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Teams and top managers in the National Health Service

a survey and a strategy

Schulz and Steve Harrison

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TEAMS AND TOP MANAGERS IN THE NATIONAL HEALTH SERVICE

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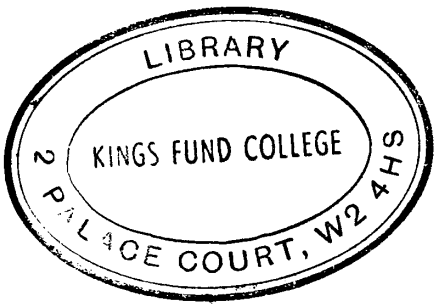
A Survey and a Strategy

Rockwell Schulz and Steve Harrison



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Introduction

The central sections of this Project Paper (Chapters 2, 3 and 4) report a study of area management teams (AMTs) carried out in England by Rockwell Schulz* between January and March 1981. The study consisted of interviews (106 in total) with team members, supplemented by examination of relevant documents such as agendas, minutes, financial and staffing data, hospital activity data, and strategic and operational plans. The outline interview schedule is reproduced as an Appendix to this paper.

The interviewees were drawn from a total of 19 area health authorities: in each case the intention was to interview all six members of the management team, giving a total possible coverage of 114 respondents. All authorities selected were single-district areas, and the 19 covered represent half of the 38 such areas in England. Hence, the findings and conclusions are unaffected by post-April 1982 changes to management arrangements. The subject authorities were chosen by Stephen Harrison in order to provide a wide geographical coverage. Because of the distribution of single-district areas, the subjects are biased towards the North of England. Two were teaching areas. Nine authorities were predominently urban, one rural, and the remainder were medium-sized manufacturing communities surrounded by rural areas.

Findings are remarkably consistent throughout the study, and there was little evidence of practices or attitudes varying systematically with geography or RAWP position. Although the study is centred upon the personal perceptions of area management team members, some opportunity was available to confirm the findings. Hence, a substantial amount of the findings are consistent with observations from health authority documents and at team meetings (seven were attended) and from discussions with relevant regional health authority and DHSS officers. It is therefore possible to be confident that the findings do not

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misrepresent the characteristics of management in single-district areas in the 1974 structure of the NHS.

But the importance of the findings goes beyond this. Firstly, they demonstrate the perceptions of top managers about their relative roles: the importance of such perceptions is argued in detail in Chapter 1, and Chapter 5 attempts to place these perceptions in the context of other relevant research and to reach conclusions about why the role is what it is. Secondly, the choice of single-district authorities effectively controls one of the post-April 1982 variables. Hence, Chapter 6 is able to examine the prospects of changes in the top management role being generated by other aspects of the 1982 reorganisation.

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Rockwell Schulz PhD
and Steve Harrison
1983

1 Theory and practice

The notion of organisational objectives is given considerable emphasis in both classical[17] and modern[15] management theory. It is generally held that organisations exist for a purpose, that the purpose should be explicit, and that all management activity should be directed towards the achievement of the purpose. Without such emphasis, it is held, there will be no standards by which to judge organisational performance, and no incentive to pursue the common purpose. The same emphasis on objectives also occurs in much of the management-oriented literature on decision making[1], and quantitative approaches to decision making seem to require a clear objective as the basis of calculation.[58] Few writers have made the claim that this 'rational' approach to management reflects actual managerial behaviour and the approach is therefore essentially normative, though this is not always evident from the language used in textbook definitions of management: hence, Brown and Moberg[7] say simply that management *is* 'marshalling . . . resources towards common organisational goals'.

This stress on organisational objectives has come under considerable criticism on the grounds that it 'reifies' organisations, that it falsely attributes human characteristics to them. Only persons can pursue objectives and, in Silverman's words, 'it seems doubtful if it is legitimate to conceive of an organisation having a goal except where there is an ongoing consensus between the members of the organisation about the purposes of their interaction'.[70] And there is an abundance of both reasoning and research to show that individuals and groups within organisations do not share or pursue the same goals.[14,61]

Yet the idea that organisational objectives are important remains remarkably resilient. Drucker argues that confusion about goals is a major explanation for the poor performance of service organisations, and many organisations are stated to have quite explicit formal objectives. The latter point is specifically true of the field of health services: under the influence of the World Health Organization[75] many countries are articulating the goal of 'health for all by the year 2000'.

The formal objectives of the British National Health Service (NHS)

have always been explicit. The 1946 Act stated that it should exist 'to secure improvement in the physical and mental health of the people . . .',[33] and that a comprehensive range of services should be provided. Since the Service's inception, the original objectives have been re-enacted[34], and a number of official documents have attempted to supplement the original objectives with more detailed statements. These have included the Report of the Royal Commission[63], the 'Grey Book'[24], *The Way Forward*[27] and *Care in Action.*[21] Whilst not all such documents set out the same objectives, and in some cases articulate objectives which are less specific than the original legislation, a number of themes recur. Firstly, health or the avoidance or cure of ill-health is mentioned. Secondly, references to equality of access to services recur. Thirdly, services are to be comprehensive or integrated, and finally are to be responsive to public need.

Attempts to match the structure and management of the NHS to these objectives, and to add the fifth theme of efficiency, have been numerous. It is not necessary to mention all of these, though notable examples are *A Hospital Plan for England and Wales*[29], the Salmon Report[31], the first 'Cogwheel' Report[28], and the National Board of Prices and Incomes Report No 166.[32] The 1974 reorganisation of the NHS, with its 'rational-comprehensive' planning system, administrative unification and stress on role clarity, can be seen as a coming together of these various strands of what Carpenter[9] has termed 'managerialism'.

In spite of these efforts, there has been substantial and wide-ranging criticism of the NHS on the grounds that it has failed to progress towards these objectives. No comprehensive discussion of these is necessary for this paper, but it is appropriate to cite typical examples. McKeown[55] has questioned the contribution to improving health status of much of the kind of activity performed in the NHS. The Royal Commission on the NHS[63] demonstrated the geographical and social class inequalities in health status and health resource distribution. Various reports (one example is the DHSS report, *Orthopaedic Services: Waiting Time for Out-patient Appointments and In-patient Treatment*[25]) have highlighted problems of integration, and Cochrane[12] has indicated the reluctance of health service providers to think in terms of the effectiveness of services or the efficiency with which they are provided.

Whilst there may well be a large number of explanations for the above, not the least of which are difficulties in measurement*, some relate to the activities of health service managers. Hence, a number of empirical studies have demonstrated that objectives are not pursued in the way suggested by normative management theory. Haywood and Alaszewski (Chapters 4–6)[44] have shown that the formal management arrangements of the service are not the prime determinants of events, and that the overall shape of the service delivered to patients is little more than the aggregate of individual clinical decisions. Consistent with such findings, Elcock and Haywood (Chapter 4)[16] have shown the inability of the planning system to secure the implementation of high level policy objectives. Hunter[45] found that NHS management teams were primarily reactive rather than proactive in pursuit of any clear goals, a finding somewhat confirmed by Stewart and her co-authors' study of district administators.[72]

There is thus, with respect to the NHS, a gap between normative theory and actual practice, a gap which management theory argues ought to be narrowed. Many radical commentators[65,70] have however pointed out that the notion of organisational objectives can be used to give the illusion of unanimity over what are actually sectional (that is, managerial or professional) objectives, and it is a commonplace observation that organisations consist of a number of groups each with their own legitimate objectives.[18] The considerable merits of such arguments as applied to organisations in general do not mean that sectional interests within the NHS should be allowed completely to override the service's formal objectives. There seems to be a strong case, grounded in public policy, that more attention should be directed towards these than has hitherto been the case; the combination of the nature of health care, touching as it does matters of life, death and permanent alterations to life-chances, and the limits to resources for such care puts, in particular, a clear ethical imperative on effectiveness and efficiency. There is therefore a case for greater motivation of those responsible for providing health services towards the objectives of those services.

That such a view is widely shared is indicated by criticisms of the

*This paper does not attempt to deal with the issue of how NHS objectives might be measured: some of the problems are cogently outlined in Klein's *Auditing the NHS*.[49]

alleged shortcomings of NHS managers from very different points on the political spectrum. Thus *Patients First* concludes that 'the structure and management arrangements . . . introduced in 1974 do not provide the best framework for the effective delivery of care to patients . . . whatever . . . arrangements are devised must be responsive to [patients'] needs'.[26] Haywood and Alaszewski, on the other hand, suggest that more orientation to the end product of services and not the level of input 'is required on the parts of managers and others in the NHS'.[44]

A second consideration is whether any more vigorous pursuit of the objectives would render their achievement any more likely. From all that is known about managerial activity in organisations, it is easy to conclude that objectives and plans are rarely implemented in their original form, and therefore to argue against the value of planning or orientation towards long-term objectives. This would be too extreme a conclusion. Whilst it is certainly possible to expect too much from such an orientation (for there is an interaction between ends and means), policy objectives, as Majone and Wildavasky have argued[57], do serve to ensure that action is at least linked to actors and issues relevant to the policy. Thompson has shown that properly constructed health policies with clear objectives are capable of being implemented.[73] A third consideration is whether it is realistic to regard NHS managers as the most appropriate actors to pursue formal objectives, for as Haywood and Alaszewski have shown[44], they have not to date been generally responsible for the shape of the service. Aside from the normative argument that such a role is the distinctive duty of top management in any industry, there are two pragmatic reasons for regarding NHS chief officers as capable of making at least a substantial contribution to a more vigorous pursuit of the Service's objectives. One is that, compared with clinicians, top management is a compact group with *relatively* homogeneous interests, and whose behaviour might more easily be modified. The second is that, as a number of studies including the present one (see Chapter 5) have shown[69,4], managers are capable of improving the performance of health institutions in respect of at least some of their formal objectives.

It is therefore a premise of this paper that top NHS managers ought to be more oriented than at present towards the objectives of the service, and that such an orientation would be unlikely to be entirely without effect. A next step is to consider the means by which such a

change might be brought about. Existing studies provide much evidence upon which suggestions might be based. For instance, Haywood and Alaszewski set out preconditions for such change.[44] Amongst these is recognition that the local level political system within and around health authorities is a prime factor in decision making, and recognition of the fact that NHS managers are not the most powerful influence in the Service. There are therefore two further conclusions to this Chapter. One is that any strategy for change which involves a key role for NHS managers must have regard to their relative power as well as their orientation towards Service objectives. The other is that any such strategy must take account of the perceptions of managers, especially top managers, in the Service.

It is with these two issues that the remainder of this paper deals. The perceptions of NHS managers have not to date been systematically researched, but are important on account of the known link between actors' influence and their own and others' perceptions about it.[61] Hence, Chapters 2 to 5 aim to fill this gap with data derived from a study of top managers. The first part of Chapter 6 reviews the structural changes and monitoring devices introduced in the 1982 reorganisation, with a view to assessing their likely impact on both the orientation of NHS managers towards formal objectives, and on the power of managers to influence movement towards these. The second part of Chapter 6 considers other possible influences on these factors.

The importance of considering these issues is currently very great. Firstly, there is an apparent atmosphere of innovation and optimism with regard to external monitoring devices: these devices will themselves need to be evaluated and the present construction of hypotheses for this process is not premature. Secondly, it is vital for the NHS to improve its performance. There has been growing concern with its direction and its effectiveness, and in the context of the present economic climate and the growth of the private health care sector, the Service has been argued to be increasingly vulnerable to being dismantled; in the face of this prospect there is a case for 'almost total preoccupation with what the Service actually does for the welfare of patients'.[44]

2 Perceptions of consensus management

There are two distinct and competing rationales for the formal introduction of consensus management into the NHS in 1974.[19] The first of these might be termed the behavioural rationale and is adopted by Levitt who states that consensus decision making originates in 'academic research into the way groups of people solve problems together'.[52] Gourlay[19] cites in this connection the findings of social psychologists such as Blake and Moulton, Likert, and Lewin that problem solving by teams is likely to be effective and innovative, to bring the commitment of participants[36] to the solutions identified, and to facilitate change; Gourlay adds the points that modern technical complexity requires the pooling of specialist expertise, and that anyway participation is contemporarily valued for its own sake. Finally, Gourlay cites Argyris's list of ten characteristics of competent teams, one of which is decision making by consensus. Gourlay sums up consensus as a situation where 'all the alternatives available will have been thrashed through so that the group have a sound understanding of the problem and possible implications of each decision', resulting in 'a psychological state in which an opportunity has been provided to influence the decision and the team members are committed to the decision because of this'.[19] On this rationale then, consensus decision making is one, though only one, necessary feature of the effective teamwork which is considered necessary to solve management problems and, as Hunter observes, 'bears a marked resemblance to rational prescriptive models of decision making'.[45]

By contrast, the alternative rationale is essentially the pragmatic consideration that in an NHS largely organised around functional and professional hierarchies and collegially organised professions (doctors and dentists), no practicable alternative to team management exists and that no practicable alternative to consensus exists as a mode of decision making by such teams. In support of this rationale it is possible to cite both literature and pre-1974 practice. Hence, in spite of

early support in both Scotland[45] and England[48] for the notion of a chief executive, by 1971 the difficulties of this were widely recognised and had been specifically rejected by Naylor's influential report on the organisation and management of a unified health service.[59] As Jaques, one of the architects of the 1974 structure later wrote, 'no such solution is realistically available'.[46] Pre-reorganisation management practice commonly included a *de facto* team arrangement involving nurse, administrator and doctor, especially in single specialty hospitals, but often at group level also. The Royal Commission on the NHS observed that the decision to create management teams of equals was a reflection of the growth in influence of the nursing professions.[63] Some of Hunter's respondents also confirmed the similarity between pre- and post-reorganisation practice.[45] Focusing on the process by which it was decided to adopt consensus decision making, Brown notes that it was 'adopted with some enthusiasm by professional interest groups who were anxious to thwart an accountability system which might threaten their own autonomy'.[6] Klein regards the introduction of the practice as 'a bargain based on a calculated gamble' both by DHSS and the medical profession[50]; from the point of view of the former, emphasis on team management might produce better central control of resources, whilst the latter might consider the heavy representation of doctors (each with the power of veto) on teams as adequate protection against loss of autonomy. This pragmatic rationale is explicitly espoused by the Grey Book when it states that management teams 'will consist of those whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of health care'.[24]

It is possible that both rationales played a part in the decision to adopt consensus management formally, and indeed the Brunel University definition of consensus as 'anything from strong backing to a just minimum amount of support'[8] is consistent with both. In addition some management commentators have specified ideal conditions for the use of consensus which seem to bridge both rationales. Hence, Schulz and Filley[66] suggest that consensus decisions are preferred where the decision to be made is judgmental rather than technical, where group understanding is required, where implementation requires acceptance by group members, where the quality of the decision is likely to be enhanced by group interaction, and where it is important

for the managers involved to gain a broader perspective of multidisciplinary issues.*

Findings of the study: perceptions of consensus

Table 1 records the response of AMT members to the question of whether they favoured the 1974 consensus management structure, the pre-1974 structure, or some other structure for management decision.

Table 1 Respondents' preferences for 1974 consensus management or some other structure

	Per cent favouring 1974 consensus structure	Per cent favouring pre-1974 structure	Per cent favouring some other structure or are neutral	Number asked†
Area administrators	67	11	22	18
Area treasurers	100	-	-	10
Area nursing officer	92	8	-	13
Area medical officer	66	17	17	12
Consultant member	71	7	22	14
GP member	84	-	16	12

Only one consultant, one nursing officer and no general practitioners favoured the pre-1974 organisational arrangement. Nurses and treasurers were more favourably disposed toward the team concept, which was considered to have elevated and broadened their input to management. Of the administrators who did not favour the 1974 team structure, three preferred a chief executive system, two preferred the previous system and one thought a team of three consisting of the adminstrator, nursing officer and consultant representative was the best system. Administrators and medical officers favoured the present

* The above discussion is based on Harrison's *Consensus Decision-making in the National Health Service – A Review*.[39]

†Time limitations on some interviews prevented this question being asked of all respondents.

structure least, as both had more formal authority in the pre-1974 structure. Nevertheless, the fact that the majority favoured the new arrangements even though their authority has diminished was a strong endorsement for the current arrangement, and echoed the conclusions of the Royal Commission that consensus decision making was one of the more successful features of the 1974 reorganisation.[63]

Many team members in all categories responded that they would ideally prefer a chief executive officer (CEO) arrangement, if they could be the CEO. However, they were not all confident that an 'effective' CEO could be appointed no matter what the discipline from which that person might come; consequently, they preferred the team consensus arrangement. The most frequently reported benefit of consensus decision making was that it provided for more input of both straightforward information and of how colleagues felt about issues. Many respondents mentioned special benefits from the medical input (especially that of the GP), though, as is shown in Chapter 3, this does not seem to have made the clinical members of teams particularly influential.

The second most frequently mentioned benefit was that consensus provided for a greater commitment to implementing the decision. This is consistent with the findings of Hage and Aiken that persons who participate in decisions are much more committed to seeing them implemented.[36] Moreover, when the team can point to doctor representatives favouring the decision, it can enhance confidence to see the decision through to implementation. Some respondents gave examples of contentious decisions, such as clinic and hospital closures and the cessation of GP attachments of nurses, which were made more confidently in the knowledge that the team would withstand the resultant political pressures more easily than could an individual decision maker. This is not inconsistent with the findings that groups may be more able than individuals to take risky decisions, and a few respondents confirmed their experience of this.[11]

Other benefits of consensus mentioned by respondents were that it allowed team members to 'have their say', improved the status of some disciplines, and aided coordination.

Respondents were also asked* to report their perceptions of any

*Due to pressures of time upon interviews, a minority of respondents were not asked this question.

weaknesses on consensus decision making and all but two were able to suggest examples of such weakness. The most commonly reported weakness was that it slows the decision making process, a criticism reported in other surveys.[51,45] Respondents in all three studies made the qualifying point noted earlier by Barnard and his co-authors that speed was not the only criterion by which to judge decision making.[3] Amongst the respondents in the present study there was substantial agreement that whilst some issues which reached the team could and should have been dealt with by its members in their individual capacities, other apparently individual issues benefited from the support of the whole team. This was particularly the case when the decision involved refusal of a request for resources from an individual source. Few if any of the issues dealt with by teams seemed to require immediate decisions. Another source of slowness in making decisions was the fact, noted earlier by Haywood[42], that the AMT was the lowest level of formal interdisciplinary coordination, hence pulling issues upward for resolution. Some teams reported having introduced management teams at hospital level, in part to avoid this problem.*

Other criticisms of consensus decision making centre upon discrepancies between influence on the team and influence within the health authority as a whole. These perceived discrepancies were of two types. The first kind of reported discrepancy was between an individual's influence on the team and the actual influence of the discipline which he represented. Thus, respondents from all disciplines commented upon the lack of ability of the clinical members of the team to commit the doctors whom they were supposed to represent. Several clinicians commented that the corporate role gave administrators more influence in team decisions than they would otherwise have had in the organisation, leading to the establishment of formal priorities which were inappropriate. Several clinician members commented that the part-time nature of their own team role artificially handicapped them in relation to other team members. Two (clinician) respondents also commented that trade union influence was such that it ought to be reflected in representation on the team. These types of responses seem to constitute a recognition that the AMT is by no means a microcosm of the distribution of influence within the health authority generally.

* Thus anticipating one of the 182 changes in management arrangements (see Chapter 6).

The second type of reported discrepancy is rather different and relates to the difference between actual influence of team members and the respondents' perceptions of what it ought to be. Examples of this type of response included the view of administrators that consensus decision making gives too much influence to doctors and creates too many burdens for administrators. A number of medical and nursing officers complained that they had lost power as a result of the introduction of consensus management, and that other team members now interfered in their responsibilities. Finally, there were complaints from a number of disciplines that aggressive personalities gave undue influence to some individuals. Responses of this type logically imply dissatisfaction with the respondents' actual level of influence in the NHS, rather than with the consensus process as a mode of decision making.

The process of consensus

Many team members remarked that the socialisation process to develop a good working relationship required up to two years. It was suggested that there was an initial socialisation problem: reportedly in most cases it did not result in acrimonious arguing, but rather that members tried so hard to be compatible that they glossed over the real issues. However, once members felt comfortable with each other, they could argue strongly over major differences, but at the end of the day be good friends. There were however a few exceptions such as the Solihull case where the team could never agree and had to be replaced.[13] Reportedly and observationally it seemed that participants were open and frank in their discussions and with their feelings, even on issues where these were strong. Nursing seemed to be more defensive than others. A few members from all disciplines reported having experienced conflict between their corporate team roles and their responsibilities for their own function. Insertion of humour when discussion became tense was often mentioned and witnessed as a key to team harmony.

AMT meetings among those visited ranged from about three hours fortnightly, to over nine hours weekly. The amount of time did not seem necessarily to relate to team and management effectiveness. Some seemed to spend too little time and to seemingly ignore substan-

tive issues whilst others spent a great deal of time on trivial matters: others took time only to pursue important matters. Although agenda items will differ from the presentation of items for information or approval to those requiring joint problem solving, the types of items seemed to be dealt with as if they were the same. Meetings could have been expedited if different group processes had been used for different item requirements. The discipline of the chairman or whether or not someone was officially designated chairman made no discernible or reported difference. Some individuals were more adept at expediting meetings than others, however, and in most cases this was the administrator. It is interesting to note that most team members estimated spending from 70 to 80 per cent of their time on acute hospital matters, such institutions being considered the main source of management problems because of their complexities and the influence of consultant medical staff.

Of the teams surveyed, most could only think of one or two times since 1974 when consensus could not be reached and decisions had to be made by the AHA. Team members reported that whilst they might not totally agree with other team members on all decisions, they seldom felt strongly enough about the decision that they could not at least 'agree to agree', or 'agree not to disagree'. Matters over which they felt strongly could almost always be resolved within the group, either by persuading others to their point of view, or finding some common ground upon which they could all agree. A number of teams mentioned that they would bring in the chairman of the AHA as a mediator when there was strong disagreement, and such conflicts were worked out so that the team could bring a consensus decision to the authority. Only a single respondent considered that team members' reluctance to use their veto constituted a disadvantage of consensus decision making, a finding somewhat in contrast to that of Kogan and his co-authors.[51]

No respondent thought there was a problem of people bypassing the team on important decisions affecting the whole area, though in fact such a process did occasionally occur. Two administrators indicated that on occasion they would go directly to the authority chairman when seeking backing for action of which the team might not approve. One treasurer reported going to the chairman to get him to convince the AHA to rescind or send back team decisions with which he did not

really concur, although he had agreed not to disagree. A medical officer also reported that he would not bring recommendations to the team for replacing retiring consultants with someone from a different specialty, even though that would change health care delivery patterns in the area. It seems possible, therefore, that any excessive pressure towards reaching consensus which respondents might fear can be evaded by bypassing the team in one way or another; this is an area where further research would be of considerable interest.

Concluding remarks

It is clear that there is widespread support for the practice of consensus decision making, across all disciplines. For the most part, this support seems to be based upon a pragmatic recognition that a CEO could not command general support, and that the team is able to provide strength, commitment and support for the individual chief officer both in making and implementing decisions. Most of the respondents seemed to have a highly realistic view of the nature of their role as postulated by such studies as that of Haywood and Alaszewski.[44] Respondents were for the most part well aware that a reactive role was forced upon them by the kinds of problem generated in acute hospitals, and much of the criticism of consensus management which was made, was to the effect that the team was by no means the most influential group of actors in the organisation. In other words, the assumption of the 'Grey Book' that the team consisted of 'those whose unanimous agreement is essential to the making and effective implementation of decisions for the totality of health care'[24] was over-optimistic: clinical team members cannot serve as proxies for the organisational influence of their constituents, and the strict requirements of what was termed above the pragmatic rationale for consensus decision-making are not therefore met by AMT composition.

Although, as has been seen, some respondents seemed to indicate that they felt the actual distribution of influence in their authority to be illegitimate, most seemed to accept their role quite happily and without resort to many of the conventional criticisms of the consensus process described by Kogan and his co-authors.[51] It also emerged that team members have a number of choices concerning how the consensus process is operated. Aside from the obvious issues of chairmanship

and frequency of meetings, this choice operates on whether or not to bypass or ignore the team on particular issues, and on what kind of issues are considered legitimate team business.

The issues are returned to in Chapter 5.

3 Roles of individual team members

As might be expected, status of different members of the team varies, as does their perceived influence over decision outcomes. Salaries of team members are not equal. Historically, doctors have been considered captains of the health team, and carry most status. In terms of influence over decision outcomes there was concern initially that the three clinical members of the team would dominate. Actually, however, clinicians were perceived by team members to have the least relative influence on the teams surveyed, though each person on the team has a unique source of expertise and influence. Ranking of influence among the officers seems to relate primarily to skills in using sources of influence and communication skills or, as often stated, 'personalities'. However, five of the eighteen* teams were perceived by at least three persons really to function as a team of equals with influence of each actually being equal.

Apart from these, respondents showed little reluctance to indicate what they saw as the distribution of relative influence on the team, in a few cases going as far as to offer relative weightings. Self-perceptions of relative influence were roughly comparable to the perceptions of other team members.

Table 2 (page 24) presents a compilation of totals of how each member ranked the relative influence of others. Six points were given when a person was ranked most influential and so forth. Totals are shown in parenthesis.

It will be seen that there is general agreement in all categories of team members that area administrators are perceived to be the most influential and consultants and general practitioners the least. Generally speaking officers' self-perception of ranking is at least as high as others perceive it to be, whilst clinicians' self-perceptions were generally lower.

*Only eighteen teams are reported. Only three members of the remaining team were interviewed.

Table 2 Composite rankings by team member position

		AA	AT	ANO	AMO	CONS	GP
Most influence	1	AA (98)	AA(88)	AA(78)	AA(75)	AA(85)	AA(56)
	2	AT(83)	AT(78)	Cons(65)	AMO(64)	AT(74)	AMO(47)
	3	ANO(72)	AMO(70)	ANO(63)	AT(57)	AMO(56)	AT(45)
	4	AMO(63)	ANO(52)	AMO(60)	ANO(56)	ANO(51)	ANO(36)
	5	Cons(53)	Cons(52)	AT(53)	Cons(50)	Cons(33)	Cons(30)
Least influence	6	GP(30)	GP(35)	GP(39)	GP(40)	GP(26)	GP(21)

The responses in respect of each team member are now discussed in turn.

The area administrator

Members of twelve of the teams perceived the area administrator to have the most influence over more of the decisions related to allocation of resources than anyone else on the team. On two of the teams there was only a slight difference in rankings, with a number of the members perceiving the team to be really equal in influence. On the other ten teams the administrator was clearly seen to have more influence.

Perceived sources of influence of the area administrator relate to his or her having information about the total picture of the issues discussed, having a direct line of communication to the AHA chairman, preparing the agenda for team meetings and generally being more articulate in group management settings, perhaps due to management training and experience. Another reason why administrators are seen to be most influential in most of the areas surveyed is that they tend to define their role on the team as facilitating and expediting decision. When asked what they see as their role and what they are trying to accomplish, most responded in terms of 'seeing to it that things get done, that decisions get made, whatever the decision may be'. Conceivably, therefore, a part of the reason they may be perceived by others and themselves as having most influence may be that they anticipate the direction in which decisions are going and conclude action rather than having primary influence on what was decided or initiated for decision.

The area medical officer

The area medical officer was perceived to be most influential in three area teams. However, in eight teams the AMO was ranked as having less influence than other officers. The AMO ranked second in influence in three teams.

Since the community physician (AMO) was intended by the 1974 management arrangements to occupy a particularly crucial role[24] in influencing the pattern of health care, it is particularly important to investigate the source of this polarisation in ranking. Three* characteristics seemed to distinguish the AMOs of the six teams where their influence was high.

Firstly, each displayed an outstanding degree of commitment to change, and in particular was able clearly to describe what he saw as necessary for improving health, and to speak in specific terms about what needed to be done and how barriers to achievement could be removed, and could talk with some enthusiasm about what was being done to implement changes. Goals of other AMOs who were perceived to have less influence were much less clear, if articulated at all, and they frequently spoke more in terms of all the problems they faced or in platitudes.

The second prevalent characteristic was that the influential AMOs appeared to have developed and used sources of information more than the less influential AMOs. Research in other settings has shown that developing a tension and exposing the need for change is an essential ingredient of successful implementation of change.

The third characteristic of at least four of the six was their apparent effectiveness as *boundary spanners*. They were very active with the medical community and the community in general, and were spoken of in particularly respectful terms by others on the team. The other two were spoken of in terms which implied more a crusading than boundary spanning role; nevertheless they were influential change agents.

The area treasurer

Overall, the treasurer ranked behind only the administrator in influence. Whilst two teams perceived him to be the most influential,

*It is worth noting that two of the teams who ranked the AMO as most influential also ranked the team itself as more influential in relation to other actors (see Chapter 4).

nine ranked him as second most influential and another three as third. Thus, 14 teams (78 per cent) perceived the treasurer as one of the three most influential on the team.

As will be discussed in Chapter 5, the team role is mostly concerned with allocation of resources. The treasurer's control of resource information thus provides a strong base for influence over decisions, especially if he is seen as forceful and articulate relative to other members. Respondent members of teams whose treasurers' influence was rated as high made observations to the effect that the treasurer's role was to say what services could be provided with the available money, or where reductions could be made in order to meet cash limits. The treasurer was also frequently seen as impartial, not having substantial services of his own to provide.

The area nursing officer

The perceived influence of the nursing officer varied widely. He/she was perceived to be most influential on two teams. On one of the two, the nursing officer was slightly above the treasurer in influence, but on the other the ANO was seen as clearly being more influential than others. One was male and the other female. Ten of the 18 (55 per cent) of area nursing officers interviewed were male, whereas only 15 per cent of all full-time nurses in the service are male.[22]

On four teams the ANO was ranked most influential, on three third, on four fourth and on the other five either fifth or sixth in influence. The source of influence for the ANO seems to be that nursing represents the largest single category of expenditure. Many teams reported that the nursing officer tended to hold out longer for what he/she wanted than did other members, and that this persistence was in itself a source of influence, albeit occasionally counterproductive.

The elected consultant

It might be assumed that with the great power of consultants and because hospital issues dominate team discussions, the consultant member of the team would have more influence. Indeed, work by Eskin and Mann suggests that they frequently dominate team discussions. However, no team ranked its consultant member as having primary influence. Indeed, only eight out of the 106 team members

interviewed ranked the consultant as most influential and no two were on the same team. Four of those ranking a consultant most influential were nurses, two were AMOs, one was a treasurer, and the other an administrator. The consultant was most often ranked fifth in influence.

A number of explanations emerged for this lack of influence. Firstly, consultants (like GPs) are part-time team members. Their participation is limited to formal meetings, and their preparation for such meetings is frequently limited to reading supporting documentation usually only a few minutes before the meeting. Officers frequently discuss matters between meetings. Secondly, their relationship with other consultants is not one of authority as is that of other team members over their functions. Indeed, the elected status of the consultant team member can be argued to reverse the relationship, making him or her the servant of the medical function.

It was not claimed that this was ever wholly the case, but a third explanatory factor was that consultants elected to serve on the team are frequently not the most influential consultants. It was often reported that the most influential consultants were too busy to serve and/or that by electing the less influential representatives there is less pressure for doctors to be bound by any team actions.

It is, of course, quite possible that consultants did dominate team discussion without necessarily wielding influence. Consultant (or GP) members on the team might dominate because they had more questions than other team members, and because formal meetings are usually the only forum for expressing their views. It was frequently reported that when consultants (and GPs) first became team members they would crusade to correct all the problems they saw as practitioners. However, after being on the team and recognising other dimensions to issues, they became supportive members. Consultant respondents stressed their own proximity to the actual delivery of health care services and their ability to contribute an important practitioner viewpoint.

The elected general practitioner

The GP was ranked as least influential in 14 of the 18 respondent teams, with most team members (including the GP himself) perceiving him to have the least influence on the team. There were some

exceptions with nurses on two teams perceiving GPs to be second most influential on those teams. One might expect GPs to be least influential as they are not only in a similar position to the consultant member, but most of the agenda items deal with hospital matters. It may well be the case however that without a GP team member even less time would be devoted to primary care issues.

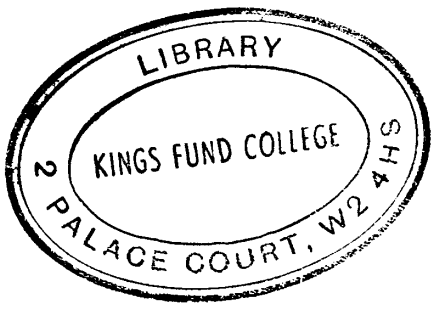
In general, the elected clinical members of a team perceive more conflict in their own roles than do their colleagues in theirs. Conflict seems to be perceived with regard to representative, personal and corporate roles. Whilst most responded that their primary objective is to represent the medical viewpoint on the team, they were quick to add that they did not see themselves as delegates for their colleagues but that they will represent the medical view. If they see a team decision which may be counter to the views of most doctors, they will ensure that the doctors' views are clearly understood, but in the final analysis will support the team position if they believe it to be in the patients' best interests. Many examples were given as evidence that practitioners on the team do support team decisions, though such decisions may be unpopular with other clinicians. Two clinicians who appeared to be among the doctor representatives more active in pursuing team objectives felt they had lost credibility among their colleagues because of their activist roles. However, they reported no efforts by their colleagues to shorten their terms of office. Two other practitioners who might also be considered as more active gave no indication of losing support from their colleagues, but the medical community in those areas appeared to be generally more active in pursuing general improvements in services. With regard to personal conflict, where medical communities were less well organised and active, clinician members spoke more about furthering some of their own personal interests. For example, one clinician admitted that his primary objective on the team was to have new facilities for his service (which had been on a priority list for many years, but never implemented), which he did achieve.

It was consistently reported by clinical members of teams that doctors were rarely, if ever, able to present a reasonably united front in support of a proposal. The combined influence of medical staff tended therefore to be negative and to protect the status quo at the expense of innovations. A few teams had instituted budgetary arrangements for

Medical Executive or similar committees in recognition of the team's own lack of ability to make certain kinds of choices: most such arrangements related to the purchase of medical equipment.

Concluding remarks

Within teams there are marked differences of influence, with administrators and treasurers consistently rated most influential, and clinical members least influential. It was widely perceived that one of the prime sources of influence within teams is control over the supply and presentation of information, an issue which is returned to in later Chapters.



4 Roles of other actors

This Chapter focuses on relevant actors outside the AMT and examines the respondents' perceptions of their respective influence.

AHA members

The DHSS defined the duties of AHA members as to:

> '. . . focus [their] limited time . . . on the critical policy, planning and resource allocation decisions which will shape the services to be provided . . . [to] review policy recommendations . . . decide on priorities . . . review and challenge objectives, plans and budgets . . . [monitor] progress . . . [and] efficiency and effectiveness.'[24]

This clearly implies a role of ultimate authority for the effectiveness of area health services. Yet the present study provides little evidence of authorities fulfilling such a role. Moreover, with the exception of only two AMTs, AHA members are perceived to have little impact on health services. Only rarely does the AHA not follow recommendations of the AMT. Whilst this is not necessarily a criticism of the AHA and can be seen as a testimony to the merit of AMT recommendations, there was little evidence of AHAs calling for, or being presented with, alternatives or options for decisions.

It also emerged that the prime concern of AHAs was resource allocation, especially of development money. In the rare cases where AHAs were rated as influential this seemed to be related to the willingness of authority members either to pursue projects in which they had an individual interest, or to become involved in detailed day-to-day management. The only exception was an AHA whose members had become actively involved in joint planning with local authority members.

The prime role of AHA members therefore seemed to be one of legitimising decisions taken elsewhere. This can be seen as an elementary form of managing the environment, a process noted by

Schulz and Johnson amongst boards of hospital trustees in the USA[67], where trustee support is used to gain community support for decision.

The regional health authority

AMT members tended to see regional chief officers as staff advisers to themselves, with little weight attached to the official monitoring relationship.[24] The main perceived influence of regions was over the allocation of capital funds and the creation of additional consultant posts. Although RHAs are also responsible for allocating revenue expenditure to AHAs, it was not generally perceived that there was much effective discretion in the face of the RAWP formula, though the speed of movement towards RAWP targets might be important in the short term.

Some regional medical officers were reported to be helpful in making approaches to individual consultants whose practice gave rise to some kind of concern, though in other regions this was not at all the case.

DHSS

In the final analysis the funds provided to and by DHSS determine the global allocation of resources to each area. DHSS also determines national priorities for improving health which are currently to promote the so-called 'cinderella services' for the elderly, mentally ill and mentally handicapped. A few teams appear to take a more provocative role, usually with assistance from AHA and CHC members, to implement these priorities over the opposition of consultants who see needs for more acute services. Other teams however are more responsive to local consultant pressure in finding legitimate reasons to give lower priority to 'cinderella services'.

DHSS and regional authorities also provide information comparing health service data such as perinatal mortality, causes of death, waiting lists, length of stay, cost per stay, and so on for areas in the region. This is intended to provide at least gross bench-marks for identifying needs. Whilst this data is usually quoted in strategic and operational plans, discrepancies are usually explained away because ranking will vary drastically from year to year and it is difficult to separate influences

such as population differences. Such information is therefore little used in practice.

Community health councils

Consumer representation through CHCs was viewed by most teams as of little or no influence, confirming the view of Ham in *Power, Patients and Pluralism*.[37] Such influence as was possessed was often considered to be negative. Some CHCs were seen as lobbyists for the status quo in that they opposed consolidation of inefficient small scattered services, and there were complaints that others, at least initially, interfered in the delivery of services without productive results. However, in two areas the CHC was reported to be helpful as a positive counter-force to promote 'cinderella' and preventive services over consultant pressures for the expansion of acute care services.

Local authorities

Only one AMT reported that the local authority, via the Joint Consultative Committee (JCC), was influential with regard to the pattern of health care delivery. JCCs were a statutory feature of the 1974 reorganisation, intended to recognise the importance of social and other local government services for health. Subsequently, provision was made for joint financing of projects and an allocation of NHS money 'earmarked' for this purpose. In one area there were reported to be especially strong links between the AHA and the local authority, involving representatives of the latter on all AHA planning teams in an attempt to adopt a fully integrated approach towards health care needs. The local authority involved is itself known for its progressive and innovative attitude towards social policies, and was said to have allocated particularly competent councillors to these teams.

More generally, however, local authority funds have in recent years been under more pressure than NHS funds, leading to a natural reluctance to commit them to joint projects. In addition, the general view of respondents was that JCCs have been relatively uninfluential as a result of the parties' needs to protect their own interests in a situation where these might not coincide: for instance, it would be in the AHA's interest for the local authority to expand residential accommodation for the elderly and in the local authority's interest for

the AHA to increase the number of geriatric beds. There was also general dissatisfaction with the local authority representatives on JCCs on the grounds that they lacked influence within their own authorities.

Consultant medical staff

On 12 of the 18 teams questioned, there was overwhelming agreement that consultants had the primary influence on the pattern of health care delivery in the area. Only two teams ascribed the primary influence to themselves, with the remaining four teams either divided on the issue or ascribing equal influence.

Three main sources of consultant influence were put forward by respondents. Firstly, it is consultants who, within the parameters set by GPs' referrals and by total available resources, control much of the pattern of care through their admission/discharge, prescribing and diagnostic testing practices: as Haywood and Alaszewski have noted[44], these piecemeal decisions add up to the larger pattern of care. In addition, consultants are able to dominate planning teams, whose output thus becomes a rationalisation of clinician's preferences.

Secondly, consultants are the educational elite of the Service: this educational and professional dominance creates the impression of certainty in clinical decisions[5] and creates a reluctance to challenge medical opinion, a situation approximating to Lukes's third dimension of power.[54] Thirdly, not only are consultants clinically free and not therefore organised in hierarchies, but the role of NHS management is itself ambiguous. Thus, whilst much official writing in the decade prior to the 1974 reorganisation stressed 'rational' managerial values[44], there was and remains a simultaneous assumption that management's role is to serve the doctor; one example of this ambiguity is to be found in the Grey Book which states that 'the objective in reorganising the NHS is to enable health care to be improved. Success in achieving this objective depends primarily on the people in the health care professions who prevent, diagnose and treat disease. Management plays only a subsidiary part, but the way in which the service is organised and the processes used in directing resources can help or hinder the people who play the primary part.'[24]

In effect, therefore, the consultant body was regarded as setting the NHS's objectives and it was rare to find top management attempts to

influence these. Thus, to refer back to the first of the five objectives of the NHS set out in Chapter 1, almost all respondents admitted the existence of unsatisfactory health outcomes in their area. For example, there were highly variable standards of care given by different clinicians, varying inclination to keep up with developing medical practice, and reluctance to look at potential performance measures such as perinatal mortality rates. In one area with a poor record on this measure, consultants were unwilling to review deaths, provide cross-cover for each other at night, provide protein assessment tests or refer complicated cases to a nearby neonatal intensive care unit: the perinatal mortality was simply written off without serious investigation as the result of population characteristics and the need to modernise hospital facilities. Virtually all teams reported at least one example of a consultant providing unsatisfactory levels of care, due to alcohol or drug abuse, ill-health or incompetence.*

Most teams also reported problems of access, comprehensiveness and responsiveness to public demand. These were manifested in the tendency of consultants to regard beds as 'their own'[38] and their unchallenged control over admissions and lengths of stay: hence there were reports of great discrepancies in average lengths of stay for particular diagnoses, a reluctance to be concerned about the size of waiting lists and disinclination to investigate remedies for so-called 'bed blocking'. Most teams reported all these issues as being well within the area where clinical freedom applies, thereby accepting a definition of clinical freedom concerned exclusively with the individual patient rather than a population.

Finally, the majority of teams reported no attempt to improve the effectiveness or efficiency of the health services within their areas. Hence there were few restrictions on prescribing or choice of equipment, and little attempt to inform doctors of the costs of their treatment and diagnostic choices.

The overall picture therefore is of little conscious management attempt to pursue the formal objectives of the NHS. However, this was not universally true; there were a few teams who reported, and were

*Only two teams reported having initiated action leading to the eventual dismissal of a consultant during the whole period 1974–1980. One of these cases was the result of a criminal conviction.

able to supply specific examples of, attempts to influence clinical practice in a way more in line with NHS objectives. Thus there were attempts to affect doctors' duty rotas and thereby the quality of care, and attempts to get medical committees to review perinatal mortality rates and other key health status indicators. Such teams also pursued improved access and comprehensiveness by seeking to implement the kinds of suggestions set out in the Duthie report for reducing waiting lists.[25] There were also attempts to encourage peer review of medical practice by drawing the attention of medical committees to apparently excessive lengths of stay and by establishing committees to review the drug stocks of hospital pharmacies with a view to standardisation. In addition two teams had begun projects involving in one case the negotiation and provision of budgets to clinical departments[74], and in another the provision of cost information to clinicians in the hope of generating increased consciousness of the need for economy.

Concluding remarks

Three main points can be reiterated in concluding the present Chapter. Firstly, there is a definite coincidence between the team members' perceptions of their influence in relation to other actors in the health service setting and the assessments of empirical researchers such as Haywood and Alaszewski[44] and Elcock and Haywood.[16] Consultants appear as by far the most influential, with the team and its members some way behind. Other influences such as RHA, CHC, AHA members and the local authority are relatively minor except with respect to certain specific matters.

Secondly, there is a marked discrepancy between the influence of consultants generally and the consultant representative elected to the AMT. It is clear that the election process is failing to act as an adequate channel for consultant influence on the formal managerial process.

Thirdly, there is a clear minority of teams which have, notwithstanding the above, made vigorous attempts to influence the pattern of health care delivery to a much greater extent than seems to be the norm. The nature of the present research has precluded any serious attempt to evaluate these efforts, and not all were reported as successful by those who attempted them. Nevertheless, the characteristics of those teams which are motivated to make such efforts deserve discus-

sion, as does the question of whether these efforts do effectively increase AMT influence. These matters are examined in the next Chapter in the context of a summary of the NHS top management role.

5 Conclusions: teams and top managers in the NHS

*The overall picture**

The present study provides clear corroboration of the empirical studies cited in Chapter 1 in two important respects. Firstly, team members do not in practice generally pursue formal NHS objectives such as improvement in the health of the population, comprehensive and accessible services, or services which are efficient or responsive to public need. Secondly, the team members perceive themselves as lacking in influence in relation to consultant medical staff at large.

The major emphasis of the team members' work was on what might be termed 'process' that is, the allocation of resources in an incremental fashion and the tackling of specific issues which in some way presented themselves as 'problems' to the team or its members. When asked about their major objectives respondents overwhelmingly expressed concern to keep existing services intact, and if possible respond to internal demands for expansion; only thirdly was the need to move towards national priorities mentioned. Respondents were asked about how they evaluated organisational performances and, consistent with the above, rarely indicated that they thought upon such lines. Instead, action was concerned with specific problems or complaints, with the phrase 'management by exception' being used by some respondents: this seems close to the notion of managers' reacting to the stimulus of perceived problems which Simon considered to be dominant.[71] Team members did, however, report frequently visiting the institutions under their control, and holding frequent meeting with subordinates: many reports were sent to team meetings (often causing congested agendas) but the format of these was not predetermined with performance evaluation in mind. Thus, whilst these activities must create the illusion of services being under constant scrutiny, the process is often arbitrary and unsystematic without any relationship to prior objectives. Team members reported few attempts to use the

*The present Chapter summarises some of the material already presented in Chapters 2, 3 and 4 but also introduces some new material derived from the study.

team as a forum for raising questions about each others' services: individual responsibility was strongly felt in such matters.

The same general approach to management was also reflected in respondents' planning documents: these contained few references to objectives, but rather concentrated on changes in particular services, treating these as ends in themselves, a classic manifestation of incrementation at work.[53] Similar tendencies emerged in discussions with respondents. References to 'cinderella' services in planning documents seemed often to be in the nature of a genuflection. A few teams cited the amelioration of a health problem as an objective – most often the reduction of the perinatal mortality rate. The most frequent approach to such problems was the establishment of the multidisciplinary task force or planning team. Except in two cases* the conclusions of such groups were that additional facilities were needed to solve the problem: there was no discussion of environmental or behavioural factors associated with high perinatal mortality rates, or of possibly unsatisfactory practices by health workers.

A similar general picture emerged with respect to the methods of resource allocation used by the teams. In those areas where development funds were available, the process followed that described by Hunter[45], with attention concentrated entirely on allocation of the increment. Where finance for the area was at a standstill or contracting, the usual process was a round of across-the-board percentage cuts (incrementalism in reverse) followed, if further economies were necessary, by the closure of a small institution. It is worth noting that such closures were often opposed by community interests but carried the support of the medical profession locally. The treasurer on the team was reported to be particularly influential in situations of contracting finance and some treasurers had been able to devise other methods of meeting deficits such as transfers from capital or joint financing monies. Only occasionally was there a reallocation of existing resources in accordance with some predetermined priority.

Lastly, the teams' use of information also reflected a lack of concern with objectives. There was little interest in the development of information systems, and existing routine information (concerning waiting lists for instance) was employed mainly in pursuit of additional

*See next section of this Chapter.

facilities. A few areas had produced rather more sophisticated data, but these were not always used: such information often appeared, almost as a ritual, in the introductory or background sections of reports without any attempt to relate subsequent arguments or conclusions to it.

In summary then, team members tend to accept health services as symbolically good, making little attempt to manage with formal NHS objectives in view. AMT members saw their roles as highly constrained by the influence of hospital consultants in allocating resources and in resisting change. A majority of respondents seem to fit Stewart and her co-authors' 'reactive' category of chief officer.[72] In Haywood's terms, they were 'directors of process'[43], a facilitating and arbitrating role; they were concerned firstly with making possible what service providers asked for, and secondly with smoothing out conflicts and problems of coordination. It is of course possible to argue that all this is as it should be. Reference has already been made to the ambiguity concerning the role of management set out in such documents as the Grey Book[24] and 'Patients First'[26]: on the one hand managers are responsible for efficiency and for the best distribution of resources whilst on the other hand clinicians are responsible for providing the service, management being expected to facilitate this. On the premises that the whole shape of the NHS is the sum of its constituent parts and that, as Haywood and Alaszewski[44] have shown, individual clinicians control most of the parts, then it would be logical to expect the clinicians, rather than the managers, to be accountable for progress towards NHS objectives.

To an extent, therefore, too much may be expected of managers in the present circumstances, though, as will be seen below, some found it possible to extend their role beyond the above summary. In the light of the empirical work on NHS management referred to in Chapter 1[44,16,72], it is a conclusion of this study that top managers in the NHS possess a highly realistic view of their role. They do not in general think in terms of or pursue objectives of improved health, identifying and meeting health needs, or efficiency and effectiveness. They are in addition well aware that they are not powerful enough to do so in any wholesale way, and therefore confine their role to the management of process.

The exceptions

Yet a few teams and individuals, whilst subject to all the general constraints discussed above, were able to widen their process role to include consideration of at least some aspects of objectives. This wider role is exemplified below: it proved impossible in conducting the present study to devise any detailed scoring system on the items discussed, but it is clear that the items are distributed *cumulatively*. That is, a few individuals pursued the majority of the actions described; in addition, these few individuals were concentrated into a few AMTs. This section therefore describes the exceptions to the general pattern of teams and individual respondents.

Examples of the kinds of management practices pursued by these exceptional respondents included

the use of Hospital Inpatient Enquiry and other relevant data in attempts to improve patient throughput; this included AMT review of discrepancies in lengths of stay of patients of different consultants, of bed occupancy rates on different days of the week and the *re*distribution of facilities to meet a new consultant surgeon appointment;

the conduct of studies into quality of care and health outcomes, followed by the implementation of recommendations (other than those simply calling for additional facilities) for improving the situation; the monitoring of complaint levels and patterns by the AMT, in association with patient satisfaction surveys;

the development of interdisciplinary forums (including GPs) whose task is to focus on alternative methods of improving access, efficiency and outcome of services;

the undertaking of comparative studies with other AHAs, in such areas as nurse staffing;

the introduction of patient dependency as a criterion for allocating nurse staffing;

the development of associations with neighbouring AHAs both to evaluate comparative services and to investigate the possibility of obtaining improvements by the sharing of services;

the identification (by the AMO) of cardiovascular disease as the main health problem of the area followed by aggressive anti-smoking campaigns (utilising doctors, schools and local industry) to combat this: in another area, respiratory disease was identified (again by the AMO) as a special health problem, leading to attempts to work with industry and the local authority to reduce environmental hazards.

In addition to the above examples of team concern with NHS objectives, there were a number of examples of areas where there was similar concern by medical staff. In most cases, these were the same areas where the AMT was exceptional, suggesting some connection between the two phenomena. The data gathered for the present study do not allow conclusions to be drawn about the direction of possible causal connections, but this is clearly an area for further and more detailed research. Examples of management practices carried out by medical staff, in some cases with AMT agreement, were

weekly medical conferences at which deaths, complications and rare cases were discussed with a view to improving the future management of such cases;

the establishment of 'therapeutics committees' to promote the standardisation of pharmaceuticals and other medical supplies, so as to reduce cost and stockholdings;

an especially active 'three wise men' system (see HM Circular (60)45[30]) oriented towards the resolution rather than evasion of problems of clinicians' unsatisfactory care or behaviour;

postgraduate medical tutors especially active in seeking to promulgate relevant research findings and to promote discussion of them;

a hospital medical committee ('Cogwheel') system which sought to consider issues of population needs, access, quality and efficiency rather than simply reflecting members' views: this shows signs of developing into a system of medical audit.

There are some obvious limitations in the findings presented above, so that they need to be treated as the basis for further investigation rather than as conclusive in themselves. Firstly, most (though not all) of the examples are as given in interviews with respondent AMT members

and there is always a possibility that some might wish to present an optimistic picture of their own areas. Secondly, the existence of procedures and structures for enhancing the pursuit of NHS objectives does not guarantee their active employment to that end: such arrangements only help to make things possible. Thirdly, the present study was able to gather little information about the effectiveness or success rate of the various management practices exemplified above: certainly there were some failures, including the environmental health campaign against respiratory hazards, which ran foul of concerns that jobs might be lost in local industry if stricter controls were enforced.

A few points do however emerge as clear. Firstly, the management pursuit of NHS objectives does not vary systematically with differences between health authorities in regard to RAWP position, level of financing or pressures for economy. This represents an oblique confirmation of the recent findings of one of the authors and his colleagues[68] that perceptions of the quality of care provided by American psychiatric hospitals were independent of their relative levels of cost. Secondly, it is reasonable to conclude that the kinds of management practice described above render the attainment of improvements in health care more likely: Schulz, Greenley and Peterson found that the more effective managements in the USA did employ such practices. Thirdly, although these exceptional AMT members fully recognised their general lack of influence, they were prepared to look more carefully for particular areas where they could carry more weight, and actively to pursue objectives related to health and efficiency. These findings therefore confirm the findings of Stewart and her co-authors[72] (in respect of administrators) that top managers, no matter how constrained their roles, did retain an area of choice about how to do the job. As has already been noted above, this managerial activism seems to be distributed cumulatively, suggesting either that activists are attracted to areas where there are known activists in post, or that some managers can be stimulated by an activist environment into choosing an activist role for themselves, or both.

Thus it is clear from these exceptional situations that there is no necessary reason why NHS objectives cannot be pursued by top managers: relative lack of influence and the difficulty in operationalising such objectives are not sufficient explanations of inaction. The present study is unable to fully explain the distinguishing characteris-

tics of the exceptions. Certainly one such characteristic was the personal commitment of the exceptional individuals to improve health as well as health care. It is also fairly clear that, irrespective of their reported relative influence*, the roles of the medical members of teams were potentially crucial. Those teams who reported influential AMOs were among the exceptions discussed above, and it is noteworthy also that these were AMOs who appeared to be respected within the medical profession. In addition, it was clear that some clinical representatives on AMTs, in spite of the collegiate organisation of their profession and the individual accountability in ethics and law of doctors to their patients were prepared to take their managerial role seriously by agitating on subjects such as access, quality and efficiency.[24] There were other factors which tended to be commoner amongst the exceptional teams than among respondent teams generally: these were a general atmosphere of progressiveness, high levels of influence by younger consultants, the ability to attract committed recruits at all levels of management, and a concern to produce and use information so as to make the consequences of the operation fully visible.[69,4]

Conditions for change

It is immediately tempting to seek an explanation of these exceptional teams and individuals in terms of personality. Such an explanation may or may not be valid, and it is not the purpose of the present paper to reach any conclusion upon this matter. The immediate concern is rather to consider how managerial activism in pursuit of NHS objectives can be encouraged more widely, and the knowledge that such behaviour was commonest amongst certain personality types (if indeed this were the case) would not provide an immediate recipe for change. Thus the important question is why it is only the exceptional individuals† who are active in pursuit of the formal objectives of the National Health Service.

There are a number of factors which may help to account, *a priori*, for the apparent disinclination of the average NHS top manager to

*See Chapter 3.

†It is worth noting that in terms of individual achievement, the most successful manager might be the one who produces *some* improvement in an unpromising environment.

pursue formal organisational objectives. Firstly, it is clear that AMTs lack influence in relation to hospital consultants, and it would not be surprising if this led to the conclusion that not much could be done to change things, and hence to inaction. Secondly, it is well known (see for instance Pfeffer's *Power in Organizations*[62]) that organisational patterns, such as that of the NHS, which confine managers to one function or profession throughout their careers, tend to produce a lack of consensus about organisational objectives and the best ways to pursue them. Thirdly, it is also necessary to consider the kind of incentives which exist to confine managers to such a role. Insecurity of tenure is certainly one; as a result of NHS reorganisation some top managers have had to undergo selection procedures for what is virtually the same post up to three times in the past eight or nine years.* This cannot encourage innovative behaviour against the tide of vested interests, and there have indeed been reported attempts to prevent the re-appointment in 1982 of managers whom such interests have considered to be too abrasive. Further, managerial status is closely connected with maximising the size of the managed operation, and the NHS is a case in point. Status and grading tend to vary with the size of the *institution* managed, thus reinforcing the tendency towards institutional solutions to perceived health problems. Moreover, managerial status reflects the status of the clinical speciality with which it is associated; acute and teaching hospitals carry status and high gradings for managers as well as doctors. Also, the professional standing of many health service occupations is a disincentive to the 'lay' manager to question their assertions.

There would seem, therefore, to be two basic prerequisites for a substantial shift in managerial behaviour towards the active pursuit of NHS objectives of improved health, and comprehensiveness, effectiveness, efficiency and acceptability of health services. These requirements are the enhancement of top management influence, together with the motivation of managers to use their existing plus any additional influence towards the pursuit of the above objectives.

It is towards the prospect for such change that Chapter 6 is directed.

* A number of the subjects of the present study did not have to compete for jobs in 1982 – they were 'slotted in'. At the time of the study they did not know that this would be the case.

6 Future prospects

During the last three years there has been substantial official concern with the role and accountability of NHS Managers, culminating in 1982 in attempts to strengthen these by a further restructuring of management and planning arrangements, and the introduction of various experimental monitoring and control arrangements external to district health authorities. If it is assumed that the somewhat polemical language of *Patients First*[26] (see for instance p. 5) is intended to convey that it is now intended that objectives of the kind discussed above should be vigorously pursued by the NHS, then it follows from the arguments employed in the present paper that these various innovations must meet the prerequisites of enhancing both management influence and motivation.

This final chapter begins with a brief discussion of these two requirements. It then examines the revised 1982 NHS management arrangements and the various external monitoring proposals from a perspective of whether they seem likely to lead to changes in top management influence and motivation.* Finally, there is a discussion of other devices which, if adopted, might add to the probability of such an outcome.

Sources of use of influence

There have been a large number of typologies of 'influence terms'[2] such as power, authority, coercion and so on, employed in the literature. Similarly, there have been different treatments of the bases or sources of influence, for the notion of power remains a contentious, contested concept.[54] For the present purpose, however, a fairly straightforward approach is sufficient: hence, no distinction is made between different influence terms, 'power' and 'influence' being used generically to signify the ability to bring about desired outcomes.[61] The concept of influence is of course a relative one: an individual or group

*At the time of writing there is of course no experience of these innovations and in some cases relatively little information about what is intended.

is more or less influential than another individual or group. Moreover, relative influence may vary over time and across different issues.

Pfeffer[61] has summarised a wide range of empirical findings on sources of power within organisations, listing the following.

> Resource power originates in the ability of some sections of the organisation to provide resources, especially money, for other sections.
>
> Power may stem from the ability of a section of the organisation to cope with uncertainty, especially where the uncertainty relates to a central part of the organisation's activities, and where there is no substitute section which could cope.
>
> Power may also accrue from the ability to control certain aspects of the decision making process, in particular the content of the agenda, the premises upon which decisions are based, identification of constraints upon decisions, and the control of information concerning alternative choices for decision.
>
> Consensus and cohesion within an organisational grouping may enhance the group's influence.
>
> Where a particular organisational group is perceived to be important by other groups, its influence is likely to be increased.
>
> A group which possesses political or bargaining skills will be able to maximise its influence within an organisation.

Based on these findings, it is possible to advance a judgement as to whether, *a priori*, revisions to the NHS's management arrangements and the introduction of external monitoring devices is likely to enhance the influence of top managers by changing any of the above factors. At the same time, as has been argued, it is necessary to consider the question of whether the various new arrangements will affect the motivation or willingness of managers to make use of their existing (plus any additional) influence in order to pursue NHS objectives. It is clear that power need not necessarily be employed, and that whether it is employed is likely to be affected by such factors as the perceptions of its legitimacy by those over whom it is exercised and others, whether or not those who do possess influence are able

effectively to measure compliance with their wishes[61], and upon the general structure of incentives within the organisation (see Chapter 5). Thus it is necessary to add such factors as these to the possible sources of influence when considering the likely effects of the new NHS management, planning and monitoring arrangements.

It is this analysis with which the next sections of the present chapter are concerned.

The 1982 restructuring of management arrangements

The relevant key features of restructuring are the removal of a management tier and the strengthening of management at sub-district (unit) level.

Whilst the area tier of the 1974 reorganisation was the subject of widespread criticism on grounds that it obscured responsibility, the present findings give no support to the notion that its removal will result in management behaviour more oriented towards NHS objectives. It will be recalled that all the areas of study were single-district areas and, although no attempt was made at a comparison with multi-district areas, there was no marked tendency for the former to be proactive. Nor is it necessarily the case that the removal of the area tier enhances the influence of the district tier; as has been noted, influence is a relationship rather than a finite phenomenon so that removal of area need not leave district more influential over consultants*, though it might enhance the DMT's influence over the health authority itself since (assuming the continuing rarity of failure of consensus within teams) a united officer front is more likely. So far as overall resource allocation is concerned the disappearance of area means an increase in influence at regional level since, as Barnard and his co-authors have observed[3], allocation of resources at districts will now take place at the higher level. In addition, RHAs will remain the employers of most consultants.

It remains to be seen whether the appointment to the new authorities of large numbers of members who lack previous NHS experience will make a difference: it is possible that 'new blood' might help to

*It is noticeable that *Patients First*[26] perpetuates the ambiguity of the manager as the servant of the professional.

reshape the premises upon which decisions are made, perhaps with more emphasis upon formal NHS objectives, and this might well encourage top managers to employ their influence in this direction. Alternatively, managers who wished to avoid any such change are in a strong position to socialise new members into existing modes of operation, and there is some indication that such a process is occurring in some parts of the NHS through officer domination of member training. It may well be the case that the abolition of the area tier will make pursuit of comprehensiveness in health services more problematic in those parts of the country where there are several health districts within one local authority and/or FPC area, thereby reducing the motivation of managers to seek this particular objective.*

The notion of strong unit management in the 1982 NHS is based on the assumption that too many decisions were previously made at higher organisation levels and needed to be delegated. But, as has been seen, the influence of chief officers is already extremely limited, and it is difficult therefore to see that delegation of some of this will create proactive managers. Indeed, it may well be the case that even more reactive management will result, since unit managers will be less insulated from direct consultant pressure than were managers at higher levels. The present study has confirmed the difficulties faced by elected clinicians at team level, and there is no reason to assume that an elected clinician at 'unit' level will, in general, be any more influential. Management motivation may well also be affected by the design of 'units' which the new authorities adopt: these are likely to form an important focus of loyalty[10], and the extent that they are designed around institutions will tend to ossify patterns of service and resource allocation.

The revised planning arrangements

The revised NHS planning system introduced during 1982, has associated with it some devices apparently intended to orient authorities and managers more towards health service objectives. The first of these is the introduction of annual reviews[23] at which ministers will examine the progress of RHAs towards government priority services: RHAs

*Growth in the private health sector may reinforce this distinction by making integration even more difficult to achieve.

will in turn examine the progress of DHAs. It does seem likely that this arrangement will assist managers to reallocate resources in line with those priorities since it will effectively modify the premises upon which decisions are made. It should be noted, however, that since the priorities are themselves expressed in terms of groups and services, rather than outcomes[21], it is a moot point as to whether there will be any effect in terms of the objectives as set out in Chapter 1.

The second device which has been discussed is the development of 'performance indicators' initially within one region (see *Guardian*, 18 February 1982). Little is at present known about the nature of these, except that they are comparisons of hospital costs in both clinical and manpower fields. Once again, it is not clear how these will relate to NHS objectives unless some concept of output is introduced so as to allow a consideration of efficiency in the strict sense of outputs compared with inputs. Indeed such an exercise could be a disincentive to innovation and efficiency unless costs are used sensitively in relation to the activities of institutions: for instance, high patient turnover would tend to produce higher costs. It is straightforward enough to introduce such sensitivity into the calculations, but the drawback is that the comparisons become less influential as more 'loopholes' are provided by which to rationalise differences in costs.

Thirdly, capital plans are to be accompanied by a systematic statement of options for achieving the same objectives[20]; clearly, this entails having explicit objectives, and indeed it is envisaged by the DHSS that these will normally be available from strategic plans. Hence, there is a *prima facie* case that the result will be more objective-oriented behaviour since unless options are generated, resources for capital development will not be forthcoming. Again, however, much depends upon the form in which objectives are expressed and it seems likely that these will be in terms of service deficiencies.[20]

External monitoring of health authorities

Patients First referred to suggestions that 'responsibility for monitoring the quality and efficiency of the ways in which health services are managed . . . might be discharged . . . by an advisory group of experienced NHS officers . . .'[26] Such suggestions had been discussed

within the Service for some two years prior to this, stimulated in part by the Pethybridge Memorandum (1978), and the work of the Public Accounts Committee. It was subsequently decided that such advisory groups should be established in four NHS regions on an experimental basis. Hence there are groups in North Western Region, Wessex Region, and a joint group between Oxford and South Western Regions.*

At the time of writing, the advisory groups (usually referred to as 'management advisory services' – MAS) are only just beginning work, and it is therefore difficult to say very much about their operation. In addition, the three experiments differ quite markedly in their scale, composition of personnel, and choice of subject matter. All that is possible here, therefore, is to make a tentative judgement on the basis of documentation issued in connection with the MASs.

It does seem reasonably clear from this that the MASs could both enhance the influence of top managers in pursuing formal NHS objectives and increase their motivation to do so. The very existence of the MASs places the issue of performance review on the agenda in a way which has not occurred previously. Moreover, such questioning of performance is now likely to be seen as legitimate and is therefore more likely to occur. In addition, the continuing existence of MASs would allow assessment of the extent to which changes had actually been made in response to earlier reports: this ability to measure compliance should be an important factor in encouraging top managers to use their influence. Finally, the fact that at least two of the MASs will render reports to the Secretary of State may well ensure that their content is taken seriously. Much will, of course, depend not only upon the services and expenditure patterns which MASs choose to investigate, but upon the objectives and criteria which are set. The precise nature of these remains to be seen, but it is noteworthy that the documentation relating to two of the experiments is generally unclear on this, using the terms 'efficiency', 'quality' and 'adequacy' fairly indiscriminately. It may therefore be that the MASs will enhance pursuit of some, but not all, of the objectives set out in Chapter 1: this point is discussed further in the next section.

*All three trials are to be evaluated over a two-year period by a team of researchers from Brunel University in conjunction with Professor M Kogan and Professor R E Klein. The exercise is being coordinated by the King's Fund on behalf of the DHSS.

In addition to the MASs, three other forms of external monitoring are to be introduced to the Service on a trial basis. One is the use (following representations to the Secretary of State by the Institute of Chartered Accountants) of private firms of accountants to audit the accounts of district health authorities. Secondly, the objectives of 'Rayner Scrutinies' of the kind employed in the Civil Service are to be agreed between the Secretary of State and RHA chairmen, and the scrutinies carried out by NHS personnel detached from their normal work. Thirdly, an enquiry team has been established to identify land and property surplus to NHS requirements, and to dispose of it in order to provide development funds. As with the MASs, there is little doubt that these innovations will place the issue of performance review upon the top management agenda, though again much will depend on the choice of criteria and subject matter.

With all these devices there exists a danger that enquiry will be restricted to politically 'safe' areas such as efficiency in support services and administration, and in this context it is not reassuring to note the contrast between the suggestions for good practice contained in *The Way Forward* and *Care in Action*.[27,21] Whereas the former includes suggestions for the better use of beds and other clinical facilities, the latter concentrates almost wholly upon hospital support services. Nor are the initial choices of subject matter for 'Rayner Scrutinies' very reassuring in this respect.

Summary: top management influence and NHS objectives after 1982

The argument of this working paper may now be summarised as follows:

There is general agreement that the formal objectives of the NHS are to provide services which are *effective* in improving health, *comprehensive*, *accessible* to all, *responsive* to the perceptions of users, and delivered in as *efficient* a manner as possible.

These objectives are worth pursuing both because of their intrinsic value and because formal organisational objectives can be shown to have an effect on events even though they do not completely determine them.

Top managers are a group to which much of the responsibility for such objectives should fall.

In practice, few NHS top managers are proactive in pursuit of these objectives; they lack influence in relation to consultant staff (who are largely responsible for the pattern of health care services) and are in many cases reluctant to use the influence which they do possess.

If these objectives are to be pursued more vigorously, it is desirable that NHS top managers' influence is increased, and that there is greater inclination to use it for these ends.

The introduction to the NHS of certain changes in the planning process, and of various methods of external monitoring are felt to be likely to contribute to such changes in influence and motivation, though this is less likely to result from changes in NHS management arrangements.

It seems that these changes manifest a major shift in attitude on the subject of NHS performance. However, it should be noted that the various devices of planning and external monitoring do not seem likely to have equal weight on all the five objectives of the NHS listed above. In particular, they seem to stress *efficiency* and *access*, whilst giving less weight to the others. In one sense, something of the sort is to be expected since multiple objectives are often potentially contradictory: it is easy to see for instance that the kind of service demanded by the public need not be either efficient or effective. But unless one simply chooses to regard health care as nothing more than a commodity, it is clear that, once patterns of ill-health have been identified, *effectiveness* has logical priority among the stated objectives. It is therefore a matter of serious concern that effectiveness has not been a more prominent consideration in the changes which have been made in the 1982 NHS. This is not to underestimate the difficulties, for it is still the case that relatively little is known about the outcomes of many forms of health care, and the expense and methodology of finding out are formidable.

However, if public support and funding for health services rely ultimately on the belief that they improve health, there is no excuse for not making a start. It is to be hoped that the new climate of enquiry into

performance will persist and perhaps be extended into this field of effectiveness.

Other possible changes

An analysis of this kind would be incomplete without some mention of other possible changes which might assist in attaining the desired ends. This final section attempts such a discussion, though it should clearly be understood that none of the suggestions made are intended to be regarded as panaceas. Change, if it occurs, seems likely to result from the cumulative influence of a number of measures and multiplication of the measures employed is aimed at making more probable the active pursuit of formal NHS objectives.

It seems clear that there exist a number of possibilities for enhancing the influence of top managers beyond the likely effects of the MASs and other monitoring agencies. Most obvious amongst these is the power which accrues from control of 'slack resources'[61], that is where new resources distributed conditionally within an organisation, without any guarantee that there will be a recurrence of such a distribution in the following year. At present, development funds in the NHS are often committed on a recurring basis thereby abandoning the leverage which managers can obtain by granting such funds only on a discretionary basis year by year. Thus it is suggested that such development funds as continue to be available in the Service might be disbursed more as bridging finance or 'seed' money, in the hope of stimulating innovation and the reallocation of existing funds. An alternative arrangement which would have a similar effect in terms of the enhancement of managerial power would be the disbursement of development funds in such a way that recurrence of the distribution was dependent upon performance. It seems likely that the introduction of such policies would require DHA approval, and might even be instigated at DHA initiative.

A second strategy which a DHA might pursue is generally to adopt a more questioning attitude to proposals and plans put forward by officers. Such an attitude would not necessarily be embarrassing or uncomfortable for top managers, since it would allow them in turn to adopt a similar approach towards clinicians and other members of the organisation. Thus management influence would be enhanced by the

legitimacy conferred by the active and critical involvement of DHA members.* Such an approach would need to be linked with a much more conscious consideration of the probable levels of effectiveness of any new or expanded services which an authority was considering. There is so much uncertainty about the outcomes of health care activity that there is little inclination to reduce existing services in order to fund speculative developments. Clearly, the greater knowledge needed to offset this is outside the immediate grasp of NHS members and managers (though it is suggested that greater research and dissemination of findings is called for), but it might be a much more practical proposition to begin by ensuring at least that changes in services are considered in terms of effectiveness.

It is arguable that DHAs might more easily adopt the kind of posture outlined above if outside assistance were available, and it is to be hoped that the innovations in performance review which have been described will help. However, it is appropriate in this context to draw attention to one suggested mechanism for improving health services which might have borne on many of the points raised in this section had it been adopted. The Royal Institute of Public Administration's suggestion for the establishment of regional development agencies for health services[64] included the possibility of the agencies being able to influence the allocation of development funds for 'pump priming' purposes, a central concern with the effectiveness of services and with innovation, the ability to commission research, and a *modus operandi* emphasising collaborative work with practising professionals. It is unfortunate that no NHS authorities have as yet been prepared to support this initiative.

The kinds of changes which are already taking place in the NHS together with the adoption of the approach outlined above are likely to make some changes in the attitudes and motivation of top managers. At present, one factor which reinforces the status quo is the structure of incentives in the Service: top managers apparently gain status and reputation by their ability to suppress or evade conflict rather than their ability to improve the performance of their services. Many managers display very considerable skills in this respect, and it seems likely that

*Although it is the CHC which is formally regarded as representing the health care consumer, there seems to be a widespread *de facto* attribution of this role to the DHA.

the same skills could be employed in a more proactive approach. This suggests that an approach to top and senior management education which paid attention both to the realities and possibilities discussed in this paper would pay dividends in terms of more proactive behaviour. It would firstly be necessary for managers openly to recognise the political nature of their roles[41] rather than continuing to articulate the myths of the management textbooks discussed in Chapter 1. Secondly, as Stewart and her co-authors have observed[72], it is necessary for them to recognise that choices of role do exist. Thirdly, those who choose* the proactive role in pursuit of NHS objectives will need to learn how to exercise it. This suggests that top management education needs to include conceptual and contextual knowledge[47], together with skills of policy analysis and the political skills concerned with maximising and using influence.[62] Whilst 'action learning' projects may be the occasion for putting these various components together into practice, their nature is such that the need for formal management education courses will continue. Although all top managers have a part to play, it should be that the present study has shown that the role of DMO may well be crucial in the ability of a management team actively to pursue NHS objectives. It is probably the case that more attention needs to be devoted to recruiting and educating community physicians who will be personally influential within the medical profession.

In conclusion, it needs to be borne in mind that none of the mechanisms for obtaining more active pursuit of NHS objectives which have been discussed can guarantee the desired change in behaviour. All that can be done is to increase the probability, and there remains much which can be done towards this end. The primary purpose of this paper has been to report an empirical study, and to present it in the context of an analysis of the top management role as it might relate to NHS performance. The strategy outlined above is to some extent a secondary purpose, but it is to be hoped that the contribution of these ideas to the current debate about performance will stimulate further thought.

*As has already been noted, this choice will be affected by the structure of incentives bearing upon the manager, including security of tenure, the operation of external monitoring arrangements and the criteria by which performance is judged.

Appendix: Outline interview schedule

Questions asked of area management team members

Note: Whilst attempts were made to structure interviews in order that responses would be comparable, time and circumstances did not permit asking all questions of everyone and asking them in the exact same way. However, in so far as one author conducted all interviews, care was exercised to ensure a common understanding of information sought, and to try to ask the same questions of at least two members of the team, or more if there seemed to be any inconsistencies. Questions 3, 4 and 9 were asked of all AMT members interviewed.

1 Please name one or two primary strengths, and one or two primary weaknesses of the 1974 management team/consensus management as practised in your organisation.

2 Given the circumstances of today, do you favour the team/consensus management concept initiated in 1974, or do you think it would have been better under the previous system, or would you think some other arrangement would be better?

3 What group (for example, DHSS, region, authority, AMT, community health council (CHC), consultants or GPs) has the greatest influence over patterns of delivery of health services (for example, whether hospital, primary care, mental, geriatrics, are emphasised most) in your area? Please rank the relative influence of others.

4 Although the AMT is considered to be a team of equals, even after considering that each has expertise over specific subjects, some team members are found to be more equal than others. On decisions related to allocation of resources please rank the relative influence of each team member.

5 Please describe how allocation decisions seem to be made, for example, does the team seem to require members to present objective information and data, do the more articulate members seem to carry the day? Does your area have development funds to allocate or are you

in a position where you have to actually cut spending from the previous year? Do you reallocate funds from one unit to another? What methods have you used to determine allocations, for example – treat each equally, negotiate and compromise, relate to planning priorities (if so, describe how those priorities were established)? Please give case examples for each of the above.

6 Do you as a team consider allocation of resources within nursing, administrative, financial and medical services as well as between those services? Please give examples. Do you let these services keep savings? Do you as a team provide incentives for containing costs within services? If so, please explain with examples.

7 What are the greatest needs for improvement in your area? For instance, if you had all the authority and resources, what would you want to do? If not expressed in the previous question, what do you see as the greatest need for improving health of the people in your area? What steps are being taken to meet these needs?

8 How do you evaluate the effectiveness of health services in your area from a team and your own service management standpoint?

9 How do you think you compare in efficiency and quality of health services in your area in relation to other comparable areas? Please give me examples of what you are doing to manage, that is improve, the efficiency and quality of health services including nursing and medical care in this area.

10 What do you see as your special role on this team? What is it that you would like to accomplish in the next couple of years or so? In what priorities do you see your role in representing your own responsibilities (for example, for nursing, consultants or administrative services) versus corporate responsibilities for team accomplishments?

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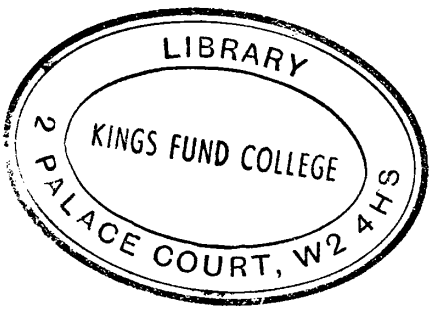

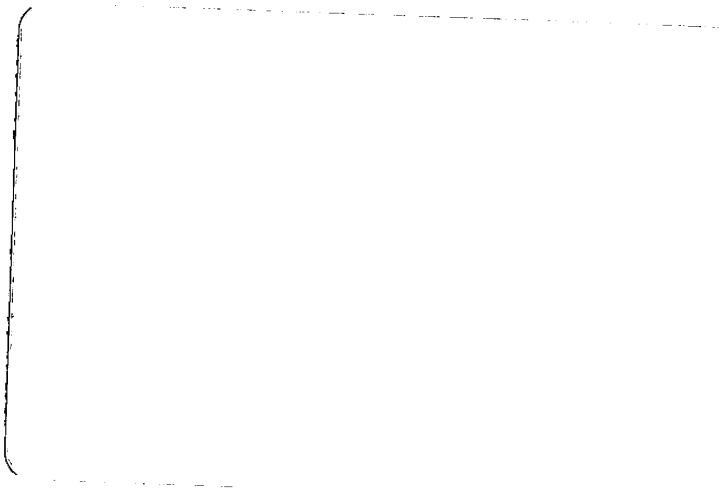

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