Key points

- NHS management has, over time, developed into an increasingly distinct, accountable and professional entity, moving from administration, through general management, to the current focus on executive leadership and management.

- NHS management had a strong professional association (the Institute of Health Services Management) until the early 1990s, linked with educational standards and qualifications.

- NHS chief executives are a relatively homogenous community, the majority being of an NHS management background, and just 5% being medically qualified.

- International experience reveals that health management is typically viewed as a generic function without formal regulation, although some countries have developed strong professional associations that codify management and organisational ethics, accredit development programmes, and operate self-regulation for managers.

- NHS management culture has been criticised over the years for a tendency to be top-down and operating within a 'chain of command', unforgiving of failure, and subject to relatively rapid turnover of senior managers. Any moves to strengthen regulation of managers need to be explored within this context.

- Following the Bristol Inquiry, a Code of Conduct for NHS Managers was developed, although its implementation into management contracts, and practical impact, are open to question.

- Following the Darzi Review, work has been undertaken (and set out in the Dalton Report) to explore the ways in which the quality of NHS senior managers might be assured. This provides a useful platform on which the NHS can now build.

- Options for moving forward with managerial regulation include: the status quo; enacting the main recommendations of the Dalton Report; focusing on a set of core standards for health management, along with a form of self-regulation and accreditation; and a serious examination of how formal regulation might operate.

- Formal regulation needs to be explored in the context of current NHS structures and culture - greater regulation could prove to be yet another burden of oversight for local managers, unless developed in a holistic manner that helps to focus accountability.

- Moving towards more transparent and robust regulation of managers is necessary but not sufficient - it has to be addressed along with a significant investment in the development and support of NHS leaders.

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**Introduction**

This paper has been written to inform the Mid Staffordshire Public Inquiry seminar on the training and development of trust leaders in the NHS. We make a brief examination of the history of NHS management, the nature of the NHS management workforce, and the support and development that has been put in place for managers over the years. We then explore the culture of NHS management, and consider previous attempts by NHS management to develop a code of conduct and stronger self-regulation, along with a selection of international experience. This is followed by a consideration of the arguments for and against formal registration and regulation for NHS management.

The paper concludes with an analysis of options for regulation and registration of NHS management, and discusses the support for managers required alongside any such development.

**Background**

**The history and nature of NHS management**

The history of NHS management can be characterised by three main phases:

- prior to 1979, consensus management (the administrator);

- from 1983 to 1990, general management (the general manager); and

- from 1990 onwards, the NHS internal market (the chief executive).³

In the consensus management phase, the emphasis for the administrator of a hospital, community health, or mental illness/handicap service was on facilitating a team comprised of a senior doctor, senior nurse, and other professional staff such as the treasurer and works officer. The administrator in many senses 'oiled the wheels' of the NHS organisation, ensuring that resources and processes were in place to enable clinical staff to pursue their work. The approach was however subject to criticism for inhibiting tough decisions, and leading to a 'lowest common denominator' approach to managerial decision-making.⁴

Following the Griffiths Inquiry into NHS management in 1983, initiated by the Thatcher Government in light of increasing concern about consensus management and its apparent role as a 'way of avoiding decisions' general management was introduced into the NHS in response to Sir Roy Griffiths' diagnosis of the ills of NHS management which he famously summed up as follows:

> 'if Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge.'⁶

The recommendations of Griffiths' review included:

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³ Newdick C and Smith JA (2010) The structure and organisation of the NHS. A report for the independent inquiry into care provided by the Mid Staffordshire NHS Foundation Trust. Stafford, Mid Staffordshire Public Inquiry

⁴ King's Fund Commission on Leadership in the NHS (2011) The future of leadership and management in the NHS: no more heroes. London, the King's Fund


• a general manager (regardless of discipline) should be identified at all levels of the NHS with greater freedom to organise the management structure to suit their needs;

• there should be a clear accountability review system starting centrally and establishing a chain of command through to unit managers;

• there should be a reduction in the number and levels of staff involved in decision-making and implementation; and

• clinicians should be more closely involved in management decisions, having a management budget and necessary administrative support.

The government accepted Griffiths' proposals and hence general managers assumed responsibility for planning, implementation and control of performance within NHS units, districts and regions. There was a move to recruit managers from beyond the NHS, and some new general managers joined from the military and the private sector, albeit that a majority of posts were taken by former NHS administrators, along with some doctors, nurses and other health professionals.

The key points to draw from this move to general management are: the focus on a more entrepreneurial management culture; the development of a stronger 'chain of command' making individual managers personally accountable for NHS organisational performance (in comparison with the prior team or more consensual approach); and the importance of clinicians taking on budgetary responsibility for teams, departments and divisions of hospitals and other health bodies. This emphasis on lines of control, personal managerial accountability, and someone being 'in charge' at once clarified responsibility and yet put potentially enormous strain and pressure on the shoulders of individual local managers. The challenge faced by new general managers is described by Rivett in his history of the NHS:

'A long and divisive conflict was in prospect if management was going to be autocratic, challenge clinical decisions and overturn the 1948 agreement between Bevan and the consultants about clinical freedom.'

Such personal accountability and pressure begs the question as to what support and development was made available to this new cadre of NHS leaders. One key source of support in the 1970s, 1980s and early 1990s was the Institute of Health Services Management (IHSM).

The Institute of Health Services Management
The then Institute of Health Service Administrators, the professional body for NHS administrators, responded to the implementation of the Griffiths Inquiry by changing its name to the Institute of Health Services Management, and hoped that given their training and experience, professional administrators would play a full part in the development of general management in the NHS.8

The Institute at this time was the awarding body of the recognised qualification for health service managers, the Diploma in Health Services Management, for which a three-year programme of study was required, and 12 public examinations had to be sat, covering subjects such as health service law, personnel management, NHS finance, information

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systems, and public administration. For all aspiring senior NHS managers in the 1980s, the DipHSM was a required qualification, and all NHS graduate management trainees had to study for and achieve the Diploma, as did other junior administrators and managers wishing to progress their careers within the NHS.

The IHSM was also, as had been the Institute of Health Services Administrators before it, regarded as the mouthpiece of NHS managers. It was also a source of networking for NHS managers, and arranged many national, regional and local conferences, seminars, and other training activities.

Barbara Young, who became the first woman president of the IHSM in 1987 asserted the role of the institute to be the promotion of excellence in health services management, the development of good managers, and a significant contributor to the debate on health services policy. These roles were enshrined as the mission of the IHSM following an internal review after the NHS internal market reforms of 1990.

In the 1990s, the IHSM appeared to diminish in its influence and stature, partly as a result of internal financial and other difficulties, and also as the NHS management and leadership community looked to other sources for networking, support and representation. Such sources included: the First Division Association (the professional body for senior civil servants); the NHS Trust Federation (a body for the early wave of chief executives of NHS trusts which subsequently merged with the National Association of Health Authorities and Trusts to become the NHS Confederation); and bodies such as the New Health Network.

Furthermore, the Diploma in Health Services Management appeared to wither on the vine, as the 1990s' NHS internal market saw the encouragement of generic management and leadership study and qualifications for senior executives, including the Management Education Syllabus and Open Learning (MESOL) initiative developed by the IHSM with the Open University. Significant investment was made in the funding of MBAs for NHS managers, and in other executive development such as coaching, and bespoke leadership programmes which were tendered for and subsequently delivered by a range of university, business school and independent providers.

This development activity was driven and supported by a succession of central NHS bodies, including: national education centres funded by the DHSS until 1987 (e.g. King's Fund, HSMC Birmingham); the NHS Training Authority (from 1985 to 1991); a National Accelerated Development Programme; The NHS Training Directorate (from 1991 to 1996); Regional Education Development Groups (from 1996 until the founding of the NHS Leadership Centre); The NHS Women's Unit (a specific programme of activity in the 1990s, aimed at increasing the number of senior women chief executives, chairs and medical directors in the NHS); the short-lived NHS University; the NHS Leadership Centre; the NHS Modernisation Agency; the NHS Institute for Innovation and Improvement; and currently the National Leadership Council.

It should be noted that the ISHM is now the IHM - Institute of Healthcare Management - and continues to develop and uphold professional standards of development, management conduct, and practice. However, it does not command widespread membership across NHS senior management, and does not appear to have the profile within the NHS or senior management circles that it enjoyed until the 1990s.

It is of note that other public services in the UK have developed a central academy for the purposes of shaping, delivering and accrediting the training and development of senior leaders. For example: the National College for School Leadership based at the University of Nottingham (www.nationalcollege.org.uk); the National School of Government for the civil service (www.nationalschool.gov.uk) based in London, Edinburgh and Ascot; and Local
The nature of leadership and management is a critical factor in the success or otherwise of health system performance, a message underlined in the recent King's Fund Commission on Leadership in the NHS. The commission summed up the importance of leadership for the NHS as follows:

- Leaders make improvements in service and outcomes;
- Leaders promote professional cultures that support teamwork, continuous improvement and patient engagement; and
- High performance requires distributed leadership including clinical champions.

The commission also pointed to the high cost of management and leadership failure in examples such as Bristol, Maidstone and Tunbridge Wells, and Mid Staffordshire, saying that these:

'demonstrated painfully and acutely what can happen when leadership and management fail. They show not just when they fail at board and chief executive level, and even when a medically qualified chief executive is in charge, but when failure occurs throughout an organisation, and among stakeholders who should have been aware earlier what was going wrong.'

Before going on to examine the support and development made available to NHS senior managers over the years, it is worth pausing to reflect on the nature of the chief executive community in the NHS.

Research in the 1980s revealed that a majority of NHS unit general managers (managers of hospitals, community health services, mental health units, and learning disability provision) came from an administrative background, 10% from a medical background and some 10% from nursing. Just under 10% were from outside the NHS, and 83% were men. This suggests that in 1987, following the introduction of general management, the NHS management community remained, despite policy emphasis to the contrary, conservative in nature, being largely drawn from the pre-Griffiths NHS and predominantly male.

Further research in the 1990s (the Creative Career Paths study by IHSM consultants, funded by the NHS Management Executive) sought to map the career of 'top managers' in the NHS and concluded that there was a largely homogenous senior management community drawn from NHS administration, and lacking in gender and ethnic diversity. Research carried out in 2003 and 2006 into the demographics of the NHS chief executive community revealed that despite an increase in the number of women chief executives to one quarter of the total NHS chief executive population, almost all chief executives had come to their post from a previous NHS chief executive or director position, revealing a homogenous base of

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experience and expertise. Recent study of medical chief executives concluded that 5% of the chief executive community in the NHS in England is medically qualified.\textsuperscript{12}

Indeed, the NHS has a strong tradition of recruiting its senior managers from within the health service (which is undoubtedly one reason for its relative lack of diversity of background and experience), and of being relatively agnostic about the specific nature of their academic background, hence leading to a focus on lay, rather than professional (in terms of accredited training) managers. A competency (rather than formal qualification) basis for NHS leadership has been developed and applied to chief executive (and other managerial) recruitment\textsuperscript{13}, including elements such as political acumen, emotional intelligence, and setting direction. This has recently been updated as part of the work of the NHS Leadership Council.\textsuperscript{14}

**International experience of recruiting and regulating health managers**

Within Europe, France appears to be the most regulated country in respect of entry to hospital management (personal communication, European Health Management Association, 10 October 2011) requiring that individuals have completed the Hospital Director training programme at the Ecole Nationale des Hautes Etudes en Sante Publique in Rennes. Indeed, the first tenet of the mission of EHESP is: ‘to provide initial training for senior public sector managers and inspectors in the health and welfare services.’ EHESP delivers a 27-month programme for people wishing to be hospital directors or assistant hospital directors, and there is a formal examination to gain entry to the programme, in common with other areas of French public administration within ‘grandes ecoles’.\textsuperscript{15}

Other countries appear to be less formal in their approach to the recruitment and development of health managers, perhaps because in many cases there is a tradition of clinicians (especially doctors) being put into management positions, and hence management becomes regarded as a function rather than a profession. In these cases of course, the individual would be first and foremost subject to professional regulation as a doctor. It is also of note that in some countries, direct political choice of senior health managers is a significant issue, despite the background and training of the individual.

In the Netherlands, experience has been similar to that of the UK, with health services management emerging from hospital and health administration during the 1980s. Managers in Holland have sought to become ‘professional’, by organising and structuring education, training, occupational standards, and codes of conduct.\textsuperscript{16} There is also a similarity with the English NHS in terms of how the introduction of ‘managed competition’ along with advocating entrepreneurial action, have, in the words of Noordegraaf and Van der Meulen: ‘increasingly affected medical professionals and day-to-day service delivery, not in the least because the rationalization-through-managerialization has fuelled the rise of managers and executives’ (p1057).

\textsuperscript{12}Ham C, Clark J, Spugeon P, Dickinson H and Armit K (2010) Medical Chief Executives in the NHS: facilitators and barriers to their career progress. Warwick, NHS Institute of Innovation and Improvement
\textsuperscript{13}NHS Leadership Centre (2002) NHS Leadership Qualities Framework. London, NHS Modernisation Agency
Senior hospital executives in the Netherlands have formed their own association which explicitly seeks to 'enhance the professional practice of its members', and it upholds a professional code of conduct which it describes as 'an ethical guide for good and incorruptible executives', along with a governance code which seeks to circumscribe 'good' health care management. This development and adoption by the managers' association of codes of conduct and governance is described in the article as an example of 'soft control' (ie voluntary and beneficiary, latently standardising managerial work but without strong coercive means). This contrasts with 'professional control' or 'occupational closure' operated by traditional professions such as law and medicine.

In New Zealand there is a statutory basis to the standards and regulation of the provision (and indeed management of delivery) of health services. There is a statutory Code of Rights of health consumers, together with duties on the part of health providers. The code includes: the right to be treated with respect; the right to dignity and independence; the right to services of an appropriate standard; and the right to be fully informed. The Code of Rights is monitored and upheld by a Health and Disability Commissioner, whose role includes making sure that complaints are dealt with fairly and efficiently. The office of the Commissioner has wide-ranging powers, including the promotion and protection of the rights of health and disability consumers, the resolution of complaints, the running of a national advocacy services for people making complaints, and an office of the Director of Proceedings which can take action with providers where the code has been found to have been breached.

In previous cases, the NZ Health and Disability Commissioner has found individual health services managers to be in breach of the Code of Rights, for example where they have failed to ensure the provision of services of an appropriate standard.

There are other examples of a Netherlands type of approach to health management developing a clear sense of 'profession' and establishing some form of national college to act as an independent professional association. Some of these examples were identified in research that fed into recent Department of Health-funded research (carried out by Price Waterhouse Coopers) examining ways of assuring the quality of senior NHS managers, and two are cited here. In Canada, the Canadian College of Health Service Executives (CCHSE) administers a comprehensive Certified Healthcare Executive programme, administered by a Professional Standards Board. This requires managers to demonstrate prior knowledge, experience and CPD in order to be admitted, along with setting out a process for reaccreditation on a five yearly basis. In Australia, the Australian College of Health Service Executives (ACHSE) has set out a Code of Ethics for members, along with details of CPD requirements. The organisation also accredits formal healthcare management courses in academic institutions throughout Australia.

This international experience points to some interesting alternative approaches to the regulation and accreditation of health managers. The French example is one of strict control of entry to the profession, through codified qualification criteria, competitive entry to postgraduate education, and strict control of subsequent career development and job placements. The Netherlands, Australia and Canada suggest how the NHS might take forward some of the recommendations in the Dalton report (discussed later in this paper), in particular in relation to the potential of a self-regulating professional association for health managers, taking responsibility for accrediting standards, shaping professional development, and providing a strong professional support network. The New Zealand Code of Rights

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offers a different perspective, highlighting how a more holistic and far-reaching response to the issue of regulating managers might be found in a new approach to the overall rights, duties and regulation of the overall health and social care system.

Culture and conduct of NHS management

The culture of NHS management

It is impossible to examine the issue of the possible regulation and registration of NHS managers without an initial exploration of the culture of NHS management. The system of values and beliefs underpinning the way in NHS management sees itself and operates, is a critical factor in shaping what managers do, how others perceive them, and how they respond to pressure and challenge. One of the most important assessments of NHS management culture in modern times was made by the Bristol Inquiry when it reported in 2001. This inquiry criticised what it regarded as unhealthy 'club culture' at the hospital in Bristol, with inadequate external challenge of powerful individuals running the trust, and concluded19:

'The culture of the future must be a culture of safety and of quality; a culture of openness and of accountability; a culture of public service; a culture in which collaborative teamwork is prized; and a culture of flexibility in which innovation can flourish in response to patients' needs.'

The Bristol Inquiry also pointed to the need for chief executives to be supported and enabled in carrying out their statutory duty for the protection of standards of patient care and called for an overarching body to assure quality in healthcare, over and above existing multiple regulators. It called for more joint courses and development across medical, nursing and management schools, and that 'senior managers in the NHS should be subject to CPD, periodic appraisal and revalidation'. There was a call for professional codes of conduct to be written into employment contracts, given that it was the employer who would first and foremost have responsibility for tackling poor performance or misconduct.

Academic research confirms the importance of healthy organisational culture for the performance and safety of health services2021. Commentary on the NHS frequently highlights its centrally directed approach, distinctive in the international context.22 Expert evidence to the Mid Staffordshire Inquiry23 has revealed that the 'chain of command' referred to earlier in this paper, can at times operate in an informal and at times threatening manner for senior NHS managers, with the 'phone call' from a higher authority (such as the strategic health authority or Department of Health) being used to convey displeasure at the performance of a chief executive and their team.

Commentary on NHS management culture over the years has pointed to its sometimes macho, centralising, and unforgiving nature242526. Research undertaken by the NHS

23 Newdick C (2010) Evidence to the Mid Staffordshire Public Inquiry, 15 November 2010
Confederation in 2009\(^{26}\) cited the 'top-down and directive style' of NHS management as a particular challenge and reported interviewees describing the environment in the NHS as 'brutal, arbitrary, prone to favouritism and intolerant of risk-taking that isn't successful' (p4).

What this highlights is that any consideration of the possible regulation and registration of NHS managers has to take place in the context of current management culture. Whatever approach that is explored, it needs to take account of existing culture, prevailing ways of doing business and dealing with people, and consider how any new approach might shape or be shaped by the cultural context.

**A code of conduct for NHS managers**

The Institute of Health Services Management started work on ethics and health services management during the 1990s, and in 1999 started more formal development of a code of conduct for NHS managers. When the report of the Bristol Royal Infirmary public inquiry was published in 2001, it recommended that the government should consider statutory regulation of senior managers. Ken Jarrold, who had led the IHSM development work on a code of conduct for managers, was asked to chair a Department of Health working group on such a code. This resulted in the publication of the Code of Conduct for NHS Managers in October 2002.\(^{27}\) The principles set out in this code were:

- to make the care and safety of patients one's first concern, and to act to protect them from risk
- to respect the public, patients, relatives, carers, NHS staff, and partners in other agencies
- to be honest and act with integrity
- to accept responsibility for one's own work and the proper performance of the people managed
- to show commitment to working as a team member by working with all one's colleagues in the NHS and wider community
- to take responsibility for one's own learning and development

In the foreword to the code, Sir Nigel Crisp, then chief executive of the NHS noted: 'The code should apply to all managers and should be incorporated in the contracts of senior managers at the earliest possible opportunity.' As was discussed in Judith Smith and Chris Newdick's evidence to the Mid Staffordshire Inquiry in November 2010, it is unclear how far the code has been enacted in practice, and how real it feels to individual senior NHS managers. There is also some apparent lack of clarity about how far the code is deemed to apply to managers of NHS foundation trusts.

The code points out that it is for local employers to decide when and how to investigate alleged breaches of the code of conduct. This suggests a significant reliance on local boards, chairs and non-executive directors (and governors in the case of foundation trusts), albeit that the NHS Confederation, Institute of Healthcare Management and Healthcare Financial Management Association are cited as bodies maintaining lists of people able to undertake such investigations. It is not however clear if any such investigations have taken


\(^{26}\) NHS Confederation (2009) Reforming leadership development....again. London, NHS Confederation

place, nor how one would go about finding out about this. Interestingly, however, the code was introduced to the NHS with the force of directions (as opposed to guidance) so there was clearly an intention of implementation and action by local bodies.

In practice, one has to assume, in the absence of any formal national reporting of the utility and operation of the Code of Conduct, that the use of the code has been largely left to local discretion. A number of important issues are raised by this uncertainty, including: the risks of leaving the operation of a professional/ethical code to a government department which is understandably preoccupied with multiple tasks and pressures; the need to explore the possibility of an independent professional body that can act as guardian and champion of the code; the need for a code to be highly visible to the public, patients and NHS staff, and hence be regarded as fundamental to the operation of the NHS.

The debate about regulating NHS managers

Background
As noted earlier, NHS management has become increasingly more distinct over the years, assuming a greater degree of individual accountability (especially after the Griffiths changes) and visibility (in view of high profile management failures). Along with this emergence of NHS management as a more distinct function has come significant effort in respect of codifying the competences required, development support needed, and codes of ethics or conduct to underpin management practice. This activity took place initially mainly at the behest of the profession itself, through the IHSM/IHM, and more recently, within the Department of Health and the Institute for NHS Innovation and Improvement.

The report of the Bristol Inquiry recommended that the government should consider statutory regulation of senior NHS managers. Work to develop and implement a code of conduct of NHS managers was part of the government's response to the Bristol Inquiry, but detailed work on possible approaches to regulating managers was not taken forward at this time (i.e. around 2002).

Responding to the Darzi Review
The Darzi NHS Next Stage Review Final Report in 2008 acknowledged that a very small number of NHS managers were causing public and professional concern, and asserted that steps needed to be taken to prevent cases of poor performance by managers. It also noted the importance of any measures being proportionate, and the need to examine how the Code of Conduct for Managers was working, along with the effectiveness of recruitment procedures.

In response to the Next Stage Review report, the Department of Health asked Ian Dalton, chief executive of the North East Strategic Health Authority to chair an advisory group on assuring the quality of NHS senior managers. This group commissioned independent research from Price Waterhouse Coopers (PWC), asking them to develop an evidence base to inform policy development in this area. The main conclusions of this research by PWC were:

- Generic managers are rarely accredited or regulated in any sector - regulatory systems in other sectors and countries are usually focused on professional staff such as lawyers, accountants and pilots.

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- NHS stakeholders emphasise the vital importance of the Department of Health, and local NHS boards, providing significant support to senior managers to enable them to fulfil their role, and caution against disproportionate, costly and onerous regulation.

- The current NHS Code of Conduct for Managers does not appear to have applied and used in a consistent and active manner.

- The potential to learn from other sectors about effective self-regulation as a basis for subsequent licensing of professionals, possibly supported by examination of management and leadership as part of wider organisational inspection (as with teaching in the UK).

- There is a framework of options for the Department of Health to consider:
  - strand 1: recruitment, vetting and employment
  - strand 2: corporate governance
  - strand 3: accreditation, licensing and regulation

- Options related to strand 1 that emerged in the research included: doing more work to develop and implement the Code of Conduct for NHS managers, in view of experience to date, and the introduction of NHS foundation trusts; and ensuring robust, transparent and comprehensive approaches to recruitment to senior posts.

- In respect of corporate governance, it was suggested that more could be done to develop the role of board remuneration committees in respect of assessing board performance, and assuring the appraisal, development and performance management of NHS executives. There was also a call to consider the use of an 'independent director' role on a board to challenge the chief executive.

- It was noted that existing work could be used to support further developments in recruitment, vetting and corporate governance, including the use of quality accounts, work to revise the Code of Conduct, the Top Leaders initiative, and work by the IHM on management accreditation.

- The research revealed mixed views about strand 3 and the idea of a regulatory regime for managers. Concerns focused on proportionality, cost, and a potential top-down punitive approach compromising work to shift NHS management culture to be more focused on patient care and quality.

- There was more support for voluntary accreditation or self-regulation within NHS management. It was emphasised that any such approach would need the involvement of lay and professional representatives at local and national level, to assure public confidence.

The PWC report concluded that it was important to explore options for greater regulation and accreditation alongside work to develop and support senior managers more effectively:

'The evidence indicates that whatever approach is taken forward in seeking to quality assure senior NHS managers, that there is a need for clarity on the aims of any new system. The balance of opinion was that the primary aim of the work should be to improve quality in senior leadership and management, whilst at the same time developing a framework to address the issue of poorly performing managers.'
The Dalton Report
The subsequent report\(^{30}\) of the advisory group led by Ian Dalton came out in February 2010 also emphasised the importance of addressing assurance issues alongside the development and support of senior managers. It acknowledged that pressures on managers were due to increase as the financial context got tougher and public expectations of the NHS continue to rise. The report talked about the importance of:

‘fair, credible, robust and proportionate proposals to provide effective assurance of the quality of senior NHS managers.’ (p8)

The proposals set out in this report have an overall focus on preventing management failure via support, development and self-regulation, and assuring public and patients’ confidence in managers. The recommendations in the report were as follows:

1. The Code of Conduct for NHS managers should be replaced with a new statement of professional ethics, and embedded in every part of the NHS via employment contracts, appraisals, and the operating framework.

2. Clear standards should be developed about the skills and competences expected of good senior NHS managers, including minimum standards for entry to senior posts, and using these as the basis for exploration of options for more formal regulation.

3. Guidance on employment contracts needs to be strengthened, especially in respect of what national consistency is required alongside necessary local variation.

4. All NHS organisations should comply with best practice on recruitment and vetting procedures, including in respect of appointment panel composition and role. Such practice should be subject to independent assessment.

5. Appraisal of senior managers should be strengthened, including the use of 360 degree feedback, and with clear connections to overall board assurance.

6. The capability of boards and their sub-committees to hold senior managers to account needs to be strengthened. This work should be linked formally to National Leadership Council work on board expectations and accountability.

7. The National Leadership Council (NLC) should consult widely on the costs, risks, practicalities and benefits of a system of professional accreditation, and options for more formal regulation of senior managers.

8. The NLC should lead and enable the development of system of professional accreditation for senior NHS managers, with a view to starting with independent voluntary accreditation.

9. The NLC should explore how such developments might also apply to middle and junior managers in the NHS, as they represent the next generation of senior managers.

10. Implementation should be staged, and carried out via the NLC, working on behalf of the NHS Management Board.

It is striking that the above report set out a number of dates by which it suggested that actions should have been taken, or new proposals developed. All of these dates were before the end of 2010. It is not clear what the status of the Dalton Report now is, given that

there has been a change of government since it was published, and we are not aware of additional publications or guidance based on its recommendations.

The arguments for formal accreditation and regulation of NHS managers

One of the most powerful arguments in favour of formal accreditation and regulation of NHS managers is that health managers occupy significant positions of responsibility for public money and patient safety, and as such should be subject to similar regulatory requirements as the doctors, nurses and other health professionals who surround NHS managers in the workplace. This could help to assure the public of confidence in the leadership of local health organisations.

One argument put forward in the PWC research for the Dalton Report was that there should be a 'fit and proper person' test put in place for NHS managers, demonstrating to the public, patients and NHS staff that those people leading NHS organisations have met a required set of professional and managerial qualifications and experience. Fit and proper person tests are in place for many public and professional roles in the UK, including: company directors; managers of charities; and nursing home managers. Within the definition of 'fit and proper', it would make sense to draw on the Nolan principles of standards in public life, standards which are applied to NHS boards.

Education has moved to such an approach in relation to the appointment of headteachers where there is now a set of national professional standards for headteachers which are used to guide recruitment, professional development and performance management. For each core standard, there are detailed knowledge requirements, professional qualities, and actions needed to achieve the core purpose of a head, and these were developed in close collaboration with the education sector.

A set of national standards could also underpin the development of more formal arrangements for continuing professional development of NHS managers, with minimum requirements along the lines of those put on lawyers, doctors, accountants and others. As health management has become more complex and accountable, it would seem reasonable to expect continuing professional development undertaken with accredited providers, along the lines of the approach taken in Australia, Canada and in the Netherlands.

A system of accreditation for NHS managers, whether voluntary or mandated, would also have the benefit of helping increase the standing of NHS managers in the eyes of their clinical colleagues who themselves face registration, continuing professional development requirements, and (soon) periodic revalidation to practise.

An important argument for having core professional standards is that these provide a baseline against which to assess individual and organisational performance, and to give any complainant or assessor a basis on which to mount a private or public challenge about a perceived breach of such standards. Thus the standards could serve to protect public and patient safety, if properly implemented with clear guidance about how they were to be operated, inspected, and challenged. The New Zealand Health and Disability Code of Rights, and the role of the commissioner in upholding the code, is interesting to examine in this regard.

Another benefit of having more formal standards to underpin health management as a profession would be to protect individual managers or boards from undue pressure from the Department of Health (or its agencies such as the NHS Commissioning Board and Monitor) where a local manager or board felt it needed to use professional standards and/or a code of ethics to make a stand in the face of pressure to implement policy that was felt to be detrimental to local services. This argument could also apply for an individual manager facing pressure from the local board. Such a provision would clearly be for
exceptional circumstances, but is an important element underpinning the development of professional standards and codes, as is seen when doctors or nurses appeal to their professional code of conduct in situations where they feel an organisation is impeding the delivery of safe patient care.

**The arguments against formal accreditation and regulation of NHS managers**

It is interesting to note that both the Department of Health advisory group on assuring the quality of senior NHS managers, and the King's Fund Commission on Leadership report **mixed views amongst experts about the issue of formal accreditation and regulation of health service managers**. There seems to be consensus in most quarters about the value of enhancing recruitment and vetting processes for NHS management, reinforcing the code of conduct for managers, and addressing further the quality of corporate governance of NHS bodies. It is in the area of moving to formal registration, accreditation and regulation of managers that disagreement emerges.

One of the main arguments used against a more formal approach to regulation and registration is that **managers' work is generic, hard to codify, and difficult to test for competence in relation to a discrete body of knowledge**. Comparisons are typically drawn with law and medicine, where professional bodies codify education, training and qualifications, and carry out periodic assessment of fitness to practise, and take action where complaints about such fitness are made. It is the generic nature of management that has led to the rarity of registration of such roles in health and other sectors, as noted in the PWC research report in 2009.

Another important argument against formal regulation is the potential **cost of setting up a professional body, developing standards, assessing all managers against these, putting in place processes for ongoing assessment and development of managers' standards**, and linking all of this with existing organisational and professional regulation (e.g. the work of the Care Quality Commission, Monitor, the General Medical Council, and others). Indeed, as noted in the PWC research, it could be that to move straight to such an approach could be a 'sledgehammer to crack a nut' if the assertion of only a tiny minority of managers performing poorly is correct.

It should also be borne in mind that **NHS management costs are currently subject to significant cuts, and there has been a move to reduce the number of arm's-length bodies within the NHS**. This would suggest that rather than set up a new body to accredit and regulate managers, it might make sense to explore the potential of using existing entities such as the NLC and the IHM, albeit in new and more extensive ways.

As well as the cost of developing a more formal and extensive approach to regulation of managers, it would also carry the **risk of exacerbating those elements of NHS management culture currently considered to be unhelpful in respect of enabling healthy, creative and patient safety-focused culture**. In particular, it might add to the 'top-down' nature of some NHS management and make managers less willing to admit when things are difficult, or if they feel their team or organisation is failing in some way. What this points to is the importance of the way in which any new approach to regulation is implemented, and in what spirit such work is carried out.
Options for moving forward

Based on the analysis in this paper, the main options for moving forward with regulation of NHS managers would seem to be as follows:

1) **Continue with the status quo**, focusing on the role of boards to make sound appointments, manage the performance of NHS organisations, CQC and Monitor to assess quality and governance, and the Department of Health National Leadership Council to provide support and development. It should be noted that the planned abolition of the NHS Appointments Commission raises questions about how NHS boards (including those of new clinical commissioning groups) will be appointed to in future. There is also work to do to ensure consistency across foundation trust and other NHS boards.

2) **Develop a clear plan for enacting some or all of the recommendations of the Dalton Report**, with an initial focus on revisiting and implementing fully the NHS Code of Conduct for Managers. As a minimum, this would entail the code (or revised code) being made mandatory for senior management contracts (whether foundation trust or other NHS bodies - and arguably for all senior managers of providers to the NHS).

3) **Make the development of a set of core standards and ethics for NHS management a key priority, and work towards setting up an independent body to be the guardian of these, within a clearly defined timescale**. This body could then become the professional body for all senior NHS managers, through which they would feel compelled to seek professional registration and accreditation (albeit on a voluntary basis) and through which their CPD would be monitored and accredited. Options for such a professional body could be: the Institute of Healthcare Management; the NHS Confederation; Monitor; or a new regulatory council. There is useful experience in Australia, the Netherlands and New Zealand to explore in this regard.

4) It would perhaps make sense to **focus initially on the registration and regulation of senior managers - chief executives, executive directors and non-executive directors as 'fit and proper people'**. To try and address, in a single programme of work, the standards and registration of all NHS staff with a management component to their role would risk bureaucratising the initiative into the ground.

5) **Undertake more extensive work to scope a system of formal regulation for senior NHS managers**, perhaps once work to put in place a fully functioning code of conduct has been completed, and a system of voluntary self-regulation and accreditation in operation. Given that other countries do not appear to have formal regulation of health management, it would seem that the NHS should first of all learn from its own and others’ experience in developing a more powerful code of management conduct and ethics, and a system of voluntary professional registration and accreditation, before leaping to a formal regulatory approach which may lack the necessary organisational development experience and support that could be gained through managers working to establish a robust voluntary approach within the context of a strengthened ethical code.

**Conclusion**

In the spirit of the discussion we expect to engage in at the inquiry seminar on 18 October, we conclude that the NHS management is part way through a journey of becoming more professional, accountable and distinct. What is critical is that it does not rest on its laurels, and assert that just because it is functioning well overall, it does not need to explore more formal and transparent accreditation and regulation. As with the experience of headteachers in education, the public expects more scrutiny and accountability of people in senior positions within public services, and more can be done to codify the role, standards, and
expectations of NHS managers, to explain how these will link to recruitment, performance assessment, and inspection of NHS services, and put in place nationally accredited development for NHS leaders.

It seems to us that moves to enact the recommendations of the Dalton Report (at least in respect of recruitment, vetting, corporate governance, and voluntary accreditation) will be necessary but not sufficient for the NHS. These will help to clarify roles and expectations, both for the NHS and the public, and to provide assurance of efforts to safeguard minimum standards. A lesson from various management failures of recent years is the risk of organisational and managerial isolation. What is also needed to go beyond the ‘necessary’ is a commitment to provide specific support to senior managers and boards (and to require organisations to take up such support, through professional standards) and for such support to include mentoring, coaching, peer networks, and confidential counselling. How such support will be organised and funded in the reformed NHS is not yet clear, but it will be of critical importance as managers and boards face the financial and service pressures ahead.

To conclude, regulation is just part of the picture of management and leadership development in the NHS, and needs to be part of a wider debate about developing the culture of the NHS in a way that encourages greater openness, admission of difficulty, and a need for support. If this does not change, we will keep reinventing national leadership centres, writing codes of conduct that never quite develop ‘teeth’, and wondering why turnover of senior managers is high.

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