A new rung on the

Many administrators want chief executives at each level of the NHS. Tony Carr, SRN, NDNCert, Queen's Nurse, FRSH, FHA, MBIM, calls it the creation of a supreme commander – the wrong style for the NHS. He says power must be shared: a corporate team must make the decisions.

THE IDEA of a chief executive at each level in the NHS has been suggested by various groups from time to time – and Health Service administrators have always been to the fore among these groups. No doubt the Royal Commission on the National Health Service has been, or is, giving some attention and time to clarifying its position on this matter. There is, to my mind, one serious reservation to the proposal which needs mentioning right now.

In industry, the board of directors with its chief executive, whatever his title, spends money – but produces it first. They are essentially wealth creating organisations. A profit, either medium- or long-term, must be shown on production and investment. A man or a woman with a good subordinate team who creates wealth, perhaps when acting within the policy of that company and within the Companies Acts, has a right to be the ultimate decision maker. Generally, his contract can be ended if the performance does not match expectations and promises. But today, even in the cut and thrust of business, the idea of one man or woman holding the destiny of a company single-handed is declining.

Sharing power

Many believe corporate management decision taking is the better way of managing the business affairs of a company. Not all the expertise is necessarily in the hands of one man. Whatever the reasons, the power and authority in practice, even if not in name, are being shared.

There are many functions connected with the wealth-creating aspects of a company that do not apply necessarily to the Health Service. Proper investment, for instance, is vital for the organisation's survival. Its marketing function is also critical. I include in that, of course, the packaging of the particular product and its sales promotion. The product can be superb – but if it will not sell, the business will fail.

It should not be assumed that managing an enterprise in the private sector is simple. The ultimate product may be easy for the public to understand: an electric light bulb, a tin of grease or a motor car. But the management skill in obtaining co-operation and co-ordination from production and support departments is immense. I say this because many Health Service workers, and perhaps in particular nurses, may think that when comparing their organisation with industry, the NHS is very much more complex. That may be so. But industry is not a simple organisation to manage.

Wrong style

I do not believe, however, that the chief executive is an appropriate management organisational style for the NHS. Many supporting the chief executive idea would use the local authority as an example of how it could work in the public services. It is forgotten that local authorities do, in part, create their own wealth by the raising of taxes, and can use it for what the councils wish. But I have also seen, even in local authority organisation, that when professions are involved – for example, in social services – then that department seems to operate, in some sense, as apart from the rest of the organisation. I believe it is this large professional input of caring for people which creates this difficulty. Its policy is influenced far more, to my mind, by the professionals in the social services organisation and the councillors in the major social services committee, rather than direct non-professional senior management intervention.

Tony Carr

Turning to the NHS, we have a complex organisation very different from the industrial model. The wealth is created by the country as a whole through taxes allocated by Parliament. The amount of departmental moneys for each financial year, allocated to the NHS, depends to a large extent on the prosperity of the production: the performance of industry and the results of investment.

The NHS contributes indirectly to this wealth by returning to the community able-bodied people who will in turn contribute to the nation's productivity. This is counteracted to some extent by elderly and long-term psychiatric patients. So the NHS management team concentrates its time on the 98 per cent recurring revenue, not on how to change its production capacity to create more money – well, not very often!

Power problem

Another major difficulty in the creation of a supreme commander, is what would he or she command or control? In American hospitals, where there is a chief executive model, the complaint is that the chief executives have no real control over the way most money is spent. Doctors and nurses, according to one source, spend 84 cents in every dollar. It should be noted, too, that generally this type of administrator has to raise the finance and also has a major marketing function in a very competitive market.

The chief executive cannot, by the very nature of the hospital, control or influence the day-to-day work or output of the ward or department to any real extent. Certainly, I have not seen very much resulting from concentrating one person's energies on altering the work performance of a ward or a department such as an operating theatre. The chief executive could only attempt to control the secondary resources. This, among other things, can take the form of a restriction of service, closure of a ward or

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department and reduction of supporting ancillary staff.

Reducing the yearly budget to a department is just fraught with difficulty. A pharmacist can be asked to cut costs, but the medical staff are just as likely to use an effective, expensive drug issued on general release during that year, and this money, unbudgeted for, is spent. The treatment is so effective that the patient turnover increases and, with it, the total cost for each bed. A delight to the caring staff – a nightmare to the person trying to control the situation.

I really do question the validity of placing one person in overall charge in this situation, even if that person has medical training and background.

Prime purpose

Many industries are complex organisations, but a review of a hospital shows just how difficult it is to manage in the Health Service sector. A hospital's prime purpose is to diagnose and treat patients. This is followed closely by teaching students in a variety of the professions and, third, by engaging in research.

The doctor in this situation is the prime member of staff. The organisational chart is vastly different to that of other organisations. Most people will appreciate that this senior, articulate and highly qualified person relates more directly with a first-line manager in the nursing services than anybody else.

The relationship between a ward sister and a medical consultant has to be close and clearly understood on both sides. The ward sister, in turn, will relate to her own profession through a hierarchy of nursing officer, senior nursing officer, divisional nursing officer and the district or area nursing officer.

The medical consultant, on the other hand, relates to his peers through consultative and staff committees and is responsible either to the regional health authority for his employment contract, or to the area health authority in a teaching area. I think no-one can break into the working relationship between doctor and ward sister and succeed in changing working arrangements, alter the way they work or influence greatly how the work is conducted.

Group pressure

A greater influence will come from peer group pressure on consultants – or through the management structure as affecting nurses. A decision made by a chief executive could be challenged on professional grounds by doctors, nurses and paramedical professionals. They could even call in professional statutory bodies to support their view. It would be very difficult for a chief executive to challenge much of the work of the professionals. So what authority would he or she have? Very little, I suspect.

Many have criticised the reorganised Health Service. But what really is the alternative? At present, we have nursing represented at the highest levels of management, with administration, finance and medicine. This truly is a partnership that needs many years' practice before the relationships can be effective. I believe that with all its faults, it is only now coming into its own.

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Starting point

Is there really any other way than through general agreement with the major professions and the administrative support services? I have not seen an appropriate model yet, even from the critics of the reorganised Health Service. If we are talking of changing the management structure below team level, then I think this is a different subject – and change may well be necessary in the next few years.

If a review is to take place, and no doubt the Royal Commission may give its views on this, I believe it has to start at the bedside. The problems we have run into over the past few years are because the review starts at the top and works down. But the vital part of any organisation should be at the patient's bedside, to see what sort of structure those working at the patient care area need. It would soon be found that some of the management structures do not produce an efficient service. For instance, the domestic working on a ward is managed by the ward sister, domestic supervisor, assistant hospital secretary or who else? I do believe a reappraisal of management structures from the bottom up, across all the disciplines, would be beneficial for all staff.

A full circle may turn so that all the immediate services are managed by the one profession, nursing. Look at the advantages. Nursing has a highly organised management structure at each level of management. That structure is in operation 24 hours of the day all through the year, including Bank Holidays. It is represented at ward level, where most staff are nurses or auxiliary nurses, and at district and area level. What more natural arrangement than to make accountable to the most senior nurse, the heads of those support services such as domestic services, catering services, laundry and so on?

Time for review

I know the cry over the past 10 years has been: "Relieve nurses of non-nursing duties." In retrospect, I think many nurses would now say it is time to review this concept. They see services often having different aims to that of the ward team, because the particular manager of, say, the domestic services, has developed concepts of management in a different way. Another advantage is that nurses are there all the time. There would be continuity of service and supervision.

It must be seen that caring for the patient involves more than the basic central nursing function, that it embraces many, if not all, of those other necessary services a patient and the nursing team have to rely on before effective care can take place. And the nurse knows the needs of the patient far more readily than any other officer. She writes about those needs and changing demands several times a day and she has regular contact with the public through visitors and by telephone.

I suppose I could continue on these lines until a point is reached where a strong case is made for the nurse to be the chief executive. I resist that temptation because it must be a corporate team making the appropriate decisions. But if there is a single profession capable of making a bid for the chief position, who better than the nurse? □