The District Administrator in the National Health Service

Rosemary Stewart
Peter Smith
Jenny Blake
Pauline Wingate

King Edward's Hospital Fund for London

QUESTIONNAIRE FOR DISTRICT ADMINISTRATORS

1. Distribution of Time

1. Place of Work

On average how much of your time is spent?
In your office and adjacent offices
Travelling
Tours of hospitals/units
In other offices/conference rooms
Others, please specify

2. How would you describe the pattern of your days, apart from meetings?
   Often Hectic - switching from one problem to person
   6 or more times an hour?
   4-5 times an hour?
   Pretty fragmented - switching from one person/problem
   2-4 times an hour?
   Can often work uninterrupted for an hour or more at a time?
3. What short-term deadlines do you have to meet?

2. Subordinates

1. How many do you have reporting to you?
2. What are their job titles?
3. Which subordinates do you spend most time with?
4. How do you keep in touch with your subordinates' work?
   monitoring?
   handling mail?
5. How do your subordinates know what matters they should discuss with you?
6. Are there any matters that you do not want subordinates to bring to you?
7. What subjects would you handle yourself rather than leave to your subordinates?
8. In summary, how do you see your role with your subordinates?

3. The subjects/issues that you were involved in during the last month

1. What aspects of nursing were you involved in?
2. What medical aspects were you involved in?
3. What aspects of finance were you involved in?
4. What aspects of personnel were you involved in?
5. What aspects of works and buildings were you involved in?
6. What aspects of community health were you involved in?
7. What aspects of patient care were you involved in, including C.H.C?
8. What aspects of P.R. were you involved in?
9. How and why did you get involved in these issues? (probe who initiates)
10. Is the picture of the subjects that you were involved in during the last month typical? If not, what was unusual?

4. D.M.T.

1. Is there a Chairman of the D.M.T.?
2. If yes, who is the Chairman? How Long? Before Whom?

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1. Is there a Chairman of the D.M.T.?
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6. What do you see as being the main choices open to you to interprete the role differently from that of another D.A.?
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   (probe whether he wants to distinguish between his district and in general)
8. What are the main constraints on pursuing the ideal?
9. What aspects of the job do you find satisfying? Frustrating?

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King Edward's Hospital Fund for London

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Printed and bound in England by The Pitman Press, Bath

ISBN 0 900889 81 0

Produced and distributed for the King's Fund by
Pitman Medical Ltd

King's Fund Publishing Office
126 Albert Street, London NW1 7NF

Acknowledgments

The four of us are obliged to the King's Fund for inviting us to undertake this interesting and, we believe, worthwhile study. We acknowledge with thanks all the help we received from Pat Torrie and his colleagues at the King's Fund in enlisting cooperation for the study. We are particularly grateful for the high level of co-operation, interest and helpfulness from all the administrators who took part, but most especially to those who agreed to be observed. We hope that what is said in the book will be seen as a contribution to identifying training needs, rather than as a criticism of individuals.

We are indebted to Tony Earle, district personnel officer of Carmarthen, for Appendix C, the analysis of meetings attended by the administrators. We have made considerable use of Meredith Belbin's specifications of team roles and are grateful to him for allowing us to do so. We found John Kotter's and Paul Lawrence's book, *Mayors in Action,* particularly germane to our research.

Preface

This report arose from an invitation from Geoffrey Phalp and Pat Torrie of the King's Fund to study what the job of the district administrator is really like. They suggested that such a study could help to identify more clearly the training requirements for it. I was attracted by the invitation, both because of a long-standing interest in management problems of the National Health Service and because a current research study of mine provided the concepts for designing the study. However, I was especially busy at the time and said that I could undertake it only if I were able to find good research help. This I was most happily able to do. Jenny Blake and Peter Smith joined me on a part-time basis for a pilot study of three district administrators. The pilot study encouraged us to believe that a full-scale study could be useful. A research proposal was formulated and put to the Education Committee and by it to the Management Committee of the King's Fund.

Field work on the main project began at the end of January 1979. Peter Smith and Jenny Blake worked part-time on the research throughout, bringing with them their experience from the pilot study. We were joined by Pauline Wingate, who also worked part-time. All three carried out the interviews with a cross-section of district administrators and area administrators in single-district areas. The first two did all the observational studies. Pauline Wingate is primarily responsible for the analysis for Chapter 3, Peter Smith for the appendices, and, primarily, for the analysis for Chapters 2 and 4. All three researchers contributed to the final editing.

All three research workers lived in different counties, none of them in Oxfordshire. The two women worked from home. We met when we could for research discussions. Otherwise, coordination was by telephone. We were much helped in this by Frances Campling, the half-time secretary to the project and who also did some of the research analysis. I wrote this report in Brazil where my husband was on a lecture tour.

This report should naturally be of most interest to district administrators, and administrators in training, as well as to their teachers. It may also be of interest to all those who have to work with district administrators, especially other members of the district management team, and some of it, especially Chapter 5, could be useful to local government officers.

Many people ignore appendices, thinking that they contain dull material which is not for them. Readers unfamiliar with the structure and organisation of the National Health Service will find Appendix E indispensable. Many others may find Appendices A, B and C as interesting, and some perhaps more interesting, than the main body of the report. They provide detailed information on the work of different DAs. Those who do not want to know about the design of the study need only read the summary of Chapter 1, and the last section headed 'Framework and concepts for analysis', as it is necessary for understanding some of the later discussion.

We shall commonly use, for the sake of brevity, the term district administrator, and the abbreviation DA, rather than district administrator and area administrator in a single-district area, although our study also included the latter. When we need to refer specifically to the latter, we shall say 'AA in an SDA'. Many of the findings apply to both jobs. We shall describe any differences.

Rosemary Stewart

1980

Notes on authors

Rosemary Stewart PhD is a Fellow in Organisational Behaviour at the Oxford Centre for Management Studies. She was formerly director of the Acton Society Trust. She is the author of seven books on management, including the best seller, *The Reality of Management* (revised edition, London, Pan, 1979) and *Contrasts in Management* (London, McGraw-Hill, 1976), which won the 1976 John Player award.

Peter Smith, formerly head of Behavioural Studies at Ashridge Management College, is now doing research and tutoring at the Oxford Centre for Management Studies. He is the joint author of *Behavioural Science in Industry* (Richard Drake and Peter Smith: London, McGraw-Hill, 1973).

Jenny Blake worked as a behavioural scientist in Shell International, the central personnel department of Philips Industries and at the Tavistock Institute. She now lives in Wiltshire and does action research in management development and autonomous group working.

Pauline Wingate read history at Oxford and is now a freelance researcher, editor and writer. She has contributed to various management studies in industry and to a previous study in the NHS, and has co-edited *Newspaper History* (James Curran, George Boyce and Pauline Wingate: London, Constable, 1978).

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Aims and design of the study

Summary

The main aim was to provide information for use in developing or reappraising training programmes. It was also hoped that the information would contribute to discussions on policy.

A sample of 32 district administrators and nine area administrators in single-district areas was selected to cover a wide range of National Health Service districts in England. The main study was preceded by a pilot.

The methods were interviews with the whole sample, using open-ended questionnaires, and observations of six DAs and two AAs over three days.

The data were interpreted within two analytical frameworks: one developed by one of us (RS) which describes a job in terms of demand, constraints and choices; the other taken from a study by Kotter and Lawrence which uses the two concepts of 'domain' and 'agenda', the latter being a continuum from 'reactive' to 'proactive'.[6] The terms are defined in this chapter and are used throughout the report.

Aims

The main aim was to provide information that can assist in the development or reappraisal of training programmes, for those preparing for the post of district administrator (DA) or of area administrator in a single-district area (AA in an SDA), and for post-experience development.

We also hoped that greater knowledge about the job of the district administrator would contribute to any relevant policy discussions.

Methods

Pilot study

A pilot study of three DAs was made both to explore the likely value of a larger study and to help in its design. The pilot consisted of interviews with the DA, with members of the district management team (DMT), the DA's principal subordinates, the area administrator and some other major contacts. It also included a week's observation of each DA with detailed recording of activities, contacts and the subjects in which he was involved. At the end of the pilot, the three DAs met with the researchers to discuss the possible implications of the comparative analysis, and the design of the main study. The pilot showed a wide variation between the three DAs in the pattern of their working day, their activities, contacts and in their view of their role. These variations pointed to the desirability in the main study of analysing both the similarities and the differences in the DA's work and his perception of his role.*

Design of the main study

In the main study we had to balance the desirability of breadth and depth. We decided that we needed both: a broad study of a cross-section of DAs and AAs in SDAs and a more intensive study of a small number. The broad study consisted of lengthy interviews, using an open-ended questionnaire, with 32 DAs and nine AAs in SDAs in England. These interviews lasted from three to seven hours. A small testing of the interview questionnaire was made with three DAs and one AA in an SDA. There was also a

* For convenience, the masculine pronoun is used throughout to refer to DAs and AAs, though some are women.

separate questionnaire which the DAs completed about the nature of the district and about the committees they attended.*

We decided that we must use an open-ended questionnaire for the interviews, despite the burden of analysis that it imposed, because a more closed questionnaire would pre-judge much that we were trying to discover. With hindsight, as is common in research, we could have designed a better questionnaire.

In the main study, unlike the pilot, no interviews were held with people other than the DA, although his contacts were, of course, included in the observation. This decision, which may appear a surprising one, was made on the basis of the experience of the wider interviews in the pilot study which yielded little additional information about how the DA did the job. Had we been trying to assess his effectiveness, such interviews would have been essential, but we were only seeking to discover what he did and how he saw his role.

In the intensive stage of the study, we observed eight administrators, of whom six were DAs and two AAs in SDAs. They were selected to include both those who had been in the job since the reorganisation of the NHS in 1974, and those who were relatively new to the job. They were also chosen to represent, as far as we could judge from the interview, different ways of doing the job. What is meant by 'different ways' is explained in Chapter 5 (pages (74–108). The observation period was three days, selected to include a meeting of the DMT or area management team (AMT) in the middle, so that observation could include the meeting itself and some of the work before and after it. The period of three days was a compromise necessitated by the number of administrators to be observed and the duration of the observation.

* The research instruments have not been included in this book. They are available on loan from the King's Fund College, 2 Palace Court, London W2 4HS, or from the Oxford Centre for Management Studies, Kennington, Oxford OX1 5NY.

(inserted in front of book)

Three days is a short time for an observation—shorter than we would have liked, because it makes it difficult to compare differences in the distribution of time between those observed. This would still be true, though to a lesser extent, for a week's observation. Even so, it was long enough, we think, for the purpose for which it was intended.

The purpose of the observation was to check the information and the impressions of the DA's role given by the questionnaire. It was also intended to provide material for case studies that could be useful in training. The observation consisted of a detailed recording of the DA's or AA's activities and contacts, as well as more subjective comments by the two observers who were given a set of questions to consider at the end of the day. They also made fuller notes during the day of episodes that seemed worth recording more fully than was possible in the observation form.

The observations proved to be of value in confirming, rather than changing, the material from the interviews. They gave more depth of understanding on certain topics. They provided, too, illustrations of the different ways in which the administrators tackled their jobs—illustrations which, we hope, help to give life to our analysis of our findings of the DA's job. From the observations, we give (in Appendix A, pages 149–171) detailed examples of particular DAs' work. These show the kinds of problems they got involved in, and also give some insight into the nature of their involvement. However, they are case examples and should not be considered as illustrating all DAs' work.

It will be asked whether the presence of an observer inhibited or changed the administrator's normal behaviour. We cannot know for sure, but all those observed thought that it had not done so, and commented upon how unobtrusive the observer was. These comments are similar to those made by the managers who have been observed in Rosemary Stewart's other studies.[11, 12] It seems

that managers and administrators easily get caught up in their work and can soon forget the presence of an observer.

Sample of main study

We wished to study a representative cross-section of districts and single-district areas. One of the first research decisions was which of the many possible criteria of representativeness should be used. Peter Smith made a detailed analysis of the information in *The Hospitals and Health Services Yearbook 1978*[2], which is given in Appendix D (pages 195–200). This gave a range of differences between districts on the following three characteristics.

	small	*average*	*large*
number of hospitals	1	9	36
number of beds	300	1800	4400
percentage of acute/ long-stay beds	10%/90%	55%/45%	100%/0%

These are the extreme ends of the scale of each type of difference but only eight districts were found to be average as described by these three characteristics. To obtain a larger number of 'average' districts, the definition of 'average' was widened to

number of hospitals	7–15
number of beds	1300–2700
percentage of acute beds	30%–70%

Forty-eight districts were 'average' by this definition. We selected 23 districts of this average size, 12 districts that were larger or smaller and ten single-district areas.

We also tried to ensure that our selection of districts took into account variations in the following.

Urban concentrated—hospitals near each other.

Rural scattered—large area with hospitals widely dispersed.

Teaching and non-teaching hospitals—to ensure that our sample included districts with teaching hospitals.

Geography—we sought to get a good regional distribution.

Single-district areas, and multi-district areas with two to five districts.

This selection also included districts that were RAWP-gainers and RAWP-losers.* Even so, our criteria for selection did not cover all the characteristics that could make a difference to the job of the DA, but they did, we think, give us a reasonable distribution of different types of districts. However, neither our sample nor our methods enable us to distinguish clearly the effects of different types of district upon the job of the DA, although we are able to include comments about this in our case studies and to make allowance for differences in our description of the job. The separately completed questionnaire about the nature of the district helped to give us an understanding of some of the conditions that affected the work of our DAs.

Each administrator in the 35 districts and ten single-district areas was telephoned by a member of the King's Fund College and asked if he would be interested in cooperating. All those telephoned who expressed an interest in taking part in the main study received a letter from the research team. Four of these—three DAs and one

* RAWP—Resource Allocation Working Party, whose report in 1976 has led to a redistribution of NHS monies throughout the country.[3] The term, which is used as noun, adjective or verb, has passed into common usage in the NHS.

AA—were used for a small pilot test of the questionnaire. Only four DAs and one AA were unable (because of the local and national disturbances affecting the NHS at the time we did our research) or unwilling to take part in the main study and these withdrawals were replaced with another four DAs and one AA. The final sample comprised 32 DAs and nine AAs in SDAs. One reason why the study could be done in a comparatively short time, compared with that usual in social research, was the high level of cooperation and the work done by the King's Fund staff in obtaining this.

Framework and concepts for the analysis

The collection of information should have as simple a framework as possible, so that the data are not distorted or impoverished by too specific a framework. However, any method of collecting data must select, because the richness and diversity of what happens in even the most ordinary day's work is greater than can be captured, far less described, by any interviewer or observer.

We sought to find out what work the DAs did by the subjects in which they were involved, and the roles they said they played and which we observed. In our interviews we asked about their activities in the previous month and they also gave us a record of meetings attended (analysed in Appendix C, pages 181–194). We kept detailed records during our observations of subject matter and contacts, some of which are reproduced in Appendices A and B (pages 149–180). We distinguished between the DA's own function and work with subordinates, and his work with other functions, for instance, nursing, medical, finance, and works and buildings. We explored the work done for and with the DMT, the area team of officers (ATO) and area health authority (AHA), the community health council (CHC), and with the press and other external bodies. Over all, we looked at the extent to which the DA worked with other individuals and groups outside his own sub-

ordinates. We distinguished the form of the contact and the content of these relationships. Contact may, for example, be by formal, programmed meetings or be frequent, spontaneous and informal. The content may range from minor administrative matters to wider issues of concern to his district. In our observations, we also considered the pattern of work* (that is, the ways in which activities are distributed throughout the day) and the extent to which, and the way in which, the DA tried to manage relationships and exercise influence. The latter we illustrate primarily by means of the case studies in Chapter 5 (pages 74–108).

The study of any job, but especially a complex job, requires a conceptual framework. One must have some theory about the characteristics of jobs to make sense of what one is told and what one observes. Such a theory, or theories, may be explicit or implicit. An explicit theory is better because it can be used in the design of the study and can be explained to others, so that they have the opportunity to consider its relevance to what is described and its effect upon the description itself.

Our interpretation of the information collected was guided by two analytical frameworks. Our first was that developed by Rosemary Stewart in her earlier study† and was being used in another study at the time. This framework is to describe the nature of a managerial or administrative job—from now on the term 'managerial' will be used for both—or the work done by a particular job-holder, in terms of demands, constraints and choices. Readers need to be familiar with the definition of these terms as they will be used throughout this report.

Demands what any job-holder must do; cannot avoid doing without invoking penalties that will make it harder to do the job, or may lead to sanctions being taken against him or her.

* For a description of the different aspects of pattern of work see chapter 4 in Rosemary Stewart's *Contrasts in Management.*[11]

† *Ibid,* chapter 10.[11]

Constraints the factors that limit what the job-holder can do. These include legislation, policies and procedures, available resources, attitudes and time.

Choices all the opportunities for one job-holder to do the job differently from another, including what is done, how it is done, with whom, when and where.

In our study we sought to identify the demands, constraints and choices of the job of DA and that of AA in an SDA. The pilot study had suggested that the DA's job is a more fluid one than that of many other managerial jobs, and that, therefore, a study of the nature of the choices in the job should be particularly relevant to understanding its nature. We summarise the demands, constraints and choices of the DA's job in Chapter 7 (pages 120–138).

Demands, constraints and choices can provide a dynamic description of a job. The extent and nature of the choices are determined by the space left by demands and constraints. Jobs differ in how much time must necessarily be spent on work that any job-holder would have to do; that is, on demands. They also differ in the nature and severity of the constraints. Both demands and constraints may vary over time and thus affect the opportunities for choice. The individual job-holder also creates his own personal demands and constraints, which will limit his choices, at least in the short term. A simple illustration of this is agreeing to serve on a particular committee. This is a choice, but once made there is a demand to attend most of the meetings. The job-holder may also create constraints for himself by the expectations that he encourages in other people about his behaviour. If consultants, for example, come to expect that he will always respond personally to any problem they have, this will be a constraint upon subsequent delegation of medical problems to one of his staff.

The second analytical framework for our study was taken from Kotter's and Lawrence's study, *Mayors in Action,* a study of the

behaviour of 20 mayors in the USA.[6] This made use of two concepts that we decided would be useful in understanding and comparing the work of district administrators. The first of these is 'domain'; that is, the areas in which the job-holder behaves as if he had responsibility. We used this concept to compare the DAs' activities, to distinguish the different areas in which they got involved and to try to identify those in which they acted as if they were responsible. The second concept from the Kotter and Lawrence study that we have used in this report is 'agenda'. This does not have the usual meaning, but refers to the DA's priorities and preferences in deciding what he is going to do. Kotter and Lawrence described four types of agenda—a continuum ranging from 'reactive' short-term objectives, responding rather than self-starting in the job, to 'proactive', longer-term, wider, self-organised activity.*

The analytical frameworks briefly described above are used in the report both to describe the nature of the DA's job and to help to explain the differences in behaviour that we observed. We believe that these frameworks are helpful to understanding the job. We were further encouraged in this belief by using them in a seminar held for some of those who cooperated in the research. Their reactions suggest that the ideas of demands, constraints and choices will be found helpful as a way of thinking about the nature of the job and about the distinctive characteristics of one's own approach to it.

* We have made only limited use in this report of their concept 'agenda' in describing the different ways of doing the DA's job (see Chapter 5, pages 74–108). It is well worth reading their full description.

2

The district administrator as manager of his own function

Summary

We look primarily at how district administrators managed their own administrative function and related to their subordinates. We hope, thereby, to illuminate some of the opportunities for choice in this aspect of the job, many of which are similar to those of any senior manager in charge of responsible and educated staff. The more unusual features merit longer discussion.

We look at the DA's involvement in managing his function from a number of different perspectives, from the more specific to the more general: what the DA chose to do himself and what he delegated; the different forms of contact with subordinates; the DA's focus of attention, whether upon his own functional responsibility or upon other aspects of the job; and the nature of his role with subordinates. We describe and comment on the problems in relationships with subordinates. Finally, we look at the implications of the choices that DAs made in the management of their own function.

Organisation

The district administrators who took up the post soon after reorganisation in 1974 had considerable choice in the organisation of their own function, both in terms of the structure itself and in the distribution of the more senior staff between different posts. These choices were constrained by limits on total numbers of staff and on numbers at different grades. DAs who were appointed later

inherited their predecessors' structure, which constrained their choice of organisation.

Colin Hayton, at the University of Birmingham, has studied the structure of the DAs' subordinate organisation in more depth than we have*, so we shall limit ourselves to describing one main difference relevant to the rest of the chapter. It is the variation in the number of people reporting to the DA, which was, we found, an indicator of whether the DA was involved in administrative details. Those with a large number tended to be involved more.

Those who were most involved in the administrative services also tended to have a larger number of subordinates reporting directly to them than that shown on the organisation chart. This was particularly true of the personnel officer or district personnel officer, the planning officer, the personal administrative assistant helping with the meetings of the district management team, and the sector administrators in charge of hospitals, even if these staff were shown as formally reporting to the district general administrator or other senior subordinate.

The number of subordinates the DAs said reported to them is as follows.

Number of subordinates	2	3–4	5–7	8 or more
Number of DAs	4	18	6	4

The number of subordinates said to be reporting to the nine area administrators in single-district areas ranged from three to eight, with five being the average. There are more demands on the AA from the area health authority chairman to take him away from his administrative function. Even so, we found that some AAs got involved in, for example, hospital services, and this again seems to be indicated by a large number of direct subordinates.

* MSc dissertation, University of Birmingham; in preparation.

Delegation and what is not delegated

The following interview questions were particularly relevant to delegation and to what the DAs chose to do themselves.

> Which subordinates do you spend most time with?
>
> How do your subordinates know what matters they should discuss with you?
>
> What subjects would you handle yourself rather than leave to your subordinates?
>
> Are there any matters that you do not want subordinates to bring to you?

We also got indirect information about delegation, as we have seen, from the question about how many subordinates reported to the DA. The final question, In summary, how do you see your role with subordinates?, provided further information, as did the description of the DA's activities in the previous month.

Which subordinates do you spend most time with?

The most common answer was the three main subordinates, in charge of operational services, planning and personnel. We shall discuss later the differences in involvement in personnel work because the answers about this were the most varied; 12 of our interviewees did not mention the personnel officer or district personnel officer (PO or DPO), whereas seven said they spent most time with them. Some DAs also mentioned other subordinates, including sector administrators (SAs). The DAs in districts with teaching hospitals especially mentioned SAs, and appeared to be more hospital-related than the DAs in non-teaching districts.

It should be noted that the question asked which subordinates took most time. The answers gave us no indication of how much time was spent.

How do your subordinates know what matters they should discuss with you?

The answer was generally from experience and from frequent contact with the DA. This shows that for many DAs our question was too formal, probably the reason why some had difficulty answering it. (Only a few of the administrators said they had official or written guidance for subordinates.) Those who work closely with their subordinates and see them every day will not have, and are not likely to need, the kind of clarification that the question implies. Some of those who were relatively new to the job or to the district said that their subordinates had difficulty in knowing what to refer to them if their expectations and style were markedly different from their predecessors.

What subjects would you handle yourself?

The DAs varied widely in what, and how much, they chose to delegate, but they commonly reserved certain subjects and contacts to themselves. The main subjects mentioned by DAs in 32 districts were

Subject	*Number of DAs*
DMT	17
Press	15
Consultants/doctors	13
Patients' complaints	13
Public relations	12

Subject	*Number of DAs*
Area/ATO	10
Personnel and IR	8
CHC	7

The main subjects mentioned by the nine AAs in SDAs were

AHA	5
Press	5
Patients' complaints	4
IR negotiations	4
AMT	3

All the subjects mentioned—with the possible exception of personnel and industrial relations, which depend upon which staff are involved—are wider than the administrative function and require contacts outside it. The DA, in common with many other senior managers, sees his own particular role as dealing with important contacts outside his own function, who may affect its work or that of the district as a whole.

Constraints on delegation

The constraints that limit the choice of delegation vary somewhat from one district to another. One district may have more factors affecting the smooth running of administration; some may have crises, or severe long-running problems, that are more likely to demand the DA's attention. The competence of subordinates will be another constraint. Although a DA who has been in the post for some time will have had the opportunity to try to develop his subordinates within their capacity, a new DA may be constrained,

at least for a time, by subordinates' expectations of his role that he inherits from his predecessor. All these constraints were mentioned by DAs.

There are also personal constraints that can affect the DA's ability, or willingness, to delegate. Some managers find it harder than others to believe that subordinates can safely be left to get on with particular tasks. Some managers feel they can only know what is happening if they are actively involved; it is their way of keeping in touch. Both personal and situational constraints can limit, but not eliminate, the DA's choice in what, and how much, he delegates.

Involvement in personnel work

We take this as an example of differences in delegation because the month we asked about—January or February, or occasionally March—had an unusually high level of personnel activity due to the current industrial disputes. Therefore, it is easier for us to compare the involvement of different DAs, even though allowances must be made for the greater severity of industrial disputes in some districts than in others. In the month, we found considerable variations in the extent and nature of the DA's involvement in personnel work.

Before we describe these variations, it may be of interest to note the differences in reactions to the disputes. Many of the DAs who were actively involved in industrial relations and their repercussions regretted the disruption to their work. Some, however, remarked that they found the difficulties a rewarding experience because it tested and confirmed the administration's capacity to handle disturbances; it illuminated their competence and importance.

We distinguished the differences in the DA's involvement in personnel work, as follows, ranging from the most to the least.

1 The DA takes on much of the personnel work himself; for example, negotiation, counselling and discipline.

2 The DA has frequent contact with the DPO, who is dependent upon him for advice and help.

3 There is frequent contact between the two but the DA leaves the DPO to handle most issues. We called this relationship an 'interdependent' one.

4 The DA is little involved in personnel work, seeing the DPO about once a week. The DPO operates independently.

A number of factors are likely to affect which of these approaches the DA adopts. These include the competence of the DPO, the severity of the personnel problems, and the DA's interest in, and experience of, personnel work. The role adopted by the DA may also, as we found in more general discussions, be influenced by his attitude to a specialist in personnel. He may welcome the specialist as giving him further opportunity to delegate, thus leaving more time for other work; or he may see the development of specialist functions as undesirable, because he may think of personnel work as being an essential part of any manager's job, or because he fears the loss of influence that may come from the further development of a specialist personnel role.

Form of contact with subordinates

We asked how DAs monitored the work of subordinates. More importantly for our understanding than the answers to that question, we observed how a smaller number of DAs worked with their subordinates. There are, as one would expect, wide variations in the methods of contact between the DA and his subordinates. We illustrate these in general case studies in Chapter 5 (pages 84–108). Here it may be more useful to simplify and to

describe two ends of a continuum which ranges from close, informal contact to more distant, programmed contact. Nor are these theoretical poles: we talked with, and observed, DAs who came at each end.

The DAs who had close, informal contact saw most, or all, of their chief subordinates every day. There might be a mail meeting each morning with them. But whether there was or not, both DAs and subordinates worked closely together, popping in and out of each other's offices, working jointly on current issues. The DAs at the other end of the continuum had scheduled meetings with subordinates, sometimes individually and usually as a group; there was little informal contact, except occasionally with one or another of a small number of principal subordinates.

The DAs who came at the close, informal end of the continuum usually had a large number of subordinates working directly with them. Those at the more distant, formal end had an average or small number.

Two factors seemed to determine whether the DA was at, or towards, the informal or the formal end: the first, and probably the more important, was the DA's focus of attention, which we consider next; the second was personal preference. Some people, and especially some DAs, are happier with a more formal, programmed contact; others are at home with a personal, closer, informal contact.

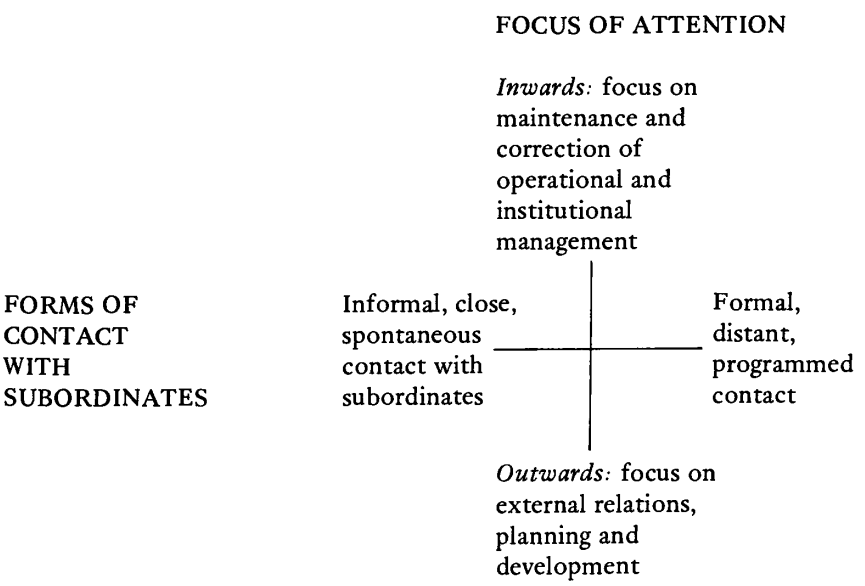
The DA's focus of attention

This also is a subject we shall illustrate in the case studies in Chapter 5 (pages 84–108), because it is important to understand the differences in how DAs perceived and did their jobs. Here we are interested only in whether the DA was focused primarily on the work of his own administrative function or on activities

outside it. The dividing line is not, of course, a clear one. Many of the DA's contacts with people other than his subordinates will be about administrative matters. However, we found it easy to distinguish between DAs who tended to focus inwards and to concentrate on current problems in administration and those at the other extreme who focused on external relations, planning and development.

Figure 1 sums up what we have described under this and the previous heading. We observed DAs who came in each of the quadrants as well as at different distances along each line.

Figure 1 TWO DIMENSIONS OF HOW DISTRICT ADMINISTRATORS WORK



The amount of time a DA spends with his subordinates is a good indication of the importance he attaches to being actively involved

in the management of the administrative, institutional and support services. Our DAs spent widely varying amounts of time with their subordinates. This shows that the DA's job provides, like that of many other senior managers, a wide choice in the extent to which the job-holder chooses to emphasise the supervisory aspects of the job, and to involve himself in the details of his subordinates' work.

A simple guide to assessing whether a DA is focused primarily upon the work of his administrative function or upon his work with other parts of the service is to ask whether the distribution of his time shows that he has a 'hub' or a 'peer-dependent' contact type. These categories were developed by Rosemary Stewart in her previous research[11], and have since been found to be a good way of predicting how people choose to do their jobs.[12] A hub contact type is one where the manager spends more time with his subordinates than any other group of people, but also has contacts with people at different levels in other departments. A manager with a peer-dependent pattern spends as much or more time with people outside his own department as he does with his subordinates. Many senior management jobs, and some more junior ones, offer the individual a choice between these two patterns. Usually, it is more effective for a senior manager, except when he is new in a post, to have a peer-dependent contact pattern rather than a hub one. When he has been newly appointed he will need to spend longer with his subordinates so that they can get to know each other's work and expectations. Whether and, if so, how soon, he should move from a hub to a peer-dependent contact type will depend upon the competence of his subordinates, the improvements that he sees to be necessary or desirable within his sphere of responsibility, and the need that his subordinates may have for help in dealing with severe and unexpected problems. Later in his tenure of the post, he should be able to spend more time with managers of other functions, concerned with the running of the organisation rather than primarily with managing his own department. However, a change in his senior subordinates may require a change back, for a time at least, to a hub contact type.

Differences in the DA's role with subordinates

Our interviews and observations suggest that the role which most, but not all, DAs played in their relations with their subordinates can be described by one of the four categories given below. Naturally a DA's relations will tend to differ somewhat between different subordinates and over time, but such differences seem to us less important than the overall tendency for most DAs to adopt one of these roles; hence, although the individual DA may be conscious of his own variations in approach, these are likely to be less than the differences between him and some other DAs.

Joining A DA who operates in this mode with his subordinates has constant informal contact with them. They jointly do the mail, discuss problems as they arise and keep each other informed throughout the day. The DA is part of the team with his subordinates. It is egalitarian and the DA, like his immediate subordinates, is actively involved in operational matters.

Supporting The DA is very available when subordinates want to discuss their work, but he leaves it to them to decide when they need to do so. The mail comes to the DA from senior subordinates. There is frequent contact between the DA and his immediate subordinates, but the initiative for the contact usually comes from the subordinates.

Monitoring and pushing The DA is available to subordinates and has frequent contact with them. However, much of the contact is to monitor subordinates' work and push them to improve it. The DA handles most of the mail and signs all letters, or checks letters sent by subordinates. Like the 'joining' DA, he gets involved in operational issues. A DA who operates in this way will usually have a large number of direct subordinates.

Separate The DA tends to be separate from his subordinates. Much of the operational work and supervision is handled by a

deputy or other senior subordinates. The DA monitors through prearranged, regular meetings. There is less spontaneous contact than in the other three categories. Access to the DA is protected by a secretary and a deputy. There may be an official open door, but it is not used by subordinates.

These four roles are simplifications of a more complex reality, but they have the advantage of summarising some of the main differences in approach of DAs to the management of subordinates. The main aspects inadequately expressed by these categories are, especially for the second, how, and the extent to which, the DA monitors the work of subordinates, and whether he sets objectives for them and makes initiatives for improvement.

Problems in relations with subordinates, and their implications

Half of those whom we observed had problems in the relations with their subordinates; some of these they discussed with us and others we observed. This proportion seems to be unduly high, especially as our interviews did not suggest that it is untypical. In making this judgment we are not drawing upon parallel studies but on our experience from interviewing and teaching managers in other kinds of organisations. Whether or not we are right in this judgment, it can still be useful for the purposes of training and self-development to list some of the problems that were described to us, or that we observed. The main problems we noted are listed below, starting first with those seen from the DA's point of view.

Those of a recently appointed DA who follows one with a different supervisory style, and who feels that his subordinates have difficulty in adjusting to the change and, therefore, do not behave as he would wish.

General complaints about the competence of subordinates.

Specific complaints about subordinates of a different age from the DA, usually older subordinates.

Our information about the problems in the relationship seen from the subordinates' point of view is much more limited because we only interviewed some of the subordinates in the pilot study. However, from these and, more especially, from our observations we noted the following problems.

Insufficient support or help from the DA, who was too separate from his subordinates.

Over-centralisation so that the DA was heavily involved in operational detail, leaving subordinates with little responsibility. The opposite problem to the one above.

Leaving subordinates unsure of what was expected of them.

A tendency to blame the age of the subordinates, rather than the DA's failure to make real contact with them or to discuss problems in a way that was meaningful to them.

Bypassing immediate subordinates.

Being more comfortable with women subordinates because they were not seen as competitors.

There are bound to be other problems, but these are the ones we noted.

Comment

Considering first the problems from the DAs' point of view, we must ask whether the DAs are more unfortunate than managers in other organisations in the calibre, and in the adaptability, of their

subordinates. Before we discuss this, we should say that in some ways we thought the DAs' task of supervision was easier because their subordinates struck us as more long-suffering of the problems the DA may cause them and more dutiful than those at comparable levels elsewhere. Complaints about subordinates are, of course, made by managers elsewhere, but they seemed to be more widespread amongst our DAs. One explanation may be that changes in the National Health Service, particularly the increase in organisational size of districts compared with that managed by the hospital management committee before the NHS reorganisation, and the development of professionally trained administrators, mean that there is more of a gulf between the younger qualified administrators and some of their older staff than one finds in some other types of organisation. This seems to us to be part of the explanation, but not a sufficient one if we turn to the problems that we noted, even with our limited information, in how the DAs managed, or failed to manage, their subordinates.

Implications of the choices made

The different perspectives we have used to discuss the DA's management of his own function can also be used to highlight the choices that DAs make. Such choices will have implications for the efficiency of the administrative, institutional and support services, though our research contributes little new here because we were not appraising efficiency. The choices made will have implications for the development and morale of subordinates. They will have implications, too, for the DA's other work, both simply the time and energy that he devotes to it and, more importantly, the reputation that he helps to establish for administration and the strength that a high reputation can give him in discussions with his colleagues in other functions.

The choices that the DA can make in managing his own function and his staff are likely to vary at different stages in his occupancy

of the job. He will be constrained by the kinds of staff he inherits, by their expectations of his role and by changes in personnel. He will, or ought to be, constrained when he is new in the job by his need to understand the particular situation and to develop a reputation as a competent administrator.

There seemed to us to be two opposing dangers in the way that some of our DAs managed their own function. One was of being too separate from the work, too focused on longer-term planning and on work with other officers and outside contacts, so that subordinates did not get the stimulus for improvement, and the guidance and support they needed and could justifiably expect. The temptation for a DA with this approach is to become too absorbed in the interest and morale-boosting work of contact with people outside the administrative function. He may feel this is more important than his work with subordinates. Such an outward approach (see Figure 1) can be effective if the DA has a deputy who is competent and interested in managing the function; otherwise, the work of administration is likely to suffer. The opposite danger is of the DA who is so immersed in operational details, and who spends so much time with his subordinates, that he gives inadequate attention to the other aspects of his job and does not offer his subordinates the broader perspectives that his position can give him. The temptation here is to become predominantly reactive, to revel in the busy-ness of solving short-term problems.

3

The district administrator's role in the district management team

Summary

The methods of operation of the district management teams are compared: the frequency and duration of meetings, appointment of chairman, attendance of members, preparation of agendas and records, and the ways in which the concept of consensus management is being interpreted. The demands and choices of the DA's role in the DMTs are described. Three case studies—the burdened administrator, the team builder and the administrative leader—and quotes from interviews illustrate differences in the ways that DAs have developed their roles. Training implications are discussed in relation to the tasks to be performed and the roles taken by members of groups. Belbin's analysis of group roles is explained: 'chairman', 'shaper', 'plant', 'monitor-evaluator', 'company worker', 'team worker', 'resource investigator' and 'completer'. His description of each role includes its strengths and tolerable weaknesses.[1]

Discussion of their function in the district management team figured largely in the administrators' descriptions of their job, perhaps because this was an innovation in the 1974 reorganised management structure which required senior administrators to accept a new philosophy—consensus management—and to take on a new, uncustomary role—equal member and coordinator of the management team. This role was not defined in great detail but rather left to each administrator to work out. There are at least two possible explanations for the prominence of the DMT in the DAs' accounts of their work. One is that many found the preparation for meetings, attendance at them and subsequent work very

time-consuming. The other is that some at least of the DAs attached particular importance to their role in the DMT.

We shall begin by describing the details of the working of our DMTs because readers may be interested in how they and the area management teams in our sample differed in the mechanics of their operation.* These details can also help to show some of the choices that may be available to the administrator who wishes to influence the management team.

Operation of the DMT: comparative details

Frequency and duration of meetings

Fourteen of the 32 DMTs met formally once a week. Most of the remainder met once every two weeks. One met informally every week and formally once every four weeks. Another had alternate formal and informal meetings every week. One DMT only met once every four weeks for just over two hours with no additional informal meetings or meetings of officers. Four of the nine AMTs met weekly, the remainder fortnightly. Appendix C (pages 181–194) gives more details about the time spent in meetings.

A few districts, and more single-district areas, also had regular meetings of officer members before the full DMT or AMT.

Chairmanship of the DMT/AMT

Again, practice varied widely both in whether there was a chairman and, if so, the methods and duration of appointment. It is summarised below.

* Area management teams (AMTs) are the equivalent of DMTs but operate in single-district areas. They are different from the area team of officers (ATOs) who operate in multi-district areas. Both AMTs and DMTs are responsible to their area health authorities (AHAs). See also Appendix E (pages 201–204).

In 32 DMTs

No chairman	*Chairman by rotation*	*Long-standing chairman*
11*	11	10

* In four of these, the DA said he was unofficially chairman.

In 9 AMTs

No chairman	*Chairman by rotation*	*Long-standing chairman*
4*	3	2

* In three of these, the AA said he was unofficially chairman.

The frequency of rotation varied from weekly, for those DMTs whose DA stressed equality of membership, to annual or biannual, but usually then only amongst those interested in being chairman. Long-term chairmen were usually the administrative or a medical member, most commonly the consultant.

The chairman's role was usually confined to guiding discussion at the meeting. In a few DMTs and AMTs, he also had a public relations role, such as opening health centres or giving prizes. He could also be spokesman for the DMT to the AHA.

Attendance of others at DMT/AMT meetings

Some of the DMTs, but none of the AMTs, were reluctant to have outsiders at the meeting, not even deputies for absent members, because to do so would undermine the cohesiveness of the team. Some teams invited members of staff to speak on specific subjects, but they were expected to leave when they had done so. The majority permitted deputies when necessary, but some were reluctant to, or would not, meet without the DA. Seven of the AMTs would meet if necessary without the AA, accepting one of his staff instead. A few DMTs and AMTs invited other officers to attend regularly.

Preparation of the agenda

The DA or AA commonly either prepares the agenda or at least vets it after his secretary or assistant has done so. In one of the DMTs, the agenda was prepared in a meeting with his subordinates and the district finance officer. In another, the agenda was prepared by the committee clerk working with the chairman, who was not the DA. The role adopted by some DAs and AAs in setting the agenda is discussed later.

Minutes or other record of meetings

There were two main variations. One was whether there were formal minutes, as in most of the DMTs and all the AMTs, or just notes of decisions. The other was whether the minutes were prepared wholly, or mainly, by the DA—true for eight of our DAs—or by his secretary, committee clerk or other member of his staff and then checked by him. In all the AMTs, the minutes were not prepared by the AA, though he would check them.

Role of the DA: demands and choices

The minimum role of the DA (the demand) in each aspect of his work for the DMT will be described first. However, a DA can choose, as many of them did, to play a bigger role. We shall describe later the DAs' views of their overall role in the DMT and give brief case studies to illustrate the main differences. Here, we shall discuss the options (within the constraints imposed by other team members) in different aspects of the DMT's work, and the reasons that DAs gave for their own choice.

In describing these choices, we make a broad distinction between those DAs who believe in, and seek to develop, the DMT as a team and those who adopt, when they can, a more individualistic, do-it-yourself leadership role.

This distinction we believe to be important, not merely for understanding the differences in the ways our DAs saw their role and, for those we observed, the differences in the ways they behaved in the DMT, but also for understanding the operations of consensus management. The report of the Royal Commission on the National Health Service quotes Professor Kogan's study finding that 'support for consensus management was wide-ranging and only a small minority thought could never be successful'.[9,10] Such reported support may not reflect either how people view their role in consensus management teams or how they behave in them. Our DAs' attitudes were more varied and more complex than Professor Kogan's study might suggest.

Frequency and duration of meetings

The DA has no distinct minimum role here, apart from the administrative duty of arranging for the meeting. He may choose, like the other members, to try to change the frequency or the duration of the meetings, particularly if he regards them as too time-consuming. One way of reducing the frequency is to get agreement about what issues must be brought to the DMT and those that are properly delegated to lower levels of management.

> *A weekly pattern of meetings encourages too much haphazard detail on the agenda.* (AA)

> *Too much time-consuming, superficial consultation and communication . . . You can get to a point where people spend more time telling each other what they are going to do, or what they have done, than doing it.* (A DA whose DMT met for two hours every week.)

Some DAs sought to encourage attendance at meetings, because otherwise there might not be full attendance, or some members (usually the doctors) might arrive late and/or leave early. They

could encourage attendance by raising interest beforehand, putting interesting ideas to the meeting and promoting team involvement.

Chairmanship of DMT/AMT

Our administrators had different views about the desirability of being chairman of the DMT or AMT. Those who really believed in the value of consensus management were likely to favour either no chairman or, more commonly, that each member should have a turn at being chairman in order to encourage equality and to develop team skills. Some thought that being chairman would handicap them.

> *It is easier to have your say and to get your own way if you are not.*

One thought that he should not be chairman because he needed brakes, otherwise he would act as chief executive. Others thought that it was important to be chairman.

> *To ensure that the team is doing what it should.*

Often the DA said he acted as chairman whether this was formally acknowledged or not.

> *In the meeting the DA plays a very positive role . . . keeping a firm hand on the team to get them to stick to the point, come to agreement and make a decision.*

Setting the agenda

The DA's minimum role has two parts.

He is responsible, as head of administration, for 'input' from his

department, and he must decide which administrative matters should be brought to the team's attention for decision and which should be decided at a lower level.

He is the administrative coordinator for the team and so must provide secretarial services: to collect items, collate them and send an agenda to team members.

He may choose to take a much more active role than this. He may think that he ought to if he considers that other members are not putting forward enough items, or the wrong kinds of items, for the agenda. A DA who has strong views about what the DMT ought to be discussing may choose to encourage members to put forward agenda items, and may advise on what should be discussed and decided by the DMT and what should be delegated to lower levels of management. He may additionally advise on the timing and handling of items.

The DA who sees his role as team building is likely to choose to try to educate—he may use that word instead of 'persuade'—members about the nature and timing of topics for discussion.

> *As problems come up, he recommends which can be dealt with by officer decision and which should go to the DMT.*

He is likely to take a more active role when he is chairman, when there is no chairman or when the chairmanship rotates frequently.

The DA may go further and take direct responsibility for setting the agenda.

> *The DA's role is to make the DMT think and concentrate their minds on important issues, and not get involved in operational details.*

> *The DA must pick out the right subjects for them to spend their*

time on, subjects that need broad discussion or consensus agreement, without bothering them with trivia.

A DA who chooses to take, or to accept by default, this responsibility will take a lot of decisions outside the meeting, which he considers are of less importance. He may also seek to discourage other members from putting forward items or papers which he thinks are inappropriate.

The DA who chooses to extend his role in setting the agenda may meet with opposition. Other members may resent being, as they see it, nagged. Another member who is chairman may prefer to decide on, or agree, the agenda.

Briefing the DMT

Here again, the DA's minimum role comes from his job as head of the administration and as coordinator of the DMT.

As head of the administration he must see that sufficient background information is provided for any agenda item from his own department, so that other team members are in a position to discuss it knowledgeably, and he must brief himself by reading other people's papers, and by getting colleagues' and subordinates' opinions.

As coordinator of the DMT, he must make it possible for other members to brief themselves by providing secretarial services for collecting and circulating papers in time before, though in some DMTs at, the meeting.

The DA may choose to play a more active role than this. One who is interested in team building may seek to help any member who lacks the confidence or ability to explain issues to the meeting by discussing possible questions that may be asked at the meeting,

and by advising on what background information is likely to be needed. He can seek to alert members to issues on the agenda that particularly concern them, so that, for example, the consultant can get the views of his colleagues beforehand.

Generally warming people up beforehand.

A DA who chooses to take more responsibility himself and is less interested in team building will take a different approach. He may consider that high standards of presentation are essential, and that the provision of background information is properly the responsibility of the administrative function. Most of the agenda items may come from his department so the information is naturally provided by it. He may use his own wide network of contacts to brief himself, especially about medical opinion, rather than relying upon the relevant team members to do so.

Discussion in the meeting

The demands for the DA here (his minimum role) are to represent administration in the district, and to act as the linkman with the administration of the area or region, and the Department of Health and Social Security.

His minimum role also demands that he act as coordinator, with involvement in the work of all departments of the district. This demand, though commonly expressed, could be interpreted in different ways. He has to try to present a general view of the district's problems, compared with the narrower professional view other team members are likely to take, although they could also choose to see problems more broadly.

The DA who is concerned with team building may choose, whether he is chairman or not, to play a very positive role in involving people in discussion.

Vitally important to stimulate the officers, keep their ideas fresh, keep them aware of new fields—it is a form of motivation.

A DA who takes this view will see it as his responsibility to encourage all to contribute. He may think that the standard of discussion and awareness of problems are not high enough.

Try to train the others how to think.

The DA who is a team builder is seeking to develop equality of discussion, including counterbalancing where necessary a dominant personality, and the team's wider view of the district as a whole.

The DA who chooses to be more active than the minimum role demands, but is less concerned with team building, will take a more individualistic approach. He may see it as his task to tell the team what to think.

I regard it as my task to bend the members to my will in as nice a way as possible.

I cannot claim that the DA makes all the decisions but the way that I analyse and present the problem makes the action to be taken self-evident.

This kind of DA, unlike the team builder, is not worried if members do not contribute, but only if they oppose what he sees to be the right decision. This view he would consider justified by his broader perspective and careful analysis of problems.

The DA who chooses the more individualistic leadership role may meet with opposition from someone else who wishes to play that role. Alternatively, he may find that members react by being passive and leaving him to do most of the work.

Reaching consensus

The demand on the DA here, as for other team members, is to share in the task of reaching agreed decisions. Where there is a chairman, and where the chairman is not the DA, the DA has to work with the chairman because he has responsibility for general coordination. The DA has to share some of the burden of helping the chairman to get the team to agree.

A DA who believes in team building may choose to take actions aimed at developing the members into a team whose first loyalty is to the team and the district. He may set an example by not playing the advocate or defender of the administration, but by being rather an objective member discussing the problems from the point of view of the district. He can use his skill in arbitration of competing interests both in the meeting and outside. He may watch out for, and seek to prevent, practices that encourage divided loyalties.

> *The DMT only meet as a team. We studiously avoid officers meeting separately from gentlemen.*

Or he may encourage practices that can bring the team closer together. Examples cited to us included the following.

> Discouraging deputies at meetings.
>
> Taking notes of the meetings himself because the presence of a committee clerk, an 'outsider', might inhibit discussion.
>
> In general, cutting out formalities to encourage more intimate discussion.
>
> Organising an annual two-day group self-examination.
>
> Promoting informal continuous contact between members, such as eating lunch together or ensuring proximity of their offices.

The DA who worries, as many of our DAs did, about the quality of the DMT's discussions and the team's willingness to recognise and seek to deal with realities, has a number of alternatives. He can choose to do little, or believe himself unable to do anything, beyond his minimum role. He can choose the team building approach, thinking of ways in which members can be encouraged and helped to think as a team responsible for the district rather than as a group of separate professionals. He may see consensus management as a time-wasting activity that results in decisions of poor quality, and may decide to act more independently. This, he reasons, is justified because it is his responsibility to run the district, which involves making decisions, which in turn means gathering information, consulting people and making up his mind on the best course of action. Only an important decision needs to be ratified by the DMT which, he expects, will nearly always accept his view. He may need to prepare carefully for the meeting in order to get this acceptance. This preparation may include the following.

Meticulous planning of the structure of the meeting, considering each item separately, anticipating questions and possible conflict.

Providing papers of high standard. Considering the placing on the agenda of important items.

Clear and thorough analysis and presentation of problems and of the discussions, so that the rightness of his decision is self-evident.

Seeking understanding before the meeting, by informal discussion or in formal officers' meetings.

Some of our DAs did not need to take so much trouble, because either they had gained the complete confidence of the team or they were the dominant personality, or because other members also felt that the DA should carry a greater burden of responsibility for the team's decisions.

Making the team's decisions effective

The DA's minimum role (demand) has four parts.

1 To ensure, like other team members, that any action required of him or his department is carried out efficiently.

2 To ensure, like other team members, that his subordinates are aware of the DMT's policy and work to its guidelines.

3 In his role of general administrative coordinator for the DMT, to work with the chairman, or alone if there is no chairman, to stimulate action between meetings.

4 To write all letters resulting from the team's decisions that are not specifically the responsibility of one of the other officers. He may delegate this task though remain responsible.

The DA may choose to go further than this. He may, if he values teamwork, seek to persuade other members to take on more of the executive work; for example, by getting clear agreement in the meeting on who is to do what and by initialling each minute appropriately. He may insist that the team always defends its decisions in public, even if it has disagreed in reaching that decision. He may seek to maintain the dignity and authority of the DMT by never referring such disagreements to the ATO or AHA. Similarly, an AA would not refer disagreements in the AMT to the AHA or the regional bodies.

The DA who chooses the more individualistic approach will consider that nearly all the action arising out of the minutes is his responsibility. He either does it himself, or decides who will do it, discussing it with that person and checking that it gets done. This approach may help to overcome one of the problems of team management, that of uncertainty amongst staff about who is responsible.

Accountability for the team's decisions

There was disagreement amongst our DAs about whether they had greater accountability than other members for what happened in the district and for the DMT's decisions. Some argued that they had, because of the coordinating role. Some believed that criticisms of the administrator in reports of investigations, like that of Normansfield Hospital[5], showed that he was seen to have greater accountability. Others thought the idea inimical to that of consensus management, and that since the DA was explicitly *not* the chief executive he must not be held to be more accountable.

Case studies

So far we have made two broad distinctions in the DA's role. The first is that between the minimum role (the demands that any DA has to meet) and the wider choices that are available, subject to the constraints imposed by other team members. The second is that between the DA who chooses to emphasise team building and the one who adopts a more individualistic role. The latter distinction, though potentially useful to understanding the demands, constraints and choices of the DA's role in the DMT, over-simplifies reality. The case studies and quotations which follow aim to give a better picture of some of the variety of approaches that our sample adopted. In all the case studies, we refer to the DA and the DMT even where it is a case study of an AA and AMT. This is to help protect anonymity.

Case study 1 The burdened administrator

This DA has been in post since reorganisation in 1974. In the first year he agreed to be chairman. At the end of the year no one else wanted to take it on, so since then the DMT has not had a chairman. But, in effect, the DA fills that role still, helping the members to come to acceptable decisions, acting as their spokesman.

They would not have a meeting without him.

He does all the preparation for the meetings: the agenda, and the associated papers, which he keeps short. Most agenda items come from him. He explains them and their background. The other members expect him to advise on what can be done and what is politically desirable. He takes great pains to see that every decision is talked through, and accepted by all. He listens carefully to everyone's point of view, in the attempt to achieve consensus, since everything must proceed by agreement.

He takes the notes of the meeting: there is no committee clerk and his secretary is not trained to do so. He drafts the minutes, passes the draft to other members to make sure that he has interpreted the sense of the meeting correctly. Then he does the final version. He has to make sure that all know what they are agreeing to, in order to prevent later disunity.

The action arising from the minutes is nearly always his responsibility. He has to coordinate it, decide who will carry out the decisions, explain how and why, and check their progress.

The DMT meets twice a month. The DA sees this cycle as a heavy burden of preparation, meetings and follow-up. He sees consensus management as slow and inefficient.

> *It is not wrong in principle, but it takes a lot of talking, a lot of paper and the final decisions are often compromises. Endless compromise is dispiriting.*

He sees himself as much more passive than before reorganisation.

Case study 2 The team builder

This DA has also been in post since reorganisation. He sees wide

choice in the DA's attitude to the DMT from commitment to making it work as a team, going along with the group, to adopting a contemptuous attitude. Much, he thinks, depends on circumstances. In a weak DMT, the DA would have to take up direct leadership and force the pace, dragging the team after him.

He sees it as the DA's responsibility to make the DMT work. He has two roles in the DMT—one as an individual with managerial responsibility, the other as coordinator. In his latter capacity, he must make sure that decisions are clear, communications right, and that all relevant matters are exposed to the team and understood by them. He must help the DMT to become a team, not just a group of people who do not disagree.

The chairmanship rotates every six months amongst all the members, except the DA. He thinks that, as coordinator, he should not be chairman but should have some separation and independence. Rotation suits the team because it ensures that no one is bidding for power.

Before the meeting, the DA usually goes through the agenda with the chairman, discussing how to play major items, what they are looking for and what are the objectives. The DA's role is to help the chairman think the meeting through and, thus, to lead it. In the meeting, the chairman raises the items, brings in others and controls the pace. Outside the meeting, he plays a supportive role to the DA. He speaks for the team to the medical executive committee (MEC), AHA, ATO and other groups. He and the DA go to the AHA chairman's briefing meetings. The whole DMT goes if there is a major topic of concern to it.

The DA's contribution to each group to which he belongs, including that of DMT, is to be a team builder. He works through communication, knowledge of what is going on, informal contact and respect for each individual's contribution. He reacts positively to every member's ideas and opinions.

The DA collects items for the agenda, but they come from other team members as well as from himself. He briefs himself by reading all the papers. He sees his role as helping the team to think clearly; in *how* to think, not in *what* to think. He will prepare a paper to stimulate discussion on a topic, such as mental handicap, so that members sit down and think about the issue, particularly what they ought to think about. The DA puts down open-ended questions so that the members have to go through the issue in a logical pattern. He sees himself as leading from behind.

The atmosphere of the DMT meeting is lively, with all contributing. The group acts as a team accepting joint responsibility. They sit round a small table and no one appears central. The chairman brings in the DA to give the basic information on the issues to be considered. Then there is general discussion. The DA then summarises and simplifies, then summarises again after further discussion. The DA does not push a decision: it accumulates amongst members and decisions come smoothly and quickly. The role he plays in summarising will depend upon the ability of the current chairman to do this.

The team invites subordinate members when their expertise is required. The district general administrator (DGA) can act as the DA's deputy in the meeting and the personal administrative assistant (PAA) takes notes. This helps to give the DA's subordinates experience of the DMT's work.

A reminder slip is sent out after the meeting to anyone who has to take action.

Case study 3 The administrative leader

The DA has been working with the same team since reorganisation. It has never had a chairman but, in practice, the DA performs that role. His secretary collects the items for the agenda and he decides

which administrative ones need to go to the DMT. The DA guides the team through the agenda, analyses the discussion and brings them to what he, after previous informal consultation and discussion, has decided to be the best conclusion.

The DA sees it as his task to persuade the members to talk and think about difficult issues, policies and big decisions. So he takes small decisions himself outside the meeting. He has nearly always made the decisions in his own mind about issues that come to the DMT. He has taken into account the views of others and is well informed of the facts.

He is in frequent informal contact with other members of the team and second-in-line officers. Any financial matters are discussed and decided with the district finance officer (DFO) before the meeting.

He takes notes at the meeting because the members did not want a committee clerk who might inhibit discussions. There are no formal minutes, only a record of decisions, which takes him less than an hour to write up.

The meetings usually last over three hours every week, but his views are nearly always accepted. People expect the administrator to be the leader. He sees himself as responsible for the district and accountable if things go wrong. Even so, half a day once a week is, in his view, a time-consuming way of proving that his views are correct. The discussions do not improve the quality of decisions. Sometimes, by diluting them, they make the decisions worse. However, for big decisions, approval by the DMT carries more weight and facilitates acceptance. Over all, he sees the DMT as rather a burden because of the time that it takes.

These case studies have illustrated some of the different roles played by the DAs. The following short quotations also present

the different views that DAs had of their roles in the DMT.

The DA is the main driving force of the DMT. No one else has the breadth of support to fulfil this same sort of role. There is a danger of becoming too dominant too obviously. The DA has a great deal of sway over the DMT but that carries with it the peril of alienating colleagues.

The DA always has a target in his mind. Consensus-getting is sales talk. He moves a little to one side or another, keeps the balance and achieves his target.

The DA must share in the leadership of the team.

His main contribution is setting objectives with the DMT and making them conscious of their role.

The DA is the DMT 'teacher' for the DNO, DCP and DFO.

The DA acts as chief executive without the role or the authority. But he has to act. He is forced to pick up the events without authority.

I try to avoid hand-holding in the DMT; everyone has his own responsibility.

He is the team builder, the consensus-getter, the coordinator, who draws out their strengths, sees their weaknesses, gets the right atmosphere for consensus.

He is the coordinator of the DMT. He is also the innovator and leader. He must change people's thinking so that they can encompass new things.

A DA makes or breaks a DMT. His skill shows in how he creates a team.

He is not a leader but puts the pros and cons in the best way for the service.

The DA's leadership lies in putting deep questions to the DMT. Pointing out the dangers of loose thinking and forcing the DMT into positive action.

It is an enabling role, translating DMT ideas into positive action.

He keeps up the quality of the DMT's work. It sinks if he is not there.

His key responsibility is to ensure that things get discussed, actioned and reported back.

The last quotation is an example of those DAs who see their role in the DMT purely as administrative. Most of the DAs had a wider view of their role than that. Some, as the quotations and the case studies show, thought of themselves as team leader, *primus inter pares.* A few thought their main contribution was that of team builder, and saw virtue in consensus management. Others were, to a greater or lesser extent, impatient with the concept of consensus and with what they saw as the inability of their colleagues to face up to reality, to tackle the big issues, to think innovatively. The DAs who thought like that saw themselves either as teachers or leaders, but camouflaged if necessary.

Comment

Most of the DAs thought positively about the contribution that they could, and should, make. Only a few were disillusioned or may have opted out. It is encouraging that our DAs and AAs—because there was no difference in their views—had a large conception of their role. The DMTs and AMTs are probably better for that view, and for their sense of responsibility, but this con-

ception has both its dangers and its disturbing reflections. Were the strictures of many of the DAs and AAs upon their fellow team members correct? If so, can or should anything be done by training either the members themselves or the DAs and AAs to equip them better for their educational role?

The DA who takes the major responsibility upon himself may contribute a lot, but he runs the risk of antagonising some of his fellow members or, apparently more commonly, of encouraging them to leave much of the DMT's work to him. There is an opposite risk, or temptation, for some DAs: that of being too pleasant, too self-effacing, and so contributing too little to the decision-making at DMT meetings. The DA who is a team builder and, if necessary, teacher probably makes a greater contribution to the effectiveness of the DMT than the one who acts as a general manager. But what role will contribute most will vary with the individual DA and with the composition of the team. It will vary, too, with how long the DA has been a member of the team, and at different stages in the evolution of the DMT.

It may be objected that what we have been describing is the DAs' view of their role, which may not coincide with what they do in practice. However, our observations of eight administrators and of their DMT and AMT meetings suggest that usually what they say reflects how they behave.

In this chapter we have tried to show the different roles taken by our DAs and AAs, and to describe some of the choices which exist in that role, both in terms of general aims and in detailed practices. A summary of the demands, constraints and choices of the DA's role in the DMT is given in Chapter 7 (pages 122–138).

Reviewing the operation of the DMT and the roles adopted

The tasks that must be performed if meetings of the DMT are to

be effective can be summarised as

ensuring that appropriate subjects are put on the agenda

ensuring involvement and interest

ensuring that discussion focuses on the major issues

providing the information needed for discussion

reviewing and summarising this information

giving everyone who wishes to, a chance to express opinions and to contribute any information that has been omitted

pushing the meeting along

agreeing the nature of the problem

reviewing alternatives for action and their pros and cons*

reaching a decision, and accepting the collective responsibility for it

determining action roles.

The idea behind the formation of DMTs and AMTs is consensus management—the acceptance of collective responsibility. That may be an ideal which cannot always be reached. Indeed it may, as we described earlier, not be seen as an ideal by some DAs but as a burden to be borne or, where possible, to be shed. We observed one meeting of each of eight DMTs or AMTs. We thought that

* Some DAs would disagree with this item, considering that that was their prior task, and that they should put up what they see to be the best alternative, with its implications.

four of them were definitely not a team, that one definitely was, that two others probably were but that we could not be sure on the basis of one observation and that the eighth probably was not.

The divergences that we noted from the above list of tasks to be performed were as follows.

Chaotic discussion, lots of comings and goings. DA gets annoyed at inability to control meeting.

Unclear aims, low gear discussion, no coordination by DA or anyone else.

Superficial discussion, too easy-going, described by one DA as *'playing happy families'*.*

DA hogging the information, which was not previously circulated, and reading aloud letters of which only he had a copy.

DA playing a major but rather flat and unstimulating role, no humour or encouragement.

DA dominating the meeting, never asking for others' opinions or decisions.

No sense of collective responsibility; discontent and complaints at end of meeting.

Many groups of managers, not only DMTs, have problems; this is recognised by the training designed to help groups work more effectively. Many different approaches can be helpful: here we outline that of Meredith Belbin[1], whose analysis of group roles, which is given below, could, we believe, be of help to DAs and to

* However, this may be an unfair judgment based on one meeting. There may have been good reasons why this particular meeting was like that.

other members of the DMT in reviewing the effectiveness of the group, and the appropriateness of their own contribution. We shall use his analysis in Chapter 5 (pages 74–108) to describe the roles that the DAs whom we observed played in the DMT.

Belbin has pointed out the need for eight different roles to be represented if a group is to be effective in defining, analysing and completing a task. He further says that any individual will tend to adopt one or two roles, but if necessary, will adopt one or two others appropriate to different situations. It is this potential flexibility that makes it worthwhile for an individual member of the DMT to evaluate what role or roles may be lacking in the team and to ask himself, or herself, whether he or she could contribute to that role. As coordinator, the DA has a special responsibility to ask himself such a question. If the answer is that no one in the DMT is capable of playing a missing role—which may be especially true of the role of 'plant' (see below)—the DA could try to use a subordinate in the preparation of papers, or in subsequent work, to fill the gap.

Belbin describes the attributes of the role in terms of 'strengths' and, tactfully put, 'tolerable weaknesses'. These are included in the description below because they contribute to an understanding of the role. Belbin points out that the roles 'chairman' and 'shaper' are alternatives, hence only one is essential for the effectiveness of group working, although both may successfully exist within the same group.

Team role specifications

Chairman

Role: Controlling the way in which a team moves forward towards the group objectives by making the best use of team resources; recognising where the team's

strengths and weaknesses lie and ensuring that the best use is made of each team member's potential.

Attributes: Strengths—an ability to command respect and to inspire enthusiasm, a sense of timing and balance, and a capacity for communicating easily with others.

Tolerable weaknesses—no marked creative or intellectual power.

Shaper

Role: Shaping the way in which team effort is applied, directing attention generally to the setting of objectives and priorities and seeking to impose some shape or pattern on group discussion and on the outcome of group activities.

Attributes: Strengths—drive and self-confidence.

Tolerable weaknesses—intolerance towards vague ideas and people.

Plant

Role: Advancing new ideas and strategies with special attention to major issues and looking for possible breaks in approach to the problems with which the group is confronted.

Attributes: Strengths—independence of outlook, high intelligence, imagination.

Tolerable weaknesses—a tendency to be impractical or to be 'up in the clouds' at times and to be weak in communicating with others.

Monitor-evaluator

Role:
1 Analysing problems.
2 Evaluating ideas and suggestions so that the team is better placed to take balanced decisions.

Attributes: Strengths—critical thinking ability, including the ability to see the complications of proposals; an objective mind.

Tolerable weaknesses—hypercritical; unexciting; a little over-serious.

Company worker

Role:
1 Turning concepts and plans into practical working procedures.
2 Carrying out agreed plans systematically and efficiently.

Attributes: Strengths—self-control and self-discipline combined with realism and practical common sense.

Tolerable weaknesses—lack of flexibility and an unresponsiveness to new ideas that remain unproven.

Team worker

Role: Supporting members in their strengths (building on suggestions), underpinning members in their shortcomings, improving communications between members and fostering team spirit generally.

Attributes: Strengths—humility, flexibility, popularity and good listening skills.

Tolerable weaknesses—lack of decisiveness and toughness; a distaste for friction and competition.

Resource investigator

Role: Exploring and reporting on ideas, developments and resources outside the group; creating external contacts that may be useful to the team and conducting any subsequent negotiations.

Attributes: Strengths—an outgoing relaxed personality, with a strong inquisitive sense and a readiness to see the possibilities inherent in anything new.

Tolerable weaknesses—over-enthusiasm and a lack of follow-up.

Completer

Role: Ensuring that the team is protected as far as possible from mistakes of both commission and omission; actively searching for aspects of work which need a more than usual degree of attention; and maintaining a sense of urgency within the team.

Attributes: Strengths—an ability to combine a sense of concern with a sense of order and purpose; self-control and strength of character.

Tolerable weaknesses—impatience and an intolerance towards those of casual disposition and habits.

The roles that we saw our DAs playing in DMT meetings and subsequently were, for each of the eight, as follows.

chairman, completer, company worker

team worker

chairman, plant

plant, resource investigator

chairman, company worker, team worker

completer, shaper

monitor–evaluator, plant

plant, shaper

It is not appropriate to say what roles the DA ought to be playing because these will depend upon the roles being played, or capable of being played, by other group members. When a member leaves a team it is important to consider what role(s) may now need replacing.

4

Work with other functions

Summary

The demands and choices in the administrators' work with other senior staff—nursing, medical, finance, works and buildings—are described, with examples of the events and issues in which they become involved, and with quotes illustrating their views. The external relationships with the community health council, social services, public and press, and with central, regional and area authorities and officers, are also discussed, with reference to the differences between the roles of district administrators and area administrators of single-district areas.

The material for the first part of this chapter is taken from the section of the interviews in which we asked the district administrators and area administrators in single-district areas to describe the issues in which they were involved during the previous month.

The DA's administrative and coordinating role necessarily involves him in other functions. He has, as we saw in Chapter 2 (pages 11–25) a choice as to the extent and nature of his delegation. He has a choice in the use he makes of his own contacts on administrative matters. He also has a choice in whether, and if so how and the extent to which, he gets involved in the activities of other functions.

Nursing

The subjects of the DA's contacts with the district nursing officer

(DNO) or members of her* staff during the previous month and during our observations can be classified under the following headings.

Administrative matters

nurses' accommodation

admission of patients

removal expenses.

Personnel matters

industrial relations

decisions on and handling staffing problems

disciplinary issues.

Planning and public relations

community services

new hospital

reorganisation of nursing management.

* For convenience, the feminine pronoun is used throughout to refer to nurses, though some of them are men.

Wider policy/procedural matters

legal advice

medical procedures

financial problems

EEC requirements.

Our DAs differed widely in the number of nursing matters in which they had been involved outside the district management team during the month, ranging from virtually none (though, of course, their subordinates are likely to have been) to as many as nine. The reasons for these variations can be attributed to three factors, apart from any special difficulties during the month. Each of these factors can be seen as a range from minimum to maximum involvement by the DA.

	low DA involvement	*high involvement*
1 DNO's requirements of DA	basic administrative services, DA's functional role only	working with DA on both nursing and district issues, as members of the DMT
2 DA's position	primarily administrative	central figure in the DMT and the district
3 DNO's competence and confidence	competent as nursing manager, not seeking help in her managerial role	DNO having difficulty in nursing management and in DMT

It can be seen that the DA can be actively involved with the DNO, and sometimes with her staff as well, for quite different reasons.

They may meet frequently because of their mutual interest in DMT matters, because these will often have a nursing aspect. They may meet often because of the DA's major role in running the district, or many of their contacts may arise from the DNO's need for help in management problems. Some of our DAs thought that the DNO was more in need of such help than other officers: a view that was sometimes resented. Their relationship varied from interdependence (probably the best from the point of view of effective consideration of the district's problems) to independence (the most common); to the DNO being dependent upon the DA; to counterdependent, that is, the DNO resenting the DA's concern with nursing matters.

Medical matters

The discussion of the DA's involvement in nursing centred mainly on his contacts with the DNO, although he might also have contacts with other nursing staff, particularly on personnel and industrial relations problems. A discussion of the DA's involvement in medical matters is much more complex because he will have contacts with the three medical members of the DMT as well as with some of the other medical staff. The DAs varied in whether they were personally involved in administrative requests and queries from consultants, or whether they delegated these matters to one of their subordinates. Those who chose not to delegate believed that personal contacts with the medical staff were helpful in establishing their reputation and building up a network of friendly doctors whose support, or lack of opposition, might be useful.

The purposes of the DA's contacts with doctors can be broadly divided into the short-term and the long-term (see Figure 2).

There is a demand on the DA to see that A is done, but not necessarily by him. Some of B can also be delegated but there are

likely to be issues that will come to the DMT and, therefore, necessarily involve the DA as administrator. Involvement in C may be mainly or wholly a matter of choice, as they are matters that will, or should, be dealt with by a medical member of the DMT or another doctor, if the DA does not. D is a choice, an extension of the DA's domain, but a choice that may be prevented by the DA's inability to establish such a position.

Figure 2 PURPOSES OF CONTACTS WITH DOCTORS

Short term	Long term
Medical disturbance handling (C)	District initiatives and politics (D)
Administrative maintaining and responding (A)	Administrative planning and liaison (B)

We give below examples of medical aspects with which our DAs were involved, divided into these four categories.

A *Administrative maintaining and responding*

effect of industrial relations problems on admission of patients

car parking problems

supplies to surgeon corrected

secretary of medical executive committee.

B *Administrative planning and liaison*

developing space needed for medical services

setting up a commissioning team

requirements for equipment and beds.

C *Medical disturbance handling*

personality clashes in medical staff

doctor's annoyance over a change of holiday

violent patient

problem with medical practice.

D *District initiatives and politics*

initiates plan to combine two orthopaedic services

works with AMO on consultants' relationships

trying to increase doctors' cooperation with the DMT.

Many of the DAs seemed to attach particular importance to their relations with doctors.

Many DAs would be horrified if the DCP performed his role as was intended. They see the doctors as theirs, and contact with them as adding to their status.

The DA who sees himself as responsible for the district will seek to get involved in medical issues. There is a potential choice for him to extend his domain in that way, but there are also constraints imposed by the reactions of doctors to such attempts, and by the alternative claims on his time.

Finance

The demand is the same for the DA as for other heads of functional departments: to prepare a budget and to keep within it. The DA can choose to be more actively concerned about the economic use of resources in his own department. As a member of the DMT, he can also choose to emphasise financial planning and evaluation. Or he can choose to side with what tends to be the medical and nursing view, that standards in the care of patients are more important than punctilious attention to budgetary controls.

Relatively few financial subjects had arisen in the month before our interviews. Most of the examples we were given related to the district rather than purely to the administrative department. Examples from the interviews and from our observations are given below.

Administrative items

district office budget: DA talks to subordinates about their delegated budget responsibilities

error in social club's accounts: DFO and DA discuss ending the district's relationship

financial reduction in courses and conferences.

District items (discussed between DFO and DA)

use of free monies

new charges for GPs in health centres

implications of RAWP: now always on DMT agenda, but also discussed between DFO and DA

political implications of under-spending.

The frequency and the purpose of the DA's contact with the DFO varied almost as greatly as those with the DNO. The role of the DA in finance and his relationship with the DFO seemed to take one of the following four forms.

1 The DA took over much of the financial management for the district from the DFO, who performed a purely financial accountant role rather than a management accountant role.

2 The DFO was helped by the DA's support and counsel.

3 The DFO and the DA worked together, sharing financial responsibility for the district.

4 The DFO worked for the district, rather independently of the DA.

Works and buildings

The DA's role in this area was described as *'the greyest of grey areas'*. The demand is that the DA sees that the DMT vets the district's works maintenance programme. But some of our DAs chose to take on much more responsibility than that, acting as if

they had direct managerial responsibility for the works programme. They saw themselves as ultimately responsible if they judged that the DWO was not performing adequately.

One explanation for these variations was the differences in the status of the DWO or AWO. In one SDA he was a full member of the AMT, responsible direct to the AHA. In some of the districts he was described as the DA's subordinate. It is probably the variations in both official and unofficial status which account for the statement quoted about grey areas. Other explanations for the differences in the frequency of contact were similar to those we gave for contact between the DA and the DNO, which include the DA's position and the DWO's competence and confidence.

Reported contact between the two ranged from the DWO dropping in two or three times a week, to monthly discussions and occasional other contacts. One DA said that one of his subordinates was responsible for reporting on progress on the works side; he met with him and the DWO regularly once a month to discuss non-routine items. Topics that DAs said they had discussed with the DWO during the last month included the following.

Investigation of the reasons for a breakdown in the laundry.

Major reorganisation of all the grounds in the district.

Priorities for maintenance.

> *The DWO is the expert on what needs doing where. But it cannot all be done. So he has to discuss priorities with the DA, who has the better overall view of the service and reserves the right to have his say and of ultimate decision on what must be left out.*

Minor capital improvements.

Implementation of incentive bonus schemes.

New career structure for third-in-line works officers.

Planning aspects of building a new health care unit.

Patients' complaints

There is a demand for the DA to coordinate initial action on complaints from the public about the hospital services, a demand which involves him with other functions. We did not ask specifically about his involvement in patients' complaints. Some DAs referred to them when asked what subjects they would handle themselves rather than leave to their subordinates, some when describing the recent nursing topics in which they had been involved. More information was collected during the observations. Our rather limited information can be summarised by saying that some DAs delegated the handling of complaints to one of their subordinates, though they might sign any letters. Such delegation might be to sector level or to the district general administrator (DGA).

> *The DGA deals with planning, legal [matters], complaints, CHC etc . . . while the DA is concerned with longer-term issues on reshaping the district and opening it up to new ideas.*

The proper handling of such complaints was generally seen to be of the greatest importance and ultimately the responsibility of the DA. One DA said that he personally dealt with three or four complaints a week. He chose to deal himself with *'anything that can be embarrassing'.*

Comment

Each of these functional areas offers a choice of role for the DA, though that choice may be constrained by the competence and

attitude of the officer concerned. The choice for the DA, within these constraints, is one of domain; that is, the areas within which the DA acts as if he had responsibility. He may feel, and act, as if he had responsibility for the whole district service and, therefore, concerned with monitoring the performance of all other functions. Where he thinks that performance is inadequate he may choose to try to intervene, even to try to take over the management of the key aspects of that part of the service. Where such intervention is opposed, he may feel that it is his duty to report his concern to the area officers or authority.* Instead of adopting the role of chief executive, he may make himself available as general counsellor, saying 'everyone's problems are the DA's'. The implications of this flexible domain are discussed and illustrated by case studies in Chapter 5 (pages 84–108).

External relations

Community health council

The demand for the DA is to respond to reasonable requests for information. He can refuse some information; for example, about disciplinary hearings.

There were considerable variations in the nature and frequency of contact, and in the DAs' statements about the CHC. Some DAs never went to CHC meetings and had little informal contact with the chairman or secretary. One of their subordinates might go to meetings. More commonly, DAs went to some or all the CHC meetings, sometimes with some or all of the other DMT members. A small number of DMTs had periodic closed sessions with the CHC. A few of the DAs were actively involved, usually with other DMT members, with formal meetings and working groups. The

* His relations with the area are discussed on pages 66–72.

CHC was sometimes seen as a useful ally in fighting the district's battles.

We noted, without being sure of the reasons, that almost half of our DMTs had contact with the CHC, in addition to the DA's contact, but that only in one of our nine AMTs did other AMT members have contact with the CHC. This may be because those concerned with health care have closer relationships in the comparatively smaller districts, or because single-district areas have fewer battles to fight.

The general impression given by the DAs was of minor contact, and of a rather critical attitude towards the CHC. There was some feeling that CHC members, unlike AHA members, are critical without having to be responsible. However, our information on the DA's relations with the CHC is limited to one question in our interviews. The observation period was too short to provide further information.*

Public relations

To most DAs, public relations meant primarily relations with the press. It is a demand for the DA to deal with the press or to ensure that one of his staff does so. He must seek to minimise adverse public relations.

Nearly all the DAs preferred to handle anything other than routine press handouts and queries themselves. Such contact was predominantly by phone. A few DAs delegated press relations completely. A few tried as far as possible to avoid contact with the press. The majority handled press relations and responded to press

* Ruth Levitt has reported on the first five years' development of community health councils.[7] These bodies, like the concept of consensus management, are comparatively new to the NHS and their future is under review.

enquiries, but did not initiate contact. A smaller number also initiated contact with the press to explain difficulties, such as the effects of an industrial dispute upon admissions, to describe changes, or to enlist public support for decisions or difficulties of the DMT. In one district, journalists were invited to DMT meetings for information on plans. Most DAs seemed to enjoy their contact with the press: for some it was a useful way of advertising themselves, their concerns and their problems.

Region, DHSS and social services

It is a demand for the DA to be the link in the administrative chain. We have very little information from our interviews or observations about the work involved. Our main information came in answer to a question about the frustrations of the job, which we discuss in Chapter 6 (pages 117–119).

Relations with the area

Area team of officers

Our information comes from the DAs. Most of their remarks refer to the relationship between the DMT and the ATO. This relationship varied widely. There were a few districts which had good relations with, and trusted, the ATO.

> *The ATO and the DMT act as one and the AHA accept their view . . . no officer disagrees with another in front of the authority . . . any bugs are knocked out before the AHA meeting. These area officers are very good and can be trusted implicitly.*

This view was unusual. The most common attitude reported by the DA was mistrust of the ATO. There were two main grounds.

The first, and more important, was that the ATO would act as a barrier to the area health authority. In the competition among the districts for scarce resources, the ATO could not be relied upon to give a DMT's case. Sometimes there was also anxiety about the competence of the ATO, either because of the calibre of the members or because they could not know enough about the district to prepare good background papers. A more minor criticism was that the ATO was *'just a cause of frustration and irritation'.*

The second reason for mistrust was that the ATO would trespass in what were seen to be the district's prerogatives. Even districts with the most amiable relationship with area officers could still be on their guard.

> *This area does not get in the district's hair. They do not try to run the operational services from the area. District officers have made it quite clear that area officers must keep off their patch and they are very watchful of their prerogatives.*

It was also suggested that DAs in an area *'must be very close in order to maintain the district role . . . They must act together in their own interests.'* One indication of the success of the DAs in protecting their operational role is the answer to the question: Who runs common services, the DAs together or the area officers? The relative roles of district and area were described by one DA as follows.

> *The DMTs are the managers responsible to the authority, the ATO are advisers on planning and policy-making—they cannot talk on district matters. So district officers are at the chairman's briefing meeting and speak freely at the AHA meeting.*

The prime need that many DAs saw in their relations with the area was to try to safeguard the district officers' access to the AHA.

We now go on to consider separately the relationships of the DMT and AHA, and those of the AMT and the AHA. There are differences in the formal management structure between a DMT and AHA in a multi-district area, and an AMT and AHA in a single-district area, and these differences are reflected in the ways in which the DAs and AAs see their roles and relationships with the AHA.

DMT and AHA

We can distinguish between the formal provision for the DMT to get its voice heard by the AHA and the informal opportunities that the DMT, and usually especially the DA, may seek to create.

The DA can ask the AA to put items about his district on the agenda. In some areas, the DA writes papers for the AA who then presents his own version to the AHA. In others, the ATO writes the papers after discussion with the DMT. In a minority of districts, the DA and/or the DMT's chairman, or the whole DMT, have a standing invitation to the briefing of the AHA chairman before the monthly AHA meeting.

In nearly all areas, the DA went either regularly or some of the time to meetings of the AHA; sometimes in rotation with other members of the DMT, sometimes with one or more of the other officers. This widespread attendance conceals considerable variations in the opportunities for the DA, or other DMT member, to speak at AHA meetings. This might be indicated by the places they were given. In a few areas, the DMT members, as the managers of the service, were free to speak and were expected to contribute. In most, the DA or other member of the DMT could ask to speak. In some, they could only speak when invited to do so. In one area, no one from the DMT went to AHA meetings: the ATO was trusted by the DMT to put its point of view.

Where the DA feels there is need to increase the DMT's influence with the AHA, and/or to improve the AHA members' knowledge, he may seek to encourage formal contacts, with the opportunities these may provide to promote more informal contacts. The most common additional formal contacts were visits to the district by a small group of AHA members accompanied by the DA, *ad hoc* working groups, meetings between the DMT and a panel from the AHA, and invitations to an AHA member to a ceremonial occasion, such as inviting him or her to open a new health centre. Some AHAs have a system of allocating members to particular districts to visit health units and to meet the DMT. In a few AHAs there is little contact between AHA members and the districts.

The DA may seek to get to know individual members, particularly the chairman. He may cultivate those AHA members who live in his district. Two DAs said that they knew all the AHA members. Such individual contact is one way of making sure that the district's case is known. This may also be a way of bypassing the ATO, so that the latter cannot pretend that it has the district's cooperation if it has not.

The DAs had different views about the role and value of the AHA. Some welcome the greater distance from the authority that they enjoy now compared with the original management system with hospital management committees. Some regret the loss of the closer personal contact of HMC members with their greater knowledge of, and interest in, their hospital or group of hospitals in one district. Some DAs complained about the remoteness of the AHA.

> *The DMT are a voice crying in the wilderness because AHA members are too busy, too uninterested or too ignorant to hear them. The DMT feels that the AHA do not understand their position and do not care.*

> *They haven't got the time to get briefed and if they are not*

briefed they cannot understand the issues involved. Their lack of knowledge and understanding is a potential worry.

Some DAs spoke as if they had a similar role to play with the AHA as they had with the DMT.

We should help them to concentrate on the right issues.

Brief them with papers and explanations at the meeting.

Educate them.

A few saw the AHA as a potential source of support against the RHA and DHSS.

The DAs' view of the AHA did not seem, as one might expect, to be related to the number of districts in the area. There were DAs in two-district areas who felt that they had virtually no contact, and those in large multi-district areas who felt that there was reasonable contact.

AMT and AHA

The relationship of the AMT with the AHA is, of course, a direct one. There is none of the problems of intervening relationships with the ATO. A great difference for the AA, compared with the DA, is that the AA is secretary to the AHA, although he may not be called that, and normally has a close working relationship with the chairman of the AHA. Eight of our nine AAs said they were seen as the obvious point of contact between the AHA and the AMT. The ninth said that, although he would like the chairman to have a close working relationship with the AMT, the chairman preferred to preserve his independence.

The extent to which this contact with the chairman involved extra

work for the AA varied with the time and interest of the former. In one case, the chairman was in the area offices two or three days a week and usually saw the AA on his own twice a week. In another, the contact was described as a strong father-and-son relationship: the key relationship in the organisation for the AA. In some others, it was more distant and less time-consuming. However, in none did the AA complain of the time involved. This relationship is potentially a source of power for the AA, although he may try to get the chairman to recognise that he should work with other AMT members as well.

It may be easier for an AA than for a DA to fulfil the objective role towards the use of resources, of which some DAs spoke, because he does not have the potential problem of feeling that he should compete for resources with the other districts in the area. One AA said that he felt that no one else could play the role of trying to influence people to follow the AHA's policy.

In six of the nine SDAs, all AMT members went to AHA meetings. In two, usually only the officers went; and in one, only the AA. There were no complaints about the AHA members being remote, although there was a worry about the difficulties of including the AHA properly in the process of consultation. Members do not have sufficient time or sufficient background knowledge to read and understand all the documents.

Time demands of area business

The AHA will usually make more demands on the AA's time than on that of a DA. The AA usually has closer links with the AHA chairman. Then there are the secretarial duties to be performed. The estimated time needed for preparation for AHA meetings varied from one to eleven hours for the AAs; with most AAs spending from two to four hours. The estimated time spent by the DAs varied from nothing to five or six hours when an issue

concerning their district was to be discussed. The AHA can also make demands on the time of a DA or an AA to meet members on working parties, on visits and at social functions. There are also requests for information.

The demands on the DA's time made by the ATO seemed to vary considerably, but we have no detailed information. A common complaint was of unrealistic deadlines for the provision of information.

Comment

The DA has a variety of choices in his relations with the ATO, within the constraints imposed by the latter's attitudes and competence. He has a choice in the extent to which he will cooperate with the ATO and trust it to put the DMT's case to the AHA. If he decides that his duty to his district requires him to seek to influence the AHA directly, he has, as we have seen, a variety of possibilities. He also has a choice in whether he adopts, and encourages the DMT to adopt, an objective view of its situation and its need for resources compared with other districts, or tries to get the most that he can for his district.

The AA has a choice in how he seeks to handle his relationship with the chairman of the AHA, which is similar to that of other officers with a lay chairman; that is, the extent to which he aims to give neutral advice or to influence him. The AA has an additional choice as a member of a consensus management team, and that is whether he seeks to use his special relationship with the chairman to give himself additional status and influence. The AA and other members of the ATO also have a choice in the trouble they take to brief members of the AHA and to consult them.

More generally, both the DA and AA have a choice in the relative importance that they attach to work for the AHA, compared with other uses of their time. The DA also has a choice in the extent of his involvement with area matters.

This chapter has pointed to a number of choices in the DA's role that we explore more fully in the next chapter.

5

Different ways of being a district administrator

Summary

Five main roles are identified: administrator, linkman, shaper, innovator and general manager. The strengths and weaknesses of each role are discussed. One other role, the figurehead, is described. The reactive-to-proactive approach, developed by Kotter and Lawrence[6], is used as one way of describing how different DAs do their work. The power bases that managers may be able to use are described as they apply to DAs. Eight case studies are presented to illustrate the main roles identified in the study. They show how DAs differed in their focuses of attention, their relations with subordinates, the roles they adopted in the DMT (using Belbin's team role specifications) and their methods of working. The aim is to show the differences both in what our DAs did and in how they did it.

We now take an overall look at the roles adopted by our administrators. First, we describe the main roles we identified; then we illustrate some of the differences between our DAs by means of brief case studies.

Main roles

We identified from our observations and interviews five main roles. We did not start our research with the idea of these roles, but found that they were a helpful way to describe the differences we discovered. Any categorisation has its limitations, but we believe that our description of different roles, together with their

strengths and weaknesses, can be useful to DAs, and to those preparing for that job, as a way of thinking about the role they adopt and its relevance to the circumstances in their district.

The roles are not exclusive. A DA may move from one to another, or use more than one, but for any individual a particular role is likely to be the major one at a particular time, though he may be capable of playing a different one. We believe we can categorise the DAs we interviewed and those we observed—because we found the observations usually confirmed the interview—as belonging primarily to one of these roles. The Table shows in note form the roles, their characteristic activities, and their strengths and possible weaknesses.

One role is not necessarily better than another. Which role is appropriate depends both upon the individual's personality and upon the role that other members of the district management team permit and require him to play in his capacity as a DMT member, though he is less constrained in his own department and in the external relations he takes on. The appropriateness of the role will also depend upon the state of the district, whether it is a stable one or not, and upon the roles played by other members of the DMT and by his immediate subordinates.

We found an additional role, played mainly by a few of the DAs who had been in their districts for some time: the 'figurehead'. This was the person people knew they could go to if they had a problem. This was true for staff, patients, and for any other person with an interest in, or problem related to, health services in the district. We have not included this role among our main five. It is an additional role that a DA with an appropriate personality and interest can choose to play. It has advantages for the service, in that people feel there is someone they can go to for help and for access to information. The disadvantages are the time absorbed by such a role, and the availability it demands, which must necessarily be at the expense of other activities.

Table Five main roles: their strengths and possible weaknesses

	Characteristics
Administrator Basic role that all DAs must perform. Some concentrate almost wholly upon it, some delegate most of the work.	Servicing and maintaining
Linkman A role that a DA as a coordinator needs to perform to some extent. Our DAs varied considerably on the strength of this role.	Coordinating and collecting
Shaper* A role that fewer of the DAs adopted; but some did, as we saw in discussion in the DMT.	Initiates and influences; directs attention to objectives
Innovator Very much a personal role that only some individuals will wish to play or be capable of playing.	Changes, challenges and confronts
General manager Only a few of the DAs played this role. A few others may have wished to, but failed to get it accepted by others.	Determines and controls

* Taken from Belbin's roles; see Chapter 3 (pages 49–53).

Strengths	Weaknesses
Does not reduce others' sense of responsibility. May help to ensure efficiency of the administrative work.	Concentration upon this role is at the expense of other roles. Whether the DA needs to play others depends upon the roles played by other members of the DMT and by his subordinates.
Can serve as a nerve centre for collecting and transmitting information. Brings people together. Does not reduce others' sense of responsibility but ensures their involvement by lubricating channels of contact.	Requires concentration on setting up and maintaining a network of relationships—to deal with shorter-term, rather immediate issues. May need frequent use to confirm the network.
Gives focus and pattern to the group discussions. Has clear sense of direction and the drive to try to get others to accept it.	Sense of direction may be wrong. May be at the expense of team-building and developing others' strengths and responsibilities in management. Potential 'leaving the DA to it'.
Contributes a fresh approach and an interest in change and improvement. Has longer-term vision and can encourage others to do so, too.	May not have the tact and other skills to get ideas accepted. May neglect the problems and details of change resulting from imaginative ideas.
Has a clear sense of purpose, drive and the personality to get acceptance to play this role. May, in consequence, be able to achieve a great deal.	Encourages dependence in others, so they do not contribute as much as they could. His views may not get adequate examination. When he goes there is a vacuum, but there may have been one when he arrived.

Different methods of working

Our observations showed that DAs differed not only in *what* they do but also *how* they do it. The case studies we give later in this chapter are intended to illustrate both these differences, and to show the variety of choices in the job. The aim is to help the DA, or prospective DA, to be aware of the choices he is making and to appraise their relevance to the situation. The case studies also aim to show the advantages of, and possible dangers in, the different approaches. We make use of the concepts we have described to help in the understanding of the DA's job, including that of the different roles which DAs play. Therefore, the case studies can most usefully be read after the preceding chapters.

One of the major differences in *how* people work is in how reactive or proactive they are. Another is in the methods they use to obtain and to pass on information. Yet another is the methods used to influence people. We show in the case studies how the DAs differed in each of these respects.

The distinction between a reactive and a proactive approach to a job has been usefully elaborated in Kotter's and Lawrence's study of how 20 American mayors did their job.[6] The distinctions are equally applicable to other types of senior post, including that of the DA. Kotter and Lawrence identified four stages, from 'reactive' to 'proactive', which we give below with examples from the DA's work.

REACTIVE

▲*Stage 1* The pattern of the day is determined by response to immediate issues and problems. They come in by phone, or colleagues and subordinates pop into the DA's office to use his experience to get ideas for solutions or to start discussions on matters of common interest. The DA has spontaneous or very short meetings, lunch and coffee often being the starter. He will also go out to sector administrators to work on current prob-

lems, supporting them and helping them in their decisions. He gets the more junior staff to do work for him directly and makes frequent contact to monitor their performance. The DA leaves the planning to his deputy. He does not attend meetings of the district planning group and avoids contact with the ATO and AHA. He is the centre of information coming in and going out. The day is hectic, but mostly administrative, short-term and corrective.

Stage 2 Much time is spent also in daily contact, sharing and distributing information, but the DA has more deliberate contacts to maintain and develop relations necessary for the DMT and for the other functions. While his subordinates have unrestricted contact with him, dropping in when they need to, the DA self-starts and initiates contact in the district and the area to work on reports and reviews of functions. Not only is the diary full with arranged meetings, but the day is also frequently interrupted with problems, which can determine further *ad hoc* meetings or contact, as soon as possible—and time presses. Such pressures draw the DA back into administration, which limits his wider, longer-term concerns.

Stage 3 The DA delegates, particularly operational management, to well established deputies. There is daily contact with the two or three main subordinates, maybe a regular morning meeting for half an hour. The DA keeps himself well informed on local and present problems, gets his mail—which has already been sorted—from his deputy, and then takes on work in order to involve himself in selected issues. These are not always longer-term issues of the district: he wants, for instance, to get involved in the consultants' complaints about medical records filing, or in an item on the agenda of the deputy's meeting with sector administrators about problems with the ambulance service, or the patients' waiting list. But the DA is mainly an adviser to subordinates for the problems they bring to him, and much time is spent on longer-term and wider management con-

cerns. More time is spent in contact with other functions and with colleagues in the DMT than with subordinates. The DA's time is more programmed, with fewer but longer discussions. He is less hasty in dealing with current problems. Wider implications are the basis of the DA's contact with the area and region about other functional concerns; for example, issues of financial and nursing management.

Stage 4 The DA is separate from most of administration. While he may see his operational deputy each day, he is very little involved in the problems and issues of running the hospitals. He makes more contact with the subordinate concerned with planning. The district personnel officer does not report direct to the DA; the latter is involved only when issues such as industrial relations and establishment, which concern the area and regional authority, arise. Much more time is spent in handling planning issues. The DA is reading and writing, making and arranging formal and informal contacts, for information, for data and for decisions about development. Project groups and commissioning consume his time, with behind-the-scenes informal contacts to ensure common ideas and opinions. Such contacts may involve walking around a building site with a senior consultant as they discuss the new hospital, or being involved with the DNO on the design of the next new health clinic. There is little spontaneous personal contact; much time is spent alone in the office and there is a secretarial barrier except for senior staff in other functional departments. Time is planned and disciplined—forward vision determines the sequence of contacts—and the DA's focus of attention is more outwards to area, community, regional and local authorities, than inwards to the district's administration.
PROACTIVE

The power bases of the DA

The case studies include brief discussions of the methods that the

different DAs use to try to influence other people; which is another way of saying the 'DA's power base'. It may be useful to look at these in a little more detail. The main five possible bases commonly developed by managers are described below.

Expertise

The role of administrator offers some scope for earning the right to be seen as professional. This includes some knowledge of a range of more specialist expertise; for example, personnel, industrial relations, planning and law. It may also include political skills, like those required by a fixer who copes with awkward problems and relationships.

Expertise is unlikely to be, or to become, an important power base but the DA's competence as an administrator can give him some influence; more important, it is a necessary component of his capacity to influence.

Control over information

A DA may choose to acquire power by his access to, and possible control over, formal information. The DAs we studied differed both in whether, and, if so, the extent to which, they centralised the flow of administrative information by seeing all incoming and outgoing mail, and in the extent to which they shared their information with other members of the DMT.

The DA's greater access to information relevant to many decisions is potentially, and often actually, his greatest source of influence in the DMT. The most common activity of the DAs in the DMT concerned information: presenting, summarising and analysing it. The skill and knowledge with which they did this contributed to their influence upon decisions, and their overall understanding of consequences was often wider than other DMT members.

Access to informal networks

The DA's professional position can give him, if he chooses, access to an informal network of DAs and AAs who can help to keep him informed about developments elsewhere. DAs in the same area may also, on occasion, link together against the ATO or AHA.

Some DAs took trouble to develop a network of medical contacts by meeting doctors socially, and by services such as acting as secretary to the medical executive committee (MEC) or undertaking visits on its behalf. Some got to know members of the AHA and the CHC informally. Others have developed regular, personal contact with the chairman of the AHA.

A few developed wider political contacts with the RTO and RHA and with local MPs and press, which they used, for example, to get the RAWP* decisions affecting the district reconsidered.

The use of informal contacts as a way of getting information, and establishing friendly contacts to support the DA when needed, are methods of influence open to most managers. The DA's potentially wide range of contacts gives him considerable scope in making use of this.

Perceived status

Once a DA has built up his status by some or all of the previous methods, he is in a better position to exercise influence—even better if he can successfully act as if he were the leader of the DMT.

Another method of adding to one's perceived status is to act as a figurehead. Some of the older DAs seem to have additional status

* See footnote on page 6.

as the 'grand old men of administration'. Perhaps the NHS culture encourages this role; it is rather like the traditional status of the medical elder.

Formal authority

DAs sometimes complain of their lack of formal authority, yet they have this as one of their power bases. Despite the change in industrial relations, the NHS feels more hierarchical than many other types of organisation, perhaps because of the still pronounced hierarchies in nursing and medicine. Formal authority in administration extends the DA's influence into other functions because administrative responsibility in the district embraces a wider area than that of others' functions. The administrators maintain and ensure the continuous services which provide the conditions for work of those caring for the patients. Reliable, stable, trusted services from administration relieve the professional staff from disruptions to their work. It is the provision of these services which enhance the DA's formal authority.

The professionalisation of administration and the better salaries of administrators during the last few years have supported the DA's formal authority.

The boundary between the district and other organisations concerned with health and social services means that individual contacts are necessary. The director of social services, for example, will want to talk to the DA rather than the DA's subordinates.

The inquiries on Normansfield and Solihull hospitals[5, 13] laid responsibility on the DA's shoulders. This shows that the DA is seen as the one with formal authority, regardless of the concept of consensus management.

In sum, though DAs may deplore the ambiguity of their position

in a consensus management team, they have available a number of possible sources of power, other than their own personality, that they can use in their efforts to influence others.

Case studies

The presenting of case studies poses problems of anonymity. We are much indebted to those DAs and AAs who were willing to be observed. We owe it to them to camouflage our case studies. We have done this in several ways. One is by referring to all case studies as if they were those of DAs, though they include some AAs. Another is by leaving out any detailed description of the particular district or area. Yet another is by including elements from other observations and interviews, though in writing the case study we have almost always used one individual as the starting point. We have particularly used examples from elsewhere in discussing the relationships between the DA and other members of the DMT. We have said little about the nature of the DMT meetings because this has been discussed in Chapter 3 (pages 26–53).

Case study 1 A reactive administrator

This DA has been in post since 1974.

Pattern of work The DA's day is a very busy and fragmented one, except when he is in meetings. Almost all his time, apart from meetings, is spent in his office.

He has a morning-mail meeting with his subordinates, and allocates the letters to them. He expects to see the answers before they are sent off. He encourages his subordinates and other people to come and see him when they have a problem. He is interested when they come, if sometimes preoccupied, and takes on the solution with them. He makes a lot of telephone calls about queries arising

from the mail or about any problems brought to him. He is also freely available on the phone. When his secretary brings in any paper he will apply himself to that rather than to what he was doing previously. Despite the interruptions, a lot of time is spent reading papers that come into his office. He may take some of them home, especially if he wants to prepare a background paper for the DMT.

In addition to the usual formal meetings, he will have frequent conversations with senior subordinates and other members of the DMT about urgent administrative problems.

He has a number 1 reactive pattern of work.

Focus of attention Immediate issues and problem-solving.

Role with subordinates The DA's role is of monitoring, pushing for improvements and, with some subordinates, getting them to self-start their work without his reminding them. There are seven subordinates reporting direct: they are the ones responsible for various parts of the operational services. The DA also makes direct contact with more junior staff in initiating their work.

Role with DMT members and doctors The DA has most contact with the DFO, who has been the chairman of the DMT for two years. They have daily contact, both by phone and by face-to-face discussions, on the concerns relevant to the DMT and the area. The consultant-member and the GP-member encourage and support the DA in getting problems solved. Consultants contact the DA frequently and he responds readily to their problems and gives the required explanations. However, the DNO and the DCP have a rather unsupportive relationship with the DA: they tend to show a critical resistance to the DA's secretarial role in the DMT. They strain towards their independence and this causes difficulties for the DA in holding the DMT together to produce shared

decisions. Working with subordinates on current difficulties is, he feels, more productive.

Preparation for, and role in, DMT meetings Virtually all the items on the DMT agenda come from the DA, with the final agreement of the DFO as chairman, just before the meeting. There is a standard, automatic compilation of the agenda. The DA goes through the papers of the last meeting, checks by phone the action-initials with other members and subordinates, and over the weekend he and other members go through the papers and the summarised information. Further papers will have been made ready for the coming meeting, the agenda being mostly items on immediate problems and corrections. The DA contributes a sense of urgency to the resolution of problems. His main roles in the DMT are completer and company worker.*

External relations The DFO, as chairman, attends meetings of the AHA. He also handles contacts with the ATO because he and the ATO have offices near each other. So the DA has little contact.

How he gets his information Mainly by reading, by formal meetings and from his subordinates.

Methods he uses to influence people Since his role is confined to administration, he is mainly concerned with influencing his subordinates. This he does by monitoring them closely and by being rather dominant. Subordinates rely on his directions and solutions; they are rather dependent. His influence in the DMT is achieved by his knowledge and his readiness to carry through its decisions.

Comment

The advantages of this kind of approach are that the administrative work gets close attention, and immediate problems are known and

* See Belbin's team-role specifications in Chapter 3 (pages 49–53).

usually dealt with before they become crises. Since the DA is not contending for power, there is room for another member of the DMT to play the main role if he wishes, either as a leader or as a team builder. However, this depends a great deal upon the capacity of the membership and upon the DMT's concept of itself.

One possible disadvantage of this approach is that there may be no other member of the DMT able and willing to take on the role of chairman or shaper. Another disadvantage is that the potential of the DA's role, and of the information belonging to it, is not fully used and, apart from formal administrative responsibility, cannot be extended into the district. The DMT is concerned with short-term management problems, and the individualism of its members restricts its development and the longer-term opportunities for the district. Yet another disadvantage is that the DA's subordinates, because of the close monitoring, do not have enough scope for development.

This indicates that the role played by the DA can limit—or even prevent—the development and growth of trusted interdependence, both in administration and among other members of the DMT.

Case study 2 Administration by meetings

The DA has been in post since 1974.

Pattern of work The DA spends more of his time in formal meetings than our other DAs. These consume about half of his total time. This is his preferred method of contact, and includes regular programmed meetings with his subordinates and attendance at a variety of meetings that other DAs might avoid—because they might expect a subordinate to go, or think the meeting not worth the time, or because they prefer an informal personal contact for solving problems. Apart from meetings, the DA does not initiate face-to-face contact; there is little contact with individuals except

for the preparation for meetings. There are frequent incoming phone calls, often concerned with current problems and requiring explanations to consultants, the press and trade unions, but some of the calls have to be redirected to other officers.

The DA is tending towards reactive (number 2 of the scale).

Focus of attention Administrative problems, difficulties in external relations, public relations and the press.

Role with subordinates The DA is rather separate from the seven subordinates who report direct to him, not because he delegates a great deal, but because his main contact with them is through formal meetings. On the whole, subordinates work mostly by themselves, but the DA gets involved in the problems if they produce adverse publicity, or are connected to other functions, such as nursing. Subordinates do not have joint contact with the DA apart from the formal meetings, and this means that, with their physical separation, the administration is not a team.

Role with DMT members and doctors The DA is not strongly related to any member of the DMT and, apart from the DMT meetings, only one member has further contact with him during the week. The DA does little initiation of face-to-face individual contact or of informal discussion of information. He works mainly through meetings and by telephone, so an informal network of joint responsibility has not developed.

Preparation for, and role in, DMT meetings Much of the agenda comes from the DA. It is routine, with an established list of items, and is prepared by a committee clerk. There is no chairman, but the DA acts as the unofficial chairman. He is the source of most information and frequently has papers which have not been circulated before the meetings because of secretarial pressures and lack of time. The DA gives his own opinion on issues, raises preferences and points out the problems. There is a common famili-

arity with, and acceptance of, the problems, but agreed solutions are absent and no concrete, relevant information comes from other members. Each member is concerned primarily with the problems of his own function and it is only the DA who is viewing the district as a whole. His role is completer. He also tries to work as shaper, but does not have the collective support for this since the other members have not developed collective responsibility. The DA manages the decisions and has close contact with the ATO and AHA.

External relations The DA attaches high importance to external meetings, and exercises his public relations role in that way.

How he gets his information Mainly from meetings, and from papers prepared mostly by subordinates.

Methods of influencing people Primarily by the close control of information.

Comment

This approach to the job can be used in any type of district. Its advantages are that the DA knows where he is. It suits someone who is happiest with a rather formal approach to people. It helps to ensure easier, more manageable relationships. It has the merit of a concern, expressed by attendance at meetings, with the DMT's relations with the community and social services. It gives the DA visibility and allows him to establish contacts outside the district.

The possible disadvantages are that informal contacts and the building of friendly relationships are usually necessary to obtain support within the DMT and elsewhere. The DA's role also makes no contribution to the development of the DMT's analysis and solution of problems, or to a deeper, shared understanding about

planning. Because the DMT is not a team and lacks collective responsibility, it is limited in its handling of management issues. The DMT may be too dependent on the DA, in his formal, official role, with contact mostly in meetings, and this allows the DA a possessive role. The meetings are linked by the DA's formal co-ordinating role, not by the development of familiarity and trust between members.

Case study 3 The figurehead

The district is relatively small with no special problems. The DA is fairly new, and it is his first post as DA.

Pattern of work When the DA is not in his office, he is often paying informal visits to parts of the district. When he is in his office, he receives and makes many telephone calls. His door is normally shut, but people who want to talk to him come straight in. His efficient secretary, who is also committee clerk, is not used as a barrier.

He does not work long hours. He does not see it as his task to deal with immediate crises. He tends to take a relaxed approach to his job, and he enjoys it.

He is more reactive, although not concerned with immediate crises, than proactive, because he appears to have few longer-term aims or involvements.

Focus of attention He thinks that the DA should be the 'front man' for the district, taking on the PR role both within the service—hence his visits—and in the community, representing the DMT to social services, education authorities, the press and the community generally. He attaches importance to improving relations with the CHC and to joint developments with the social services. He talks easily with all members of staff whom he meets

on his hospital visits—indeed, faces often light up when he approaches.

Role with subordinates The DA likes to be liked, especially by his subordinates. He very much adopts the joining role with his subordinates, whom he also meets socially. There is perhaps a feeling among his three immediate subordinates that he needs to be more separate from them. He holds regular meetings with them, both all together and separately, and is very welcoming if they come to see him on other occasions.

Role with DMT members and doctors The DA gets on well with all members. He plays no special role with doctors, and leaves any medical issues to the consultant-member of the DMT.

Preparation for, and role in, DMT meetings Much of the preparation is done by his subordinates. The DA takes a back seat at the meetings, avoiding conflict when it arises, but willing to take on responsibilities outside the meeting on behalf of the DMT. Discussions are fairly low key. The DA contributes information to each subject on the agenda. His main role is that of team worker.

External relations He initiates and maintains contacts with the press and is a very well known local figure. (See also his *Focus of attention.)*

How he gets his information Mainly from subordinates, discussions with other members of the DMT, informal contacts during his visits and, to a lesser extent, from reading.

Methods he uses to influence people He does not specially try to influence people, but when he wants to he uses general pleasantness and personal friendship as the main bases. His administration earns respect, and so does he, for getting things done.

Comments

This is an example of how even a relatively newly appointed DA can adopt the figurehead role by the choices he makes: to spend considerable time representing the DMT; to make contact with those who are potentially influential for the DMT; and to establish contacts with a wide range of staff by his visits. It is easier for him to do this because he has competent staff working for him, and because the district has no special problems.

The advantages of his approach are that he helps to establish a good reputation for the DMT and, by his visits, gets himself and, perhaps, administration generally, liked and appreciated.

The possible disadvantage is that his desire to be liked and to avoid conflict means that he is making little or no contribution to the direction of the DMT or to the development of its members.

Case study 4 The linkman

The district has won through, after many difficulties, to a more stable situation and shows steady improvement. The DA has been in post since 1974.

Pattern of work Most days begin with frequent contacts, particularly with subordinates, but in the afternoon there are longer periods for reading through papers or meeting a DMT colleague. The days are busy, but under control, so the overall effect is not of pressure. Most days can finish to time, though reading may be taken home. Most of the DA's contacts, apart from subordinates, are determined either by preparation for, or the results of, meetings. He and others share equally in making contacts. He has an efficient and experienced secretary, but people can come direct to him if they wish and they sometimes do that.

Focus of attention This DA has a very clear view of the role that he thinks he should play both in the DMT and in other groups. It is best described as a 'philosophy of management', though he would not use that phrase. Part of this philosophy is his belief about the best way for decisions to be taken. He does not pursue his own clearly articulated aims, as a few DAs do, but seeks to create the situation from which the best decisions will emerge and be acted upon. He concentrates on how people think things through, not so much what they think about. It is the process rather than the content that interests him. He is somewhat towards the reactive end of the reactive–proactive scale, and is mainly occupied with immediate and medium-term issues.

Role with subordinates He acts in a supporting way with his subordinates. He has a deputy and two other subordinates reporting to him. There is frequent contact with them and they come easily to him. Discussions are often informal and joint, with the DA exercising informal monitoring, but he leaves much of the administrative management to the deputy and concentrates on the DMT.

Role with the DMT and doctors He is allied to all members of the DMT, but especially to the DFO. There are complementary roles. He will often discuss problems with members before and after a meeting. The DA's secretarial role in the MEC helps in the relevance and development of medical relationships generally and in the DMT. Apart from one member, the group is now established and has been together for four years. The DA's role as linkman is to find out the source of information, suggest and then set up an *ad hoc* meeting for some members, and he may then leave them to it.

Preparation for, and role in, DMT meetings The well established pattern for meetings is followed by an experienced committee clerk, who prepares the agenda. Many items are routine. She collects other items from members, in consultation with the

chairman. The DA will go through the agenda before meeting with his clerk. He will discuss any important item with the member chiefly concerned before the meeting.

Chairmanship is by six-monthly rotation; the DA is excluded, at his request. But, using Belbin's concepts, the DA plays the role of chairman, when he summarises information and points out implications and possible alternatives. He also contributes the roles of company worker and team worker. This latter, both in meetings and outside, is part of his linkman role: he brings people together, encourages team spirit and builds on the suggestions made. In the former role, he makes practical suggestions and gives clear explanations in the meeting, he appreciates detail, has a good memory, and is persistent in checking and following up.

External relations He leaves public relations to the consultant-member of the DMT, and IR negotiations to his deputy—*'they are better at it'.*

How he gets his information By careful analysis of papers and reports he is thoroughly aware of the practical meaning and consequences. He also gets information from his informal contacts and his discussions with subordinates, but primarily from his study of papers.

Methods he uses to influence people He does not push his position openly, but is persistently linking people and information, and arranging discussions before formal meetings. He is the stage manager using a script to which many have contributed, but he sorts out those who could make the most relevant contribution and links them together. He influences decisions by his experienced information, his practical, neutral approach based on a careful analysis of the facts, and his ability to present clearly and simply the facts of the situation. He is deliberately and visibly modest in the way he influences and works behind the scenes.

Comment

The current, relatively stable, state of the district suits this administrative linking role. Earlier there were more difficulties and the DA was much more involved in trouble-shooting. The DMT has developed and accepts joint responsibility, and should be able to cope with changes.

The advantages of the roles which the DA plays are that they have contributed to the development of the DMT, and to the development of individual members. He is generally seen as an experienced, practical administrator who is helpful and not a threat. He understands his own abilities and makes good use of them, while recognising his limitations and encouraging others to make up for them.

The possible disadvantage is that there is no long-term view or radical thinking about the district, but for the present that may be unnecessary. However, the personal preference for linking and for detailed, careful maintenance of relationships and management practices will not develop into the innovative role.

Case study 5 The linkman by information

This DA is relatively new to the district.

Pattern of work He plans his time more than other DAs because he attaches great importance to the careful analysis of information, which needs peace. His door has a large 'Private' sign. His secretary protects him from unplanned callers, and there are few interruptions. He arrives early to give more time for uninterrupted reading and preparation for meetings. There are few telephone calls and those there are are mainly handled by the secretary.

The DA is towards the proactive end of the scale.

Focus of attention In general, the DA is focused upon the careful analysis, and the political implications, of information.

During the last year one of the main issues he concerned himself with was the behaviour of the medical staff because of their unwillingness to cooperate with one another. The DA had spent a lot of time trying to ensure positive changes in their attitudes, but he hoped to spend less time in the future. The consultant-member of the DMT is positive and has supported the DA in his efforts.

The DA has also had to devote some of his time to industrial relations, although he has left much of the detailed discussions to the DPO.

Role with subordinates The DA is rather separate from subordinates, although he adopts a pushing/improving role. There is little informal, spontaneous contact, but they have regular arranged meetings. While subordinates are left to do their work on their own for several days, the meetings are long, with detailed analysis of the issues.

Role with the DMT and doctors There is friendly contact with all DMT members and a close relationship with the DCP. The consultant-member also makes contact several times a week.

The DA's contacts with other doctors are discussed in his *Focus of attention.*

He sees himself as giving a lead in getting regional and governmental policy implemented in the district and in giving objective advice.

Preparation for, and role in, DMT meetings There is a disciplined agenda with detailed, well prepared, supporting papers. There is a rotating chairman (yearly), whom the DA briefs carefully beforehand. Discussion is relaxed, egalitarian and friendly.

The main role played by the DA is that of monitor-evaluator; he analyses problems and evaluates ideas and suggestions. He describes the complications of possible decisions. A lesser role played by the DA is that of plant, advancing new ideas and strategies.

External relations The DA has contacts with the chairman and some of the members of the AHA, and is interested in political thinking. He has good relations with the AA.

How he gets his information Primarily by reading and the careful study of all documents available, from the other members of the DMT and, to a lesser extent, from subordinates.

Methods he uses to influence people Mainly by the depth and proven ability of his information and his logical analysis of the consequences of decisions. In the DMT meetings, he takes members and visitors through a careful analysis before the chairman can summarise the decision.

Comment

This approach could be used in many different kinds of districts, although it would be less appropriate in one facing a crisis or where there was poor morale.

The advantages of this approach are that the DA enriches the information available to the DMT and helps it to make better-informed decisions, with a wider consideration for their consequences. The DA also contributes political sensitivity to this analysis of information. The information is freely available and the DA does not seek to dominate, so he contributes towards an egalitarian team, without positively helping to create one.

The possible disadvantage of this approach is that the emphasis on careful analysis and detailed information may slow down

decision-taking and cause boredom, rather than pushing towards solutions. The separateness of the DA from subordinates, and the lack of informal contact, may lead to lower morale and their failure to contribute as much as they could.

Case study 6 The shaper

The district is relatively small, stable, with closely located units and with few current problems. The DA has been in post since 1974.

Pattern of work Almost all his time is spent either in his own office, in the nest of rooms which serve both for formal meetings and for informal discussions, or in DMT members' offices. He makes occasional visits to one of the hospitals, sometimes alone, more often with other members of the DMT, but mostly he invites significant visitors to lunch for arranged, informal meetings with DMT members.

When alone, he works with relatively few interruptions. His secretary acts as a shield and usually the only contact with subordinates is a brief coffee meeting in the morning.

He works a regular nine-to-five day, apart from some evening meetings.

Focus of attention This DA is best described by stage 4 on the reactive–proactive scale. He has a very clear view of what he wants to achieve for his district—to make it as separate and self-contained as possible. He attaches great importance to planning: he appointed a senior man to be planning officer and did all he could to back the development of the long-term plan which the district now has.

Role with subordinates He is separate from his subordinates, spends little time with them and does not encourage them to come and discuss problems except important ones. The DA has

occasional discussions with individual subordinates and sometimes with the three who report direct to him. However, the deputy is the main link between the DA and subordinates and, thus, runs the administrative function.

The DA has been in post since reorganisation in 1974 so his relations with his subordinates, most of whom have been working with him for some years, are well established. He attaches great importance to training and he has taught them that he does not want to know about detail.

Role with the DMT and doctors He works with the DNO on both nursing and district matters as fellow members of the DMT. She will occasionally discuss a nursing problem with him, but the district has few problems with staffing and she rarely feels she needs help. He works closely with the DFO on the long-term plans for the district. They will discuss together any financial matter before the DMT meeting. Both the consultant-member and the GP-member have offices near the DA and he attaches great importance to his contacts, both at work and socially, with consultants. He largely ignores, and displaces, the DCP.

Preparation for, and role in, DMT meetings He gives careful thought to the composition of the agenda, the placing of items and the accompanying papers. He encourages other members to put forward items for the agenda, and when they do will always discuss the subject with them beforehand and advise on timing and tactics. For any difficult items, he will make sure that he knows what people are feeling before the meeting. He will try to ensure that no item comes to the DMT until the agreed solution is fairly clear. The roles he plays are shaper and resource investigator.

The DA encouraged the practice of chairmanship by six-monthly rotation. He has also got it accepted that he is not included in the rota. He thinks he can have more influence that way, and the close

location of all DMT members enables the DA personally to inform and discuss issues with them.

The DMT operates as a team which largely accepts the DA's views of where it should be going, and is keen to cooperate in getting there.

External relations He attaches great importance to his relations with the chairman of the AHA, and has got to know a number of the members. He has also lobbied his local MP. He bypasses the area management team as much as possible. He has friendly relations with the press and will give them stories about interesting developments in the district. He can always get a rejoinder published if there is any unfavourable press comment.

How he gets his information Partly by study, and partly by his network of personal contacts.

Methods he uses to influence people He has a clear view of where the district should be going, which has general appeal. He has political sensitivity. He goes in for advance fixing: sounding out and discussing people's views before meetings; having a social interlude for drinks and food beforehand, so that the formal meeting starts in a relaxed atmosphere. His methods include general pleasantness, friendship and getting to know influential people socially. Over all, there is a persuasive influence in directing people's thinking towards the objectives of the district's independence and self-sufficiency.

Comment

Various features of the district make it easier for the DA to operate as he does. The district is so small that he can know many of the consultants. The plan for the district includes building a new hospital without the need for any closures, so it is a plan that

was readily accepted. The district has no major problems to cause dissension.

The advantage of his approach is that he has a clear and carefully worked out view of where the district should be going. He also has a clear view of his objectives in each activity and relationship. He focuses on the people who are important to the achievement of his objectives and has the social skills to enlist their cooperation.

His very decentralised attitude to administration gives his subordinates plenty of scope to use responsibility.

The disadvantage of this approach is that the very political and social skills may prevent adequate analysis of his objectives for the district or the relevance of these objectives to a wider view of health care. Both the advantages and the disadvantages of the approach indicate that he is a shaper who has a clear view of what he thinks should be done, and is concerned with getting others to accept it, rather than with trying to encourage a mutual exploration of the situation and what should be done about it.

His separateness from subordinates means that they may lack the support they feel they should be entitled to. It may also mean that a potentially serious problem is not brought to his attention soon enough. The DA's exclusive network limits subordinates' contacts with him. The smooth social and political skills which display the image of administration may hide the pressures and difficulties being experienced by subordinates. By concentrating on external relations and longer-term planning, the DA may lose the practical realities of the present.

Case study 7 The innovator

The DA is fairly new to this district but has held a previous DA post.

Pattern of work The DA works mainly by personal contact and through meetings with *ad hoc* and arranged groups. He generally does little reading of papers during the day and only very brief dictation and writing. When in his office, he is freely available for individuals and groups to drop in for discussions on a wide range of issues, both current and long-term.

Focus of attention The DA is towards the proactive end of the scale, number 3. When he is further established and his department runs more proactively, he may move to number 4 on the scale; but the more detailed work, which will be needed after plans for the district have been established, may cause him to move for a time to the number 2 stage. The DA is looking 20–30 years ahead and is trying to stimulate others to shift their attention from solving short-term problems (of which there are not many in this stable district) towards the future they should seek to determine. He uses a current problem, such as industrial relations, to exercise, and give an example of, a longer-term view of management.

Role with subordinates The DA has a deputy and leaves much of the detailed work to him. He has informal contact with subordinates, including sector administrators, mainly through meetings arranged by the deputy. The DA always attends these meetings. He and the deputy have complementary roles, both in the training seminars they run and in the monthly administrative meeting. The DA's approach is to push for improvements, particularly in the way that subordinates approach the analysis of problems, and to indicate the limitations of their form of solutions. The deputy takes up these ideas for improvement and adds practical descriptions of the changes they will require in the subordinates' work. The DA is friendly, open, active and expressive, and most of the subordinates join in and test the DA's ideas, though some are daunted and hesitant.

Role with DMT and doctors The DA has a complementary role with the DFO in their shared activity: handling issues before and

after the DMT. The DA's energetic ideas and the DFO's practical methods complement each other in a shared responsibility. There is not this strong relationship with other officers who prefer to work directly with the DMT. Nor is there full agreement with the DA's wish to shift the emphasis towards the longer term. The consultant-member and GP-member adopt a neutral position and wait to be convinced of the merit of the DA's ideas. The DA has recently established himself as secretary to the district medical committee.

Preparation for, and role in, DMT meetings As we have seen, the DA is trying to shift the agenda topics from operational details to longer-term planning. The main roles that the DA plays in the meetings are those of plant and resource investigator: advancing new ideas and searching for the relevant information. The DA persuades the DMT to examine itself and this leads to lively confronting discussions of his ideas. Even when there is acceptance in the meetings, there could later be resistance to the changes agreed.

External relations The DA has good relations with the ATO, and particularly with the AA. Contacts with the AHA and the atmosphere in the area are supportive and helpful, with jointly agreed administrative practices. The DA leaves much of the contact with the press and the CHC to the deputy, but discusses things with him when necessary.

How he gets his information For the longer-term issues on which he focuses, he gets his information from contacts in meetings, including the MEC, and from individuals, rather than from reading papers and reports. He will not stick to the formal hierarchy to obtain the information he needs, but will also go direct to the regional officers.

Methods he uses to influence others By his vision and by the momentum of his arguments. He is a preacher and a teacher and

sometimes shocks people with ideas they had not considered before. He is expressive, stimulating, and will confront and challenge others' ideas and answers to him. He seeks to open up people's limited vision by pointing to longer-term needs.

Comment

This approach is most likely to be useful in districts which have drifted into an acceptance of the *status quo,* and have not recognised opportunities to develop the services.

The advantages are those of an energetic divergent thinker who can see the possibilities where others see only difficulties and impossibilities. Others may say to an idea for improvement, 'we have no resources', but this would never be an adequate answer to the innovator. His approach stimulates the review of situations. It enlivens others' jobs. Life will never be dull with a risk-taking innovator.

There are disadvantages, too. Risk-taking, which often necessarily accompanies innovation, may fail to obtain the support of the more conventional people. People may resist: it is easier for them to see the costs of change, the politically sensitive issues and potential problems, rather than the advantages. The costs usually come before the benefits of change, and are more certain. One danger, therefore, is resistance. Another is that DMT members will apparently accept the ideas for change, but will either resist their implementation or just leave the work to the DA. There is a further danger, in the innovative role, that the DA will operate independently, rather than seeking to encourage collective responsibility. To be successful, he must either play other roles himself, such as linkman, or pair with another member of the DMT who accepts his ideas and has the skills to get them accepted.

Another potential risk of the innovator is that he will get carried

away by his own eloquence and by his need to hear his own voice explaining things. There may be a failure to listen either to what people say or to the meaning of how they say it. He may be so interested in ideas that he does not take them to their practical implications. Again, there is a need for him to pair with someone who can.

Case study 8 The general manager

The DA has been in post since 1974.

Pattern of work The DA tries to keep the first part of the morning free for work on his own, and for answering any important letters brought in by his deputy. He will have coffee with the DNO once or twice a week, and with the DCP and DFO, individually.

His competent, pleasant secretary answers calls and screens him from callers, but members of the DMT and his deputy will go straight into his office. About half his time is spent in formal and informal meetings, but he also likes to have face-to-face conversations with individuals. He tries to keep to a regular programme of monthly visiting around the district, usually with other members of the DMT. He is towards the proactive end, number 3.

He comes in early in the morning and often takes work home.

Focus of attention He believes he is accountable for everything that happens in the district. The Normansfield and Solihull inquiries[5, 13] only helped to confirm this belief, which stems from his deep sense of responsibility. He believes that he must try to know what is happening, and must try to intervene where he thinks this is necessary.

A lot of his time had recently been spent on an analysis of the effects of RAWP—his district is a RAWP-loser*, but he thinks that

* See footnote on page 6.

the basis of the calculation is wrong. He managed to persuade the regional authority, with the help of the local MP and the chairmen of the AHA and the CHC, that his basis was correct.

He had also been devoting a lot of time to trying to improve the balance between the long-stay and community services; he had presented a paper on this to the DMT and had discussed it with the director of social services.

Role with subordinates He has a competent deputy to whom he delegates much of the detail. He has discussions with him several times a week and meets his two other senior subordinates individually each week. He likes to handle patients' complaints himself, because he thinks it is a way of checking how the service is working.

Role with DMT members and doctors His regular informal contacts with the other members help to foster good relations and give him an opportunity to discuss their problems and to advise them.

He attaches importance to being secretary of the MEC, and to having lunch once a week with the doctors. He treats the older ones deferentially. He has found that it pays.

Preparation for, and role in, DMT meetings The roles he plays are shaper and resource investigator. He has persuaded the DMT to meet only once a fortnight. He is chairman, because he thinks that helps to keep the meetings down to two and a half hours. He tries to ensure that everybody's opinion is heard, although he prepares brief papers for all important issues which summarise the main points and outline the best solutions. Occasionally, he puts up an alternative solution. He does not want the others to think he is dictating to them, though they mainly accept his proposals.

Where he knows medical opinion is strong, he will talk with the

consultant-member beforehand, and will attempt to check out views of other doctors informally, too.

He always discusses financial alternatives with the DFO before any relevant items are presented to the DMT.

External relations He attaches great importance to establishing relationships with any influential person who can help the district. He has had long discussions with the chairman of the AHA and the secretary of the CHC about his concern for improving community care. He has written articles for the local press on the subject. He also ensures that local MPs are kept informed of topical subjects.

How he gets his information From reading, conversations with his extensive network of contacts, and from his subordinates. He has a monthly meeting with all his more senior subordinates to discuss developments and problems. He has fairly good contacts, formal and informal, with the officers and authorities in the area and the region.

Methods of influencing people Primarily by taking on wide responsibility, but also by the recognised competence of his administration, and by his use of informal contacts. The clarity of his analysis of issues, his persistence about detail and his understanding of most situations make others dependent upon him.

Comment

His approach could be used in many districts, but its success will depend in part upon the composition of the DMT, and in part on the ability and sensitivity of the DA. Conditions in some districts may make the role relevant and necessary: for example, there could be temporary conditions such as problems of communication or the replacement of senior staff—turbulent issues which need a central person with visible responsibility. Some DMT

members may be new, so the team could take time to establish itself. Conditions can limit shared responsibility: for instance, when other functions have previously been unrelated. Change can threaten disadvantages to various sectors and other functions.

The main advantage of his approach is that there is someone who is both trying to keep an overview on the service in the district and is also pushing for improvements or changes in key areas.

One possible disadvantage is that his assumption of responsibility for others' activities may be resented, unless it is done very skilfully, or may make people become dependent on, and accept, the DA's influence, both internally and externally. Another disadvantage is that he may not obtain real commitment to collective responsibility because most of the ideas are his. Also, he may have to work long, tiring hours in order to fulfil all aspects of what he perceives as his role.

Concluding general comment on the case studies

We have tried to ensure that the needs for camouflage and anonymity, and the inclusion of examples from our study of other DAs, have not been allowed to distort the essential differences in the ways in which DAs play their roles, and in the methods they use. We have commented on the advantages of these different approaches, and have also suggested some of the possible disadvantages and dangers. Knowledge of these can be of some help to the DA himself, so that he can try to ensure that his strengths, and weaknesses, are counterbalanced by complementary roles. It can also be of help to other members of the DMT in recognising what roles may be missing. Members of the AHA might also consider what effect the appointment of a new officer could have on the balance of roles represented in the DMT.

6

The district administrator's view of his job

Summary

From our interviews with DAs we collected material on how they saw their jobs: their roles and contributions; the differences between the ideal and the actual; the constraints and choices; the satisfactions and frustrations. Generally, they found the job worthwhile and satisfying, with many choices and satisfactions but many constraints and frustrations—some of which were caused, they felt, by the organisational structure of the NHS.

This chapter is based upon the answers our administrators gave to questions at the end of the interview. We asked about their view of their role and contribution, what they thought they ought to be doing and what constraints hindered them, and what were the satisfactions and frustrations of the job. Some of our informants found it easier than others to answer such general questions.

The DA's view of his role and contribution

Most DAs saw their role as important, worthwhile and, often, unique. They differed in what they said, as one would expect from the analysis in the previous chapter, though some of these differences may only reflect what they chose to emphasise at that time. Even though a DA did not mention a particular contribution, he might not disagree with those who had.

The DA's views of their main contribution can be summarised

under the following headings. The terms are the DAs' own. Individual DAs commonly mentioned more than one.

Enabler providing service, helping other people to do their jobs.

Organiser mentioned by two DAs, one of whom we quote.

> *Pressure he is bringing to bear for a more careful look at the organisation—relationships, accountability, who is doing what and does everyone know exactly what they should be doing. They are a bit sloppy here.*

Coordinator a commonly used term which meant different things to our DAs: getting people to work together to sort out their problems; team building (its most positive meaning); acting as the focal point for information.

Overviewer seen as more positive than coordinator and including identifying problems, analysing them and presenting alternatives, arbitrating between competing interests.

Leader in the DMT giving a sense of direction, making people face issues.

Leader of staff being known by staff, maintaining and improving morale (rarely mentioned).

Educator of the other DMT members, and of the next generation of administrators (one mention).

Spokesman for the district making sure the district's problems and aspirations are known, presenting a good public image.

Innovator as described by two DAs.

> *Any new direction given for the district by the DMT is my responsibility.*

Asking nasty questions about changes and alternatives.

It is noteworthy that this list of contributions is much longer and more important than that suggested by the gloomy view taken by some administrators at the time of reorganisation of the NHS when they feared they would have little role beyond that of running the 'hotel' services. Most of our DAs had a view of their importance which went well beyond that of head of administrative services. This view often derived from the role they felt that they played, and must play, in the DMT. We could distinguish no clear differences between the views of DAs and of the AAs in SDAs.

The ideal and the actual

We asked three questions which sought to identify whether the DAs saw differences between the ideal and the actual, and if so what these were. One question was very general and asked what the DA should ideally be doing and what were the constraints. (We discuss constraints below.) Another asked what the DA must do and what he ought to do. The third question was specific, and asked whether the DA thought the balance of his work the previous month—about which we had already asked him—was about right. Unfortunately, the period of interviewing was during the industrial disputes in early 1979, which influenced answers to that question.

The first two questions produced very varied answers; sometimes no answer at all, because some of the DAs found it uncongenial to think in such general terms. A few DAs were quite satisfied. They felt that what they were able to do coincided pretty well with their view of the ideal. A few were wholly dissatisfied. Most were in between, mentioning an array of things they would like to have found time to do, or roles they would like to have played if they had been permitted to do so. The most common regret, mentioned by eight of our DAs, was insufficient time for visiting

to see what is really happening and to get to know staff. It is likely that, for some, this lies in the realm of aspirations they will never fulfil, because they do not really consider it important enough. A pointer to such an explanation comes from a study of educational administrators in the US, which found that although administrators listed various activities as important, such as visiting schools and seeing parents, in practice, at a particular time, they always considered some other activity to be more important.*

There was no other commonly mentioned 'ought'. Three of our DAs thought they should spend more time looking for ways of improving the administration, rather than being *'bogged down in the nitty gritty'*. Two others thought they should keep in closer touch with consultants. Two more wished for more time to think and read, or talk to people to get new ideas. Two is a small number compared with the number of industrial managers who, in our experience, make similar comments about time. This may reflect the fact that many DAs can, and do, delegate much of the day-to-day operation so that they have time for reading. It may also reflect that in their job they must do quite a lot of reading if they are to digest the written information that comes to them, and if they are to speak knowledgeably at meetings of the DMT or the AHA.

The specific question about balance in the work of the previous month brought, predictably, a number of responses that too much time had had to be spent on industrial relations. By no means all DAs gave this answer, sometimes because industrial relations had been fairly uneventful in their districts. Another reason for this difference in response is that our DAs varied, as we saw in Chapter 2 (pages 14–17), in the extent to which they got personally involved in industrial relations. But there were few common answers to the question about balance. Some thought it had been

* Jane Hannaway, *Effect of uncertainty on managerial behavior: or, who does what, when and to whom?* Unpublished PhD dissertation, Stanford University, 1978.

about right; others that too much time was spent on crisis management, apart from industrial relations; too much time in the office; too much time on superficial consultation and communication.

Constraints

One of the findings of this study has been the amount of choice that the job of DA offers. Many of the DAs saw this, as we describe below, but all were conscious, too, of the constraints within which they had to operate, and which limited their choice. These were extensively aired in evidence to the Royal Commission on the National Health Service, so only a brief summary is needed here.

The NHS structure and decision-making machinery The following is a rather extreme example of a constraint mentioned by many.

> *An immovable, clogged-up machine with too many people doing each other's jobs, too many managers, too many layers of management, having to go up and down the ladder on every issue.*

Some found the consultation process and the *'endless compromises between interests'* more frustrating and constraining than others. But there were also complaints about too little consultation with the area health authority and its officers.

Shortage of resources The reaction depended upon whether the district was a RAWP-gainer or loser.* The shortage of resources included money, often, more importantly, good staff, old buildings, and badly located offices.

Resistance to change There were general complaints about those, especially doctors, who were unwilling to change.

* See footnote on page 6.

A certain proportion of very conservative, long-established doctors who do not want change at all.

More specifically, some DAs, particularly in RAWP-losing districts, said they must try to change the attitudes of doctors and nurses.

Must persuade them to change their professional attitude of caring only for their patients and accept the administrative realities of diminishing resources and the necessity of working together to make the best of what is left.

Industrial relations and legislation In common with many managers in other types of organisation, there were DAs who regretted the constraints on their freedom of action imposed by recent legislation.

Choices

The DAs were asked what choices they saw in their jobs. A small minority felt—as it were—'locked in'.

The exigencies of the financial deprivation take away all choice.

Because I had a predecessor, the DA job here is almost pre-determined by history.

More common were statements such as

Tremendous scope: you can play the game in a whole series of ways.

Infinite variety of possible emphases.

As wide as one can interpret.

The DAs can be broadly divided between those who described the choices open to them in their administrative work, and those who focused on opportunities for choice in other aspects of the job. The former talked about choices in the amount of delegation, in style of management and in the issues they would concentrate upon. The latter often presented their choices as dichotomies.

The chief executive or to operate behind the scenes.

The man who knows about hospitals and visits, or a theoretical planning chap.

To treat it as a nine-to-five job or go looking for problems: they are always there.

To be the operational manager or the long-term planner.

To be the innovator or to maintain the status quo.

To treat the AA according to the book or to bypass him.

Often these were presented with a clear indication that for the DA the choice was theoretical. His interests, temperament or his view of what he ought to do determined his choice. One DA felt that one's age determined what one did more than the nature of the district. There were other choices seen in the DA's relationships in the DMT, which we have already described in Chapter 3 (pages 26–53).

Satisfactions and frustrations

For all but a small minority, the satisfactions of the job seem to well outweigh the frustrations. However, any other finding would have been surprising, because the many varied studies of job-satisfaction in different types of job show that most people are

reasonably satisfied with their jobs. The job of the DA is a rather unusual one. What particular satisfactions and frustrations did our DAs describe?

Satisfactions

There were three which, though not peculiar to the DA's job, distinguish it from that of many other managers.

1 Sense of idealism, a worthwhile job.

2 Range of problems, the number and variety of people.

3 Being a member of a team, a sense of belonging, handling problems together.

Some managers feel this team-membership with their subordinates; for some DAs, the DMT provided another team to which they belonged.

The DAs also mentioned the satisfactions that are common to managers in many kinds of jobs.

> *Leadership, exercising responsibility, seeing the consequences of one's actions, being at the centre of things.*
>
> *Development and training.*
>
> *Getting the true potential out of them.*
>
> *Training a new generation of administrators.*

And, finally, the personal satisfactions. The DA's job, like—but more than—many other senior management jobs, offers a choice. Those who like pace can play it that way.

Fun.

Exciting.

Adrenaline in the blood.

The whirl and pace of it.

Those who prefer a more reflective, longer-term approach can organise their pattern of work to achieve it, at least some of the time.

Frustrations

Just as some of the satisfactions were rather distinctive of the DA's job, so were some of the frustrations. These could be seen as anything that hampered, or was thought to hamper, the proper provision of services and the continuing improvement in the care of patients. They were similar to, but not identified with, the constraints.

Some DAs mentioned having to downgrade services and to lower standards because of RAWP.*

Being the person who has to say NO to just demands for improvements from professionals and public.

Gives the administrator a bad image.

Others remarked on the slowness, inefficiency, waste of money that result from participative management being carried too far.

* See footnote on page 6.

Like swimming with your clothes on.

Often stops people bothering to start.

Endless compromises do not produce the best results.

The reorganised structure of the NHS was felt to be a frustration especially by the older administrators who had been group secretaries before and complained that they had less responsibility now.

Not masters of our own destinies.

However, there were a few DAs who thought there was more responsibility now than before the 1974 reorganisation.

There were, not surprisingly, more complaints about the scale of, and slowness in, the NHS structure from DAs than from the AAs in SDAs. There was a variety of specific complaints.

Too much routine.

Too much time spent solving problems that come to the DA on paper.

Lack of cooperation or communication.

Closed minds.

Low calibre, and/or insufficient number, of administrators.

Other frustrations mentioned are common to many managers: difficulties in industrial relations: the new industrial legislation; long hours; inadequate rewards and no promotion prospects. These were mentioned only by a few.

Some of these frustrations are described in Chapter 4 of the report

of the Royal Commission on the National Health Service[9], and may be remedied by the proposed further changes in the organisation.[4]

Comment

The DAs' views of their jobs can be summed up as worthwhile, important, satisfying, offering a lot of choice but with many frustrations, some of them due to structure. This summary is a general one; not all DAs felt like that. The nature of the district, its intrinsic problems and RAWP-position, the calibre of one's subordinates, the attitudes and competence of other DMT members, the attitudes of the consultants, the role played by the ATO, the legacy of one's predecessor if one is relatively new to the district—all these can affect the satisfactions and frustrations of being a DA.

7

An overview of the job

Summary

A new form of job description is provided in terms of the demands, constraints and choices of the district administrator's work and, since there are some differences, that of the area administrator in a single-district area as well. This description will be used in Chapter 8 (pages 139–146) to help in considering the training implications. We begin by making a brief comparison with other managerial posts so as to give some perspective on the difficulties of the job.

Too much for one person?

Is this, a query by one of our DAs, a fair verdict on the DA's job? We shall attempt to answer it by comparing the job with other managerial jobs known to us.

A job can be 'too much' in many different ways. The range of understanding required, the volume of information that must be digested and remembered, the sheer complexity of the decisions which have to be taken, may be too great for comprehension. These are some of the ways in which a job can be too much: they are primarily what the DA we have quoted had in mind. The volume of information, perhaps more than its complexity, is one of the burdens of the DA's job. It is hard to make an adequate comparison between this aspect of the DA's job and that of other managerial jobs since the latter vary greatly in the complexity of

their decisions. Some are clearly more complex, such as those in international companies concerned with rapid political and technological changes; at the same time, however, these jobs will also have much greater support in information collection and analysis.

A job can also be too much because the pressure and pace of work are too great. This is not our impression from the interviews and, more particularly, from the observations, compared with our knowledge of managerial jobs in industry and commerce, though these vary considerably. The pressure and pace of work are more under the DA's control than in many other jobs. It can be, as one DA put it, *'an all-consuming job'*, but that is a choice.

A job can be too much because of the number and level of frustrations; that is, the obstacles to achieving what one is trying to do. There are more frustrations for the DA—some resulting from the 1974 reorganisation of the NHS and some from the current cuts in resources—than in many other senior management jobs. Some of these might be avoided with a different structure; others are intrinsic to the job.

A job can be too much psychologically, primarily because the responsibility outweighs the authority. Managers in other organisations, especially those in staff jobs, often complain about this. So did some of our DAs. It is a common feature of many jobs, and one that is particularly trying to those who like to know where they are, and to those who have a high sense of responsibility combined with some timidity. The Normansfield and Solihull inquiries added to the anxiety.[5, 13] A job can be too much because of the intensity of what sociologists call 'role conflict'; that is, differing expectations about one's behaviour. This exists in any managerial job. It did not seem to us to be particularly high in the DA's job. He has an unusual advantage compared with most other managers: he has no real boss to worry about. However, this has the disadvantages of loneliness and lack of direct support. A job can be too much, particularly for some individuals, because

of a high level of uncertainty in its environment. The DA works in a relatively stable environment compared with many in industry and commerce, but the problem for some DAs may be that their choice of a career in administration assumed secure stability with clearly defined work.

Finally, a job can be too much because of the range of choice it offers. This is particularly true for those who temperamentally like to have a clear remit. It is also true for those who, like some of our DAs, have a highly developed sense of responsibility: for them, there are too many things that they see need doing. A job with no clear bounds can be seen as challenging and interesting, as many of our DAs saw it, or as introducing stressful uncertainty. However, because of the range of choice, it is a job that offers more opportunities for adapting one's role to suit one's personality than many other jobs.

In sum, the DA's job is potentially a difficult one, but in some districts it offers the choice—not available in all senior management jobs—of doing it in a limited and relatively easy and unstressful way. However, for those DAs who have a wide view of their role and of the contribution they believe they ought to make to the management of the district, the job is difficult and can be frustrating.

Demands, constraints and choices

We have used this framework in the discussion of different aspects of the work of the district administrator, distinguishing between what all holders of the post must do—the demands—the constraints upon what can be done and the choices for one holder to do the job differently from another both in terms of the actual work done and in style (how the work is done). We shall now give an overall description of the jobs of the district administrator and of the area administrator in a single-district area, in terms of demands, constraints and choices.

Demands, constraints and choices in the DA's job

We consider these separately for different parts of the DA's job.

Head of the administrative function

Main demands To retain credibility as a competent administrator and manager of the administrative function.

To ensure that there is an effective administrative budget and organisational structure.

To demonstrate administrative effectiveness to the AHA (that is, to be accountable).

Consequential demands To know enough about the administrative services to be able to speak for them at the DMT meetings.

To have enough contact with subordinates and others to acquire that knowledge.

To see that the complaints procedure is carried out.

Constraints The ethos and history of health care in the district.

Availability of buildings, equipment and finance, together with the effects of RAWP.*

Dispersion of hospitals, units and services in the district's territory, with consequential communication, transport and other problems.

Dominance of another district, which, if it provides most of the doctors and supplies, will constrain the administrative services.

Quality, number and age of his subordinates, and their allocation

* See footnote on page 6.

between different posts and grades (the latter for a new DA inheriting his predecessor's organisational choices).

Inherited expectations of the role of the DA—especially constraining for a DA succeeding another since 1974.

Inherited expectations of the DA's leadership style.

The difficulty of removing incompetent subordinates.

National and local pressures of industrial relations issues.

Interference from the ATO and, sometimes, the CHC in the running of operational services (in some districts).

Main choices To change the organisation and structure of the administrative function.

To delegate authority, though not responsibility, for all or any of the administrative services.

Preferred leadership style, within the constraints listed above.

To choose what to get involved in, and the nature and extent of the involvement. (This includes contact with the press, other local involvement outside the NHS, preparation of planning documents, contact with the CHC, trouble-shooting, and contacts with professional bodies, universities, foundations and others.)

To become personally known as the head of administrative services, by whom (consultants, press, patients) and in what role (for example, the person to go to with problems), inside and outside the district.

Other choices Pattern of the day and the extent to which the DA makes himself available.

How hard and long he works.

Whether he makes visits and, if so, his aims, and time spent on these.

Amount of attention given, and methods used, to encourage subordinates' training and development: for example

involvement in work for the DMT; working directly with DMT members; team development; appropriate training encouraged and planned.

Methods of monitoring subordinates' work: for example

regular programmed meetings individually and/or as a group; visiting units, with open discussion and/or inspection; location of subordinates and whether there is constant discussion and how information is shared.

Organisation, including division of work, span of control and grading of different posts: for example

triumvirate reporting only to the DA; wide span of subordinates (including SAs) reporting directly to DA; single deputy, and all the rest reporting to him.

Delegating some problems outwards: for example

industrial relations problems away from the district to the AA.

The attention that the DA gives, or encourages his staff to give, to requests for information, or to instructions from the area or regional authority or DHSS.

Using administrative services as the means of influencing the district's solution to problems and plans: for example

becoming the prime source of information by writing up most papers; determining the composition and subject of special meetings; getting personally involved in personnel matters and in organising work for medical and nursing issues; getting more involved in meetings of the DMC or MEC and in the actions required afterwards; fulfilling individual AHA members' requests.

District management team

Demands To go to DMT meetings all or most of the time.

To play a part as a member of the group, in his role as spokesman for the administration and coordinator of services.

To ensure that secretarial services are provided.

To provide administrative coordination for the team's work.

To ensure administrative follow-up of the team's decisions.

To ensure that he, or someone else, acts as DMT spokesman to the press and the public.

To be loyal to DMT decisions.

To keep watch over issues affecting the district on behalf of the AHA. (The DA can be held responsible for giving or not giving advice to others on general issues—but not for ensuring that others accept his advice—and for not conveying his concern to the AHA.)

Constraints Inherent problems of the district, which may affect members' ability and willingness to reach decisions and to co-operate in implementing them.

Strengths, weaknesses and interests of the other team members, and the roles they want to play inside and outside DMT meetings.

Dynamics of the group, including willingness to tackle difficult problems, and cooperation.

Difficulties of consensus management, including the amount of time that members can or will give.

Divided loyalties of members.

Administrative responsibility of the DA can encourage members to leave DMT action with him.

Main choices To play his part only as the administrator or to have a wider influence: for example

whether, and if so how, he seeks to determine or influence what is on the agenda of DMT meetings, at what stage, and how much prior investigation and consensus-building he promotes;

whether, and if so the extent to which, he seeks to influence what is discussed at DMT meetings and the decisions reached, and the group process;

the importance or unimportance he attaches to making consensus management work, and how he seeks to do this;

whether he seeks to promote collective responsibility;

whether he takes over some of the work of another team member, especially if he or she seems in need of help;

whether he develops an alliance with one or more members.

Other choices To become chairman if invited, to continue as chairman, or to persuade someone else to be chairman.

To arbitrate or not between other members of the DMT.

To promote the patients' case or views at DMT meetings.

What role he takes on if he is not chairman.

Arrangements for secretarial services to the DMT, including which tasks, if any, he undertakes himself, and how simple or elaborate is the paperwork.

Relationship to the DMT clerk/secretary (if there is one).

Responsibility for allocating small amounts of money.

Area team of officers and area health authority

Demands To be a channel of communication between the district and the area.

To tell the AA about major administrative problems in the district.

To attend with other DAs meetings called by the AA.

To help, if required, members of the AHA visiting panel in their inspection of conditions in the district's hospitals and of patients' complaints.

Constraints These vary from one area to another.

Role of the ATO in monitoring the operational parts of the management of the district.

Attitude of the ATO to the AHA's contacts with the district, and whether ATO members seek to limit the district's involvement in AHA meetings.

Attitudes of members of the AHA, especially the chairman, to

discussions with members of the DMT and to their contributions at AHA meetings.

Competition from other districts for the attention of the AHA.

AHA members' extent of interest in, and knowledge of, the district.

Main choices To mobilise forces in the district in support of it.

To trust the ATO to look after the district's interests or to lobby the AHA for the district's case and to seek to bypass the ATO.

To cooperate with the ATO or to seek to be as independent as possible.

To cooperate with other districts in the area or to strive to make the district as self-sufficient as possible.

To cooperate with other districts in order to keep the ATO at a distance.

To invite AHA members to become more aware of the district's problems through meetings and visits.

To attend AHA meetings or to persuade another DMT member to go (they may want to).

Other choices Establishing good personal relations with the press, writing articles for them and seeking to counter any undesired criticisms.

To establish personal contact with local politicians and MPs and to lobby for their support in dealing with the district's problems.

To become known outside the area by participating in professional activities or working parties at regional or national level.

To establish social contacts with consultants and with the director of social services.

Special situations

The DA may have special demands, constraints and choices stemming from the need to expand services and the demands that this will place on the administrative services, or to reduce services if the district is a RAWP-loser. There are many other characteristics of a district that will affect the nature of the workload on administration, and with it perhaps the scope for delegation, as well as the willingness of nurses and doctors to cooperate in expenditure cuts and reduction in standards of care for patients. Some geographical factors such as long distances from area offices, and from regional and national centres, may also influence certain demands, choices and constraints.

Demands, constraints and choices in the AA's job

We do not have as good a picture as we would like of the differences between the jobs of the DA and of the AA of a single-district area. Clearly, some of the work and concerns which preoccupied many of our DAs in their relations with the ATO do not exist in the AA's job in an SDA. For many, the lack of these preoccupations will be regarded as an advantage; there will be fewer demands and more choices. However, it is not all gain because there are some extra demands on the AA for service to the AHA and to its chairman, and for more concern with planning. The latter will make harder, though not impossible, the choice to focus primarily inwards* and to be involved in operational matters. For some, this will mean spending less time on, or even losing, what they enjoy most.

* See Chapter 2 (pages 18–20) and Figure 1 (page 19).

Head of the administrative function

Main demands To retain credibility as a competent administrator and manager of the administrative function.

To ensure an effective administrative budget and organisational structure.

To demonstrate administrative effectiveness to the AHA (that is, to be accountable).

Consequential demands To know enough about the administrative services to be able to speak for them at the AMT and AHA meetings.

To have enough contact with subordinates and others to acquire that knowledge.

To see that the complaints procedure is carried out.

Constraints The ethos and history of health care in the area.

Availability of buildings, equipment, and finance, together with the effects of RAWP.*

Dispersion of hospitals, units and services in the SDA's territory, with consequential communication, transport and other problems.

Dominance of another area, which, if it provides some of the doctors and supplies, will constrain the administrative services.

Quality, number and age of his subordinates and their allocation between different posts and grades (the latter for a new AA inheriting his predecessor's organisational choices).

* See footnote on page 6.

Inherited expectations of the role of the AA—especially constraining for an AA succeeding another since 1974.

Inherited expectations of the AA's leadership style.

Difficulty of removing incompetent subordinates.

National and local pressures about industrial relations issues.

Main choices To change the organisation and structure of the administrative function.

To delegate authority, though not responsibility, for all or any of the administrative services.

Preferred leadership style, within the constraints listed above.

To choose what to get involved in and the nature and extent of the involvement. (This includes contact with the press, other local contact with the CHC, trouble-shooting, and contacts with professional bodies, universities, foundations, and others.)

To become personally known as the head of administrative services, by whom (consultants, press, patients) and in what role (for example, the person to go to with problems), inside and outside the area.

Other choices Pattern of the day and the extent to which the AA makes himself available.

How hard and how long he works.

Whether he makes visits and, if so, his aims, and time spent on these.

Amount of attention given, and methods used, to encourage

subordinates' training and development: for example

involvement in work for the AMT; working directly with AMT members; team development; appropriate training encouraged and planned.

Methods of monitoring subordinates' work: for example

regular programmed meetings individually and/or as a group; visiting units, with open discussion and/or inspection; location of subordinates and whether there is constant discussion and how information is shared.

Organisation, including division of work, span of control and grading of different posts: for example

triumvirate reporting only to the AA; wide span of subordinates, including SAs, reporting direct to the AA; single deputy, and all the rest reporting to him.

Passing some problems outwards: for example

industrial relations problems to the region, away from the area.

The attention the AA gives, or encourages his staff to give, to requests for information, or to instructions from the area or regional authority or DHSS.

Using administrative services as the means of influencing the area's solutions to problems and plans: for example

becoming the prime source of information by writing up most papers; determining the composition and subject of special meetings; getting personally involved in personnel matters and in organising work for medical and nursing issues; getting more involved in meetings of the AMC or MEC and in the actions

required afterwards; fulfilling individual AHA member's requests for contact with regional officers.

Area management team

Demands To go to AMT meetings all or most of the time.

To play a part as a member of the group, in his role as spokesman for the administration and coordinator of services.

To ensure that secretarial services are provided.

To provide administrative coordination for the team's work.

To ensure administrative follow-up of the team's decisions.

To ensure that he, or somebody else, acts as AMT spokesman to the press and the public.

To be loyal to AMT decisions.

To keep watch over issues affecting the area on behalf of the AHA. (The AA can be held responsible for giving or not giving advice to others on general issues—but not for ensuring that others accept his advice—and for not conveying his concern to the AHA.)

To ensure positive links between the AMT, ATO and AHA.

To ensure that decisions of the AHA are conveyed to the AMT.

Constraints Inherent problems of the SDA, which may affect members' ability and willingness to reach decisions and to co-operate in implementing them.

Strengths, weaknesses and interests of the other team members, and the roles they want to play inside and outside the AMT.

Dynamics of the group, including willingness to tackle difficult problems, and amount of cooperation.

Difficulties of consensus management, including the amount of time that members can or will give.

Divided loyalties of group members.

Administrative responsibility of the AA can encourage members to leave AMT action with him.

Main choices To play his part only as the administrator or to have a wider influence: for example

> whether, and if so how, he seeks to determine or influence what is on the agenda of AMT meetings, at what stage, and how much prior investigation and consensus-building he promotes; whether, and if so the extent to which, he seeks to influence what is discussed and the decisions reached, and the group process; the importance or unimportance he attaches to making consensus management work, and how he seeks to do this; whether he seeks to promote collective responsibility; whether he takes over some of the work of another team member, especially if he or she seems in need of help; whether he develops an alliance with one or more members.

Other choices To become chairman if invited, to continue as chairman, or to persuade someone else to be chairman.

To arbitrate or not between other members of the AMT.

To promote the patients' case or views at AMT meetings.

What role he takes on if he is not chairman.

Arrangements for secretarial services to AMT, including which

tasks, if any, he undertakes himself, and how simple or elaborate is the paperwork.

Relationship to the AMT clerk/secretary (if there is one).

Responsibility for allocating small amounts of money.

Area health authority

Demands To attend AHA meetings.

To act as secretary to the AHA, including briefing the chairman, either alone or with another AMT member.

To help, if required, AHA members in their inspection of conditions in the area's hospitals and of patients' complaints.

Constraints History of the AHA.

Expectations of AHA members, and especially of the chairman, about the role of the administrator.

Extent of AHA members' interest in, and knowledge of, conditions in the area.

Frequency of contact with AHA members, particularly with the chairman.

Main choices How much time to give to work for the AHA, compared with his administrative function, or work for the AMT.

Whether, and if so the extent to which, he seeks to influence what is discussed at AHA meetings and the decisions reached.

Whether he acts as spokesman for the ATO and/or for the AMT.

Whether he chooses to work via the chairman only or also through other AHA members.

Whether he seeks to encourage AHA members to become more aware of the area's problems, and the methods he uses to do this.

To act as formal communication link between the region and the area. (We collected very little information about this relationship. There seemed to be very little personal contact.)

Other choices Establishing good personal relations with the press, writing articles for them and seeking to counter any undesired criticisms.

To establish personal contact with local politicians and MPs, and to lobby for their support in dealing with the area's problems.

To become known outside the area by participating in professional activities or working parties at regional or national level.

To establish social contacts with consultants and the director of social services.

Special situations

The AA may have special demands, constraints and choices stemming from the need to expand services and the demands this will place on the administrative services, or to reduce services if the area is a RAWP-loser. There are many other characteristics of an area that will affect the nature of the workload on administration, including perhaps the scope for delegation, the willingness of nurses and doctors to cooperate in, for example, expenditure cuts and reduction in the standards of care. Some geographical factors—for example, long distances from regional and national centres—may also influence certain demands, constraints and choices.

Comment

This description of the demands, constraints and choices of the jobs of district administrator and of area administrator in a single-district area shows that these posts, in common with many other senior management posts, offer a wide variety of choices within a considerable array of constraints, and that the demand element is a comparatively small part of the job. This means that holders of these posts can, as we have seen, do very different kinds of work and do it in very different ways. The differences of style are important, but much more important to understanding the nature of the job are the differences in the actual work done. The latter can usefully be described in terms of the individual's focuses of attention. Because there is so much choice in what the administrator actually does—which aspects of his diverse and many-faceted job he concentrates upon—it becomes crucial for him, if he is to make an effective contribution to the provision of health services in the district or area, to determine his personal objectives and to recognise the close inter-relation between them and the objectives and work of senior subordinates and other members of the DMT. In the next chapter we shall point to the training implications which stem from our analysis of the job and role of the district administrator.

8

Training implications

Summary

The distinctive training needs of different parts of the job of the district administrator and of the area administrator in a single-district area are considered. The administrators seemed to have a special need, compared with other senior managers, for help in improving their supervisory relations. The implications of the choices the DA makes in his role(s) in the DMT merit particular attention. Belbin's team roles[1], described in Chapter 3 (pages 49–53), are suggested as a useful way of analysing how the DMT works and the roles which may be missing. There is a need to help administrators, and other officers of the DMT, to work towards more interdependent relationships, rather than independent, dependent or counterdependent. Over all, a distinctive feature of the DA's job is the great variety of choice in what work is done and how it is done. Hence, the DA should be taught to recognise and to appraise his own focuses of attention and methods of working; that is, the choices he makes.

Many of the training needs are similar to those of other senior managers. We shall not seek to add to what has already been written on that subject. Many training needs are specifically professional: others can describe these more authoritatively than we could. We shall limit our discussion to what else our analysis can suggest about the training implications of the job as we have described it.

Training must seek to help with the demands of the job. Where, as with the post of district administrator and that of many other

senior managers, the demands take up a small proportion of the time, training should also help the individual to recognise the more important choices in the job, to assess which ones are most relevant to the situation, and to utilise them to contribute to effective health care.

We shall take each part of the job in turn, as we subdivided it in the previous chapter, and look at the implications for training.

Head of the administrative function

The management, as distinct from professional, training needs for this part of the job are similar to those for other managers, one exception being the importance attached to planning in the NHS. However, we suggested in Chapter 2 that more DAs than one would have expected (perhaps as many as half of those we studied) had unsatisfactory relations with their subordinates. Therefore, there may be a special need to give some administrators further training in supervision. The difficulty may be partly, and for some wholly, a question of attitudes. There seemed to be more 'Theory X managers' among the DAs than one finds elsewhere.* The administrator who deplored the need to prod and poke his underlings was using language, if partly in joke, that would explain some of his problems. Help in man-management for experienced administrators might usefully take place with managers from other types of organisation which have a different ethos from the NHS.

In Chapter 2 (pages 21–22) we described the four roles that differentiated the choices made by most of the DAs in their relations with their subordinates: **joining, supporting, monitoring and pushing,** and **separateness.** The first, third and fourth each

* McGregor's Theory X and Theory Y: see his book, *The Human Side of Enterprise.*[8]

have potential dangers. The joining relationship may mean that too little guidance is given and, more importantly, it is likely to mean that the manager becomes too involved in operational matters. Absorption in the work of his own department may be necessary when the DA is new in that job, to make sure that it runs efficiently and that subordinates know what standards are expected, but continued absorption is a form of escape from his wider responsibilities.

The third choice of relationship, monitoring and pushing, can also have a danger: that of a predominantly negative attitude towards subordinates and the way that they do their work, which is unlikely to encourage development or willing cooperation and effort. The fourth choice, separateness, though it may be an appropriate one in some situations, has its dangers too: that the choice will be made because of the personal inclination of the DA rather than the needs of the situation. Before a DA can effectively be separate from his subordinates, he needs to be satisfied that there is someone else to play the roles that he may not be taking—target-setting, monitoring, support and morale-building.

Training should help the administrator to recognise the role he adopts with his subordinates and the real reason why he does so. It should also help him to reappraise the relevance of his role to the situation, and the price which may be paid for that role. Training should also—though this is more difficult—help to develop the social skills which will enable the DA to change if that seems necessary. Or, if he cannot change, to convince him of the need to have a deputy who can fill the gaps.

This analysis of the administrator's role with his subordinates should not be seen as just a description of supervisory style. It is more than that, because it also reflects what work he chooses to do himself.

There are many choices of emphasis between different parts of the

job and within the administrative function itself. The DA who chooses to take a particular interest in one aspect of administration, say planning or personnel, needs to ensure that the other aspects are not neglected. In an SDA, it is particularly important, compared with a DA's job, to ensure that planning receives adequate attention.

One choice that exists in all service managers' jobs, including that of the DA, is whether he seeks to become known as the head of administration services who is available to those who need him. There is a further choice in whom he seeks to become known to. Is it primarily the consultants? Or is it much more generally as the person whom anyone can approach? Such differences will reflect the role he is trying to play. Again, training should help to make him aware of that, if he is not already. Training can also help him to understand fully the possible advantages and disadvantages of being personally known: the figurehead, a role we described in Chapter 5 (pages 75 and 90–92).

External relations

There are some easily recognisable training needs here: public speaking, relations with the press and methods of presentation on television.

The distinction we made in Chapter 5 (pages 78–80) between reactive and proactive can be useful in examining what the DA can do to influence people, other than the staff, who can affect the work of the district. Training can also help to emphasise that many of the external activities which can be undertaken are choices. They can bring benefits to the district, but there is a potential danger that they may be undertaken more because of the DA's pleasure and interest, and for status-boosting, than because they are the most important contribution he can make, with the time that they take, to the effectiveness of the district. This is not to

say that they may not be well worthwhile, and if the DA enjoys them so much the better, but they need to be weighed against the potential value of other uses of his time. There is also a different danger: that a DA who is effective in his external relations may use these skills to push a case for the district at the expense of a wider view of health needs.

District management team

Membership of this consensus management team and responsibility for administrative coordination are distinctive features of the job which have training implications that need special attention. Some of these implications are similar to those for many other management jobs: sensitivity to the reactions of others, effective group decision-making and an understanding of group dynamics. Their importance is the greater because of the obligation to seek consensus in decision-making in the DMT.

The array of choices in the DA's role as DMT member, listed in the analysis of demands, constraints and choices, needs careful examination in any training programme. Many, but probably not all, of the choices are known to DAs, but they may need to have a wider recognition of the possible repercussions of taking different choices. We discussed these in Chapter 3, on the DMT, and illustrated some of them further in Chapter 5.

Belbin's team roles[1] (described in Chapter 3) could be helpful in getting DAs to recognise both the roles they play by preference and any other roles they may have the potential to play. Team training games, using groups composed of people with different role preferences, are a good way of helping people to recognise the roles played by members of teams, and the effect on a team's work if any role is missing.

The importance of information to the DA's job and its potential

contribution to his role in the DMT point to another training need. This is to develop the capacity to digest, assess the relevance of, and present intelligibly, the mass of information that comes to DAs. There may be a need, too, to help the more analytically minded DAs to recognise the limitations of the phrase 'knowledge is power', without under-rating its importance. A DA needs political skills and sensitivity just as much as he needs the capacity for logical analysis. Training can make a contribution to both, though individuals may be inherently better at the one than the other.

An analysis of the DA's relations with other members of the DMT, which we discussed in the first half of Chapter 4, should also be included in training. These relations can be independent, interdependent, dependent or counterdependent. We found examples of all four. The DA should be helped, where necessary, to be aware of the nature of his relationship with each of his fellow members of the DMT, and the possible disadvantages of certain types of relationship. The most effective relationship, if it can be developed, is that of interdependence. This relationship seemed more often found with the DFO than with other members. The least satisfactory relationship seemed to be with the DCP, because there appeared often to be little contact between the two. We found a number of examples where the DNO's relationship seemed to be dependent or counterdependent. This may say something about the management training needs of the DCP and the DNO, as well as those of the DA.

Relations with the area health authority

It does not seem useful to discuss the training needs for the relationship between the district and the area because of the likely changes in organisation which, as we write, are being considered. Therefore, we shall confine ourselves to the AA's relations with the AHA in an SDA.

Training needs in the analysis and presentation of information are similar to those which the DA requires for his role in the DMT. The AA and the DA also require training in the objective analysis of a situation. The distinctive training needs for the AA include an understanding of behaviour in large groups, the political process, and of politics in local government.

An AA should be encouraged to understand the choices he has in his relations with the chairman of the AHA, with the AHA itself and with individual members, and to appreciate the significance of different choices. Here, as elsewhere in his job, he needs, like the DA, a philosophy for his role as administrator.

Conclusions

The training needs for an AA in an SDA are very similar to those of a DA. Many of their training needs are like those of other managers, especially those who form part of a senior management team. However, the job has distinctive demands, constraints and choices. It is also distinctive because of the range of choices it offers and the flexibility of its domain. The DA, more than many other managers, needs to be aware both of the nature of the choices and of their implications and possible dangers. Our case studies in Chapter 5 (pages 84–108) sought to illustrate these. In a job where there is so much different work which can be done, the DA must be conscious that taking one choice will often be at the expense of another. Therefore, he, more than most managers, needs to have both a philosophy of management and a clear view of what he is trying to achieve. It should be a major objective of training to help him to develop these.

If the DA is in a better position than his subordinates and other members of the DMT to take an overall view of the 'care of patients and what needs doing—and most DAs would maintain that they are—then he should be helped to become aware of the

gaps left by his own way of doing the job. Awareness is only the first step to effectiveness: the essential step is to try to ensure that others fill those gaps. To do so is not easy because it requires skills which a DA, who is effective in other ways, may not have. These skills include a capacity to assess the nature of one's own contribution, to recognise both the present and the potential contributions of others and to be interested in—and skilful at—helping them to develop theirs. *This assessment needs to be of content and of process.* What subjects are receiving attention and which are being neglected? Which roles are being played in the DMT and the top administrative group and which ones are missing? There is a need, too, to recognise how the contributions will often have to vary over time, so the DA, like other managers, must be adaptable. Training should help to develop such analytical capacities together with the social skills and personal discipline to enable the administrator to act upon the analysis.

Abbreviations

AA	area administrator
ABO	area building officer
ACAHA	Association of Chief Administrators of Health Authorities
AGA	area general administrator
AHA	area health authority
AMC	area medical committee
AMO	area medical officer
AMT	area management team (in single-district area)
ANO	area nursing officer
ASO	area supplies officer
ASSM	assistant support services manager
AT	area treasurer
ATO	area team of officers (in multi-district area)
AWO	area works officer
CDP	capital development programme
CHC	community health council
COHSE	Confederation of Health Service Employees
CSO	clinical services officer
CTO	*see* TCO
DA	district administrator
DCP	district community physician
DFO	district finance officer
DGA	district general administrator (DA's chief deputy)
DGH	district general hospital
DHSS	Department of Health and Social Security
DMC	district medical committee
DMT	district management team

DNO	district nursing officer
DPO	district personnel officer
DWO	district works officer
GA	general administrator
GA(Ops)	general administrator (operational services)
GP	general [medical] practitioner
HCO	higher clerical officer
HMC	hospital management committee
IHSA	Institute of Health Service Administrators
IR	industrial relations
JCC	joint consultative committee
JSCC	joint staff consultative committee
MEC	medical executive committee
MP	member of parliament
NHS	National Health Service
NO	nursing officer
PAA	personal administrative assistant
PlO	planning officer
PO	personnel officer
PPA	principal personal assistant
PR	public relations
RAWP	Resource Allocation Working Party
Rcn	Royal College of Nursing
RHA	regional health authority
RTO	regional team of officers
SA	sector administrator
SDA	single-district area
SMRO	senior medical records officer
SNO	senior nursing officer
SSM	support services manager
TCO	team of chief officers (or CTO)
WTE	whole-time equivalents

Appendix A

The district administrator's day: three examples

Time	*Activity*	*Result*
First DA		
0750	DA comes in—goes through papers and reports.	Dictates (into a recorder), with notes on how to handle issues, to subordinates and colleagues.
0830	A DA phones about policy on advertising for staff. Discussion on current approach and needed improvement.	DA gives opinion—gets a committee organised for review of advertising.
0840	DA continues dictation. (The deputy who usually deals with incoming mail has left, so DA takes it on now.)	Letters to CHC, replies to complaints, and so on.
0925	A secretary comes in for papers.	DA asks secretary to set up a collection of papers for a committee, and to ask the GA to come to him.
0930	DA goes to his own secretary's office—flips through mail that just came in, including SA's request for reference for new job.	DA indicates mail requirements and also asks for sandwiches for lunch at the administrative committee meeting this afternoon.

Time	*Activity*	*Result*
0935	GA comes in. They discuss his draft letter to MP. Also review a student's request to work on a district issue.	GA will amend letter with DA's additions. DA will handle student's request and go to the chairman of a committee.
0940	DA goes to PAA's office. Talks through a number of current issues and the preparation of papers.	PAA asks for confirmation to go ahead on building alterations and lease. DA confirms, checks other items being processed.
0955	DA back in own office—goes through papers, with notes to subordinates.	Subordinates get individual contact with papers. (DA comments that he wants to get subordinates to work together rather than separately with him.)
1000	Today's mail now on DA's desk. Goes through and puts items into separate piles for distribution.	Items retained for DA's reading that evening—the rest distributed.
1010	Personnel meeting—usually twice a week. DPO comes in to discuss issues.	
	1 Regional IR practice.	DA will take DPO's paper to AA and chairman of AHA.
	2 Improved budget control methods proposed by DA (and DFO).	DA asks DPO if he agrees with budget proposals. DPO says yes.
	3 Personnel policy items.	Joint agreement on draft policy for discipline, disputes and like matters.
	4 Staff grading—DPO raises problem of request by clerical staff about regrading.	DA confirms DPO to go ahead on the regrading issue.

Time	*Activity*	*Result*
	5 Other issues Advertisement for SNO, sensitive opinions around IR steering group agenda Report from DMT to ATO on personnel Management costs Information methods DHSS circular.	DA goes through these items with DPO, clarifying information, defining aspects of the issues and checking what is being done.
1150	DPO leaves office. DA sorts out other papers.	
1200	DA goes to secretary's office. Wants to have paper from the DWO on energy conservation typed. Discussion. DA says it's too late for circulation.	Paper too late for typing and circulating before DMT meeting.
1205	DA returns to own office. Reads through an agenda, adding to and altering it. ('The content is OK, but the "how" of presentation is political.')	Alters agenda and gives it to secretary.
1215	Goes to PAA's office to show him a paper on problem drinkers, written by PAA but now slightly altered by DA. DA returns to own office.	PAA will now get it typed.
1220	DA searches for items in a pile of papers.	DA feels not sufficiently prepared for meeting—others even less prepared.

Time	*Activity*	*Result*
1225	Goes to secretary's office. DA says he has run out of paper.	DA acquires paper.
1230	DA goes to main committee room (downstairs in same building). There is a sandwich lunch before the special meeting on budget control systems, which are to be established by April 1980.	DA questions the DFO about stages and timings of new accounting methods. DA, DFO and DWO agree on methods and also agree to go ahead. DA suggests an administrative group to work it out in detail, and then apologises for the meeting having over-run.
	The attenders are senior administrative staff and SAs with DFO and DWO. DA is chairman. DFO explains the accounting method which will relate the system to the organisation's needs, and gives responsibility of budgets to departmental heads.	DA asks if it is OK if he cannot produce a report on this meeting. Members smile agreement, and then rush off. Meeting ends 1425.
1430	DA back in own office for meeting with DFO and ASO.	
	Discussion with ASO on centralised supplies shared in area with other districts. DA can't control ASO, but the budget control may produce, in some departments, evidence that this district was not over-spending. DFO also raises with ASO that there was no evidence that centralisation saved money. The district misses its own supplies organisation and	Attempt to identify some way to make progress fails, and DA

Time	*Activity*	*Result*
	wants its own stores system. DA states that improvement of supplies greatly needed. ASO remarks on problems of staffing, communications with district and industrial relations—and people do not realise how difficult supplies work is.	agrees to seek meeting with AA and AT.
1525	DA brings back the budget control issue.	Agreement on budget control issue, with laughter and joke. Meeting ends.
1555	DA asks about minutes of this meeting with ASO.	Agreement on action note only. DFO leaves.
1615	ASO talks about his and DA's hard work and responsibilities, and staff problems.	DA listens, takes it in. ASO leaves.
1620	PlO comes in and asks to discuss possible movement of infectious diseases beds to another hospital.	DA takes this on for discussion with AMO. There are 'political' difficulties with local authorities.
1635	Subordinate shows a paper he will present at tomorrow's seminar on mental handicap.	DA arranges travel to seminar and lunch for DMT after the seminar.
1648	DA asks PlO to discuss with GA(Ops) the issue of child health, without him because he has no time.	PlO agrees and then leaves.
1650	GA(Ops) comes in. They work out the timing of their joining the DMT meeting tomorrow,	DA goes off to bring back PlO for discussion. GA(Ops) and PlO agree to come to DMT for lunch

Time	*Activity*	*Result*
	with various issues on planning and operations.	and early contribution. They leave.
1700	DA signs letters.	Secretary comes in and picks them up.
1710 to 1800	DA goes through mail, reads papers and reports, makes notes, allocates.	DA goes home.

Second DA

0915	In own office, DA phones four people—gets one reply from committee clerk.	DA asks for holiday dates of chairman of MEC.
0920	Phones a doctor—not available.	DA asks for doctor to phone back.
	Goes to PPA's and ASSM's office. Discusses the definition of a 'theft problem'. Begins to give suggestions, when told there is a phone call for him in his own office.	DA goes back to own office.
0925	AMO on phone—discusses the clarification of medical appointment and other matters: who is going to be at MEC today; locum for neurology; health centre.	AMO clarifying items for MEC meeting today—DA takes notes.
0935	Mail brought in by ASSM, who goes through other mail on the DA's desk. They discuss the dismissal of a staff member.	DA and ASSM agree likely suspension and eventual dismissal of the staff member. ASSM leaves.

Time	*Activity*	*Result*
0938	DA goes through mail. Two senior officers are absent, so DA is handling the mail, but this is unusual.	Makes notes direct on letters, for less experienced staff.
0940	DA attempts to phone: number engaged.	
0942	DA reads through mail: letter on neurology, another on a refusal of blood transfusion by a Jehovah's Witness.	
0946	DA phones secretary: asks for DMT agenda items to be brought in. Secretary comes in, mentions that AHA, CHC agendas are also in. DA looks through DMT agenda.	DA says DMT agenda can go ahead now.
0950	PPA comes in with MEC papers.	DA thanks PPA—puts papers on one side.
	DA continues reading letters. Dictates replies to secretary.	Completes agenda, letters to chairman of AHA, to solicitors, and others.
1005	Coffee brought in by secretary.	
	DA phones about battered baby case.	DA requests information.
	Makes another call to main hospital about how hospitals take records of these cases.	DA gets phone number.

Time	*Activity*	*Result*
1012	DA phones PPA—asks him to come to office.	PPA comes in. DA gives instructions to get information on the refusal of blood transfusion. PPA is learning about the DMT 'angle' and DA's role.
	Secretary phones DA about DMT attendance and AWO's visit.	
1015	DPO comes in to ask when he can see DA.	DA asks DPO to come back after ASSM has left. DPO agrees and leaves. PPA also leaves and goes to get ASSM for DA.
1020	ASSM comes in to ask about equipment for anaesthetics and for kitchen. Amount of money not clear yet.	DA tells ASSM where to get information. ASSM then leaves to do the work for DA.
1035	DA phones social worker in hospital about method of records on battered babies. Phones nursing officer at another hospital—no reply.	DA checks records methods in hospitalisation of babies.
1040	DA phones DPO—asks about JCC because DPO is going away on a course and his deputy is on holiday.	Gets information on management side for JCC meeting.
1046	AGA phones DA for information.	DA gives opinion and suggestion to AGA on confidentiality.
	DA continues on internal phone with DPO.	DA requests list of JCC members.

Time	*Activity*	*Result*
1056	ASSM comes in, asks for help on a policy enquiry—wants to be sure.	DA explains the issue, gives his ideas and confirms ASSM's action.
1100	DPO comes in to discuss the definition of suspension and wages. DPO and DA discuss the JCC meeting: item on applications, regrading, a dismissed nurse, study leave of DPO.	DA will go to JCC meeting, and also give this information to deputy when he returns from holiday.
1114	DCP's secretary comes in—a new DCP is joining—is DA available for a meeting?	DA is not going—others will do that.
	DA phones a hospital about records of battered babies. DA explains that a social service report gives evidence that cards were not completed when baby was admitted.	DA says on phone that 'plot thickens'.
1120	DA phones social worker in main hospital.	She is not there—DA asks her to phone him within next hour, before MEC meeting.
1122	DA phones psychogeriatric hospital, talks to a doctor and arranges a meeting. Tries to get transferred to the SA there.	After MEC meeting, DA and doctor will meet in DA's office to discuss the psychogeriatric ward problem.
1125	Principal of school of radiography phones, wants to know about the transfer of a student, from him, to DA, to area.	DA says 'Sorry sir, but am lost about this system', gives a suggestion—should have a word with DPO.
1130	DA in corridor, meets secretary.	Checks MEC agenda and papers.

Time	*Activity*	*Result*
1131	Back in office—DA phones the SA at psychogeriatric hospital. SA had been on jury service—discussion and humour. They discuss aspects of information to staff, difficult relationships and persistent patient-complainer. Also talk about change in administrative organisation possible with a retirement.	DA checks through current issues with SA.
1148	PPA comes in—asks about the unclear equipment change. DA says 'Don't worry—get the list'.	PPA goes out to get the list.
1150	Secretary comes in, puts DMT agenda on the desk and leaves.	
1152	Social worker phones DA. Discusses the proper reporting method on battered babies, and DA identifies the problem at a hospital.	DA gets the social worker to sort it out.
1156	ASSM comes in with a report on anaesthesia equipment, requested by a division. DA goes through it.	DA suggests some changes in report and requests more copies for MEC.
1205	DA briefs himself on MEC agenda.	Lists agenda numbers of various papers.
1207	DA dials a number—no reply.	'People missing when you want them.' Pins things together.
1210	DA goes into general office. Reads the draft report on anaesthesia.	Gets secretary to photocopy it.

Time	*Activity*	*Result*
1213	APO phones general office. Discussion about an appeal against the DA's decision that union member has no time off with pay on union business.	DA confirms the decision.
1218	DA back in own office. DFO drops in. Chats about arrangements for not interfering with DMT. Talks about loss of cash at a hospital and the need for proper recording of patients' property.	DA and DFO discuss these issues as DA prepares for MEC meeting.
1225	DA sets off across the hospital to MEC room. DFO walks with him and raises present and personal subjects. DFO goes off and the DA goes to lunch with MEC.	
	Talks to vice-chairman of MEC as they gather for lunch. They sit together at the head of a long table and go through agenda.	
1250	Vice-chairman starts MEC meeting with the item on neurology locum. DA gives records of previous experience and explains cases with information. Vice-chairman doesn't always know what to do, so DA comes in with information to clarify the members' position on decisions. DA also handles unclear financial decisions. Vice-chairman requests DA's explanation of the sequence of decisions needed with dates. DA suggests July because of holidays.	MEC agrees to a meeting in July as the latest time for making decisions on finance.

Time	*Activity*	*Result*
1340	Meeting ends. Doctors chat together. Vice-chairman and DA discuss arrangements.	Agreement.
1345	DA and consultant go across the hospital and into DA's office.	
1350	They discuss the contents of the consultant's letter to DA about an integrated service for psychogeriatrics for the area, not just for the district. Consultant leaves.	DA beginning to understand and agree with consultant's arguments; wants DMT to see consultant's letter. Believes DMT will back his choice of option. Consultant agrees.
1412	DA goes into general office, gets consultant's letter copied and sent to DMT members.	Letter out to DMT.
1413	DA goes to PPA's office and looks at two complaints from patients. PPA seeks guidance on how to handle these. 'How do we put these to the AHA?'	DA suggests methods and helps with confirmation of PPA's ideas.
1420	DA back in own office. ASSM comes in with questions on type of dismissal. DA looks at his file.	ASSM gets confirmation: dismissal without notice and pay is OK with gross misconduct.
1422	Secretary comes in with letter from consultant to DA.	
1425	After lunch DA wants a walk, so goes round DGH. (Explained aspects of the district and this DGH to the researcher.)	Brief chats with a number of people, walking through the corridors, in units and school.

Time	*Activity*	*Result*
1515	Back in office. PPA comes in with a difficult issue: a patient's complaint, some confused names—who has rung up about whom.	PPA and DA laugh together, and DA gives PPA some guidance and suggests he be careful.
1525	Secretary comes in with some memos.	DA signs them.
1532	Secretary comes in with papers.	
1535	PPA phones DA: he has found out names of patients complaining.	Great laughter by DA—leaves PPA to it.
1536	DA starts reading DMT papers.	
1545	DA phones area building officer. Asks who is coming to DMT meeting about plans, and explains DMT's requirements.	DA sorts this out before phoning AWO.
1549	DA phones AWO. He is busy, not available.	
1550	An accountant phones.	DA gets him to phone the personnel department.
1552	DA phones PPA—he comes in—asks PPA to be committee clerk for DMT meeting tomorrow. Goes through agenda items and asks for research on some issues.	PPA goes out to prepare for meeting and read papers.
1605	DA phone AWO—he is not there.	DA asks AWO's secretary about who he has coming to the DMT meeting.
	DA tries to phone ABO.	

Time	*Activity*	*Result*
1607	Deputy, returning from holiday, comes into DA's office. Friendly greetings—news from DA that deputy's lecture date delayed, deputy relieved.	
1614	Senior administrator from personnel department comes in—quick question on JCC arrangement.	DA explains and senior administrator leaves.
	DA and deputy continue discussion on current and personal issues.	
1620	PPA pops in—joins the chat.	Deputy leaves, with ideas for the next meeting tomorrow.
	PPA gives DA a copy of area's plans—shows his idea about the proposed scheme.	
1630	ASSM comes in; wants MEC's list of equipment and capital development programme (CDP).	DA can't find CDP, searches in file, leaves the problem with ASSM.
1634	DA phones AMO about result of MEC meeting. Not there, only AA's secretary available.	DA gives MEC information to AMO via AA's secretary.
1635	DA attaching addresses to items in the agenda of the MEC meeting results.	Some to DMT—some to MEC committee clerk.

Time	*Activity*	*Result*
1637	DA phones ASSM to check opening of health centre, type of refreshment and drinks. Gives his opinion—should not be beer. Asks about press, ads, security.	Checks event, gives his preference, gives reminders of aspects that require attention.
1640	AWO phones DA. They discuss the ATO/DMT agenda. DA gives district's view on new operating theatres.	DA preparing AWO for DMT meeting and the ATO/DMT meeting before it.
1650	DA starts reading agenda and papers for the *ad hoc* DMT meeting at 8.30 tomorrow on psychogeriatric problem, and for the ATO/DMT meeting, and the formal DMT meeting after it.	Preparation for three meetings tomorrow morning.
1715	DA goes home.	

Third DA

0845	As DA goes into own office meets deputy, who raises the visit of the DHSS domestic services adviser. DA wants to handle the visit.	DA gives date, and deputy will organise this visit.
	Deputy continues with	
	1 letter to DNO	DA feels letter should have come to him—will write to source of letter.
	2 property issues	DA makes recommendations to deputy.
	3 two DHSS circulars	DA marks circularisation.

Time	*Activity*	*Result*
0900	DA attends management and staff vacancy meeting—fortnightly with DNO, DPO, DA and staff representatives. DPO goes through issues: replacement of porters and clerks, grading of medical secretaries. DNO reads through information on nursing vacancies. DA sits alongside DPO.	An authorisation committee—to enable DPO to go ahead.
0920	Meeting ends. DA back in office. ANO phones requesting reports on student nurses at hospital. DNO comes in, so DA asks DNO for information on a report on accommodation.	DNO says has sent report to AA. DA says ANO has not received a copy.
	DA has also been involved with Rcn which is handling the complaint of nurses about the DMT criticism of nursing.	DNO tries to give an explanation to DA but is interrupted and then leaves.
0930	DA going through folder of papers and mail.	
	Items are	
	1 a charity	DA will go to a committee meeting of the charity
	2 old HMC minutes and data	DA makes notes on these.
	3 letters from MP, DHSS and others	
0935	Phone from CSO, message that two AHA members coming next day.	DA arranges a meeting with CSO.

Time	*Activity*	*Result*
0940	DA continues with mail, signs letters.	Decides to go to a meeting in London.
0950	DPO comes in. An appeal being organised—DA discusses with DPO the area decision needed, the timing and contact.	DA suggests DPO talk about this to APO. DPO goes out.
0957	DCP phones in—DA listens, is sorry, understands.	DCP not coming to the hospital visit arranged for tonight by DMT.
1000	DA phones hospital administration, gives information about visit—it will start at 9.00pm.	Checks that hospital knows about the visit.
1003	Goes into general office.	Hands over mail to secretary. Gets coffee from machine.
1005	Back in office—goes through draft of yesterday's DMT minutes. DA concerned about DNO's recorded statement—not quite what he remembered from the meeting.	Phones DNO—but not there. Asks for DNO to phone him.
1007	DA phones DPO about DNO's statement.	DPO out—DA asks for him to phone.
1010	Deputy comes in with plans for new squash court at hospital. DA looks through the implication of using the plans—deputy had been at the meeting on this the day before. Deputy asks who is to see copies of plans.	

Time	*Activity*	*Result*
1015	Consultant phones about the disciplinary process on nursing. DA listens—there is confusion about witnesses and legal base of different appeals—what is the best?	Takes time—so deputy leaves. DA gives opinion to go for result that is best for hospital, not just for the staff.
1030	DPO phones as requested. DA asks about DNO's statement on a 'confirmation on acceptance of the job'. DPO clarifies present 'acceptance' position.	DA will amend the minutes. DNO not yet confirmed the person's acceptance of the job to DPO.
1035	DA phones secretary about DMT minutes.	Corrects DNO's statement.
1040	Secretary comes in. DA hands over some minutes—starts on the rest.	Secretary goes out.
1043	Deputy comes in. Gives notes to DA for ambulance meeting this morning, on the internal ambulance transport problem at hospital.	Deputy goes out.
1045	Deputy phones about domestic service manager's dates for visit from DHSS adviser.	DA confirms dates in diary.
1050	CSO comes in about ambulance meeting. DA and CSO discuss issues.	CSO gives information to DA before meeting.
1100	Phone call by local authority.	DA transfers call to subordinate.

Time	*Activity*	*Result*
1105	Ambulance officers come in. Friendly discussion about dramatic hospital and ambulance difficulties—seeking agreed solutions. Consultant and wards much mentioned, maternity transfers, clearing of beds, danger of using taxis, while ambulances are used incorrectly, pressure on emergencies, too few people and ambulances, information from wards too late and wrong requirement.	DA goes out to pass note to subordinate about valuers. With their common difficulties, sympathy shown on both sides. DA will take this issue to DMT. Thanks ambulancemen for clarifying problems. District now getting own vehicle.
1230	DA and CSO discuss the results, and organisation of ambulance services locally.	Ambulance officers leave.
	CSO passes notes to DA on AHA members checking out eight cases of complaint.	
	CSO asks DA if he should go to maternity department and look at the ambulance service.	DA confirms CSO's ideas. CSO leaves.
1245	DA calls in secretary.	Corrects meeting dates. Some preparation of DMT agenda next week.
1300	DA goes out to lunch at local hospital—in new postgraduate medical unit.	Some brief contact with administration in the unit. No contact with doctors or others.
1405	Back in office, reads magazines to catch up on them.	

Time	*Activity*	*Result*
1415	Phone from a divisional NO requesting a copy of Jay report.	DA agrees to send one to her.
1416	Secretary comes in with mail. DA reads.	DA asks to dictate replies.
1423	Phone from press for information on CHC report criticising storage facilities in a hospital.	DA gets the CHC paper for tomorrow night. Gives opinion to press on the report but cannot give a detailed answer. Explains that money for maintenance is meagre and needs a realistic perspective of members in visiting panels. (DA expresses worry to researcher that press takes a small item in report and then exaggerates it.)
1435	DA goes through mail.	Addresses items in the mail to other people, dispersing papers, circulars.
1455	DA calls for secretary and then dictates letters.	
1510	DA phones an administrative assistant at hospital: progress on appeals; DA will send a notice to subordinate for a two-day course; subordinate gives information about ward sister—news to DA—discussion—then	
1513	DNO phones DA	Secretary tells DNO that DA is on other phone, DNO rings off.

Time	*Activity*	*Result*
1515	DA phones DNO. DNO raises the upset caused by consultant not consulting the ward sister when the DMT this week made the decision to move her ward. There was no information to the sister and she didn't know why it was being done.	DA listens.
1520	DA dictates letter to ANO on nursing accommodation, and one to a consultant about ambulance service.	Secretary goes out.
1535	DA phones Rotary.	DA apologises for not attending a meeting.
1545	DA goes through much paper for filing.	DA calls secretary to come in.
1550	Phone call—wrong number.	
1610	DA dictates replies—handles ANO's letter criticising district.	DA's reply is tough.
1615	DPO phones DA about hospital with an appeal on dismissal and asks for details. They discuss the previous decision. Now detail on witnesses used not available.	DA asks secretary to get file on person and COHSE papers. DPO sending evidence to area; DA leaves DPO with the issue.
1620	DNO phones DA to invite him to a meeting with Rcn visitor. Checks date.	DA accepts and pulls out his diary.
1622	DA dictates letters. One letter to AA on HCO post.	

Time	*Activity*	*Result*
1625	DNO phones DA—gives information about a course.	
	DA phones administrative assistant at hospital to let him know that DNO and another nurse have taken places on the course.	Asks administrative assistant to give that opportunity only to important people.
1635	DA dictates letters	
	1 to APO—bonus schemes—criticism of DPO unjustified and should have come direct to the DA, not APO to DPO;	DA ensuring proper ATO relationship to district.
	2 to GP—DA confirms scheme to extend surgery premises as a minor capital programme.	DA says AWO will handle this now.
1655	Dictation ends.	
	Deputy comes about site development: describes site which he had walked over with a planner; DA and deputy discuss possibilities and limits of development of site.	DA gets information. Makes a date to go to hospital to view site.
1710	Day ends.	DA goes home.

Hospital tour by DMT at night

2045 DA arrives at hospital reception office. GP already there—DA and GP discuss issues and wait for the rest of the DMT except consultant and DCP.

2100 DMT moves off to meet the senior nursing officer as they enter the special unit. DNO leads the discussions with the night nurses, mainly with the DA, while other DMT members listen. Then leave with the senior nurse for further discussions of the hospital.

2105 DA and DNO get information on the main problems of the hospital.

2115 Senior nursing officer then leaves, while DMT goes to other wards. Mainly, the DNO leads the DMT into each ward and asks questions, with the DA, about the nurses' current work. About five minutes or so in each ward. Rest of DMT careful about presence, attends to explanations and visually experiences the ward circumstances.

2200 Tour ends. Members listen to night sister as she comments on good and poor conditions in the hospital. DMT members sympathise with staff, indicate understanding.

2210 Group disperses. DA goes home.

Appendix B

Trace of issues

1 All issues over three days

From	*By*	*Issue*	*DA's action*
SA(1)	phone	Psychiatric patient can't see her daughter except once a week. No record of review panel, and doctors do not attend so result unclear.	Arranges a meeting with SA(1) and SMRO, who runs the review panel and is responsible for medical records. DA spends one hour 40 minutes with them suggesting new rules of procedure.
CHC secretary	letter	Hospital screening equipment insufficient	Writes long explanatory letter.
Personnel subordinate	FF*	Medical staff retirement and appointments: problems of holiday arrangements—unclear process. Information needed.	Goes to deputy for information on appropriate method. Confusion over who has mail and file.
DA in nearby district	phone	One of our DA's staff applying for job	Gives positive opinion.

* face-to-face

From	*By*	*Issue*	*DA's action*
SA(1)	FF	SA wants to sack an employee: will go into disciplinary session and will phone back tomorrow for permission to sack.	Encourages SA to phone back direct so that they can sack quickly and not have accumulated pay resulting from DPO's delay.
DFO	FF	A clerk at hospital, handling money from League of Friends, has been accused by nurses.	Discusses accusation and clerk with DFO; decides to go to solicitor.
File	DA elsewhere	Rearrangement of visits by CHC to hospitals.	Passes mail to GA.
SA(1)	memo	Patient's complaints: the locum in charge at the time has disappeared, leaving no address.	
SA(1)	memo	A member of staff wants longer compassionate leave. DPO made it too short.	Gives the number of days needed.
DPO	FF	Summary dismissal: DA goes through reasons.	Signs letter.
DPO	FF	Application for SA(4) job.	Gets DPO to arrange interviews quickly before appointments are stopped by government.

From	*By*	*Issue*	*DA's action*
DWO	FF	Contract prices for building. Gas conversion of two vehicles. Expenses needing correction.	Discusses and accepts DWO's recommendations. Will take to DMT next week. Signs claim for back expenses.
Another DA and AA	letter	Medical planning confusion: note indicating uncoordinated responsibility.	Circulates letter to DMT.
GPs at hospital	letter	GPs want to increase number of sessions—bargaining.	Reads—will be careful and polite in reply.*
SA(2)	memo	Two clinical assistants required by obstetrics department at one hospital.	Will talk to SA and DCP on implications of decision.*
Relative of patient	letter	Patient died—nurse saw him at 6.00pm he died at 6.30pm.	Will ask DCP about normality.*
SA(2)	letter	Shortage of anaesthesia in one hospital—what can be done?	Sees this as 'political' and complicated. Will take it to DCP.
DFO	phone	Staff nurse not registered and, when sacked, payment of wages is illegal, AT has said to DFO. DFO requests guidance.	Says will phone RHA legal adviser, and does. Goes back to DFO and says we do not pay, and let girl sue us.

* The DA went to the DCP to talk over these issues.

From	*By*	*Issue*	*DA's action*
SA(1)	phone	Girl attacked in laundry.	Gets SA to give information on this to shop steward.
Doctor	letter	Chairman of 'three wise men' investigating a consultant at special surgical unit because of relationship problem.	Reads letter, decides to take it to DMT today. Gives it to DCP at the meeting for circulation.*
Rcn	letter	'Alarm' letter giving evidence for investigation of nursing problems and management.	Replies 'surprised that no satisfactory evidence of that issue. . .'. Tries to arrange meeting with Rcn regional officer.
SA(1)	phone	Reports contact with police on three issues: cruelty to patients, cigarettes missing, clerk accused by nurses. Cigarettes missing may be basis of nurses' accusation of clerk—covering own theft.	Working on form of public communication to re-establish the clerk's honesty. Suggests joint course in London. Gives information to DMT.
DA	Meeting with subordinates	Fire precaution records	Suggests file for all records of checking be put together to ensure that proper records are available when there are problems with fire.

*** The DA went to the DCP to talk over this issue.**

From	*By*	*Issue*	*DA's action*
Not known	FF	Identifying private patients problem with consultant who seems to take patients privately immediately, then gets them into hospital quickly but as NHS patients. Methods of identifying them in hospital important, difficult and failed.	Discussion with GA, then phones SA. Gives him 48 hours for enquiry into methods.
SA(1)	FF on DA's visit to hospital	Checked parking slips after doctor's complaints. Social worker to be accommodated.	Discussed all these with SA.
		Major problems with delegation, changes needed.	Confidential agreements on manoeuvres with delegation.
		Replacing deputy SA.	
		Shopping facility.	Tours shop store, initiates shopping facility idea. Will arrange visit.
		Regional work group enquiry—DA didn't know it had been there.	
SA(3)	FF	Disciplinary: staff member absent from duty.	DA will have a word with SSM and SA and keep DPO out of it.
DA	FF	Delegating personnel work: DPO delays decision and won't give details to SA.	Gets SA's acceptance (DA knew him in other job—close relationship). Arranges delegation meeting with SAs.

From	*By*	*Issue*	*DA's action*
Round table	phone	£2500 available for community care.	DA heard this at evening Round Table, now pursues it. Gets information from members and now gives possibilities to SAs.
SA(1)	FF	Regional working group: fact-finding visit to special care unit at psychiatric hospital, ignored the type of care given by consultant himself. Anger and worry over money for special care unit.	Gets deputy to find out reasons why the district was not represented at that visit. Phones AA for advice. AA gives assurance that visiting group cannot change decisions of area authority. DA grateful for AA's knowledge and trusted comfort.
DFO	phone	Safety committee getting protective clothing. DFO enquires about budgets.	Discusses with DFO, arranges method to get into suitable budget.
DA	phone	Closure of minor accident unit at local hospital.	Explains to CHC secretary that doctor resigned and, with no help, unit will have to close for a while.

2 One issue over three days

The issue is the provision of psychogeriatric beds. The AMO has presented a paper on the options. It is part of a bigger issue—that of integrated psychiatric services in the area, which the consultant psychiatrist and his colleagues are promoting.

	Activity	*Result*
Tuesday		
0920	DA phones consultant psychiatrist.	Not available—to phone back.
1120	Consultant psychiatrist phones.	DA arranges meeting with consultant after the MEC meeting this afternoon.
1350	In DA's office, discussion with consultant psychiatrist.	DA gives his opinion on the options in AMO's report, and on consultant psychiatrist's preference. DA asks if he can send to the DMT copies of letter from the consultant to him about integrating psychiatric services. DA says he is just beginning to understand the consequences of such change—DMT will not yet. Consultant agrees.
1415	DA gives letter to secretary	Copies sent to DMT members.

(The DA had already arranged an 8.30 meeting for the DMT next morning, before the 9.00am ATO/DMT meeting which is due to work out the psychogeriatric bed problem. The latter meeting includes DMTs of both districts in the area.)

Wednesday		
0830	Informal meeting in area office to discuss district's position on the AMO's options to get psychogeriatric beds provided.	DMT decides on option 1. The DA, DFO and DNO are the main discussants because the chairman is absent, but all are agreed.

	Activity	*Result*
0900	ATO/DMT meeting. AA is chairman. AMO goes through the options—some contributions from DNO and ANO on options and consequences. Our DMT presents choice of option 1 and waits for other district's feelings on the AMO's options. DA quiet, listening. Other district accepts option 1 but, if that doesn't work, would take option 5, which would alter another hospital to psychogeriatric. DNO, DFO and others discuss alternatives.	Option 1 agreed by all at ATO/DMT meeting. AMO to take it to AHA.
1500	JSCC meeting, DA with subordinates. SA gives idea of a further 12 beds for psychogeriatric hospital. Money questioned.	DA leaves ideas to be followed up by SA. DA will ascertain financial and nursing position. Says SA's idea is good.
1555	Letters from DMT accepting option 1 of AMO's paper to be done by PAA.	Decision of DMT and result of ATO/DMT going to consultant psychiatrist and others.
1637	DA phones DNO about new theatre extension at a hospital, and a meeting with him for that. Then mentions the new idea from the SA of the possible 12 beds for psychogeriatrics. DA asks DNO to think it through.	Joint confidential meeting of DNO and DA of these issues.

	Activity	*Result*
Thursday		
0924	DA phones consultant psychiatrist. Talks through option 1. Also gives the idea of the 12 beds and the possible £18 000 available. Will cover some of the bed problem, as well as option 1. (Other issues discussed also.)	Consultant psychiatrist informed and can move quickly if wanted.
1000	SA phones DA and discusses meeting. DA gives news that he has explained the 12 beds idea to the consultant psychiatrist.	SA informed.
1020	DA walks over to DFO's office, first to talk through the district's position on energy conservation and the meeting they will go to together on this, in the afternoon. Then DA raises subject of available money for the ward development.	DFO will come to DA with information on money.
1059	DFO phones—non-recurring money is £28 000; more than expected.	Now two wards are possible.
1300	DA has lunch with AA; gives news on ward and money to AA.	Keeps AA in touch.
1630	Tries to arrange a meeting with DFO about beds (would include a discussion on ward money).	Leaves note for DFO.
	(Observation then ended.)	

Appendix C

Comparisons of attendance at meetings

Many of those whom we interviewed commented upon the large amount of time they had to spend in meetings, particularly since the 1974 reorganisation. This appendix can give us a perspective upon this. It analyses the information they sent us about the meetings they had attended from 11 December 1978 to 14 January 1979. All but two of those we interviewed in the main part of the study sent us this information: 31 DAs and eight AAs in SDAs.

We asked our informants to distinguish between regular and *ad hoc* meetings, but there may be some differences in interpretation as well as in the thoroughness of their replies. We do not think that these possible sources of non-comparability can account for the exceptionally wide variations shown in the tables which follow.* The other information, collected by interviews and observation, helps to confirm that DAs and AAs in SDAs differ markedly in the number of meetings they go to and in the time they spend in them.

We distinguish, in the tables, between DAs and AAs in SDAs because, although there are similar wide variations between individuals, the AAs tended to spend more time on meetings.

* The tabular analysis for this section of the mail questionnaire was done by Tony Earle, district personnel officer of Carmarthen, during his study at Henley Administrative Staff College.

The five weeks included Christmas, so we have treated the period as four weeks and divided by four to give an 'average' week. A different period of the year may have produced a different average week, but is unlikely, we think, to have much effect on the range of variations. We start by giving the average, maximum and minimum figures for the five-week period, then compare an 'average' week for DAs and AAs, and then give some specific examples.

District administrators

Number of meetings attended in five weeks

	regular	*ad hoc*
most	24	20
average	12	4
least	5	1

Hours spent in meetings in that period

	regular	*ad hoc*
most	63½	36¾
average	29	11
least	11¼	1½

Area administrators

Number of meetings attended in five weeks

	regular	*ad hoc*
most	30	18
average	16	5½
least	8	1

Hours spent in meetings in that period

	regular	*ad hoc*
most	68	31¾
average	40½	9¾
least	17½	1

Comparison of DAs' and AAs' 'average' week of meetings

	DAs			AAs		
	regular	*ad hoc*	total	regular	*ad hoc*	total
number	3	1	4	4	1	5
hours	7	3	10	10	2½	12½

Specific examples of meetings attended by six DAs and three AAs (five-week period)

	District number						Area number		
	9	20	33	14	28	22	37	41	36
regular meetings	23	24	11	9	8	5	30	15	8
hours	63½	53¾	28	24½	24	11¼	68	49	17½
ad hoc meetings	20	11	6	5	1	2	18	4	1
hours	36¾	16	12¼	13½	2	7	31¾	7	1

Some of the differences shown above will be due to the circumstances and characteristics of the district, including the expectations others have of the DA's role, but that is not the whole, or even necessarily the major part, of the explanation. District 9, for example, can be explained in part by the district's conditions, but also by the way the DA interprets and plays his role. He adopts the role of figurehead (see Chapter 5, pages 75, 90–92).

The other aspect of these tables that deserves comment is the average time spent in meetings. We are not in a position to judge whether this is, in part at least, dysfunctional. Compared with the time managers spent in a very large British company which

Rosemary Stewart was studying at the same period, it is a rather low figure. What we can say, from the experience of all the interviews and observations, is that DAs and AAs in SDAs have some choice in the time they spend in meetings. They also have some choice in which meetings they attend, which ones they call themselves, and in whether they seek to influence the frequency and duration of meetings, particularly those of the DMT or AMT. There are, as we illustrated in the case studies in Chapter 5 (pages 84–108) marked differences in whether DAs prefer to work through formal meetings or informal personal contact.

It will be noted that the numbers of meetings given in the above table are sometimes different (usually higher) than those given in other tables. They include meetings which do not fit into the three categories explained below.

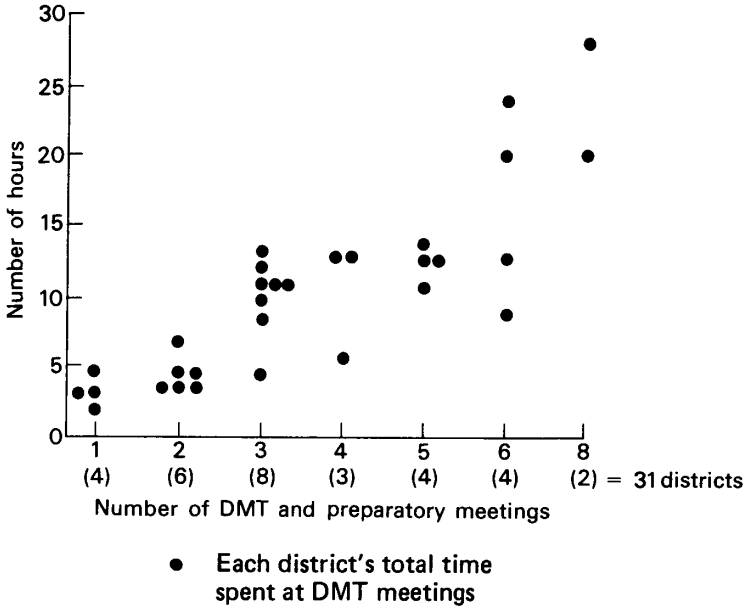
Analysis of number of, and time spent in, different kinds of meetings

So far we have given a general account of the number of meetings attended and the time spent in them. We now distinguish between three different kinds of meetings: the DMT or AMT; meetings with subordinates and personnel meetings; and other meetings. The information on DMT meetings is an elaboration of that given in Chapter 3 (pages 26–53), but also differs from it in being a description of the meetings in the five-week period, rather than a general description of the frequency of meetings, and includes meetings of officers beforehand.

DMT/AMT meetings

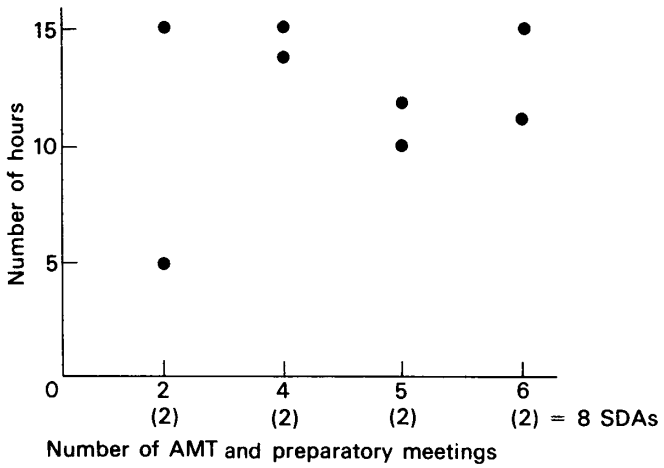
Districts differed both in the frequency of their DMT meetings, as shown in Chapter 3 (page 26) and in whether there were preparatory meetings, of all or some of the officers, beforehand.

The following figure shows the amount of time spent in DMT meetings, including any preparatory meetings of officers, in the five-week period, together with the number of such meetings.



The average amount of time for a DMT meeting is 2¾ hours—there is little difference in the average length of time for DMT meetings amongst the districts which have few or many meetings in the month. That average may indicate the typical morning or afternoon meeting (10am to 1pm or 2 to 5pm) rather than the actual agenda or frequency of meetings.

In single-district areas, the equivalent AMT and preparatory meetings during the five-week period are distributed as follows.



We are not sure of the explanation for the different distribution of the meetings in the SDAs, where fewer meetings do not necessarily mean less time (unlike the DMT and preparatory meetings), as this difference was only noted in the final analysis.

Meetings with administrative subordinates and personnel meetings

The regular and *ad hoc* meetings with subordinates and others on administrative matters listed below summarise the many different types of meetings mentioned by our DAs and AAs. We divide them into two types.

1 Meetings with subordinates or colleagues on the same level, on service or management matters.

2 Meetings about staffing, industrial relations, training, welfare and other personnel meetings on such matters as appeals and grievances.

Below are some average and some extreme examples of the number and time taken by both types of meetings during the five-week period.

District number	Meeting type 1		Meeting type 2	
	number	hours	number	hours
19	1	2	0	0
8	1	3	1	2
29 (average)	4	8	3	6
32	5	7	5	10
20	15	28	3	5

These examples help to support our account of the DAs' differences in handling subordinates, administrative work and relationships.

External meetings

These meetings, with area or regional officers or with planning, medical and other professional groups, involved the DA or AA in developmental and wider management issues. We distinguished three types of such meetings.

1 Area and regional officers' meetings (for example, ATO, not AHA).

2 Meetings for projects, liaison, planning and development.

3 Medical and other professional meetings (for example, MEC, DMC).

The table below shows examples of extremes and the average of these external meetings attended by eight DAs and three AAs during the five-week period, and gives an indication of their involvement in wider issues.

District number	Meetings	Hours
1	1	2
10	3	5
15	5	11
22 (average)	6	13
16	7	16
32	12	17
11	14	28
18	16	25
Area number		
36	1	1
39 (average)	7	13
37	20	39

Comparison of number of, and time spent in, meetings with administrative staff, DMT or AMT and other (external) meetings

We give, first, examples of a DA and an AA whose distribution between the three types of meetings over the five-week period was near the average.

	Administrative	DMT	Other	Total
District 23				
number of meetings	7	5	6	18
% of meetings	39	28	33	
% of time in meetings	38	32	30	

	Administrative	AMT	Other	Total
Area 40				
number of meetings	6	4	5	15
% of meetings	40	27	33	
% of time in meetings	36	45	19	

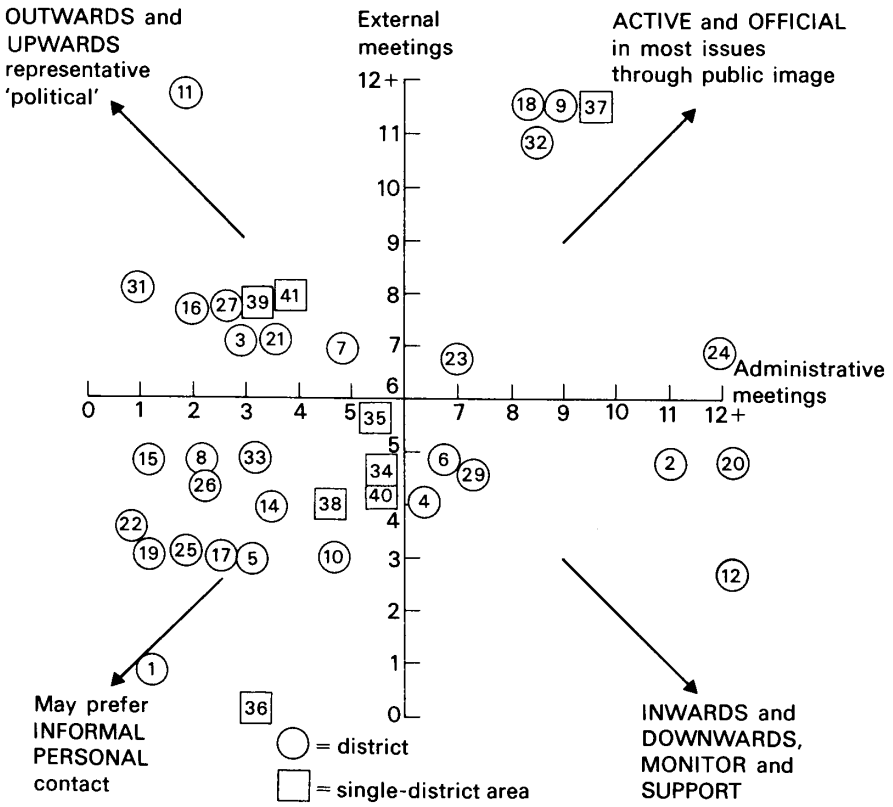
Both examples are very near the average for all proportions—except that the time used in the AMT is higher than usual.

The proportion of time spent in meetings is frequently very near the figure for the number of meetings—so in the table below we give the total number of meetings and the percentages of each kind of meeting.

The table distinguishes between those DAs or AAs who spend a lot of time in administrative meetings, and comparatively less in other meetings, and those who do the reverse. This illustrates the differences in the DAs' and AAs' domain.

District number	Administrative %	DMT or AMT %	Other %	Total number of meetings
2	58	16	26	19
12	72	19	9	32
20	67	15	18	27
27	64	18	18	11
36 (SDA)	50	33	17	6
These tend to be	high	low	very low	

District number	Administrative	DMT or AMT	Other	Total number of meetings
	%	%	%	
8	16	42	42	12
9	27	15	58	40
11	11	16	73	19
16	17	25	58	12
41 (SDA)	25	25	50	16
These tend to be	very low	variable	high	



In the figure opposite we look at the differences in the number of regular and *ad hoc* meetings with subordinates and others on administrative matters compared with external meetings, and add our interpretations. These differences reflect, at least in part, the choices the DAs and the AAs made between the two. We say 'at least in part' because differences in the nature and circumstances of the district may also affect the distribution of time between the two.

Size of the district and the attendance at meetings

We compared the number of people employed in the district or area with the number of meetings attended by the DA or AA. The larger the number of employees, the more meetings the DA or AA is likely to attend, though there are some exceptions; for example, districts 15 and 18 are the reverse of the usual tendency.* The number of hospitals in the district or area did not appear to affect the number of meetings the DA or AA attended.

This is the only difference in the nature of the district that we have been able to compare across our sample. No doubt there are other differences in districts that will affect attendance at meetings; for example, the geographical dispersion of hospitals and the severity of problems the district has to face. However, such differences are not, as we have stressed before, sufficient to explain the variation in attendance at meetings: much of it is due to differences in the DA's focus of attention between, for example, the running of the administrative services and work with people in the community, and in his preferred method of contact.

Finally, the last two tables give the complete information about numbers of meetings (regular and *ad hoc)* for all except one of

* Using the method of monotonic association, the relation between the number of employees and number of meetings attended is significant at the 1 per cent level.

the 32 districts and for the eight single-district areas. All figures have been rounded to the nearest whole number.

District number	Administrative*		DMT		External†		Total meetings
	meetings	hours	meetings	hours	meetings	hours	
1	1	3	8	27	1	2	10
2	11	17	3	11	5	9	19
3	3	6	1	3	6	14	10
4	6	11	4	7	4	9	14
5	3	5	4	12	3	14	10
6	7	11	3	9	5	9	15
7	5	8	3	6	6	12	14
8	2	5	5	12	5	10	12
9	11	19	6	24	23	51	40
10	5	9	5	10	3	5	13
11	2	2	3	11	14	28	19
12	23	33	6	8	3	6	32
13 (nil return)							
14	4	10	3	10	4	11	11
15	1	2	2	5	5	11	8
16	2	5	3	9	7	16	12
17	3	5	2	8	3	7	8
18	10	15	6	11	16	25	32
19	1	2	2	4	3	6	6
20	18	33	4	12	5	12	27

District number	Administrative*		DMT		External†		Total meetings
	meetings	hours	meetings	hours	meetings	hours	
21	3	5	5	13	6	14	14
22	1	4	1	3	3	7	5
23	7	14	5	12	6	11	18
24	13	25	8	22	6	12	27
25	2	3	6	20	3	9	11
26	2	3	2	4	5	9	9
27	7	13	2	5	2	4	11
28	4	12	1	4	2	5	7
29	7	14	3	12	5	23	15
30 (withdrew)							
31	1	3	1	3	8	21	10
32	10	17	2	4	12	17	24
33	3	6	3	13	5	10	11
Total	178	320	112	314	184	399	
Average number of meetings and time spent	6	10	4	10	6	13	
Average time per meeting	1¾ hours		2¾ hours		2 hours		

* Including meetings with subordinates, and with colleagues on staffing, industrial relations, grievances and all other administrative matters.

† Including meetings with area or regional officers, medical, planning and other professional groups.

Single-district area number	Administrative*		AMT		External†		Total meetings
	meetings	hours	meetings	hours	meetings	hours	
34	6	19	2	15	5	10	13
35	6	11	5	11	6	14	17
36	3	7	2	5	1	1	6
37	12	24	6	16	20	39	38
38	5	10	6	12	4	8	15
39	3	6	5	13	7	13	15
40	6	12	4	15	5	6	15
41	4	10	4	15	8	21	16
Total	45	99	34	102	56	112	
Average number of meetings and time spent	6	12	4	13	7	14	
Average time of meeting	2¼ hours		3 hours		2 hours		

* Including meetings with subordinates, and with colleagues on staffing, industrial relations, grievances and all other administrative matters.

† Including meetings with area or regional officers, medical, planning and other professional groups.

Appendix D

Variations in the districts' characteristics

Replies from 32 districts (all questions) and seven SDAs (some questions).

Official community population (1000s)

	Smallest	Average	Largest
Districts	132	241	518
	Below 200	200–300	Above 300
Number of districts	11	14	7
	Smallest	Average	Largest
Single-district areas	210	282	363
	Below 200	200–300	Above 300
Number of SDAs	none	5	2

Psychiatric, acute, geriatric services to 'real' populations

Sizes of population served by these and other specialist services are often different from the official population.

		Range of populations served (1000s)		
		smallest	average	largest
Psychiatric	Districts	0	312	619
	SDAs	150	343	598
Acute	Districts	132	255	580
	SDAs	170	292	500
Geriatric	Districts	25	172	354
	SDAs	41	115	314

Numbers of employees in the district

One problem in analysing the responses was that some indicated the differences between 'whole-time equivalents' (WTE) and the total—larger—number of people which included the number of part-timers; others just gave a number of WTE or the total. We have taken the single number given and then the total indicated, and hope they are truly comparable.

	Range of difference		
	smallest	average	largest
Districts	2050	4192	7 653
SDAs	2500	5778	11 100

Number of hospitals for which the district is responsible

	Range of difference		
	smallest	average	largest
Districts	5	12	32
SDAs	5	11	23

Number of beds

	Range of difference		
	smallest	average	largest
Districts	783	1932	3915
SDAs	985	2442	4100

Geographical communication problems

A DA's communications can be more difficult if the hospitals are scattered widely over the district, as they are in some districts, and if some of his immediate subordinates and some DMT members are in other locations. DAs who said that some of their immediate subordinates were elsewhere were likely to have a wide span of control and to include sector administrators as immediate subordinates. The answers given for distance from other DMT members are more comparable and are given below.

	Number of districts		Distance (miles)	
DMT members	same building or site as DA	separated from DA	extreme	most typical
DNO	30	2	1	⅓
DCP	25	7	18	1
DFO	22	10	25	1
Consultant	13	20	9	2½
GP	4	28	20	3–4

Distinctive features of population which affect the district

	Number of mentions	
	districts	SDAs
Holiday, tourists, visitors, commuters	22	1
Population, elderly, retirement, with growing numbers and zones	11	5
Urban/rural differences in district	8	1
New, young adults, single families, youth influxes (new and old towns)	6	1
Immigrant population	5	1
Population transfers or drifts to services in another district	5	
Expanding population	4	
Scattered population	2	1
Falling population	1	

Extent and difficulties of seasonal variation

Seventeen DAs replied that there was very little, minimal or no variation. Fifteen DAs specified seasonal variation as follows.

Tourism in the summer	11
Accident, respiratory and chest diseases of the elderly in winter	4
Trunk road	1
University students	2

The difficulties mentioned were extra demands for services such as accident and emergency, and for surgical and geriatric beds.

Predictability of demand for services in the district

All except one DA felt that the demands were predictable, although one said it depended on the weather, and another that the clinical professor's demands were not easy.

The exception was the DA whose district had the highest population increase, and this put variable and increasing demands on health care.

Four types of RAWP effects were distinguished

	Districts
More money, beneficial effects	11
Should have more money, but unrealised benefits, and there are problems	14
Should have less money, but no serious issues	3
Should have less money, and has problems as a result	4

The following criticisms of the RAWP formula were made.

Population figures at least two years out of date.

Inadequate account taken of centres of excellence and regional specialties.

Unfairly favours districts undertaking minor procedures.

Inadequate provision for maintaining long-stay population.

Takes no account of scattered population and social deprivation.

Other distinctive aspects of district which shape and affect the DA's work

All but one DA mentioned distinctive aspects; the most often mentioned were as follows.

Aspects	Number of mentions	Examples
Hospitals	20	Stretched services, more demands, new hospitals, planning decisions, integrating services
Medical services	20	Closing, reshaping, complexity, growth of services, consultants employed elsewhere, training and teaching demands
Area/region	10	Dominating relationships, collaboration, growth or integration of services
Staff	8	Low establishment, shortage, grading problems, age
Geography	8	Services scattered, little contact with area, socio-economic deprivation, 'free from AHA and ATO'
Location	6	Close to university, nice town, poor public transport, near to area HQ
Community	7	Needs sensitive handling, possessive, strong feelings, deprived city area, violence, no integration with hospital
Public relations	5	Political pressures, media demand and interest
Meetings and consultation	6	Staffing problems, full system of negotiation, high-level consultation

Appendix E

Notes on the structure and organisation of the National Health Service

The National Health Service Act 1946 made the Minister of Health responsible to Parliament for ensuring that health services were available to everyone throughout the country. The services are free at the time of need, except for token charges for some items, and are financed from central government funds through taxation and national insurance.

Until 1974, the NHS was organised in three parts: hospitals, general practitioners and local authority services. The hospitals were run by regional hospital boards and hospital management committees. Under the National Health Service Reorganisation Act 1973, these were replaced by regional and area health authorities with statutory responsibilities for all health services.*

Central authority

The Ministry of Health and Ministry of Social Security amalgamated in 1968 to become the Department of Health and Social Security, with the Secretary of State for Social Services at its

* This structure is being reconsidered in the light of recommendations made by the Royal Commission on the National Health Service.[9] The information given in these notes was correct at the time of going to press.

head. This is a political appointment, as are those of Minister of State (Health) and Minister of State (Social Services). The permanent officials of the DHSS are members of the Civil Service.

Regional health authorities

A regional health authority is responsible to the DHSS for strategic plans and priorities for its region and for allocating resources to, and monitoring the performance of, the area health authorities in the region. It is also responsible for identifying and providing services which need regional rather than area bases.

The chairman and members of an RHA are appointed by the Secretary of State after consultation with appropriate organisations, universities, local authorities, professional organisations and trades unions. The chairman is paid part-time; the members are unpaid but may claim expenses.

The senior permanent officials of a region are an administrator, medical officer, nursing officer, treasurer and works officer; they form the regional team of officers (RTO) and are responsible to the authority.

Each region is divided into areas.

Area health authorities

An area health authority is responsible to the RHA for assessing needs and for planning and organising services in its area.

The chairman is appointed by the Secretary of State after consultation with the chairman of the RHA. Of the members, four are appointed to represent the local authority; the remainder are

selected by the RHA. The chairman is paid part-time; the members are unpaid but may claim expenses.

The senior permanent officials of an area are an administrator, medical officer, nursing officer and treasurer; they form the area team of officers (ATO) and are responsible to the authority.

The area is divided into districts.

Health districts

There may be up to six health districts in an area, depending upon the size and population of the area. The day-to-day operation of health services in a district is the responsibility of the district management team (DMT) which comprises an administrator, community physician, finance officer, hospital consultant, general practitioner and nursing officer.

Some areas have only one district and are known as 'single-district areas' (SDAs). These are managed by teams similar in composition and responsibility to the DMTs, but called 'area management teams' (AMTs). Administrators of hospitals, formerly known as 'group secretaries', are now called 'sector administrators'.

The district also has health care planning teams whose functions are to determine the health care needs of the district—for example, services for the elderly, mentally ill—and to study particular problems, such as the reorganisation of outpatient departments or the development of primary care services.

Social services

Social services are planned and controlled by local government authorities, in consultation with area health authorities, and are financed mainly by local government funds.

Community health councils

Each health district has a community health council (CHC) which represents the 'consumer'. Its members are appointed by the local authority, locally active voluntary bodies and the RHA. The members are unpaid and appoint their own chairman. A CHC has powers to secure information, to visit hospitals and other institutions, and has access to the AHA and its team of officers. The AHA is required to consult CHCs on its plans.

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The District Administrator in the National Health Service

by Rosemary Stewart, Peter Smith, Jenny Blake and Pauline Wingate

In the study reported in this book, Dr Stewart and her three colleagues interviewed 41 senior administrators for between three and seven hours each, and observed eight of them at work for three days. The findings show wide variation in the way administrators go about their work, in their relationships with subordinates, members of the management teams and the health authorities, and in their involvement with the press and other groups and individuals outside the health service. Dr Stewart uses two analytical frameworks to interpret the findings: her own, which describes a job in terms of its demands, constraints and choices; and one developed by two American researchers, John Kotter and Paul Lawrence. She also uses Meredith Belbin's concepts of the roles that members of a team must play if the team's work is to be effective. The study has important implications for the training of senior administrators and for the future administrative structure of the health service. The report will be of particular value to administrators and their fellow-managers, and to students and teachers of management.

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