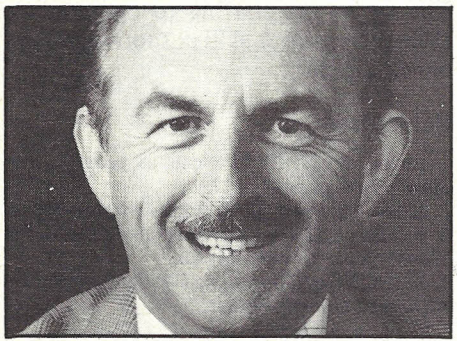
Is consensus management doomed?

Concensus management requires people to meet and to agree. ANTHONY CARR warns that the Griffiths idea of a chief executive responsible for policy means the professions will have autonomy only in professional matters.



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VARIOUS forms of management control have been tried since the NHS came into existence in 1948. The group secretary concept existed in hospital groups until 1974 and the medical officer of health in local authority service for very much longer. The medical officer of health had more executive power over such professions as medicine, nursing, social work and environmental health.

It is interesting to note that reviews of these systems at various times, particularly in local authority, produced criticisms. The Seebohm report in 1970 separated social work from medicine, while the Mayston report in 1972 gave the director of nursing control over her own staff.

Concensus management requires people to meet and reach agreement. This can be as extensive as a major plan for a district or as minor as giving permission for special study leave outside agreed policy.

This has an effect on management, similar to a revolution in thinking which is taking place in some parts of the Protestant church. Instead of focusing on one person as a minister/pastor of a local church who performs all local functions and makes all decisions, a multi-leadership team is being developed in many places. I have seen the results of this change. Rapidly increased membership, personal interaction between members, which is more committed to the corporate leadership requirements. Instead of the one pastor wearing himself out, many have taken on a new lease of life and have become more effective in their ministry.

Tests committment

The system exposes weaknesses and strengths in individuals but it also tests commitment. My personal experience during nine years has shown that the consultant member of a district management team becomes committed to the policy agreed and with his colleagues can become a formidable force for change.

All major decisions are open for in-depth discussion and challenge, the team itself setting its own deadlines. This takes time. Often it is this very time factor that allows a general acceptance

to be developed through the organisation. Not everyone wholeheartedly supports a proposal but it is very rare that one team member becomes so difficult that a decision cannot be reached, though it still does not prevent a veto being used on occasions.

Thinking has now shifted to the idea of a chief executive model. The national association of health authorities (NAHA) has been seen to give cautious approval to the idea. That decision-making is too slow is one idea emerging from the management inquiry team. Of course, decisions are made at different levels. A surgeon makes a diagnosis of appendicitis and decides to operate; a ward sister decides to introduce a new method of nursing patients – both are very important decisions in manpower resource terms for both doctors and nurses. Yet NAHA suggests that the professions are given autonomy in the professional matters but an executive chain of command is necessary for matters of policy. Unfortunately for the professional staff the decisions of the executive affect their professional performance.

The difficulty of matching the NHS with industry is that the former is much more complicated both in management structure and decision-making terms.

Outside agencies can affect the way executive decisions are made. A doctor or nurse can call on their training bodies to move or withdraw training facilities in hospitals which, while a professional activity, can very effectively block or at least make an executive decision difficult to implement.

It is more realistic to understand that for executive decision-making to be effective it must make inroads into professional decision-making. It must eventually say to a surgeon, for instance, unless he can justify in management terms keeping his patient in for three weeks for special treatment, he must change the treatment. Anything less is to destroy the whole concept of a strong executive. If it is less than powerful, strong and determined, it will not succeed. Professionals will just ignore it or, worse, use it to considerable personal advantage.

Strong executive

One thing a strong executive may do is to produce friendships based on what one can get from the chief. It may also be profitable to evaluate the chief executive in the local authority organisation. What changes have occurred? Has decision-making been improved in quality and/or quantity? More questions are raised by this subject than sowed by the ready-made answers that may be at hand.

If the DHSS wishes to try this reorganisation I suggest that it considers the function of the health authority members. The present structure seems unsuited to support a chief executive. One approach may be to reconstitute a health authority into a smaller, more dynamic group of about 12 executive and non-executive directors. Four full-time officers of the existing district management team, plus the existing chairman of the authority, could be executives. Five others chosen for particular abilities could be non-executive.

This group would either select the chief executive from among themselves or appoint one from outside. He would work for the board and would be contracted to them. The board would have power to appoint and dismiss.

My guess is the DHSS would wish "minimum turbulence" and impose a chief executive without any other change.

If this happens, perhaps early retirement should be offered to all existing district management team members. Ministers may just be surprised at how many chief officers would join that particular queue □