

BRISTOL ROYAL INFIRMARY INQUIRY

**Reforming the NHS: policy changes and their impact on professional
and managerial organisation and culture 1984-1995**

Background Paper

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EXECUTIVE SUMMARY

The purpose of this paper is to outline the general changes in NHS culture, policy and structure over the period 1984-95, to look at how these changing values were reflected in policy reforms and the introduction of specific initiatives such as clinical directorates and to consider how these developments impacted on the relationship between medicine and management over that period. The paper focuses on the acute hospital setting rather than primary care or the interface with social care. Those aspects of the 1989 reforms and their effects which have been addressed in earlier briefing papers for the Inquiry i.e. the introduction of clinical audit and the impact of the internal market on quality of care are not covered here in any detail. Three key references for this paper are the books by Rudolf Klein *The New Politics of the NHS*, Brian Salter *The Politics of Change in the Health Service* and Chris Ham *Health Policy in Britain*.^{1,2,3}

Section 1 summarises the shift in perceived sources of authority from professional leadership to managerialism and consumerism during the early 1980s.

Para 1.1 summarises some of the key social, cultural and political characteristics of British society in the early 1980s which influenced policy decisions about the NHS and draws attention to the growing pressures on NHS resources during that period.

Para 1.2 outlines the main components of the policy response in the early 1980s to concerns about NHS costs and productivity. These included a series of efficiency initiatives (efficiency savings, Rayner scrutinies, performance indicators, competitive tendering, income-generation) and, in 1983, the introduction of general management following the *Griffiths Report*. The main conclusion is that, while Griffiths represented a major change in thinking about the role of management in the NHS, its impact on behaviour and relationships among clinicians and managers on the ground was fairly limited in the first few years.

Section 2 looks at the NHS reforms introduced after the 1989 NHS Review and at the main policy developments occurring during the subsequent period up to 1995.

Para 2.1 summarises the origins and main provisions of the 1989 White Paper *Working for Patients*. It goes on to consider how the assumptions and expectations of the internal market modified during the process of implementation. Specific consideration is also given to the developing attempts during the early 1990s to involve clinicians in management through the development of clinical directorates in hospitals. More details about the agreed criteria for effective involvement of clinicians in management are provided in the Appendix to this paper.

Para 2.2 briefly describes the development of two further key policy themes during the early 1990s, represented by the White Paper *Health of the Nation* and the introduction of the *Patient's Charter*. The paper concludes with a summary of the overall changes in health service organisation and culture over the period discussed.

1. NHS REFORMS IN THE EARLY 1980s

This section:

- * summarises some of the key political, social and cultural characteristics of British society in the early 1980s which influenced policy decisions about the NHS
- * outlines the main components of the policy response in the early 1980s to concerns about cost and quality in the NHS

1.1 Changing values and priorities

1.1.1 *Culture and society*

- i. Klein¹ summarises the contrasts between the Britain of the 1940s and that of the 1980s: "The NHS was born into a working class society only slowly emerging from war, where rationing and queueing were symbols not of inadequacy but of fairness in the distribution of scarce resources. It celebrated its 40th anniversary in 1988 in what had become an affluent consumer society where only access to work was rationed." (p.133) In addition, he observes, British society in the 1980s was:
 - * much more fractured, with new cleavages cutting across or blurring traditional class divisions
 - * routinely exposed to a range of experiences and information (eg via television and mass tourism) that was previously unimaginable
 - * one in which scandal was less restrained by the self-censorship of the media and marked by the erosion of deference
 - * one whose members were far better educated, with higher expectations and greater control over their own lives
 - * experiencing rapid technological change that created both new risks and opportunities
- ii. Social change brought about political change. Klein identifies the following as key features of the Thatcher government which came to power in 1979:
 - * it lacked reverence for tradition as embodied in institutions and defined itself largely by reaction against the collectivist, corporatist bias that had dominated the post-war period
 - * it believed the collective good would be promoted not by spending more on collective welfare provision but by unleashing the energies of individuals
 - * it believed in 'good housekeeping' within tight budgetary constraints

"As the Thatcherites saw it, the horrendous economic problem which swept them into office - rapid stagflation, soaring public expenditure, apparently irreversible economic decline - reflected the ability of corporate groups to subvert the public interest to their own: to perpetuate rigidities and to oppose change."(p.137) Klein summarises the

Thatcher government's preferred vision of the future society as that of a strong, centralised state and strong, individualistic consumers, but with the role of intermediate bodies - be they local authorities, trade unions or professional associations - sharply diminished.

1.1.2 Pressures on the health service

- i. Between 1949 and 1984 the real cost of the NHS increased threefold and the proportion of the gross national product spent on it increased from 3.9% to 6.2%. In the early 1980s it was estimated that a real increase in funding of 1.2% per annum was needed to meet the costs of care for an ageing population and to fund advances in medical technology.⁴
- ii. From the early 1980s, health service policy was increasingly driven by the imperative for increased productivity. Caught between rising demands (new technology, rising patient expectations and an ageing population) and financial constraints (an ailing economy and an ideological commitment to reduced public spending), the government perceived its only option as being to squeeze more out of existing resources by increased efficiency. Thus concern about efficiency became an increasingly central preoccupation.

1.2 NHS policy in the early 1980s

1.2.1 Efficiency initiatives

- i. During the 1980s, a series of initiatives were introduced by the Department of Health focussed on improving and extending services without increased costs. These included:
 - * efficiency saving initiatives
 - * Rayner scrutinies
 - * development of performance indicators
 - * competitive tendering
 - * an income-generation initiative

ii. Efficiency savings

From 1981, health authorities were required to generate annual efficiency savings of between 0.2 and 0.5%, so that funds released from existing budgets could be used to support new service developments. Efficiency savings were renamed 'cost improvement programmes' in 1984 and by 1989 it was estimated that these programmes had achieved annual savings of almost £1 billion in hospital and community services in England.³

iii. Rayner scrutinies

From 1982, a series of short, intensive scrutinies were conducted along the lines of those carried out in the civil service by Sir Derek Rayner. In the NHS, these were carried out by NHS managers and included studies of the efficiency of areas such as transport services, recruitment advertising and the use of residential accommodation for NHS staff.

iv. **Performance indicators**

1983 saw the publication of the first 'performance indicators' about the NHS. These covered clinical services, finance, manpower and estate management and their purpose was to enable health authorities to compare their performance with what was being achieved elsewhere. Performance indicators used routine statistics generated by the NHS. The innovation was in bringing them together and using information technology to make findings comparable and accessible. These indicators were open to criticism on a number of grounds:⁵

- * they were dominated by data about activity and outputs (numbers of patients and operations) rather than about outcomes (impact of activities on health)
- * there was a considerable timelag between collection and presentation
- * there were doubts about their accuracy
- * they contained no measures of quality

Nevertheless, they did allow comparisons to be made between performance of different hospitals and health authorities on a number of criteria (eg cost per case, staffing levels, waiting lists, availability of services). As such, "they provided the policy-makers and managers within the Department with tin-openers by allowing them to ask direct questions about what was happening on the periphery."¹(p.145)

v. **Competitive tendering**

In 1983, health authorities were asked to test the cost-effectiveness of their own catering, domestic and laundry services by inviting tenders for their provision from in-house staff and from outside contractors. Some authorities extended this process to other services such as building maintenance. It was estimated that the first round of competitive tendering achieved annual savings of £110 million, mainly derived from contracts won by in-house staff.⁶

vi. **Income-generation**

In 1988, the income-generation initiative was launched. This was intended to explore ways in which health authorities could generate additional resources. A total of £10 million was yielded in the first year through schemes such as car parking charges, private patient income, and the use of hospital premises for retail developments.³

1.2.2 *The Griffiths Report*

- i. In 1982 a team led by Roy Griffiths, the Deputy Chairman and Managing Director of Sainsbury's, was appointed to give advice on the effective use of management and manpower and related resources in the NHS. The resulting 1983 Griffiths Report⁷ marked the beginning of the NHS managerial revolution, whereby the view of management as a discrete function within the system was replaced by the adoption of managerialism as an ideological approach to running the system as a whole.⁸

- ii. Before 1983, there was a clear division of role and influence between clinicians and managers in the NHS, with the latter far the weaker group. NHS managers were primarily concerned with 'organisational maintenance'. They were 'directors of process... reactors rather than initiators' with producer-oriented agendas.⁹ Their time was taken up with smoothing out conflicts and helping doctors and other health-workers obtain the resources necessary for their work. It was the clinicians who made all the key decisions about which were appropriate patients to accept, how to diagnose and treat them, and, thereby, how much to spend on them. The aggregate of all these individual clinical decisions became the pattern of service offered by the NHS. Clinical management determined operational management and strongly influenced strategic policy-making. This clinical freedom also provided doctors with a good deal of obstructive ability to resist changes of which they disapproved.¹⁰

- iv. The Griffiths Report⁷ diagnosed the absence of a clearly defined general management function as the key weakness in an NHS characterised by institutional stagnation and lack of leadership. Its proposed solution was the immediate introduction of a general management structure from top to bottom in the NHS. The new general managers to be introduced at all levels were intended to be: "a driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring their achievement."⁷ They would not necessarily be recruited from within health service and pay would be linked to performance. Their task was to mobilise consent for change and change the style of NHS decision making. Klein¹ comments that, with Griffiths, the 'vigorous virtues'¹¹ of energy, adventurousness and independence (as opposed to the 'softer' virtues of humility, gentleness and sympathy) came to be the sought-for qualities in the NHS (as elsewhere).¹

- v. The new managerialism was presented not as a threat to the NHS's professional providers, but rather as an opportunity to participate more in the decision-making process. There was no reason, Griffiths argued, why the new managers should not be recruited from the medical and nursing professions. At the same time, however, it was made clear that hospital doctors 'must accept the management responsibility which goes with clinical freedom' and participate fully in decisions about priorities and the use of scarce resources.

- vi. As well as a new management style, the new managerialism also challenged the most basic assumptions about the value system of the NHS. The new orthodoxy of managerial success in both industry and the public sector was the need to focus on producing satisfied consumers. In the context of the NHS this shift from producer to consumer values presented a major challenge to the autonomy of the medical profession, which had previously determined both the appropriateness of outputs and defined and measured standards.

1.2.3 *Implementation of Griffiths*

- i. In response to the Griffiths Report, a Supervisory Board and Management Board were established within the DHSS and a phased programme of implementation began with the identification of regional general managers, followed by general managers at unit

and district levels. By 1987, the majority of appointments at all levels (61%) were of former NHS administrators. Twentyfive per cent of general managers were clinicians (mostly doctors) and a further 12% had been recruited from beyond the NHS.¹²

- ii. The government endorsed the view that doctors should be involved in management and be given responsibility for management budgets. It attempted to facilitate the Griffiths recommendations in this area, first through Management Budgeting and later via the Resource Management initiative, which aimed to provide clinicians with computerised financial data systems to aid their decision-making. A 1986 DHSS review of Management Budgeting concluded that it had concentrated over much on the technical aspects of budgeting at the expense of winning the support and commitment of key personnel: managers, clinicians and finance officers.¹³ So Resource Management was introduced as a wider approach that would emphasised medical and nursing ownership of the system and would generate extensive clinical as well as financial information.¹⁴

1.2.4 *Impact of Griffiths*

- i. In practice, the immediate impact of the Griffiths Report, despite its comprehensive implementation, turned out to be rather less radical or dramatic than the ideas which had shaped its recommendations. For example, one study of unit general managers in the period immediately following the implementation of the Griffiths' Report found only moderate increase in management influence over doctors: "Only limited progress has been made towards ensuring that UGMs exercise greater control in the setting of clinical targets and monitoring of clinical activities, while progress towards establishing closer links between UGMs and medical advisory systems has been patchy. The perceived impact of general management at 'front line' level has apparently been slight, and general managers are not infrequently regarded as somewhat remote figures."¹⁵
- ii. In relation to Resource Management, an evaluation of experience in the demonstration projects indicated that some progress had been made in involving doctors and nurses in management but much remained to be done and the process of change could not be rushed.¹⁶ The idea that many clinicians would be interested in taking on time consuming management posts has been described as "one of the serious fallacies of Griffiths".¹⁷ Of those doctors who ventured into the field of general management itself, most decided it was not for them. Between 1985 and 1991 the number of doctors heading the management of districts and hospitals halved from 120 to 58. Reasons cited include lack of remuneration, loss of private practice and the hostility of medical colleagues.¹⁸
- iii. Klein¹ identifies as its major weakness the fact that Griffiths assumed it was possible to change style without fundamentally re-engineering the dynamics of the system. The new arrangements provided no major incentives to persuade staff to behave appropriately: "If a supermarket failed to satisfy its customers, or if it ran its business inefficiently, it would eventually be taken over or go bankrupt. If a NHS hospital failed to satisfy its customers, or tolerated waste, there were no equivalent sanctions."(p.152) It was only later, with the introduction of the internal market, that this issue was more directly addressed. Nevertheless, the invocation of consumer values on the one hand and the challenge to traditional lines of demarcation between managerial and professional responsibilities on the other set in train a series of evolutionary developments which

defined the policy agenda of much of the next ten years.

2.

NHS REFORMS 1989-95

This section:

- * outlines the background to the 1989 NHS review, summarises the main features of the subsequent white paper *Working for Patients* and looks at their implementation over the next few years. (**Note.** Those aspects of the 1989 reforms and their effects which have been addressed in earlier briefing papers for the BRI Inquiry (i.e. the introduction of clinical audit¹⁹ and the impact of the internal market on quality of care²⁰) are not covered here in any detail)
- * looks briefly at key developments in NHS policy which followed during the first half of the 1990s

2.1 The 1989 NHS Review

- i. Through the 1980s, a widening gap emerged between the money provided by the government for the NHS and the funding required. By 1987-88, the cumulative shortfall in the hospital and community health services since 1981-82 amounted to £1.8 billion, even after allowing for the recurrent savings from cost improvement programmes.³ The NHS Review set up in 1989 was prompted by widespread perceptions of a financial crisis in the NHS, caused by the failure of the various value for money strategies adopted earlier to resolve the tension between constrained budgets and increasing demands.

2.1.1 *The White Paper Working for Patients*

- i. Despite these origins, the 1989 White Paper *Working for Patients*²¹ proposed no change in the basic principles of funding for the NHS. Rather, the main focus of reform lay in the creation of a competitive environment through the separation of purchaser and provider responsibilities and the establishment of self-governing NHS trusts and GP fundholders.
- ii. These changes reflected the view that a central weakness of the pre-1989 NHS was that money did not follow the patient, but rather came in a fixed budget from the health authority. In these circumstances there was no incentive to increase activity because this would increase costs without increasing income. In addition there was no incentive to be sensitive to demands, particularly those coming from outside the authority's administrative boundaries. The 1989 reforms aimed to increase efficiency through linking hospital income more directly to their activities and to give them freedom to behave entrepreneurially in responding to new opportunities.
- ii. In addition, *Working for Patients* also aimed to strengthen management arrangements. In the new Department of Health, this was to be achieved by appointing a Policy Board and NHS Management Executive in place of the Supervisory Board and NHS Management Board. At local level, the composition of health authorities was revised along business lines. The reforms removed the previous representation on health authorities of professions working in the NHS and members nominated by local authorities. The new

authorities were modelled on company boards and made up of health authority senior managers and a small number of non-executive directors appointed for their personal contribution, rather than being drawn from designated organisations or constituencies. Similarly, Trusts were to be run by a board of directors (executive and non-executive).²²

- iii. A further important aim was to make doctors more accountable for their performance. This was partly to be achieved by general managers playing a bigger part in the management of clinical activity. Previously, consultant contracts had been held at regional level, thus insulating consultants from the managers of their immediate institutions. Now local managers were given the task of drawing up job plans for consultants and negotiating and monitoring their contracts. Managerial influence was also strengthened by extending the criteria for the basic level of consultants' distinction awards to include "commitment to management and development of the service" and including managers in the committees making these awards.²³
- iv. In addition:
 - * new disciplinary procedures were introduced for hospital doctors to enable disciplinary matters to be dealt with expeditiously²⁴
 - * emphasis was placed on involvement of doctors and nurses in management through an extension of the resource management initiative
 - * medical audit was expected to become a routine part of doctors' clinical work²⁵

2.1.2 *Implementation of Working for Patients*

- i. The 1989 reforms proved highly contentious both in their content and the process of their implementation. The proposals were not piloted, not planned in detail, and were implemented extremely fast, with the new legislation coming into effect on 1 April 1991. In a report on the White Paper²⁶, the Social Services Committee argued that the government was trying to do too much, too fast, and expressed: "serious fears that the stability of the services and continuity of patient care may suffer during the years of transition to a new, untested system."

ii. **The internal market**

On 1 April 1991, 57 NHS trusts and 306 GP fundholders came into operation.²⁷ But the internal market did not. Purchasers were advised, at least for the first year, to stick to their existing providers and maintain a steady state. Klein suggests a number of reasons for the Department of Health's decision to be cautious:

- * the managerial foundations laid by Griffiths had hardly been consolidated and the introduction of new management techniques - especially the Resource Management initiative - had proved more difficult than expected
- * the transformation of a system based on control through a managerial hierarchy to one based on negotiating contracts would clearly take time, as would the

development of adequate information systems to provide data about patients, treatments and costs

iii. By 1994 more than 400 providers accounting for 95% of NHS activity had become self-governing trusts. But "changing labels proved easier than changing the dynamics of the service"(p.205).¹ The theory of the internal market was that it would be driven by purchasers, thus reversing the provider dominance that had previously characterised the NHS and ensuring that service developments would no longer be driven by the interests and ambitions of consultants. But, in practice, there were a number of difficulties. Among these Klein identifies:

- * an asymmetry of information, whereby providers had both greater expertise and information about their services
- * an asymmetry of managerial resources, as the most able and ambitious staff had mostly gone to work for provider units rather than purchasing authorities
- * the problem that some services in some areas were monopoly providers, and most purchasers and providers were locked into permanent relationships

iv. Klein observes how the vocabulary of the NHS internal market was gradually moderated during the early 1990s in acknowledgement of such complexities:

* Purchasers became commissioners: a recognition that monogamy, rather than polygamy characterised the internal market, with most purchasers and providers locked into permanent relationships in which each partner sought to modify the other

* The internal market became the managed market: a recognition that purchasing was about shaping the nature of the services available to the local population over the long term, rather than buying to satisfy immediate wants

* Competition became contestability: acknowledging that the internal market appeared to be creating regulated local monopolies rather than a free-for-all, it was argued that this did not matter as long as new providers could move into the market and purchasers could **threaten** to move their custom

v. **Medical accountability and managerial responsibility**

Following the Griffiths report, the main approach taken to strengthening the link between clinical and budgetary decision making was the adoption of the "clinical directorate".^{28,29} Salter² describes the clinical directorate "in its pure and rarely realised form" as a semi-autonomous unit, based on a medical specialty or group of specialties, to which full budgetary responsibility is devolved and within which clinical and budgetary decision-making are combined.

vi. Within the clinical directorate it was commonly accepted that its clinical management team should be composed of a clinical director, senior nurse manager and business manager, but there was less agreement on the distribution of responsibilities and powers between them. It was also generally assumed that the clinical director should be a doctor

because "a non-medic would not be able to command respect from senior or junior doctors".³⁰ Even then, however, the authority of the director over their colleagues was problematic, given that all consultants in the NHS have equal status. A further problem was the lack of serious financial or career incentives for clinicians to undertake a greater role in hospital management and consequently many clinical directors were reluctant appointees to their jobs.³¹

- vii. The clinical directorate structure was adopted fairly slowly. A survey in 1990 found that 40% of hospital units had clinical directorates while 80% had at least some clinicians holding budgets.³² Three years later a further study undertaken by the British Association of Medical Managers found that most providers had adopted a decentralised clinical management structure based on clinical groupings but the proportion of the total unit budget actually devolved to these groupings ranged from less than 10% to over 90%.³³ By 1995, 89% of acute teaching hospitals and 86% of district general hospitals had clinical directorate structures.³⁴
- viii. Salter observes that the introduction of the internal market after 1991 accentuated the intensity of the cost pressures to which clinical directorates had been seen as the organisational answer. Trusts and their clinical directorates were now obliged to deliver their services to meet the terms of their contracts with purchasers and the effect of the contractual imperative on the clinical decision making process was to try and subordinate clinical freedom to the needs of the Trust. Doctors were now under pressure to reconcile two criteria: i) what they perceived to be the objective clinical needs of the patient and ii) the terms of the contract. Salter suggests that in the early 90s, it became apparent that purchasers were having to negotiate with clinicians as well as managers to ensure realistic contracts and that, for their part, clinicians were prepared to use their clinical discretion to manipulate their waiting lists to satisfy purchaser demands. In this way, the clinical directorate was developing as the primary demand-regulating unit.
- ix. Salter suggests that the ability of Trust managers to influence what happened inside the clinical directorates varied according to the roles taken by the clinical director and senior nurse manager but was in any case considerably constrained by:
 - * the individual nature of consultants' decision-making and their lack of accountability
 - * the use of historical accident as a guide to operational procedures within directorates
 - * professional divisions and, on occasions, tensions between nurses and doctors
 - * the absence of any single locus of power complemented by a plethora of informal power networks
- x. He concludes that "it is at the level of the clinical directorate that the long-established culture of the NHS, centred as it is on the principle of medical dominance, is most dense and immutable"(p.71).² Against this inertia managers possessed few effective levers. Whereas hospital doctors are protected by an array of professional defences which dilute the effectiveness of employment and disciplinary sanctions against them, managers have no such security, being usually appointed on the basis of a one year renewable contract. While Trusts theoretically possessed greater flexibility than their predecessors in the

way they managed their staffing arrangements and to specify the duties of their employees, in practice few Trust managers risked provoking their clinicians in this area.

- xi. During the 1990s, some attention has been given to the dilemmas experienced by clinicians who become involved in management and efforts have been made to define the organisational conditions for effective clinical participation in management. These issues are discussed in more detail in the Appendix to this paper.

2.1.3 *Impact of Working for Patients*

- i. The most thorough evaluation of the 1989 reforms to date³⁵ systematically reviewed the findings from a large number of research studies under five broad headings: efficiency, equity, quality, choice and responsiveness and accountability. The authors concluded that - overall - little measurable change for good or bad could be detected. With regard to evidence specifically about the effects of the reforms on hospitals (and other types of trust), these authors made the following observations:

- * the quality and quantity of evidence on trusts is relatively limited
- * there is only limited evidence that trust status made hospitals more efficient than they would otherwise have been
- * there was no evidence of widespread competition between trusts, but rather of a series of bilateral monopolies between individual purchasers and providers
- * there was no evidence of impact on quality of services
- * there was no evidence that trusts increased patient choice
- * there was no evidence that trusts became more accountable to their local populations

The authors comment that, if the main aim of the quasi-market reform in the NHS was to provide participants with greater incentives to improve efficiency and responsiveness to patients' needs, the evidence available shows little progress towards the latter and only lukewarm signs of the former. As far as roles and relationships within trusts are concerned, the authors concede that the reforms may have had some effects on hospital culture that were not adequately captured in the research studies they reviewed.

2.2 **Subsequent policy initiatives**

- i. There were two other significant policy initiatives during the early 1990s:
 - * the publication of the 1992 White Paper *The Health of the Nation*³⁷ which signalled the emergence of a new approach to population health which went beyond the traditional boundaries of the NHS
 - * the transformation of patients into consumers marked by the production, in 1991, of the *Patient's Charter*³⁸

2.2.1 *Health of the Nation*

- i. Starting from the premise that the population's health was the product of a variety of factors ranging from life-style to the environment, the White Paper embraced a strategy of 'social mobilisation'.¹ Within government, a cabinet committee was to co-ordinate departmental policies that might have an impact on health. Outside government, local authorities, voluntary organisations, employers and the media were all to participate in a campaign to create health cities, schools, workplaces, homes and environments. The White Paper contained 25 specific policy targets for improvements in specific health outcomes such as coronary heart disease and suicide.
- ii. The *Health of the Nation* was criticised for having chosen targets largely because they were achievable. Nevertheless it represented the government's belated acknowledgment that a health service strategy that focussed on treatment rather than prevention would never be able to solve the problem of escalating demands and costs. This new perception had two significant implications for NHS hospitals¹:
 - * it marked a shift of focus from 'the specialists exercising their magic'¹ in the hospital to the GP and others involved in health promotion and prevention in the community
 - * it put pressure on purchasers to test providers' demands for more resources against the White Paper's criterion that any services bought should make a demonstrable contribution to the population's health

These changes, in turn, reflected the broader shifts towards a 'primary care led' and 'evidence-based' NHS, which became the major policy preoccupations of the NHS in the mid 1990s.

2.2.2 *The Patient's Charter*

- i. The *Patient's Charter* was the NHS manifestation of a wider national policy initiative to define the standards of service delivery of public services. It set out a series of explicit rights for patients ranging from those previously taken for granted within the NHS such as "the right to receive health care on the basis of clinical needs, regardless of the ability to pay" to much more specific guarantees such as "the right to be guaranteed admission for treatment by a specific date no later than two years from the day when your consultant places you on a waiting list". In addition, there were nine national charter standards setting out service specifications to be aimed for, such as time limits on waiting in outpatients.
- ii. Like the *Health of the Nation* the rights and aspirations laid out in the Charter were set at fairly low and achievable levels. But, as Klein points out, the importance lay in the symbolic significance of "a new rhetoric and a new set of expectations in the NHS marking precisely the kind of shift of power from providers to consumers envisaged in the Griffiths Report."(p.212)
- iii. In 1994 the Department of Health followed up the Charter by publishing a comparative performance guide³⁹ showing the extent to which individual hospitals and departments had achieved its standards as well as various performance targets set by the NHS

Management Executive. This guide was made widely available to users, to help them and their GPs to make informed choices about their care. "In effect, the performance indicators first introduced in the 1980s as a tool of managerial control had become a way of giving the public information about the activities of the NHS."(p.213)¹

2.3 Conclusion

- i. The period 1984-95 was a time of major policy activity which resulted in a transformation of NHS culture and values. In the early 1980s, the NHS - despite a number of structural reorganisations - still conformed in all essentials to the original 1948 model of a medically led and professionally dominated service.
- ii. By the mid 1990s, the NHS had been radically reformed in accord with the new ideology of managerialism and competition in public services. Conceptually, the service had been altered from one that was provider-dominated and expert-led, to one designed to respond to the needs of patients as consumers. From being the only focus of health policy concern, the NHS had become one, albeit central, component of a wider strategy to promote the health of the population on all fronts.
- iii. In practice, however, the impact on the ground of all these major changes was considerably less dramatic. Professional autonomy within the service proved resistant to change, and the balance of power between medicine and management was altered only incrementally.

APPENDIX

1. The experience of clinicians involved in management

i. Research undertaken by Thorne⁴⁰ on the experience of doctors appointed as clinical directors in a large NHS teaching trust looked at how they perceived the role and how they felt it had impacted on them and on others.

ii. All the clinical directors studied had two common attributes: professional credibility and organisational acceptability. Their reasons for taking on the role of clinical director included both positive, defensive and pragmatic components:

- * the intellectual challenge and the opportunity to make things happen
- * a desire to give something back to the department
- * being pushed or flattered by peers
- * an opportunity for initiation into the 'inner cabal'
- * the wish to prevent someone else 'less suitable' or to retain control

iii. Being a clinical director was felt to involve:

stress: from work overload, inability to exercise control over people and issues, lack of managerial experience or expertise, ambiguity and uncertainty surrounding the role, high personal expectations and other people's conflicting expectations

maintenance of professional identity: retaining a professional focus to avoid becoming isolated from clinical colleagues; learning to operate in both professional and management 'worlds' and acting as a go-between; seeing the role as a transitory status and not attempting to be a manager; at the same time not over-identifying with their own particular specialty while acting as a clinical director

leadership: seeing oneself as 'first amongst equals' and 'leading from within' rather than attempting to directly control or manage clinical colleagues

control: dealing with the tension between managers' expectations that they would control the other consultants and professional colleagues' expectations that they would prevent managers encroaching on their professional domain

iv. On the basis of her research, Thorne identifies four issues for the agenda of doctors in management: She suggests that attention must be given to:

- * the effort and energy involved in learning the job and executing it effectively and considering the type of support that is needed
- * organisational support for and development of the professional model of leadership and for those making the transition in and out of the role
- * development of managers' understanding of and sensitivity to doctors' professional models of working

- * extending and developing clinicians' involvement beyond directorates to add value to corporate decision-making processes

2. Organisational conditions required for involving clinicians in management

- i. In 1993, a group of key stakeholders (British Association of Medical Managers, British Medical Association, Institute of Health Services Management and the Royal College of Nursing) issued a document setting out key principles and implementation measures for the involvement of staff from all disciplines in the management of NHS trusts.⁴¹ This was revised and added to in 1996.³⁴ The key principles were:

- * decentralised management: directorates or their equivalent with decision-making responsibility and devolved budgetary responsibility
- * flexible, adaptive management arrangements, changing over time
- * the multidisciplinary team as a core concept; the concerns of all professionals represented at trust management group level
- * the development of shared views of clinical services between clinical staff in provider and purchaser organisations

- i. Nine 'implementation tests' of these principles were identified. These were that directorates (or their equivalent) should be:

- * in place
- * tackling significant care issues
- * involving all staff (communication)
- * supported (staff and information)
- * involved (structure)
- * involved (process)
- * committed to training and organisational development
- * involved in discussion and debate with GPs and purchaser staff
- * managing income and expenditure within agreed business plans

- ii. Additionally, in the later document, attention was drawn to a number of management structure and process issues which were seen as crucial to successful implementation.⁰ These included the need:

- * to recognise that structures are not the only element of effective management
- * to address problems of scale in large acute trusts
- * for each clinical team to feel properly represented on the trust board
- * to ensure systematic communication with 'natural work groups'
- * for managers and clinical staff to monitor their ability to work together
- * to openly acknowledge the creative tensions between the corporate body and the individual directorates
- * to involve directorates in all stages of contracting
- * for open and honest leadership
- * for clinical staff in management to have adequate resources, support and rewards and appropriate contracts

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