Chapter

12

True Confessions of a New Managerialist

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Introduction

I became one of the new breed of medically qualified health service managers in the early 1980s and watched with fascination and some amazement at the upsurge in triumphs and disasters that accompanied the management revolution over the course of the following twenty years. In this chapter, I explore why the revolution happened, what went right and what went appallingly wrong for users of mental health services and for the professionals working in them. I end on a positive note; some aspects of mental health care improved over the forty years between 1970 and 2010 and quite a lot can be attributed to 'management'.

Three separate threads of causality in the changes in mental health services came together in the late 1970s: first, the oil crisis and its impact on global funding of health care; second, the drive to improve health care quality; and third, the global commitment to the deinstitutionalisation of people with serious mental disorders and profound learning/intellectual disabilities. Each one of these issues posed serious challenges; trying to cope with all three at once was bound to cause 'collateral damage' to the lives and careers of the cared-for and carers.

Health Care Funding

The 1973–4 oil crisis significantly raised prices and, shortly after, the Organization of the Petroleum Exporting Countries (OPEC) cut off supplies to several Western countries in retaliation for their support for Israel in its war with Egypt and Syria. Britain's ambassador to Saudi Arabia commented that the oil price rise represented 'perhaps the most rapid shift in economic power that the world has ever seen'.[1] The crisis underlined the importance of oil to the world economy in no uncertain terms. At that time, oil provided more than half of the world's energy needs – a situation that was not expected to change for the foreseeable future. Five of America's twelve leading firms were oil companies, as were Britain's top two: BP and Shell. 'The disappearance of cheap oil has transformed the world in which British foreign policy has to operate', noted the Foreign Office, with industrialised nations seeing their trading surpluses transformed into deficits almost overnight.

In the UK, this led to a stagnation in NHS funding through the years of the Labour administration. This was followed by an attempt to reduce and make more efficient the delivery of health care during the Thatcher years of 1979–90. The government then as now seemed not to understand that it is largely demographic change of an ever-ageing population that shifts demand once the parameters of provision have been established. The spending in real terms went up substantially from £9.2 billion in 1978/9 to £37.4 billion in 1991/2. Even adjusting for inflation, this rise is more than 50 per cent. However, the hyperinflationary

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effects of unionised NHS staff salary demands and an increase in pharmaceutical prices led to a real increase of only about 1.5 per cent. This, combined with real restrictions on acute hospital funding, contributed to the general perception of parsimonious funding for the NHS and subsequent raiding of conveniently 'underspent' mental health budgets by health authorities trying to balance their acute hospital budgets. Mental health underspends were largely caused by the poor recruitment of staff.[2] A quarter of all London general hospital beds closed during these years. Mental health suffered as a neglected poor relation.

The Drive to Improve the Quality of Health Care

These years also witnessed the advent of the systematic examination of health care quality, which perhaps began seriously with the work of Avedis Donabedian, who, in 1966, proposed a framework for a quality of care assessment that described quality along the dimensions of structure, process and outcomes of care. This galvanised the examination of quality in the US health system and prompted similar investigations in the UK.[3] Quality of care was defined as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'. Health systems should seek to improve performance on six dimensions of quality of care: safety, effectiveness, patient-centredness, timeliness, efficiency and equity. It was clear that the current care systems could not do the job. Trying harder would not work. Changing systems of care, however, would, it was perhaps somewhat naively believed. It followed that what was true of acute hospital systems must also be true of mental health care systems. The desire to squeeze mental health services into a management framework designed for a different model of care, omitting the key role of social services, housing, employment and service users' own shifting perceptions of what they needed, was bound to lead to difficulties and the corrosion of trust among those who worked at the front line.

Received wisdom among health care pundits declared that health systems must be judged primarily on their impacts, including on better health and its equitable distribution; the confidence of people in their health system; and their economic benefit. Outcomes would depend on processes of competent care and positive user experience. The foundations of high-quality health systems were judged to include the population and their health needs and expectations; governance of the health sector and partnerships across sectors; platforms for care delivery; workforce numbers and skills; and tools and resources, from medicines to data. In addition to strong foundations, health systems would need to develop the capacity to measure and use data to learn. High-quality health systems should be informed by four values: they are for people and they are equitable, resilient and efficient.

The message was both seductive and impressive.[4] Mental health services, however, had no well-developed way of demonstrating outcomes for their patients; they were immediately at a disadvantage. Only process measures could be assessed; and what of the half of patients with serious psychotic illness who did not believe themselves to be ill and did not want to engage in services? Where did the model get us to there? Developing an outcomes framework in mental health was a challenge that would take years and still has not affected funding changes to better target effective services.

The Global Commitment to Deinstitutionalisation

The third major impact on services was the agenda driving deinstitutionalisation, one of public and moral necessity. This was based on a growing emphasis on human rights as well

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as advances in social science and philosophy attacking psychiatry and the boundaries of what constituted mental illness, which reached its height in the 1950s and 1960s. A series of scandals in the 1970s around the ill-treatment of mental health patients and a strong, vocal service user movement provided harrowing stories of people's experiences of care, which contributed to the opprobrium heaped on services. The timing, however, created the impression that somehow delivering mental health care 'in the community', wherever that was, would be cheaper than delivering care to long-stay patients in hospital.

This moral agenda, however, was supported by other developments that facilitated the possibility for transformation. Pharmaceutical advances demonstrated that people with severe mental illness could be treated and it became clear that institutionalisation itself was harmful. Politically, there was consensus among parties about the vision for mental health services. Gradually there emerged an economic impetus for deinstitutionalisation, which accelerated as large institutions became financially unsustainable and, in many cases, were occupying prime development land that finance directors perceived as capital asset money-spinners. Ostensibly the programme was geared towards achieving greater integration of health and social care provision with the development of alternative community services, to be delivered by local authorities, which, however, were never consulted and felt unreasonably put-upon.

New organisations were set up to manage the process of deinstitutionalisation and subsequently deliver services. Many of these were charities, including housing associations. With involvement from each stakeholder group (including the district health authority, local authority and voluntary sector), a key function of these new organisations was to broker relationships to ensure that no single organisation had sole ownership and to manage the power dynamics. They provided opportunities for people to connect around a new organisational form with its own identity and purpose, underpinned by a board and trustees who were accountable for the process and outcomes of transformation. These new organisations led on many aspects of the transformation, bringing new ideas. Subsequently, they received most of the funding, led on developing new services and created systems and structures to manage the transition, including workforce management and training. Yet the people who had previously managed the whole patient experience in hospitals were often left out in the cold, with doctors pigeonholed into 'drug prescribers' and senior nurses rejected as 'more institutionalised than the patients', an insulting and inaccurate phrase I heard often. The failure to engage with the traditional professional groups caused a serious waste of human resources in mental health services that is still not rectified.

There were in fact many excellent examples in existence before the closures. Psychiatric rehabilitation specialists had been quietly moving people out into group homes and community organisations since the late 1970s, demonstrating that this could be done well and improve patients' lives if well supported by clinicians. David Abrahamson had a successful programme running from Goodmayes Hospital in the London Boroughs of Newham and Redbridge from the mid-1970s that made a huge impact on my own philosophy of community practice.[5]

The deinstitutionalisation process involved a significant focus on managing the workforce. Where it resulted in the closure of individual wards, staff were absorbed into the wider organisation. Yet many mental health professionals who had been confident of their role as psychiatrists and nurses in an institution suddenly found themselves expected to take on different working patterns, leave the comfort of the professional silos that had hitherto dominated mental health services and take on completely alien tasks. Many resented it. An

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impatient senior management cadre, unable to perceive quite what the problem was, steamrollered through the closures, leaving resentful and uncomprehending consultant psychiatrists and senior nurses marooned in different locations from their patients and the staff teams they had previously worked alongside. Psychologists and occupational therapists, however, suddenly found their skills valued more highly and grasped the space left in the vacuum. In the 1980s, I visited a mental health service in Devon where the new community teams located in small dispersed market towns were struggling to provide a service without support from psychiatrists, since all the psychiatrists had remained recalcitrantly fixed to their offices in the old but much-loved Victorian mental hospital in Exeter. It took a new generation of appointments to solve a problem that should have been thought through at the outset.

Terrible mistakes were made as a result of an ideology of community care taking hold, in the face of obvious shortcomings for the most seriously ill and especially for those with profound learning/intellectual disabilities. Everyone had to be squeezed into the same model. Some saintly staff fought to bring common sense to a process that became the end rather than the means. In a devastating critique of the process he lived through in my own health district, Nick Bouras, one of the editors of this book, gave a personal account of the obstacles and challenges he faced in developing, researching and implementing services for people with intellectual disabilities.[6] In a very personal memoir of these years, he recorded the successes and frustrations of working in a system that does not always have a shared vision and the tenacity and enthusiasm that are necessary to reform an NHS service from the inside, in the teeth of every obstacle possible.

The cost of the deinstitutionalisation process, if done properly, was to prove much more expensive than originally forecast, and the most profoundly disabled were hugely expensive to care for satisfactorily in the community. I was a close observer of the closure of Darenth Park Hospital in Kent, a vast old mental handicap hospital in the South East Thames Regional Health Authority area, containing patients from all over Kent, East Sussex and inner and outer south-east London. Glennerster's economic analysis demonstrated that the final costs of care to the NHS, local authorities, the Department of Health and Social Security (DHSS) and Housing Corporation budgets were over a third more expensive than the old hospital. With modern buildings, a higher staff ratio and more personalised care plans, this is scarcely surprising. The extra costs fell on other public sector organisations that hitherto had borne few costs of care.[7] It took many years for the skills lost when the hospital closed to be learnt in the community, before a model of largely social care replaced the old nursing model. It is still not clear whether the very high costs of caring for the most disabled patients in this way is a good use of scarce resources. It is as possible to be institutionalised in a flat for two as it is in a ward for thirty.

Then Came Management

The creation of a large managerial stratum within the NHS in the 1980s and 1990s has been one of the most striking characteristics of reforms intended to develop a more efficient and 'business-like' service that was meant to address the problems of quality and efficiency. The majority of new managers had previously already been employed with clinical titles as senior nurses or belonging to other professional groups. As a result of the new job titles, the public's misperception was that an entirely new group of employees were draining resources from the clinical front line. The growth in managers was accompanied by a political rhetoric

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of decentralisation that cast local managerial autonomy to gauge and respond more easily to the needs and preferences expressed by local communities. In fact, the role of local populations in influencing decisions and determining priorities was considerably less than proclaimed by the sustained political rhetoric in favour of the local voices. That has remained the case. The NHS is done to people; it does not invite them to participate. Again the new purchaser/provider split, the creation of NHS Trusts and a general management structure within the NHS were never created to deal with mental health services but their implementation in mental health was inevitable as systems of financial and professional accountability were necessarily aligned with acute services.

One unforeseen problem was the sudden creation of a tier of managers, formerly labelled as 'administrators', with new power and authority beyond their wildest dreams. Trevor Robbins has suggested that one possible cost of this newfound authority is that its operation may be degraded under conditions of stress (e.g. resulting from exposure to a profusion of problems requiring difficult decisions). Speculatively, this may be manifest in part as the 'hubris syndrome', which he perceives as an acquired personality disorder that we see often afflicts politicians and others in leadership positions, with serious consequences for society.[8] The same phenomenon was witnessed in the NHS, generally, but I think especially in mental health services where passionately committed new-style managers felt that they could at last wage war on consultant psychiatrists who had had far too much power under the old regime to block developments and impose their own view of the world.[9]

In 1983, I was in a relatively recent appointment as Professor of Old Age Psychiatry at Guy's Hospital, my chair held at the United and Medical Dental Schools, part of the University of London. Crucially both chair and department were paid for by the NHS, so it was clear my job was going to be to develop a much-needed service for the locality as well as to engage in research and I was enthusiastic about the new community-based approach and anyone who would support my ideas. It was a time when Guy's Hospital, part of Lewisham and North Southwark Health Authority, was at the forefront of encouraging doctors into front-line management. One of my first tasks as a new professor, a request from the Department of Health, was to spend a day showing local services to Sir Roy Griffiths, a supermarket executive who had been commissioned to review the management of hospitals (see Chapter 3). I complained to him (this was a rare opportunity to get a hearing with a VIP) that the resources and beds were all in the wrong place; that the local authorities were much more important to my work than anyone recognised; and I had a long list of frustrations I could do nothing about. At the end of the day driving round Southwark and Lewisham, he said, 'So why aren't you and doctors who feel like you becoming managers?' It had never occurred to me. In his subsequent report, he concluded that the traditional NHS management had led to 'institutionalised stagnation'. The report's recommendations, including that hospitals and community services should be managed by general managers, were accepted and he promoted the idea that clinicians who spend the money in services must be responsible for managing it too. The changes introduced as a consequence of the Griffiths Report brought a large increase in general managers in the NHS, from 1,000 in 1986 to 26,000 in 1995, with spending on administration rising dramatically over the same period.[10]

I enthusiastically accepted an invitation to join the District Management Board, without any notion whatever of what 'management' might entail. There was no process of appointment, no one was consulted, but I vaguely thought it was something one could do on a Friday afternoon after everything important was wound up for the weekend. It did not

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occur to me then but rapidly became apparent that not only did other consultant and academic colleagues resent some female 'whipper-snapper' being appointed but several important men had been slowly waiting their term to be elected by their peers as consultant spokesman for the department. Furthermore, the district health authority was permeated by Labour Party political representatives from our inner-city boroughs who had a vehement revulsion of Thatcherite policies of any kind, whether it was competitive tendering of support services, performance management, devolved financial management or any kind of change in the configuration of even unsafe services. I developed an abiding respect for the NHS professional administrators who had over years learnt to bargain, negotiate, wheedle and cajole what they needed out of a heavy-handed NHS bureaucracy above them and a dismissive set of antipathetic local politicians around them. It was clear that my formerly successful strategy of steamrollering changes through sheer cussedness laced with charm would only go so far. I will admit to developing some hubristic self-confidence that was bound to fail as a long-term management strategy.

The tribal cultures in the NHS have never really been adequately tackled then or now. The problem is both educational and ideological. It is culture that separates medium-status managers and politicians who stay in a post for a relatively short time from high-status clinicians who consider themselves intellectually superior to the managers and who are in post far longer than the managers. Senior clinicians have professional support systems in the Royal Colleges and other institutions that monitor them. Loyalty to a professional specialism is far greater than to an individual employer. This is changing but only very slowly. Nurses felt as alienated from managers as doctors did. They felt that management was too theoretical and out of touch with the daily realities of providing care in a busy and harried environment. Managers were perceived by nurses as being too ready to redecorate their own offices when wards had crumbling paint. Managers saw nurses on the other hand as hopelessly traditional, having a very narrow perspective and largely concerned with making life tolerable for themselves rather than improving the patient's journey. These tribal stereotypes were wrong and fuelled by clinical resentments at what they saw as a misrepresentation of their commitment to their patients.

Conclusion

By 2010, many early managerial innovations had been accepted as normal. There was a far greater tolerance of the notion, hardly controversial, of operating within a budget for example. However, a distinctive feature of the early reforms was also a drive to co-opt professionals themselves into the management of mental health services and it seems that psychiatrists have been peculiarly unwilling to commit themselves away from patient and clinical work. Doctors and nurses rarely now become full-time managers, or even part-time 'hybrid' professional managers, although some are willing to take on temporary clinical director roles and participate in taking responsibility for budgets. One major mistake in the beginning was to emphasise management and downplay the role of personal leadership in inspiring and guiding clinical service change. Professional bodies are now actively supporting and even driving these changes. Clinical leadership has at last moved from 'the dark side' to centre stage at last. There is even a Royal College of Psychiatrists' textbook on how to be a psychiatrist manager.[11] That would have been unthinkable in 1970.

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Key Summary Points

- Three key drivers that introduced the new managerialism into mental health services were funding constraints, the drive to measure health care quality and the move to deinstitutionalisation.
- A new cadre of managers, some of which were clinicians, but many of whom were not, often rode roughshod over traditional clinical administration and many psychiatrists and nurses felt ignored and undervalued.
- One major mistake in the beginning was to emphasise management and downplay the role of personal leadership in inspiring and guiding clinical service change.
- Managerialism brought a new understanding of budgets, human resources and objectives into mental health services that was largely positive but mental health services are still fashioned around systems that were established for the acute hospital sector and not readily adapted to mental health service provision.

Notes

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