authority. Some are well remembered as honourable successors to Florence Nightingale, others as small-time autocrats terrorising their nurses. In this latter mode they were more like the evil stepmother or witch of our childhood storybooks. This is not the place to explore why such figures are necessary to us (they are found in all cultures) but it is germane to point out that such myths do show that it is possible to carry two views in our heads as once - the organisation as a story book location and as a real place where we work or which we visit. It also demonstrates that we both desire hierarchy and subvert it simultaneously.

My interpretation of this process is that we desire a more ordered environment and think that we can recapture the good old days when, we have convinced ourselves, everyone knew their place. This fantasy leads us to believe that there is a better way of dealing with today's uncertainties if only we could find it. It appears that most of us find it difficult to tolerate things as they are. From this point of reality we are constantly striving to construct images both of a more rosy past and a happier future. Is it possible to design that future and provide an organisation which provides more assurance of future stability and greater happiness? Or are we powerless to construct such an environment doomed to suffer in the turbulence of the political, economic and social vortex?

The conventions of good narratives also affect the culture of our relationships. This is particularly relevant to the relationship of doctors and managers, traditionally seen as at loggerheads. Doctors have the benefit of popular support and, as has been shown recently in the political use of the shortcomings of two cardiac surgeons in Bristol, any attempt to control doctors must first diminish their god-like status. This may not be wise for at least one reason: faith in the power of the doctor to effect a cure is an important part of treatment. A balance has to be found between surrounding doctors with this aura of sanctity and living in the real world. Doctors are more likely to be protected by accepting that they are part of a recognised hierarchy. Their patients are more likely to be reassured.

Doctors must be able to treat their patients according to the best principles of their profession and with the benefit of their expertise. They must also co-operate with running health services in a responsible manner, that is, according to nationally agreed policies and nationally determined resource limits. Doctors fear that by this degree of compliance they may in effect become subordinates to a non-

clinician, a manager. It is therefore one of the responsibilities of both doctors and managers to ensure that the doctor can treat his or her patients without inappropriate interference from a non-expert in the clinical field but to do so with some understanding of the common good.

To this end there has been a continuing attempt to involve doctors more in management evolving from the 'Cogwheel' arrangements of the late 1960s to the present situation with doctors heading clinical directorates. This process of incorporating doctors has now been extended into general practice with the development of primary care groups where boards dominated by GPs will attempt to commission services for given communities.

Is this increasing involvement of doctors in what is called general management now satisfactory or has the balance shifted too far towards managerialism? The responsibility of the general manager is, as we have seen, to plan, provide, co-ordinate and evaluate. Such activities are presumably required as much in clinical care as in the overall organisation. But there is a fundamental difference. The clinician's contract is with his or her individual patient, the general manager does not have such a contract. Therefore there may be an ethical danger when the clinician is asked to be both specialist and generalist at the same time. Is it not better that clinicians largely stay with their patients and their interests? Furthermore the managerial training of clinicians is often scant. It is noticeable that doctors faced with a managerial problem (overuse of diagnostic tests) side-step responsibility or complicate its solution with bureaucracy. The general manager who has (or should have) a wider perspective may be more equal to what has to be done.

Leadership

This is dangerous ground because I seem to be making a case for managers to be in overall charge and critics would immediately point out that as these managers have not resolved many of the perennial problems in the NHS, they are scarcely worthy of such a position.

In fact I am not arguing for the supremacy of one group over another, or indeed for authoritarianism at all. I wish only to address unambiguously the consequences of the fact that the recognition of expertise is a key component of successful hierarchies. It makes no sense to take people away from what they are good at and give them work that they have little experience of.

The first requirement if the NHS is to be sensitive to its patients' needs, is that everyone should be doing what they are best at. Too often the current aversion to hierarchy leads to team solutions so that clinicians are left doing management badly and, even more pernicious, managers second-guess clinical judgement.

Accountability

The second requirement is that the structure should promote an unambiguous line of accountability. This is a great deal more than the simplistic chain of punishment which passes too often for accountability in the present system. Accountability is not just about conforming to standards laid down by a superior, it is also about conforming to values. It should therefore still be possible to challenge standards if it appears that they will not have the intended results. Scepticism is a virtue not a vice.

The line of accountability is currently flawed because the organisational structure allows people often to avoid the consequences of their actions. Simply there are too many emergency exit doors. Let me explain. Under the present arrangements it is possible to pass the buck or to leave by a different door from the one you came in by. Health authorities can maintain that they set the standards for a service agreement but the trust failed to comply with them. The trust in turn can say that the resources allowed for the service agreement were insufficient. Each blames the other and only a third party, the regional office can adjudicate if the argument continues. Far better if each agency has no option but to live with the consequences of their own decisions. Human behaviour is conditioned in this way after all. A simplification of the hierarchy whereby each part of the organisation is accountable to only one other, would lead to better results. The current muddle of multiple blaming is clearly unproductive.

Such a simplification of the line of accountability would not remove the more general accountability whereby health boards (authorities, trusts, PCGs) are required to answer to their constituents as well as their masters. All too often the attempts to codify accountability have been limited to responding to wrongdoing, the temptations of which are apparently always present. Unfortunately rules in themselves do not ensure that wrongdoing never takes place. The only effective control is within the value system of each individual and that is less accessible to management. Good governance ultimately relies as much on principles as procedures.

Where there is ambiguity and uncertainty there is also anxiety and suspicion. A clearer line of accountability running through a recognisable hierarchy would allow trust to develop, between public servants themselves and between them and the public generally.

To gain this trust it is necessary to be able to manage meaning, to get others to accept your way of looking at things. In the NHS this is a battleground in which doctors are more likely to be the victors. In vain will a manager marshal his or her troops under the banner 'Efficiency' against a clinical army who carry the flags bearing the words 'Life or Death'. So, for instance, managers endeavouring to

convince audiences of the need to reconfigure health facilities, know that rational argument is only one component of meaning; gaining trust will rely as much on being believed as having integrity and this is an attribute only acquired over a considerable period. A further complication is that there are ritualistic aspects of accountability which have a purpose in terms of the relationship to the public if not in resolving practical problems. Face to face discussions between managers and the public often take on the character of a ceremony whose purpose is to demonstrate the accountability of the public servant rather than to resolve the issue.

The pressures exerted by central government are also somewhat ritualistic. The ethos of performance management carries associations of success or failure which originate in the schoolroom. Punishing the manager who fails to meet his or her targets is like calling a child to the front of the class and publicly shaming them.

If all of this is true then it is obvious that a structure is needed which makes it clear to everyone, internally and external to the organisation, who is in charge of what.

Is the manner of working in hierarchies the real source of the trouble? Is it bureaucracy which should get the blame? The pejorative use of this term is comparatively new. In its purest sense, as set out in the ideas of Max Weber, bureaucracy was high-minded based on fairness and a respect for competence producing an organisation which was efficient because it depended on clear relationships which honoured individual expertise. How he would have deplored what are now said to be the evils of bureaucracy: rigidity, unresponsiveness, slowness and incompetence!

Hierarchy as the 'Natural Order'

My evidence so far has claimed that despite the bad name given to hierarchy it is nevertheless imprinted on all of us as the way organisations are structured; no real alternative has been found to work. This leads to a view that hierarchy is in fact 'the natural order'.

Fundamentally people today still recognise that there is an order which derives from our earliest civilisations encapsulated in human nature. Whatever the century, whatever the setting, human behaviour creates patterns which are apparently universal and constant. This idea is now described as evolutionary psychology or even 'neo-Darwinism'. Applying this to the NHS means that despite the various attempts to 'democratise' management in the last twenty-five years, fundamentally there is an allegiance to the traditional structures which underpinned the NHS before 1974. Indeed without this structure accountability would be difficult to invoke. Jaques has said

> ..the exercise of authority tied properly to accountability is one of the most constructive of all human activities. The real task - and the difficult one - is to replace autocratic management with accountable management.
> *from chapter 17 in Management and Learning edited Mabey & Iles Open University Press 1994*

Hierarchy expresses moral order which acknowledges the wisdom attached to age and experience - a respect on which most cultures ultimately rely despite the superficial challenges from some modern youth cultures.

People feel more secure in an understandable hierarchy and from that security are able to give of their best, confident that they know what is expected of them and to whom they can turn when in trouble. Nothing is more damaging than to leave people in an ambiguous position not knowing whether they are doing the right thing and fearing summary criticism at every turn. This leads to defensive behaviour which drives out innovation. The freedom to fail is essential as it is only through experimenting that organisations and the people within them can advance. The current mantra, taken from the quality management movement 'right first time every time', is hopelessly unrealistic and ultimately demoralising.

Managing the NHS is about keeping forces in balance: the external with the internal; the clinical with the non clinical; the efficient with the effective; the rational with the non rational; the theoretical with the practical. The only way to reconcile all these forces is to have a clear structure.

As an ex NHS chief executive of many years, my ideas about health service structure and organisation could be accused of being old-fashioned, not to say authoritarian. In order to rebut such criticism I need now to spell out more clearly what my position is.

Not Another Reorganisation - Please!

It would be confounding some of my criticisms to advocate yet another reorganisation and that I do not do, although largely in the expectation that evolution will bring us back to a point from which we departed in 1991. Already we see that the so-called purchaser- provider split does not really apply in general practice, as GPs straddle both sides. Furthermore the internal health market never could have worked effectively and the present government although taking credit for removing it, are merely recognising that fact.

My argument had been that the inherent structure within the NHS, whatever the apparent form at any point in its history, has been based on hierarchy. Furthermore this is acceptable. This again supports Elliott Jaques' view

> ...managerial hierarchy is the most efficient, the hardiest, and in fact the most natural structure ever devised for large organizations...[because it] can release energy, creativity rationalize productivity and actually improve morale.
> *source: as above*

One should add "providing the style is right". This is crucial. The criticisms of hierarchy discussed above were largely matters of style, that such structures were inflexible, unresponsive, repressive. Hierarchical organisations can be creative but only if their attendant bureaucracy is recognised for what it is, a process and one which needs in turn to be devised with the full co-operation of all those involved. Participation is essential if individual skills are to be used for the benefit of the whole organisation. People cannot develop if their boss does not recognise their own moral responsibility to help. Before damning this approach as paternalistic, it is worth remembering how successful such nineteenth century enterprises were and comparing them to many organisations which now manifest unhappy, unfulfilled people looking forward to their retirement even in those years when they should be in their prime. That this is now a prevalent mood among NHS staff must be bad for patients.

More attention to the original dedicated purpose of the NHS might have got better results. As it is, the obsession with reorganisation has led to a dangerous situation where the NHS as an ideal is now compromised. Even after fifty years, the original design has not yet been achieved. Managers and clinicians alike have not yet been able to ensure that patients proceed fluently through the system ensuring that they are in the right place at the right time getting the treatment they need given by the right people. The failure to achieve this objective can be explained by the failure to accept a common truth that hierarchy is the most natural organisational structure civilisation has yet devised. We must stop rearranging the deckchairs and rebuild the ship.

Bibliography

Ferlie E & Pettigrew A (1996) Managing Through Networks: Some Issues and Implications for the NHS British Journal of Management Vol. 7 (special issue) pp81-99

Jaques E (1994) Managerial leadership: the kev to good organization chapter 17 in *Managing Learning* ed. Mabey C & Iles P London Open University Press/Thomson Business Press

Lukes S (1974) *Power- a Radical View* London Macmillan

Mullins L J (1993) *Management and Organisational Behaviour* 3™ edition London Pitman Publishing

Nicholson N (1998) How Hardwired is Human Behaviour? Harvard Business Review July- August 1998 pp 135-147

Pattison S (1997) *The Faith of the Managers* London Cassell

Rowbottom et al (1973) *Hospital Organization* London Heinemann

Tannebaum et al (1974) *Hierarchy in Organizations* San Francisco Jossey-Bass