Roles and Behaviours of Middle and Junior Managers

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Roles and Behaviours of Middle and Junior Managers: Managing New Organizational Forms of Healthcare

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This report contains transcripts of interviews conducted in the course of the research and contains language which may offend some readers.

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Glossary of terms/abbreviations

A&E	Accident and Emergency
CCAS	Combined Counties Ambulance Service (pseudonym for the participating Ambulance Trust)
CEO	Chief Executive Officer
CQC	Care Quality Commission
CSM	Customer Support Manager
CHI	Commission for Health Improvement
DHSS	Department for Health and Social Security
GP	General Practitioner
HART	Hazardous Area Response Team
HCC	Healthcare Commission
KSF	Knowledge and Skills Framework
Lean	An operations management system originally developed at Toyota Motor Corporation
MCFT	Millfordshire Care Foundation Trust (pseudonym for Mental Health Trust)
MDC	Millford Direct Care (pseudonym for the GP commissioning consortium associated with MPCT)
MFT	Millford Foundation Trust (pseudonym for the Acute Trust)
MPCT	Millford Primary Care Trust (pseudonym for the Primary Care Trust)
MOS	Management and Organization Studies
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPM	New Public Management
OECD	Organization for Economic Co-operation and Development
OL&D	Organizational Learning and Development
PC	Planned Care
PES	Paramedic Emergency Services
PCT	Primary Care Trust
QOF	Quality Outcomes Framework
RTA	Road Traffic Accident

SHA	Strategic Health Authority
SOP	Standard Operating Procedures
TCS	Transforming Community Services (an NHS programme)

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Contributions of authors

Dr Paula Hyde was the Principal Investigator who led the project team. She was involved in the project design; data collection and analysis; and writing this report.

Dr Edward Granter carried out a literature review and was involved with data collection and analysis; and writing this report.

Professor John Hassard was involved with the project design; data collection and analysis; and writing this report.

Dr Leo McCann was involved with the project design; data collection and analysis; and writing this report.

Professor Jonathan Morris was involved with the project design and review of this report.

Executive summary

Background

The NHS has undergone significant changes in recent years. Reforms have taken place against a backcloth of major restructuring of large organizations, public and private, across OECD nations, with organizations typically attempting to adapt in the face of major performance and cost pressures. We relate developments in the management of health care to what has become known as New Public Management or NPM. New Public Management, which emerged during the 1980s, is the term associated with the wholesale reforms introduced by policymakers in an attempt to make public services more 'efficient.' A key focus then, was on efficient use of resources, which was to be achieved by the introduction of more flexible and dynamic private sector management systems. In such systems, performance measurement is a fundamental element. Previous studies of managerial work have tended to focus on senior managers while less is known about middle and junior managers. Recent research has noted the contribution of middle managers to organizational performance, nevertheless they often form one of the less contentious targets for cost reductions. This is no less the case in the NHS, where the need for cost savings has been further accelerated by government austerity measures. Research in other organizations has shown that restructuring has had significant impacts in terms of roles and responsibilities, careers and quality of middle management working life. In light of associated organizational changes, this project is dedicated to producing detailed ethnographic accounts of the contemporary realities of working life for middle and junior managers in UK health care organizations.

Aims

The study focused around one overarching question: 'What are the effects of the New Public Management ethos on middle and junior management roles?' Consequently, the aim of the study was to investigate the work life, roles and behaviours of middle and junior managers in health care organizations.

Specifically, we sought to:

1. Examine the realities of managerial life for middle and junior managers in healthcare organizations.
2. Understand and compare the various roles and behaviours of middle and junior managers in respect of competing organizational forms of governance.

3. Explore the interactions between middle/junior managers and frontline staff and their effects on service delivery.

4. Build knowledge relevant to the practice of managers in healthcare organizations.

Methods

Following a detailed review of the literature relating to the roles and behaviours of middle and junior managers, the research approach was framed by the theory and practice of Critical Action Theory, a hybrid approach developed from Action Theory and Critical Theory. The study involved an in-depth ethnographic study of the realities of working life for middle and junior NHS managers in four organizations in overlapping health economies and included four healthcare organizations: 1. An Acute Foundation Trust, 2. A Mental Health Foundation Trust, 3. An Ambulance Trust, and 4. A Primary Care Trust.

In terms of fieldwork, qualitative research techniques were used; interviewing and observation. In total, over 250 managers were involved in the study during 319 hours of fieldwork. The study design included tracking features of the lived experience of managers (what managers do in different types of health organization). Within each organization, case studies saw managers from purposively selected sub-units invited to take part. Data were analysed as the project progressed allowing insights to be explored in on-going interviews and extended observation sessions. Cross case analysis occurred following examination of trust specific data and emergent themes were discussed and refined through several iterations at regular team meetings. The main outcome of this study is an inter-related series of detailed ethnographic accounts of the contemporary realities of working life for middle and junior managers under various organizational forms of governance in UK healthcare organizations.

Results

Overall the study indicates that, far from being static, middle and junior managerial roles are changing rapidly and significantly as a result of wholesale and far reaching reforms, in part, associated with New Public Management.

1. The literature review identified a number of important issues relating to the roles and behaviours of middle and junior managers; organizational trends across OECD nations (private and public sector) have moved away from the traditions of tall chains of command and small spans of control, and towards flatter, less hierarchical organizational forms. These changes have tended to expose middle managers to redundancy, and have increased the span of control for surviving middle managers. Workloads have grown, but managers have also experienced devolved authority, which has made their working lives more interesting, and

possibly allowed for more autonomy. While many middle managers have been made redundant by change, those who survive have become more important to their organizations than before.

2. Middle management roles in our four NHS trusts replicated many of the issues identified in existing work (see point 1 above), although obviously the details reflect the nature of the healthcare industry and norms of public sector governance. NHS junior and middle managers roles included:

    a. handling staff issues (scheduling shift rotas, managing performance, handling grievances, disciplinaries, investigations)

    b. attending and running training events about new policies, restructuring, and reforms within their trust and in the NHS more widely

    c. implementing NHS and trust policies at local levels, such as patient safety initiatives, efficiency measures, or ensuring all staff are trained about new clinical guidelines

    d. dealing with large and increasing demands for internal and external reporting (of organizational performance, hitting and missing of targets, patient outcomes, patient safety, etc)

    e. seeking and attempting to implement cost savings and efficiency gains on a daily basis

3. Work of managers, generally, was often 'messy', unpredictable, and non-stop and 'came in' to managers from all angles, from staff they supervise, from senior managers above, and from unpredictable sources, such as patient complaints or medical emergencies. Managers attended numerous meetings on a daily basis, where they had to assimilate and interpret vast amounts of internal and external information relating to them and to the wider business of their trusts. Managers were increasingly aware of what went on outside of their direct business unit. This often included knowledge of national policy changes and changes at other trusts that affected their work. Managers formed a committed workforce and often played critical roles in the day-to-day organization and delivery of healthcare plugging any gaps as they became apparent.

4. Managers' behaviours varied considerably according to their roles. Many spoke of their pride for working for the NHS and of the central importance of patient care. Indeed, many experienced competing managerial identities; struggling to juggle the competing needs of patients and of business/financial pressures. Some spoke of exhaustion, having to put in long working hours (over fifty hours in many cases), taking work home, checking emails and phone messages at evenings, weekends, and even on holidays. Many were weary of organizational (often resource-based) conflicts that arose between managers and clinicians and between managers of various areas within trusts. Problems of stress, burnout and sickness absence were reported, which

compounded the already-large workload for managers who had to cover for absences. Morale was low among many junior and middle managers.

5. The most obvious change to managers' roles was the considerable expansion of their spans of control and the increasing scope of their roles. Managers were increasingly being expected to understand the business of their trust and of the NHS, and were discouraged from simply sitting in their historic silos. In some trusts, this entailed managers working across traditional boundaries, often in cross-functional teams or projects. More broadly, the organizational hierarchies of all four trusts were relatively flat, meaning that middle and junior managers' roles spanned from near – or on – the healthcare frontline and upwards into relatively senior managerial work, close to the leadership of their trust areas. Thus, managers' range of responsibilities had expanded vertically as well as horizontally.
6. All of the above points were, to a greater or lesser extent, visible in all four of the trusts that participated in this study. While there was a considerable amount of diversity within and across trusts as regards everyday organizational and working arrangements, the five trends discussed above clearly describe the broad movements as regards the structuring and change of middle and junior management roles.

Key contributions

- Multi-site ethnography of the lived experience of middle and junior managers
- Novel theoretical approach – Critical Action Theory
- Examination of how NHS management roles and behaviours are changing
- New epistemological framework – the Paradigm Domains Model
- Analysis of how the effects of the New Public Management ethos is enacted within NHS organisations

Conclusions

The roles of middle and junior managers in NHS organizations are changing rapidly. As further changes to NHS service organization and delivery are implemented, these findings offer some insights which may be of value to those responsible. These include;

- NHS organizations are increasingly operating like businesses, adopting commercial organizational forms, taking a robust approach to cost control, increasing their efforts at managing external relations, and operating with very limited spare capacity

- Attitudes to business are entrepreneurial, with NHS Trusts increasingly encouraged to bid to win contracts for new or different services.
- Middle and junior managers are experiencing work intensification, increasing demands and increased spans of control as a result of headcount reduction, upskilling and flattened hierarchies
- Managerial responsibilities are changing rapidly with occasional gaps in experience and ability
- NHS middle and junior managers play a vital and, at times,neglected role in their organizations. They have a wider understanding of the entire 'business' of their trust and beyond, and their engagement is essential in the everyday running of trusts, plus in the form of 'plugging gaps', where possible, in service provision regardless of whether it is formally part of their role.
- NHS managers are not obstructive or wasteful. Rather they are committed employees, who strongly identify with the NHS and with patient care. They play vitally important roles in keeping NHS trusts functioning and evolving. They reported being on the receiving end of unfair criticism and having a lack of avenues for advocacy and representation for their interests.

Further research is suggested in the following areas:

- The use of extended periods of contact with managers provided rich data and deep understanding about the realities of managerial work, and we would strongly advocate the continued use of such methods if we are to fully understand and articulate the life-world of managers in a changing NHS.
- Whilst this study used cross case comparisons to arrive at common findings, further studies could usefully examine specific roles and behaviours in more depth by organisation type or management group.
- This study has highlighted the impact of increasing demands for monitoring information from middle managers. The extent to which this continues and is affected by organizational change could be usefully explored.

On the one hand, the richness and depth of data collected is a strength of this study. On the other hand, the results cannot be easily generalised. However, whilst the findings here may not be exhaustive, they do provide an important account of middle and junior managerial roles immediately prior to and during a period of increasing financial pressure. As these pressures look set to continue, the findings are likely to be of relevance and

importance to other health service organizations and indeed to other public service organizations.

The report

1 Introduction

This study focused around one overarching question: 'What are the effects of the New Public Management ethos on middle and junior management roles and behaviour in UK healthcare?'

Line management is a key feature of organizations implying a chain of authority from senior managers through to staff delivering services. Whilst senior managers define strategy and junior managers control the daily detail of working practices, middle managers maintain a potentially invidious position, playing a co-ordinating role but having procedurally-limited autonomy. Managers in the middle reaches of organizations play important roles in securing performance improvements and as such have a strategic role to play. Yet, given their pivotal situation in the organizational hierarchy the roles and behaviours of middle and junior managers remains a relatively underdeveloped area of research(1).

Also, less commonly explored are the distinctive organizational arenas provided by healthcare services. In order to carry out organizational reform effectively senior managers should be able to map and interpret the human terrain of their organization. Middle and junior managers form a group that, in other sectors, have been experiencing both work intensification and decline in traditional career expectations. Whilst the main contextual variable is different types of health service organization, the study focus is the impact of these changes on middle and junior managerial roles and behaviours in the NHS.

Health service management is of particular importance, not least because health workers form a significant proportion of national employment figures and hospitals often play important roles in local economies. For example, health care is one of the largest industries in the USA, providing 14.3 million paid jobs in 2008(2). The NHS is by far the largest UK employer with 1.43 million employees in 2009 and managers account for approximately 3% of the total figure(3). Globally, there are approximately 60 million health workers and the number is increasing(4). Health service managers face particular challenges as a result of increased demand for services, fiscal pressures, half of the workforce being professionally qualified and accountable to their own professional organizations, and, in the UK, services experiencing regular, radical structural changes(5).

Despite the suggested importance of middle managers to wider organizational performance (6), ethnographic studies of managers have tended to focus on senior leaders and chief executives(7-10). Few studies have sought to understand the lived experience of middle and junior managers (for recent exceptions see Hassard et al(1); McCann et al(11))

and still fewer have done so in the specific context of the NHS (for exceptions see Currie(12); Currie & Proctor(13)).

The NHS has undergone unprecedented change in recent years following experimentation with a variety of organizational forms, notably top down performance management, governance and quasi-market models(14). These changes require different managerial behaviours and have had significant impact on the roles, careers and responsibilities of managers. We begin by briefly mapping government policy as it affects the NHS management task. To each of five policy periods corresponds a particular managerial characterisation.

1.1 Political change, government policy and management in the NHS

As explored in more detail in chapter 2, the theory and practice ofmanagement has undergone significant shifts in recent years and government policy in relation to the management of the NHS has reflected these changes. This section provides a broad overview of government policy as it affects NHS management over the life of the NHS to date (for fuller accounts of NHS policy see Harrison & McDonald(15); Klein(16); Lister(17)). We delineate five eras of NHS management that provide the framework for our subsequent review of the management literature.

Broadly speaking, NHS management came to prominence in the wake of the rise of professional managers in private sector organizations in 1960s and 1970s. The 1980s and 1990s saw Government health policy emphasising the importance of specific managerial roles to improve efficiencies as part of a number of NHS reorganizations. Coming almost full circle, more recently, middle managers in particular were criticized for being sources of inefficiency through the generation of wasteful bureaucracy. NHS policy has reflected changing academic and industrial viewpoints and has followed a similar, if somewhat delayed trajectory. Organizational changes have had striking effects on management practice, professional values and service organization and delivery in the NHS as a whole. We group these changes chronologically into five management eras of the NHS:

1. Before management: 1948 to 1982
2. Introduction of management to the NHS: 1983-1988
3. Management and the NHS market : 1989-1996
4. Business management, investment and reform 1997-2009
5. Post-managerialism: 2010- date

These management eras are related to particular periods of time, government policies and legislation (see Table 1) and their effects on managerial roles and behaviours are summarised.

Table 1. NHS policy and managerialism in the NHS

Time period	Era	Policies and legislation
1948-1982	Before management	1948 Creation of the NHS (Nationalization of health care) 1974 Reorganization of the NHS
1983-1988	Introduction of management to the NHS	1983 Griffiths Report (general management)
1989-1996	Management and the NHS market	1989 Working for Patients (introduced an internal market) 1990 NHS and Community Care Act 1991 The Patients Charter 1992 Health of the Nation
1997-2009	Business management, investment and reform	1997 The New NHS: Modern, Dependable 1999 Primary Care Groups then Primary Care Trusts established 2000 NHS Plan (10 year plan for the NHS) 2004 First wave of Foundation Trusts, Payment by Results and Patient Choice, Quality and Outcomes Framework and direct incentives 2008 Darzi review
2010-date	Post-managerialism	2010 Liberating the NHS 2011 Health and Social Care bill

1.1.1 Before management 1948 to 1982: The manager as administrator

The NHS was founded in 1948 on the three principles of; universal coverage, being free at the point of delivery and being provided on the basis of need rather than ability to pay(16). The shape of the emergent NHS reflected the political challenges of its establishment. The British

Medical Association which was a fierce opponent, negotiated substantial concessions for its members. General practitioners remained self-employed subcontractors and consultants were appointed at regional level, thus protecting them from local managerial control. They had professional autonomy in clinical practice and could use NHS facilities for their private practice. Governing boards and committees had substantial medical representation(15). Hospitals were, effectively, managed by an administrator, chief nurse and medical consultant. No one person had overall responsibility. One view suggests that much subsequent policy reform involved attempts to right the inherent power imbalances engendered by concessions to the medical profession.

Throughout the 1950s and 1960s these arrangements for NHS management came into question but it took a scandal about mistreatment of long-stay patients at Ely Hospital to lead to the creation of the Health Advisory Service (first known as the Hospital Advisory Service), which undertook hospital inspections[1]. The first major reorganization of the NHS took place in 1974, bringing together GPs, community and hospital services into single local NHS organizations. Decision making continued to follow a triumvirate, consensus-management, arrangement which was extended to multiple levels of the local organization.

Throughout this period GPs and consultants shaped service development. The net result was that management plans, decisions and capital expenditure reflected their priorities. Managers, as *administrators*, were inward looking and reactive, solving problems and gathering resources to satisfy their medical staff(15). The NHS, at this time, operated as a professional bureaucracy with clinicians exerting considerable influence and autonomy(18).

1.1.2 Introduction of management to the NHS 1983-1988: The manager as bureaucrat

The 1980s saw a new Conservative government under continued economic and financial pressure. Attempts to manage perceived declining NHS performance included two changes. First, 1983 saw the introduction of annual top-down reviews against a rudimentary set of performance indicators. These reviews allowed the comparison of performance of local health authorities. Although these reviews were said to have had little immediate effect (15), they did institutionalise the idea of performance against quantitative targets. Second, the NHS Management Inquiry in 1983(19) by Roy Griffiths, Chairman of Sainsburys supermarket, effectively abolished 'consensus' management in favour of 'general management' and provided the structural arrangement for a rational management system.

[1] NHS inspectorates have undergone many changes to date, through the Health Care Commission that issued star ratings to Monitor which regulates Foundation Trusts and the Care Quality Commission which covers health and social care organizations.

This shift in relationships included a move away from the high trust relationships involved in consensus management towards the low trust relationships of rational management(20). As a result of Griffiths' recommendations the following management reforms took place: appointment of general managers, introduction of management budgets, value for money reforms and management training and education. General managers from inside and outside the NHS were to be in place in hospitals and health authorities by the end of 1985. Management budgets were to be introduced alongside greater financial controls. Savings arising from these reforms were to be returned to improving services for patients and the NHS Training Authority was established in order to extend management training especially for doctors(19). Doctors were to become more closely involved in financial matters and budgeting. Managers had fixed-term contracts and so, arguably, managers as *bureaucrats*, became more responsive to government demands(15).

1.1.3 Management and the NHS market 1989-1996: The manager as business person

The 1989 White Paper 'Working for Patients' passed into law as the NHS and Community Care Act in 1990. This act introduced an (internal) quasi-market for health care by encouraging services to split along 'purchaser' (Health Authority and some GPs) and 'provider' (acute, mental health, ambulance and community) lines. Purchasers were given budgets to buy health care from providers. Providers became NHS trusts (independent organizations with their own management teams) and trusts would then compete with each other to provide services to the purchasers. Between 1991 and 1995 all providers became NHS trusts. GPs could hold budgets (GP fund holding) to purchase care for their patients from the NHS or private providers. Some GP fund holders were able to accelerate care for their patients leading to accusations of a two-tier health system emerging. As well as attempting to increase managerial control of services, these changes were also designed to introduce competition and a business culture. The management role was orientated towards *business* matters.

The Patients Charter (1991) saw the patient as consumer with expected standards of service. This was followed by Health of the Nation (1992) which set the scene for further development of targets as a means of performance management. Although NHS quasi-market institutions were originally abandoned by the new Labour government of 1997 these early experiences paved the way for market-orientated changes in the coming years.

1.1.4 Business management, investment and reform 1997-2009: The manager as leader

Labour came to power having promised to 'save the NHS'. This period saw unprecedented change involving the formation and dissolution and rearrangement of structures and responsibilities of NHS authorities and trusts. 'The New NHS: Modern, Dependable' (1997) saw the abolition of the internal market and dismantling of GP fund holding. This was an era of centralized management of the NHS as one organization. It involved target setting intended to reduce waiting times and improve access to services and the introduction of a star rating system for NHS organizations. Organizations were rated by the newly established Commission for Health Improvement (CHI). Although national targets were subsequently abandoned, along with the star rating system, priorities continued to be indicated through the annual Operating Framework for the NHS published each year. The National Institute for Clinical Excellence (NICE) was created to make decisions on the adoption of treatments. These two institutions (CHI and NICE) took control of areas previously controlled by the medical profession. Decisions about suitable treatments were now being made by NICE and clinical governance was being carried out by the HCC.

The NHS Plan (2000) described a ten year plan for the NHS and National Service Frameworks outlined service standards for areas such as mental health and cardiac care. Decades of under-spending on health care meant that England had notably poor health outcomes compared to other developed nations. In 2000, Tony Blair promised to increase health spending to European levels. This meant a rise from 6.6% (1999/2000) to 9% of GDP (2005/6). Real terms increases in spending of 7.1% were projected(21). By 2007/8 spending reached £113 billion. Much of the increased spending went on pay and price inflation(15). However, this period of major investment followed a period of spending cuts and substantial improvements were made to infrastructure and equipment. Clinical activity also increased.

A code of conduct for NHS managers was introduced in 2003 codifying ethical managerial conduct(22). This guidance included; putting the care and safety of patients first, the need for honesty and integrity and being responsible for their work and the work of those they manage. Breaking this code could lead to dismissal and being barred from working for the NHS. There is little evidence of it being used in this way.

Although the targets and associated penalties were initially successful in reducing waiting times, increasingly disturbing behaviours linked to intense centralized control preceded a radical change in direction towards decentralization and the re-adoption of market based reforms. These included the promotion of patient choice and competition between providers as well as allowing for organizations based on not-for-profit structures - NHS Foundation Trusts. The first wave of Foundation Trusts came into being in 2004. At the same time, the previous system of block contracts to service providers was replaced by a new funding system called Payment by Results. This system was aimed at reducing waiting times by targeting payments

towards specific treatments and thus providing a powerful incentive for trusts to direct activity towards areas of greatest need. The 2008 Darzi review laid out the second ten year plan for the NHS although it was rapidly displaced by the unfolding financial crisis. The review laid out plans to increase patient choice, improve public health provision and to extend the role of doctors as managerial leaders. This era encapsulated ideas of the manager as *leader* – leading change and complying with rapid-fire structural and policy changes.

1.1.5 Post-managerialism 2010-date: The manager as entrepreneur

Since the formation of the Conservative-Liberal Democratic coalition government, cuts to health management have been presented as a means of reducing costs and improving efficiency in the NHS. By 2010, after a period of substantial growth, NHS management costs were targeted for a 45% reduction over four years. This came alongside systematic organizational delayering through restructuring and reorganizing health bodies as the focus of policy intervention(23). The new coalition government of 2010 brought health policy almost full circle by proposing the removal of management layers to improve efficiency. They advocated what were said to be the most significant changes to the NHS since it began(24). The White Paper 'Equity and excellence: liberating the NHS'(23) proposed to reduce management costs by 45% over four years and to delayer the NHS by abolishing 151 Primary Care Trusts and 10 Strategic Health Authorities. However, these layers were to be replaced by two new layers: 300-500 GP Consortia overseen by a NHS Commissioning board. Critics have argued that decentralising budgets to local GP consortia complicate cost containment in a pluralistic system(25). The Health and Social Care Bill 2011 took the changes even further by reducing the emphasis on GPs as commissioners and providing for private sector commissioning. The 'liberation' came to refer to the liberation of provider services to make public or private provision in a competitive consumer market. Thus managers, of multiplying provider services at least, are set to become entrepreneurs in a multi-commissioning, competition-driven health service.

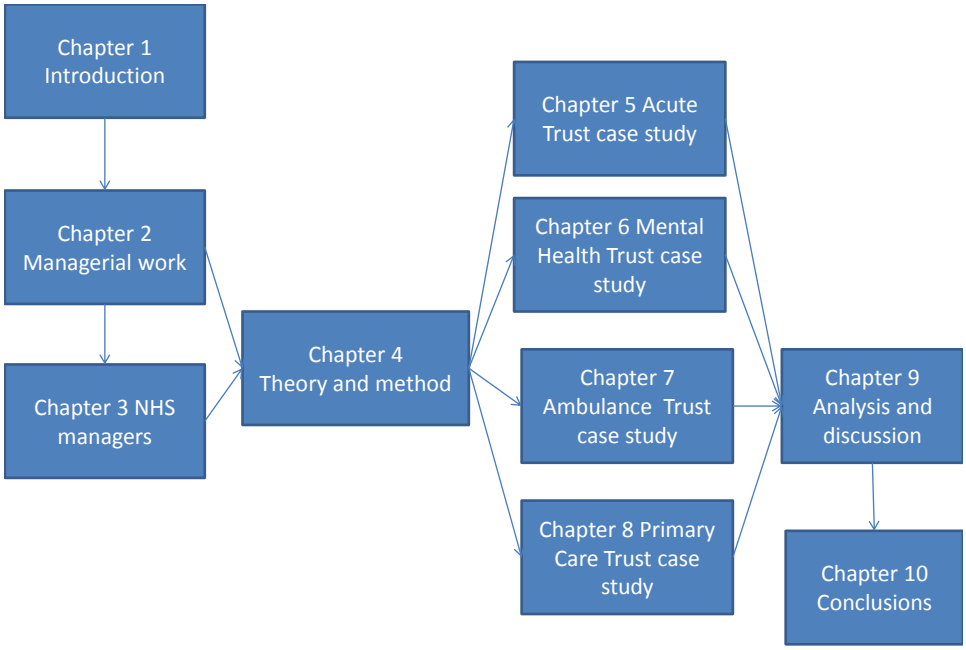
Each of the five policy eras describe three overarching themes; institutional reform, changing the balance of power and attempts at performance management. These policy themes have been driven by an underlying belief in the power of both rational management and the power of markets to increase efficiency(25, p801-2). This review provides a historical backdrop against which our empirical work exploring the realities of managerial work can be assessed.

1.2 The research and structure of this report

This report details the findings of a three year National Institute of Health Research Service Delivery and Organization programme funded project into roles and behaviours of middle and junior managers undertaken by researchers at Manchester Business School, University of Manchester and Cardiff Business School, University of Cardiff.

As outlined in the preceding section, NHS organizations have moved towards decentralised control, with increasing numbers of hospitals becoming Foundation Trusts, moves to increase patient choice and competition between health provider organizations. Middle managers have been given increasing responsibility for implementing health service reforms and have been criticised for perceived failures in carrying out their roles(23). Their roles maintain the links between those planning and organising services and those providing services to patients. Recent managerial literature suggests that while middle managers play an essential coordinating function they are also the primary target for removal during organizational restructuring. As there has been little recent work on middle and junior managers across a variety of health service organizations this research was designed to investigate the work life, roles and behaviours of middle and junior managers in health care organizations, and their place in and contribution to wider organizational performance and service delivery.

Flow Diagram: The structure of the report



The flow diagram above illustrates the structure of the report, which begins with an overview of management literature generally (especially in corporate environments) before focusing in on health service managers. Chapter 2 details how managerial work in general has changed over time and identifies significant eras of management ideology. Chapter 3 then

details how such changes in managerial work have filtered into UK health service delivery specifically in relation to the policy eras described in the preceding section. While it may seem extensive, this review indicates how changes to managerial work generally have been mirrored, if a little later, in the roles of managers of health service organizations. Chapter 4 describes the theoretical underpinning to the study which informed the Critical Action Theory approach to undertaking the research. The research methods are described in detail in this chapter. Chapters 5 to 8 present findings from each type of health service organization separately[2]. Findings common to the four case sites are integrated and developed as cross-cutting themes to develop emergent findings in Chapter 9. Chapter 10 details the conclusions as well as identifying the potential for future research.

[2] It is important to note that each of these organizations underwent considerable change during the study as a result of the fiscal crisis and policy changes associated with a change in government.

2 Managerial work

2.1 Managerial ideology over time: An overview

The corpus of ideas, theories, and concepts about how best to manage and control people and organizations (the term we use is 'managerial ideology') has a long and complex history. There have been literally hundreds of authors, traditions, paradigms and models. Here we provide a simplified historical overview, emphasizing two specific periods in the development of management ideas. Managerial ideology has tended to mix description of what organizations are with prescriptions of how they might be better run. Changes in managerial ideology are reflected in changes in managerial practice. This is true in public sector organizations just as it is for the private sector organizations from which it generally emerges.

Basic trends in description and prescription change in accordance with wider forms of economic and social change. Business historians typically identify three very broad time periods that characterise various forms of management thinking. These were: the Gilded Age or 'Robber-baron Phase of Capitalism' (mid-18th century to 1929); the era of 'Managerial Capitalism' (1930-74); and the era of 'Investor Capitalism' (1975- today). An influential study by French sociologists Boltanski and Chiapello(26) described these historical shifts as the first, second, and third 'spirits of capitalism', and their analysis of changing managerial and organizational theory explained how each distinct era had its own ideological flavour. The following two sections of this chapter describe the forms that the theory and practice of management took in the two most recent eras of the 'second' and 'third' spirits of capitalism, from the post-war era onwards.

2.2 Centralized, rational, accountable: The era of scientific managerial administration

Following the disasters of the Wall Street Crash (1929), and the Great Depression, advanced economies of the US, Europe, and Japan became much more strongly regulated, and the excesses of owner-managed firms and the markets were reined in. Industry grew in scale before, during and after the Second World War, as mass production and economies of scale became the new reality. An organizational revolution took place as the size, scale, and complexity of industrial and financial firms grew. Firms became too large and too complex to be handled by owner-managers or to survive without far greater attention on organizational and planning issues. Perhaps the most significant element of the organizational revolution was the *separation of ownership from control*. Ranks of salaried, generalist managers took over control of organizations, and the former 'hands-on' owner-managers retreated into the background. Ownership often became diffuse as companies issued securities on stock markets in order to finance their expansion. The large, multidivisional, publically-listed firm became the

dominant organizational form. This was the era of the large organization and its ranks of professional, general managers – the age of managerial capitalism.

Managerial capitalism was closely associated with a radical increase in the size, scale, and scope of managerial influence. As large firms and public bureaucracies grew larger and their spans of interest widened into new lines of business, they tended to add new departments and divisions, generating the need for devolved administration and new levels of line management. Large firms often had as many as eight or ten levels of management, meaning that senior management and the boards of directors were often remote from the line. 'Command and control', with its militaristic tone, was the phrase used to describe the strictness and stability of the large organization of the time. Standard Operating Procedures (SOPs) and strict organizational systems provided the requisite levels of control. Literature of the time was dry and technical, emphasising standards, systems, and rational procedures. New SOPs were overseen by the new ranks of professional, generalist managers, often with limited or no experience of the realities of the line. Instead, these managers were experts in generalist managerial knowledge, the likes of which management classicists such as Lyndall Urwick always believed could be taught at universities or business schools (the latter grew quickly during the period, especially in the USA).

While Taylorian 'scientific management' often formed the basis of these new organizational regimes, alternative lines of thinking were also to emerge in due course, some of which provided more advanced roles for human behaviour in managerial ideology. Foremost of these was the 'Human Relations School'; the programme of research initiated at the Hawthorne Works of the Western Electric Corporation in southern Chicago(27). These pioneering studies had a huge impact on the subject of organizational behaviour, representing one of the first major attempts to understand human and group behaviour in organizations, exploring the complexities of staff behaviour, including subcultures and forms of employee resistance. Another important strand of theory emerged during the 1960s – that of employee motivation, such as expectancy theory(28), which moved beyond the search for abstract generalizable structures of the classical management theorist, and suggested that much more attention needed to be paid to how employees oriented themselves to work and how best they could be motivated and rewarded.

Other prominent trends involved the subsequent development of the 'quality movement'. Industrial engineers and statisticians such as Walter A. Shewhart and W. Edwards Deming (both of whom worked at Hawthorne, see Best et al (29)) argued for increased standardisation and routinization of manufacturing procedures and the inculcation of a culture of 'unity of purpose' in the workplace. These changes were argued to be essential in minimizing production defects, wastage, errors, and accidents. Deming advocated working to long-range plans in order to reduce uncertainty in work and production in a repetitive process of continual, incremental improvements, rather than dramatic new interventions and change of

direction. Quality-control ideas were later to find massive favour in Japan's post-war economic recovery, and their imprint was clearly visible in the later 'Lean production' or Toyota Production System approach to management and engineering (see below).

Under the 'second spirit' of capitalism organizations became rigidly structured, and roles and procedures began to be governed by clear and unambiguous roles. Organizations had tall managerial hierarchies and spans of control at each level were small, often limited to around five or six direct reports, in keeping with the prescriptions of classical writers such as V.A. Graicunas (see Cole(30, p202)). Employees were granted what was effectively a 'job for life' with generous entitlements such as pensions, health insurance and better holiday provision, and usually enjoyed either union representation or had paternalistic 'welfare capitalism' employment relations designed to obviate the need for union organizing(31). In public services, such a model reflected the Weberian traditions of bureaucratic office.

Peter Drucker, one of the foremost managerial authors of the second spirit of capitalism, in *The Concept of the Corporation* (1946), and *the Practice of Management* (1954) strongly endorsed the idea of management as a crucial role in organizations and society at large. In the US 'management' emerged strongly as a distinct role, career, and a subject that can be taught in universities and military officer training schools. The first business school was Wharton, which opened at the University of Pennsylvania in 1881. There followed enormous expansion of business schools and MBA programmes from the 1960s onwards, with curricula tending to produce generalist managers trained in marketing, accounting, personnel, and strategy and expected to be able to apply their abstract (often numbers-based) managerial principles to all firms and contexts. This process, of academicising and professionalizing management, was eventually to be continued in other nations, such as the establishment of business schools in the UK following the recommendation of the Franks Committee of 1963(32, p148). One of the forms of management that emerged must prominently from such initiatives was 'general management', a concept that was to have a major footprint on the NHS (see chapter 3 below).

Studies of what these 'professional', 'general' managers did with their time from this period (see, for example, Mintzberg(9)) reflect a technical, functional, and programmatic understanding of managerial roles. Staff and managers might have appreciated the stability of the era, but this came with certain drawbacks. Staff had to wait patiently for promotion and keep their opinions to themselves. 'Difficult' characters could be ostracised. Organizations had very few women in managerial posts, and sexist and ethnic discrimination were common(33). Rejection of such forms of exclusion, the overbearing micromanagement and control systems, and the failure and discrediting of strategic planning all helped to give rise to the demand for 'liberation' of staff from 1960s/1970s-style organizational control. Boltanski and Chiapello(26) show how the idea of liberation from the straightjacket of tight control, number-crunching, general management,

and paternalism led to the break from the second to the third spirit of capitalism.

2.3 Smashing the pyramid: Into the leadership age

The third spirit of capitalism (also known as the era of investor capitalism) marked a substantial break with the model of postwar 'business administration' and Weberian bureaucracy. Economically, the era was associated with the increasing dominance of financial interests, as institutional investors (such as pension funds, hedge funds, and private equity) pushed for the bureaucratic and hierarchical large firm to rid itself of unnecessary burdens, to become more flexible, agile, responsive to customer need, and able to deliver higher shareholder returns. Corporate takeovers (often involving highly risky, leveraged buyouts) were common in the neoliberal economies of the US and UK, and suddenly the large managerial capitalist firm became threatened by the prospect of new owners and new senior managers. Large conglomerates started to divest themselves of lines of business regarded by the financial markets as unnecessary for the delivery of shareholder value. Firms were being radically downsized, and levels of management were stripped out, to make flatter, less hierarchical organizations(1). The power shifted again – from ranks of professional, general managers of the firm (insiders) to financial investors (outsiders).

The radical managerial ideology associated with this new order changed away from the stability, order, paternalism, and hierarchy of the second spirit, to be replaced with flexibility, networks, speed, rapid decision-making and frequent shifts of strategy and position. Such change was captured in the title of Tom Peters' book *Thriving on Chaos* (1989). This third era was characterized by the replacement of 'management' with 'leadership'. This entailed rejecting the stability and orderliness of the 'second spirit' or 'managerial capitalism' and embracing the turbulence and rapidity of a more internationalized, stock-market driven capitalism, in which long service, loyalty, tradition, and dedication counted for little.

Peters and Waterman's *In Search of Excellence* (1982) was a key early marker of the changed ideology of this new era. A strong element of Peters and Waterman's argument lay in the perceived weakness and complacency of managerial capitalism. The new managerial ideology was about 'liberation' from strict organizational control. One of the most profound changes described (and advocated) was the radical shrinking of time horizons across many aspects of work and organization. 'No long term'(34) became the theme as large private firms were more likely to look to stock markets and the investor community to provide funding, therefore they had to constantly look to satisfy financial markets by demonstrating that they were lean, agile, responsive, non-wasteful, and profitable, so that the markets rewarded this behaviour with high stock prices. The performance of the share price over consecutive quarters became the main measure used

to evaluate top managers' performance. 'Celebrity CEOs' such as Jack Welch (formerly of General Electric) justified their leadership by citing '15 quarters of uninterrupted share earnings growth', or similar track records. This private sector model was dominated by speed; faster financial returns, quicker launching of new products, shorter product cycles, and snap decision-making.

Trade unions went into steep decline under investor capitalism. Traditional 'Personnel Management' was replaced by 'Human Resource Management', and training of staff was increasingly shifted out of in-service provision to third parties (such as universities and professional associations). HR departments' influenced declines as the power of financial and accounting departments increasingly came to dominate boards of directors(35). Individual employees were told to take personal responsibility for their own career management and 'employability'. Most sections of the workforce became accounted as a cost to be managed, whereas others were 'talent' to protect and reward handsomely with bonuses.

Celebrity CEOs played to an audience of 'the investor community', made up of rating agencies, media, and institutional investors. The investment community's confidence in the business models enacted by top management had the ability to make or break entire firms, even industries(36). CEOs traded in 'visions and values', and their 'leadership' was said to be about 'coaching' staff towards voluntarily embracing these values rather than micro-managing their operations.

Alongside this visionary, cultural control, however, companies continued to use strict forms of monitoring and control, which fed into employee performance, disciplinary, and bonus systems. Employees were measured by a battery of Key Performance Indicators and rewarded according to a 'Balanced Scorecard' system or similar. Companies involved in all kinds of lines of business, public or privately owned, also looked to learn from the 'best practice' in industry, such as the much-vaunted Toyota Production System. Rebadged as 'Lean manufacturing', or simply 'Lean' by Womack et al(37). 'Lean' demanded that organizations became much more customer-focused and ruthless about eliminating 'waste' in all its forms. Lean also relied heavily on processes of standardization and work intensification, leading many to suggest that it was simply an advanced form of Taylorism(38). Elements of Lean were also visible in the Six Sigma process improvement methodology widely used by US firms such as Motorola and General Electric, which again relied heavily on standards, numbers, and protocols, with cycle times for each procedure tightly measured and used as benchmarks against which to rate worker effectiveness.

Firms under the flexible regime of investor capitalism were also known for a greater use of outside hiring, including of managers. Middle and senior managers were increasingly recruited based on generalist skills; if Manager X helped to implement a Balanced Scorecard in ASDA/Wal-Mart, then s/he was brought in to do the same in the Government Department of Y.

All of the above amounted to 'a new organizational ideology'(1, p13). This ideology moved beyond scientific management, rationalism, strategic planning, and general management, by shifting into the era of flatter, less hierarchical organizations, with fewer levels of middle management, shorter job tenures, and much wider and more demanding work roles for managers. Companies were no longer dominated by insiders – they had to be more sensitive to the needs and demands of customers, and had to reorient their whole operations according to the expectations and wishes of the customer, not the company insider. This was a key theme of the 1980s and 1990s fashion for business process re-engineering(39), culture change programmes(33), and Lean operations(37). Similarly, public sector organizations needed to become more responsive to the needs of their clients (patients, members of the public), and to their funders (taxpayers). The ideology of New Public Management (NPM) was closely related to changes in the corporate world, advocating devolution of authority, decentralization, a move away from Weberian bureaucracy and towards competition, and choice(40). Public sector organizations started to embrace the new ideology of 'leadership', rejecting their earlier turn to 'general management'.

A more positive outcome of the new era was that it tended to be associated with a greater degree of openness and honesty, and a better record on gender and ethnic diversity, as the insider–dominated, clique-based form of management associated with the second spirit of capitalism gave way to a new nimbleness, a new flexibility, and higher levels of public accountability. Managerial work under investor capitalism became more interesting and less routine, as authority was devolved downwards and spans of control were widened(1). The third spirit of capitalism mobilized the idea that the age of bureaucracy, paternalism, and long time horizons was over, and that this change, rather than being frightening for employees and managers, ought to be personally liberating. Rather than being controlled by the strictness of organizational hierarchy and culture, employees were encouraged to 'just be yourself!'(41). This message was strongly reflected in managerial ideology since the early 1990s, such as Peters' *Liberation Management,*(42) and Kanter's *When Giants Learn to Dance*(33). Jan Carlzon, former CEO of Scandinavian Airlines System published his memoirs with the Swedish title *Riv Pyramiderna* or *Tear the Pyramids Down*. A clear message was that employees needed to take responsibility for their own careers, and, in doing so, the anomie and resentment built up under strict hierarchies of the second spirit or managerial capitalism would be vented as staff enjoyed the freedom and creativity 'unleashed' in new, third spirit style organization(42).

Yet the downsized, delayered and leaned organization had obvious dark sides. While flattening a hierarchy might have appeared to be a step towards democratization and liberation, it also invariably meant eliminating managerial layers (and hence positions and jobs) and expanding managers' spans of control, to numbers far above those the classicists would have deemed either sensible or manageable. Research on recent changes to managerial work indicated significant increases in workload for managers,

amid general work intensification across the whole organization (McCann et al(11); Hassard et al(1); Tengblad(8)). Not only were spans of control widened, but managerial roles became fluid and ambiguous, with the 'silos' of the command and control structure disrupted – managers were no longer expected to 'stay in their lanes', instead they were encouraged to work in cross-functional, often short-term project-based teams. Organizations and their subgroups had to endure regular restructurings, as departments and lines of business were 'spun off', privatized, sold on, or closed down altogether(1, p72). Projects, teams, and departments, even whole lines of business, were rarely given the time they needed to develop and become established before being changed and restructured once more. Research into organizations, including 'world class', or 'best practice' corporations, continued to unearth evidence of incompetence, wastage, interpersonal conflicts, low morale, heavy workloads, stressed staff, an abundance of metrics, measures and target-chasing, and corporate governance scandals. Such findings, however, did not seem to have slowed the onward march of managerial ideology into ever-wider social, political, cultural and organizational territories, including into public sector organizations and professional bureaucracies As we shall see below (chapter 3), the NHS has gone through changes in its managerial forms which closely reflect the two major trends in corporate managerial ideology described above. As we go on to explain, NHS management has moved from somewhat rigid and bureaucratic versions of general management to much more flexible, and flatter organizational forms.

3 NHS managers: An introduction to the literature

3.1 Before management: 1948 - 1982

Until the publication of the Griffiths report of 1982, management in the NHS was by consensus; agreement between members of the medical profession and hospital administrators. Medical professionals were seen as holding the dominant position and research during the 1970s suggested that consultants tended to have more influence than management teams(43, p387). Griffiths represented a major step towards greater levels of managerialism in the NHS. It introduced 'second spirit' style general management, intended to bring the NHS under tighter, more specific, and more corporate, forms of control, representing a significant shift away from its traditions of professional bureaucracy with minimal administrative supervision. Management, and managers, therefore, became much more important actors in the NHS than they once were.

3.2 Introduction of management to the NHS: 1983-1988

The Griffiths Report spurred the development of a field of literature in the social sciences/organization studies, around NHS management as a subject in itself. Researchers such as Cousins(44) and Anthony and Reed(45) focused on the Report's effects on the management of healthcare in the NHS. Cousins argued that 'the introduction of market rationality has obscured the purposes of state welfare work'(44, p211). Central to Cousins' claims about the threats posed to NHS management by market rationality was the imposition of cost reduction targets. These three themes; market rationality, policy pressures from the centre, and targets in various forms, which entered the discourse on healthcare management around the time of Cousins' article, threaded their way through the literature up to the present day. Cousins found that the introduction of general management, and the free market reforms associated with the Griffiths report, had 'created considerable anxiety, insecurity and uncertainty about their [NHS managers'] own jobs'(44, p216).

Anthony and Reed suggested that despite the introduction of more formal management structures, informal methods of management retained central importance. Utilising interview techniques, Anthony and Reed elicited responses from nurse managers that, in hindsight, could be seen to typify later findings. Nurse managers were seen as 'reluctant' middle managers in that they did not perceive themselves as such. Nurse managers found themselves sometimes torn between patient care and organizational concerns – resources and so on(45, p22).

Anthony and Reed provided a taxonomy of management roles and behaviours. In terms of roles, these authors listed:

- crisis management
- administrative chores
- task or craft based management [including coordination] and
- corporate management (45, p28).

The following behaviours were suggested:

- [the application of] personal skills,
- personal networks of relationships,
- personal obligation,
- acquired wisdom and skill,
- formal authority and
- constitutional authority (45, p28).

3.3 Middle and junior managers and the NHS market: 1989-1996

Dopson and Stewart, 1990(46) found that middle management under changing public policy currents was more stressful, and that middle managers in the public sector were more resistant to change than their private sector counterparts.

3.3.1 Doctor-manager dynamics

Elsewhere, Dopson asserted that on the basis of her findings, '*general managers have been singularly unsuccessful in involving clinicians in managing their services*…'(47, p27). Further, '*many empirical studies have highlighted the reluctance of Doctors to be involved in management as a key issue in health-care management*'(47, p28).

Dopson contrasted the '*thought style*s' of doctors and managers(47, p28), with the former focusing on evidence and short term operational goals, and NHS managers more cognisant of organizational interests. She went on to focus on the role of clinical director, which emerged, structurally, as the archetypal doctor-manager role. Basing her findings on interviews with consultant doctors, Dopson suggested that they had a largely negative attitude towards both management and managers. A similar conclusion was reached by Fitzgerald(48, p42). In her analysis, consultants taking on senior management roles were motivated primarily by a desire to maintain their professional power within the organization, to '*considerably strengthen the sphere of influence of the medical profession*'(48, p42).

3.3.2 Nurse managers and the NHS market – development of the field 1989-1996

As the 1990s progressed, interest in NHS nurse manager, as well as NHS middle manager roles began to develop. Duffield's review(49) of the literature found that the role of first line nurse manager was increasingly associated with managerial, rather than clinical functions. While Duffield argued that this could lead to an increase in job satisfaction(49, p1248), '*the transition in nursing from the role of a clinician to a manager can result in role confusion and conflict'(49,* p1248). In this, Duffield was largely in concert with Anthony and Reed (see above). Duffield noted the uncertainty experienced by first line nurse managers over whether or not they should still have been providing direct patient care(49, p1249).

Oroviogoicoechea(50) focused on the clinical nurse manager role. In her review of the literature, she found consensus on the *pivotal* organizational role played by clinical nurse managers(50, p1273). In terms of definition, Oroviogoicoechea placed clinical nurse managers firmly in the role of *first line* managers; that is, in what we might term a junior management role. Oroviogoicoechea presented six 'role functions' of the nurse manager:

1. *'Management of clinical nursing practice and patient care,*
2. *management of human, fiscal and other resources,*
3. *development of personnel,*
4. *compliance with regulatory and professional standards,*
5. *strategic planning and*
6. *fostering of interdisciplinary, collaborative relationships…'*
   (Oroviogoicoechea 1996(50, p1275-1276, italics in original).

With these functions in mind, Oroviogoicoechea concluded that decision making was the key factor in the range of human and leadership skills presented as central to the developing nurse manager role(50, p1279).

3.4 Business management, investment and reform: 1997-2009

By 1996, authors had begun to relate developments in the management of health care to what had become known as New Public Management or NPM. Hunter listed the chief dimensions of NPM:

1. *Hands on professional management in the public sector*
2. *Standard setting, performance measurement and target setting, especially for professional services*
3. *Emphasis on output controls linked to resource allocation*

4. *The disaggregation or 'unbundling' of previously monolithic units in the public sector into provider/producer functions, and the introduction of contracting standards*
5. *Stress on private sector management style and greater flexibility coupled with a move away from formal, inflexible public service ethic*
6. *Discipline and parsimony in resource use: cost cutting, doing more with less, controlling labour union demands*(25, p801) and see also Hood(51) (our italics, our numbering)

Ferlie and Pettigrew's 1996 article 'Managing Through Networks: Some Issues and Implications for the NHS'(52) represented an early example of the application of theoretical approaches drawn more explicitly from organization studies, to NHS management as a field of study. The authors argued that the NHS had, like other large organizations of the late 20th century, entered a phase where hierarchical management styles had given way to management through networks. This can be seen to relate to New Public Management, and most specifically to points 4 and 5 of Hunter's schematic, above.

The political shift to a 'New Labour' government in the UK in 1997 saw a consolidation and acceleration of changes associated with New Public Management in the NHS. Bate(53) charted the transition of a hospital from the traditional hierarchical structure to one he described as a 'networked community'. Adopting an action research approach and utilising ethnographic methods, Bate hoped to play a role in the transformation of a hospital with very low morale (essentially a failing organization) into one that operated effectively. Bate found that '*Clinical and non-clinical sides had become locked into an escalating conflict, a cultural vicious circle*'(53) (p492), an organizational example of two tribes at war. In the final analysis, Bate conceptualised the 'networked organization' not as a matter, primarily, of structure, but of culture(53, p505), hence the use of the word 'community'.

Preston and Loan-Clarke(54) adopted a similar conceptualisation, focusing on the culture of NHS organizations. Taking as their subject the flow of information within an NHS trust (the gathering and use of information as part of governance regimes being a key element of NPM), the authors surveyed the views of hospital employees, doctors and managers. Like the organization studied by Bate, Preston and Loan-Clarke found an organization with very low morale(54, p121).

Currie and Brown(55) adopted an explicitly narratological approach in their account of group and individual identities of senior and middle managers in a UK NHS hospital. While narratives of senior managers were held by the authors to perform as legitimating discourses, individuals had their own stories to tell, and they did so as part of a process of identity construction(55, p563). They noted that while the 'sectoral transference' of managers, and management styles, from the private sector initially had an empowering effect on NHS middle managers(55, p568,569), this ran up against another dynamic that typified corporate change in the last 20 years:

delayering. Thus middle managers found themselves in a vulnerable position. Once again we were reminded of the key tenets of New Public Management (see number 6 in Hunter's schematic, above), with senior managers encouraging the use of 'business plans' by middle managers, as a way of controlling ever scarcer resources(55, p571). As Currie and Brown highlighted, the construction of robust business plans by individual managers could not fully mitigate against the risk of jobs losses as part of organizational restructuring.

Preston and Loan-Clarke(56) found that NHS managers felt they were viewed negatively by the media, the general public, and even their own families(56, p104). Managers felt that their job was difficult and stressful (a theme across much of the NHS management literature) and yet their work was largely unacknowledged. Managers felt that they received pressure from all sides(56, p106) as they worked to organise the functioning of a highly complex organization.

Using the same definitions of middle and junior managers as Preston and Loan-Clarke, Merali(57, p551) used interview based methods to elicit the views of NHS managers about both their own 'culture' and the public's perception of them. Merali found that:

> *The majority of managers stated that they believed that the common and shared core values held by all NHS employees (including themselves) were mainly altruistic in nature(57,* p555).

Merali's research supported a view of NHS managers as committed to the core values of improving people's health and being socially useful, to the extent that these values were expressed by the managers themselves. However, like Preston and Loan-Clarke, managers interviewed by Merali believed that they were negatively viewed by clinicians, politicians, the media, and the public at large.

By 2005, healthcare management was well established as a field of study and was the subject of major articles by established figures in management research. Currie and Procter(13) applied role theory within a case study approach, utilising interview based methods. Across the different cases (NHS trusts), their findings were in line with much of the literature we have reviewed so far: Middle managers found themselves caught between the Scylla of apparently intransigent medical professionals, and the Charybdis of government policy, which constantly seeks new ways to drive down costs(13, p1351), often through organizational and systemic change. Currie and colleagues, writing in 2008(58), utilised a case study approach with interview based methodology, to investigate the potential 'dark side' of managing through networks.

3.4.1 NHS nurse managers under New Public Management 1997-2009

Nurse managers were a focus of attention in much recent literature on NHS management. Willmot(59) examined the transition from senior nurse to newer ward manager roles. This change in role was implemented as part of the continued and increasing emphasis on quality and effectiveness of patient care, which had come to characterise NHS policy. Willmot noted various potential criticisms of this restructuring: Firstly, the moving of expert clinical staff away from front line patient care could be seen to be at odds with precisely that – patient care at the bedside(59, p420). Further, the move away from more direct clinical work could undermine ward managers' credibility with junior staff(59, p420). Willmot also noted that the integration of clinical professionals into management structures could be difficult(59, p420). Despite these potential difficulties, many (61%) of Willmot's respondents were positive about their new role as charge nurse/ward manager;

> *I think it's brilliant. I think it's the best thing and I'm really suited to it and I love it. The role has changed dramatically and is so forward thinking. Having the power to say this is how I want things on the ward is a good feeling (59,* p422).

Some responses were less positive, with some ward managers complaining about growing distance between them and their nursing staff. Others felt distanced from patients, and wondered if their extensive experience of caring for patients was being put to best use in their more office based new role(59, p423). Increased levels of stress were noted by 81% of Willmot's interviewees, partly due, it can be assumed, to the fact that many of them also felt they did not have enough time. This finding was supported by Adams et al (60) who found that nurse managers had an increasing workload – increasing number of students to supervise being one example(60, p546). A key finding in Adam's piece was that when attempting to 'juggle' the myriad demands on their time, ward managers retained a sense of prioritising patient care above all else, often stepping in and returning to a 'hands on' role when necessary. According to Adams and indeed across the literature, shortage of staff and resources due to financial constraints was a central reason for increased work intensity and longer working hours. In the cost conscious environment of the NHS, nurse managers often preferred to do patient-facing work themselves, in order to save money on additional staffing costs(60, p547).

Insightfully, Bolton(61) noted that in hospitals, the traditional hierarchy of roles in society was to an extent reversed, with practitioners such as nurses held in higher esteem than managers. Reflecting the literature on views of NHS managers discussed earlier, one of Bolton's respondents asserted that '*Managers don't know their arse from their elbow'*(61, p126).

Rather in the same vein as Bolton's informant, one of Cooke's interviewees was a nurse who asserted that '*We have seagull managers here, they fly in from a great height, make a lot of noise, drop a lot of crap, then they fly off again*'(62, p223). In a policy setting emphasising both empowerment for the consumer of health care as well as for nurse managers, Cooke's conclusions were that empowerment in the latter case was largely illusory and served as a veil for work intensification(62, p224). Cooke was in fact quite scathing about the whole project of New Public Management, which could be seen overall as a means of extracting more work for less money, whilst at the same time maintaining de-facto hierarchies under the guise of flexibility and decentralisation(62, p224). The contradictions of NPM were summarised thus:

- Increase political control but free managers to manage;
- Save money but raise standards;
- Motivate and empower staff but intensify work and downsize;
- Reduce bureaucracy but increase audit, measurement and juridification;
- Decentralize responsibility but centralize control(62, p224-225).

In this looking glass world, '*[m]iddle managers also felt the conflicting pressures of their role intensely*'(62, p233). Whereas Bolton noted that managerial work tended to lack cultural value amongst nurses, Cooke noted that nurse managers had begun to adapt to an alternative view emanating from more senior management strata, a view that dealing with 'strategic' issues was of more value and conveyed greater status than day-to-day operational issues. It was thus possible to see how the competing value systems of different groups could place the nurse manager in an invidious position. The result? According to Cooke and in common with much of the literature already discussed; increased stress and sickness levels.

By 2004 nurse managers were often being referred to as 'hybrid managers'. See for example Savage and Scott(63) and Dopson and Fitzgerald(64). The role of Modern Matron (introduced in 2002) was described by Savage and Scott (and citing Hewison(65) p113) to embody this hybridity, which they described thus:

> *Modern matrons can be seen to fit the model of hybrid management: i.e. a new type of management in which non-medical health care professionals engage in aspects of general (or generic) management, combining this with their clinical management responsibilities*(63, p418)

A key element of hybrid managers' roles, according to Savage and Scott was to serve as a manager who could span the boundary between senior

management and front line staff(63, p421). Thus the concepts of 'hybrid manager' and 'boundary spanner' were clearly related.

By this point in the historical development of NHS middle management, nurses and other clinicians in the NHS were increasingly expected to demonstrate qualities of 'leadership' as well as management. Oliver, provided a succinct overview of leadership issues(66), (and see Royal College of Nursing(67)), writes:

Leaders in the modern NHS were expected to:

1. *Improve the quality of patient care.*
2. *Influence improvements in the health of the population.*
3. *Promote the NHS as being well led, well managed and accountable.*
4. *Lead on strategies to motivate and develop NHS staff.*

3.5 Post-managerialism; leadership, targets and Lean management in the NHS: 2010-date

Martin and Learmonth noted the upward discursive trajectory of concepts of leadership in the NHS. Their perspective on leadership was more critical than in much of the literature. For these authors, leadership was '*generally seen as a nefarious political project, one concerned with facilitating subtle forms of control: leaders seducing their followers into accepting what may not be in their interests'*(68, p2). The authors, from a theoretical position that was self consciously reminiscent of the work of Foucault, argued that discourses of leadership were intended to influence healthcare workers' subjectivities; that is, their sense of self. By having NHS managers, for example, 'buy in' to the leadership discourse, policymakers and senior managers were able to co-opt them into ongoing reforms which may not have been in their best interest. This was certainly an analysis which would fit in with the concepts associated with New Public Management; decentralisation(68, p5), individual initiative and entrepreneurialism, 'flattened hierarchies' and 'patient as consumer'. Martin and Learmonth, however, asserted that policy and trust management discourse presented an image of ownership and leadership at local levels, but that ultimately, real power continued to lie with the centre(68, p5). Such power was enforced (enacted, perhaps?) through inspection regimes, performance targets (and ultimately, one would assume) resource allocation. Discourses of devolved leadership could serve to obviate this contradiction in the consciousness of workforce and patients alike. In suggesting that seemingly liberatory management discourses could be ideological vehicles for more effective domination of the workforce, Martin and Learmonth's analysis was similar to that of Cooke(62).

The Healthcare Commission (latterly known as the Care Quality Commission) in March 2009 published an 'Investigation into Mid Staffordshire NHS Foundation Trust'. This report was highly critical of the

use of performance targets in NHS management. Hood(69) noted the risks associated with targets in the NHS in particular. While authors tended to acknowledge that target setting had been successful in some cases – reducing waiting times in accident and emergency, for example, many have been critical of the inflexibility of centrally set targets(70). This somewhat ambivalent approach recognised that while target based governance regimes were problematic, the 'absence of an effective hierarchy' in the NHS made their use unavoidable(71).

Gould(72) noted, in the wake of the Mid Staffordshire scandal, that

> *true quality care becomes a reality, not through bureaucratic processes, but by understanding the hidden personal drivers of individuals which cause them to choose one over the other*(72, p204).

More recently scholars of healthcare management began looking at the use of 'Lean' management techniques in a healthcare setting. Waring and Bishop(73) argued that Lean techniques might not be directly translate-able from industrial to healthcare settings. Further, some of the apparent performance improvements achieved by Lean techniques appeared to result from work intensification and heightened (peer) supervision(73). In a similar manner to Cooke's take on empowerment(62), and Martin and Learmonth's(68) analysis of discourses of leadership, Waring and Bishop considered the rhetorical status of Lean. Lean 'thinking' could be seen to synthesise, rhetorically at least, the direct functional priorities of management – efficiency, and clinicians – patient care. This ontological synthesis was achieved by creating a supposed logical trajectory from the first set of priorities to the second; improve efficiency, improve patient care.

That Waring and Bishop found elements of resistance to Lean was consistent with the foregoing literature on NHS management examined here, and further demonstrates the tensions involved in reforming a massive organization with a unique workforce composition and with significant social, cultural and perhaps even moral and ethical resonances.

4 Theory and method

The aim of this chapter is to outline the theories and methods we have considered, developed and utilised in carrying out our research. We do this in four phases. First we summarise our initial consideration of various theoretical and methodological options in the process of developing a research position appropriate both to the aims of the project and our skills as a research team. Second we discuss the theoretical issues that have influenced our development of a bespoke research perspective and method. Third we outline the approach to theory and method developed and how this contributes to research in management and organization studies. And fourth we describe the process by which we have applied our theory and method in studies of managerial roles and behaviour in health service settings.

4.1 Theoretical and methodological issues

The first phase of the research process was our initial consideration of the various research options presented to us, their appropriateness to the project aims proposed, and how as a team we felt these married with our own methodological skills. In our initial meetings one of the first tasks we set ourselves was to define and locate an appropriate research paradigm for our theoretical and methodological enquiries. Although the four members of the research team had skill sets relevant to one generic research field - management and organization studies (MOS) - they individually came to this from various social science disciplines, viz. psychology, social psychology, and sociology. The first objective, therefore, was to develop a common theoretical and methodological outlook, one that would facilitate coherent research by a team that 'sang from the same hymn sheet.'

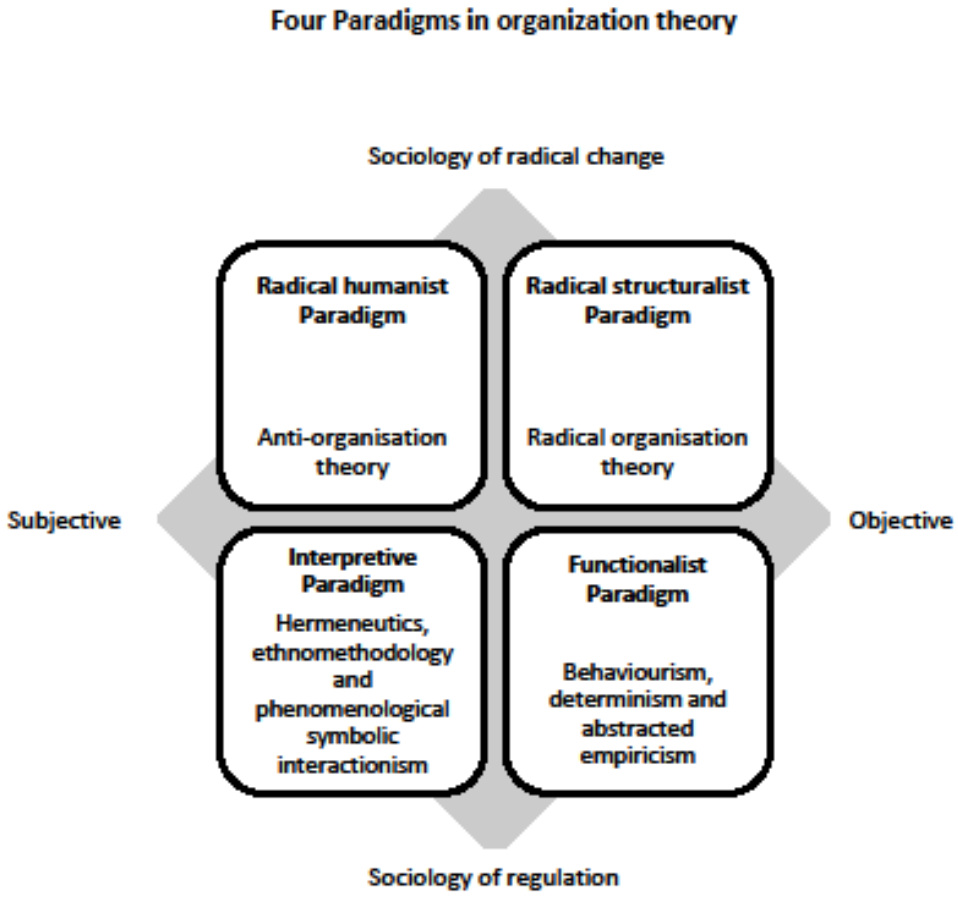
Our early meetings were focused on establishing a unified perspective on research options and their appropriateness to the project. To accomplish this it was suggested that we go 'back to basics' and consider epistemological issues (concerning the nature of knowedge) and how these would relate, logically, to the choice of an appropriate methodology. It was hoped that a philosophically oriented approach would provide us with a integrated perspective on the research options available to contemporary MOS.

To arrive at this common position the research team conducted a methodological 'reading programme' from the start of the project. So as not to delimit methodological options prematurely we familiarised ourselves with work that offered a broad sweep of intellectual terrain in MOS. One contribution that immediately came to mind was work associated with the well-known model of research paradigms provided by Burrell and Morgan(74) (see also Morgan(75) and (76)). This model offered the advantage of not only familiarising us with a range of research literatures and styles in MOS, but also, in addressing the various philosophical

principles which underpin them, tools to consider how different methodological positions could potentially be adapted in novel ways to meet the needs of this specific project - basically a contingency orientation.

Put briefly the Burrell and Morgan model (see Figure 1, adapted from Burrell and Morgan(74)) classified MOS theories and methods through a matrix based on the intersection of two sociological axes - subjective-objective and regulation-radical change. This was basically a reworking of the traditional sociological dualisms of agency-structure and consensus-conflict, respectively. The resulting 2 x 2 matrix produced four major paradigms: functionalist, interpretive, radical humanist, radical structuralist. These four paradigms are founded upon mutually exclusive views of the organizational world; each stands in its own right and generates its own distinctive analyses. Taken together these paradigms offered a map for negotiating the various subject areas of MOS, one which presented a convenient means of identifying similarities and differences between the works of researchers, and in particular, the underlying frame of reference they adopted. Above all the Burrell and Morgan map provided an expedient means of locating a researcher's own personal research frame of reference with regard to a range of other research styles that have contributed to MOS.

Figure 1. Burrell and Morgan model



The research team noted from the start, however, that despite the Burrell and Morgan model being one of the most celebrated and cited works in the history of MOS, it was a model produced three decades earlier. As such, the question remained of how applicable it was for contemporary theoretical and methodological developments in MOS. We therefore set ourselves the task of reviewing and accounting for generic developments in theoretical and methodological thinking in the interim period.

These discussions suggested that in addition to the main social science orders discussed by Burrell and Morgan - structure and agency (or as we redefined them, structural and anti-structural positions) - recent decades have also seen a so-called 'third order' of sociological analysis come to the fore, in the form of post-structuralism and more broadly postmodernism. So as to appreciate the range of methodological options available for contemporary MOS enquiries we directed ourselves to mapping the intellectual terrain of MOS research post-Burrell and Morgan, this being our first contribution to theoretical and methodological innovation.

Tables 2 and 3 summarise these early discussions about the development of MOS in the post-Burrell and Morgan period and the domains of research that currently present themselves. Our analysis adopted the framework originally developed by Burrell and Morgan model in arguing that theories of management and organization inherently reflect a 'philosophy of science' and a 'theory of society'(74, p1). For the former we proposed an argument that research in MOS that has adopted a broadly post-structural or postmodern approach can be characterized as ontologically relativist, epistemologically relationist, and methodologically reflexive; it is also work that, in 'decentring' human agency (which implies the absence of human agency), is arguably deconstructionist in its orientation to human nature. Although other terms from social theory and philosophy can be substituted to characterize such third-order analysis, we have argued that these are particularly expedient for researchers' purposes.

Table 2. New meta-theories for MOS paradigms

	Structural paradigm	**Anti-structural paradigm**	**Post-structural paradigm**
Ontology	Realist	Nominalist	Relativist
Epistemology	Positivist	Constructionist	Relationist
Human nature	Determinist	Voluntarist	Deconstructionist
Methodology	Deductive	Interpretive	Reflexive

When we expanded this analysis to consider Burrell and Morgan's second dimension - 'the nature of society' - we found our three core MOS paradigms expanded into six research domains. Table 2 lists these domains together with examples of the theories, theorists and research that

comprise them. This analysis was realised by delineating the underlying political and ideological assumptions of scholarly communities within our three paradigm orders. In so doing, to make sense of such assumptions for contemporary analysis, instead of deploying Burrell and Morgan's original terminology of the sociology of regulation (a consensus theory view) and sociology of radical change (a conflict theory view), we have felt it more appropriate to talk instead of differences between 'normative' (Habermas(77); Jacobs & Hanrahan(35); Peters(78)) and 'critical' (Alvesson & Wilmot(79) and (80); Grey & Wilmott(81); Parker(82)) accounts, especially given the now established use of the latter term as an identifier for ideologically Leftist analysis across several MOS traditions(83); see also Alvesson & Deetz, 2000(84); Corbett et al(85); Deetz(86)).

Table 3. MOS research domains: Theories, theorists and research

Paradigm	Research Domain	Sociological Theories, e.g.	Influential Theorists, e.g.	Organizational Research, e.g
Structural	**Normative structural**	Institutional theory Population ecology Social systems theory	Philip Selznick Eugene Odum Vilfredo Pareto	Scott (1995) Hannan & Freeman (1989) Roethlisberger & Dickson (1939)
Structural	**Critical structural**	Labour process theory Radical Weberianism Socialist feminism	Paul Baran Max Weber Shulamith Firestone	Braverman (1974) Mouzelis (1975) Walby (1986)
Anti-structural	**Normative anti-structural**	Ethnomethodology Phenomenology Social action theory	Harold Garfinkel Edmund Husserl Alfred Schutz	Bittner (1967) Holt & Sandberg (2011) Turner (1971)
Anti-structural	**Critical anti-structural**	Anti-organization theory Critical discourse Critical theory	Herbert Marcuse Norman Fairclough Jurgen Habermas	Silverman & Jones (1976) Phillips et al (2008) Clegg (1975)
Post-structural	**Normative post-structural**	Actor-network theory Archeo-genealogy Process theory	Bruno Latour Michel Foucault A. N. Whitehead	Hardy et al (2001) Hodgson (2000) Tsoukas & Chia (2002)
Post-structural	**Critical post-structural**	Autonomism Post-structural feminism Post-colonialism	Antonio Negri Julia Kristeva Gayatri Spivak	Harney (2007) Thomas & Davies (2005) Jones (2005)

Based on ideological characteristics, therefore, we have argued that our three paradigms reflect the following analytical domains: normative structural; critical structural; normative anti-structural; critical anti-structural; normative post-structural; and critical post-structural.

This initial exercise allowed us, to become familiar with the range of methodological and research opportunities available within MOS and on this basis to begin to look for goodness-of-fit with the specific aims of our project. Our model formed the generic basis from which methodological options could be narrowed down. It formed a springboard to developing our own theorising and a unified or common research position. This line of analysis was considered particularly useful in that it not only allowed us to reflect on methodological appropriateness (through the comparison of various 'subjectivist' and 'objectivist', and thus qualitative v quantitative, strategies and methods) but also the nature of political interpretation, reflective sociologically of traditional consensus versus conflict perspectives. This was deemed particularly apposite in light of the concept of ideology (and in particular neo-liberal ideology) being one that, from our early literature searches and discussions on healthcare management, loomed increasingly large.

4.2 A hybrid research position: Integrating action theory and critical theory

Given the back-cloth provided by our initial methodological review, the next stage in our research process saw an attempt to determine, as per our research model, a social science orientation appropriate to the political context of analysis. This would see our various theoretical and methodological interests considered vis-à-vis specification of a formal research position.

On the one hand, for our 'theory of social science,' the first three aims set out in our research proposal specified examination of the: 'realities,' 'roles and behaviour,' and 'interactions' of healthcare managers in NHS organizations. In terms of sociological investigation, the research direction suggested by these aims was an interpretive approach, founded upon a constructionist epistemology, or the view that the only reality we can know is that represented by human thought. (Note: The fourth aim, to 'build knowledge,' is represented, for example, by this report, plus dissemination via practitioner workshops, conference papers, and journal articles).

On the other hand, for our 'theory of society', the election of a new UK government and its launch soon thereafter of a White Paper directed at 'Liberating the NHS,' appeared to reflect, contextually, a heightened political and ideological climate for healthcare and its management. This was a context which, in Burrell and Morgan's terms, appeared to be characterised arguably by 'change, conflict, disintegration and coercion' more than

'stability, integration, coordination and consensus'. That is, a context reflecting, sociologically, 'radical change' more than 'regulation'.

The research orientation which seemed appropriate to our project needs, therefore, appeared one that would marry a methodology characteristic of 'interpretivism' (the view that the social world may not be subject to the same methods of analysis as the natural world, or in our terms 'normative anti-structuralism'), with a theoretical position directed at understanding the influence of political and ideological forces, such analysis potentially reflecting a 'critical anti-structural' approach. Thus, our discussions drew us to explore the possibilities for developing a hybrid approach to research, one representing a blurring or synthesis of two established sociological traditions – 'Action Theory' and 'Critical Theory'.

In our research, the influence of Action Theory (strictly speaking Social Action Theory) stems primarily from an attempt some decades ago to develop an alternative sociological analysis of organizations in work by David Silverman (who in turn was drawing upon action theory as developed variously by Max Weber, Alfred Schutz, Wilhelm Dithery, and Peter Berger). In Silverman's work on the 'Action Frame of Reference'(87, p126-7), for example, he argued that sociology should be concerned with phenomenologically understanding, rather than postivistically observing, behaviour, with this distinction being crucial in that here it is meanings that define social reality rather than social reality being self-evident through inspection. As meanings were predisposed to deteriorate they required regular reaffirmation in everyday actions. Social reality did not just occur 'out there,' but instead had to be made constantly to re-occur inter-subjectively. The inference was that through social interaction people could adjust and even change meanings.

The other main influence on our methodological position has been Critical Theory. Following discussions at a two day workshop in June 2010, during which much of the 'brainstorming' discussion turned on issues of knowledge, language and ideology in healthcare politics (at both national and local levels), we directed our theoretical attention to ideas associated with, for example, Antonio Gramsci and the concept of 'ideological hegemony' (which theorises the way in which relationships of domination are embedded in the dominant ideas of society), Herbert Marcuse and 'technological rationality' (which posits that rational decisions to incorporate technological advances into society can change what is considered rational), and especially Jurgen Habermas and 'communicative distortion' (or latent strategic action); in other words, thinkers whose work was associated centrally with understanding the relationship between, ideology, society, and language.

On examining their work we started to consider whether such theorising could be married to our suggested methodological stance - stemming from Action Theory - of constructionism and interactionism. In line with writing on Critical Management Studies (Fournier & Grey(83); Alvesson & Willmott(80)) our discussions suggested increasingly that 'critical' social scientists accept it is necessary to appreciate the lived experience of people

in context, a view which our reading suggested Critical Theory also shared with the ideas and methodologies of some interpretive theories. What made scholarship in Critical Theory different from our interpretive methodology, however, was that it interprets social action and the symbols of society in order to understand the ways in which social groups are ideologically dominated. For Critical Theory 'knowledge is power' - it asks questions about the ways in which competing interests clash and the manner in which conflicts are resolved in favour of particular groups.

A major focus of Critical Theory therefore is communication, which is addressed through two kinds of problems. On the one hand the 'politics of textuality' concerns the various ways that media produce encoded messages, audiences decode those messages, and the power and domination apparent in these processes. Research on this theme might examine, for example, the ways certain kinds of media content are produced and how those depictions are understood by audiences so as to perpetuate or oppose the power of dominant institutions, such as government. On the other the 'problematic of culture' examines the relations among media, other institutions, and the ideology of culture. Researchers are interested in how the dominant ideology of a culture subverts other ideologies via social institutions. Crucially, like interpretive analysis, both emphasize the ways social forces are produced and reproduced in the daily activities of individuals, groups, and institutions. The task such analysts address is revealing how such ideological forces operate in society, with their method being directed at exposing the underlying tension between opposing forces. The argument is that only by becoming intimately aware of such forces, for example, in an ideological power struggle, can we genuinely question the nature of political motives.

Central to our concerns has been Habermas's(88) early and influential work on the concept of the 'public sphere,' where he takes as a point of departure work by the Chicago School, and focally notions of the ideological and 'consciousness-shaping' function of media. Habermas' argument here is that the public sphere is realised in every conversation where individuals assemble to form a public body. This sphere mediates between society and state, where conversation is critical to the construction of that entity we call 'the public.' Like the Chicago School, Habermas argues that the creation of opinion takes place at the community and peer-group level. In other words, that the formation of a rational public depends upon the information available, together with the situations available for discussing the significance and the meaning of information. Such explanations suggest that the representations of social reality we receive depend upon organised effort for their production and dissemination. In studying the political context of management and organization therefore the emphasis we take from Habermas is on the means and experience of communication in work, institutions and society.

In sum, the suggestion is that communication practices are an outcome of the tension between political creativity in framing messages and the social reception of them. It is the job of the 'critical' theorist to identify ideology

in such as way that alternative explanations of such ideologies can be heard. Here an ideology can be defined as a set of ideas that structures a group's notion of reality, a system of representations or a code of meanings governing how individuals and groups see the world(89).

4.3 Methodology: A critical action approach

Our discussions on research positioning, therefore, suggested the adoption of what Clifford Geertz(90) once referred to as a 'blurred genre' - one in which social researchers access concepts from across disciplines and utilize various frames of reference in their work. In our research the suggestion is that we should blur the domains of Action Theory and Critical Theory, with the goal of providing what we might call a 'Critical Action Theory' approach for MOS, and specifically in relation to healthcare management.

We have noted how interpretive research has emphasised the importance of symbolic action and social interaction. Here findings represent the researcher's interpretation of informants' interpretations of, and negotiations with, their experiences, through words, symbols and actions. We have also suggested that the emphasis that the interpretive researcher places on human agency and localized experience may appeal potentially to 'critical' management scholars, who seek an alternative to the 'over-determinism' characteristic of mainstream structural and functional research. However despite the potential theoretical and methodological rewards from such a synthesis, there appear to have been relatively few attempts to reap them. Those works that come to mind are mainly contributions from work and organizational sociology before the so-called 'defeat of the Left'(91) in Marxist scholarship or the 'death of the subject' (i.e. the human subject) under postmodernism.

In MOS perhaps the most notable examples of a synthesis or blurring of Action Theory and Critical Theory appeared in the mid-1970s; in particular Huw Beynon's(92) study of car workers' experiences of 'factory class consciousness' in Working for Ford, Stewart Clegg's(93) analysis of power relations on a construction site in Power, Rule and Domination, and Paul Willis's(94) study of how 'working class kids get working class jobs' in Learning to Labour. Despite the higher sociological profile of Working for Ford and Learning to Labour, Clegg's work represents perhaps the most theoretically and methodologically explicit statement of a synthesis of the kind we have in mind (possibly because the book was based on his doctoral research). Clegg's thesis on how organizational power relations can only be understood as part of a wider 'form of life' resonates strongly with the hermeneutic critique of our focal social theorist, Habermas, as well as other critical theorists interested in the role of language and ideology in the construction (and 'communicative distortion') of social life. In Clegg's work however the accent is placed more strongly on 'critique'- and focally Marxist critique - than 'action,' whereas our approach seeks to achieve a more equitable balance between ethnographic inquiry and ideological criticism.

Apart from the 'defeat of the Left' and 'death of the subject', another reason for a lack of popularity in contemporary sociological investigation may reflect the view that our preferred research position of 'Critical Action' actually appears oxymoronic. A view often expressed in Critical Management Studies is that interpretive research in MOS, commonly realised through ethnographic field studies, tends to be rather atheoretical. Alternatively, 'critical' scholars are frequently deemed to be too ideological in their theoretical orientation, and thus excessively biased in their research evaluations. For some sociologists therefore the blurring of research domains on the lines we suggest may represent an uneasy alliance, one which raises serious questions about the compatibility of theory-driven social agendas and interpretive field research.

We argue however that this is to neglect the many advantages of adopting a Critical Action approach for MOS research. Although not laying out a programmatic research strategy or systematic theory for Critical Action, Willis' Learning to Labour acts almost as a poster child for such an endeavour, notably though his description of how ethnography can provide a methodological vehicle for advances in critical theorising:

> *The ethnographic account, without always knowing how, can allow a degree of the activity, creativity and human agency within the object of study to come through into the analysis and the reader's experience. This is vital to my purposes where I view the cultural, not simply as a set of transferred internal structures (as in the usual notions of socialization) nor as the passive result of the action of dominant ideology downwards (as in certain kinds of Marxism), but at least in part as the product of collective human praxis(94,* p3-4)

Ethnographic research, therefore, allowed Willis to situate his working-class adolescent informants as more than mere victims of 'false consciousness': Instead he portrays them as rational actors who clearly perceive the structural constraints on their social class, but who nevertheless, through their opposition to dominant culture, adopt the attitudes that predestine them to a life of factory labour.

In line with interpretive ethnography, the methodology of Critical Action adopts similarly a qualitative method. This is one directed at understanding cultural phenomena which, in turn, reflect the system of meanings guiding the actions of a social group, in our case healthcare managers. Critical Action also shares with interpretivist ethnography the belief that research subjects' perceptions of social reality are themselves theoretical constructs. While subjects' constructs are more 'experience-near'(95) than the researcher's, they remain, nevertheless, reconstructions of social reality.

On the other hand, Critical Action diverges from traditional interpretive inquiry is maintaining that the subject's reconstructions are frequently

infused with meanings that reproduce subjugation, and that subjects' cognisant representations serve to maintain social phenomena as much as to explain them. In Critical Action research the emphasis is not so much on ordaining the subjects of study as revealing their sociological essence. Such a perception is not restricted to the subjects themselves, but also directed at sociological concepts related to an interpretive inquiry.

Thus concepts typically deployed to construct theory and explanation in MOS - such as 'empowerment,' 'leadership,' and 'change'- are not necessarily treated as neutral descriptors of organization, but potentially as signifiers of wider, frequently ideological, processes that are reproduced in the social arena under investigation. In other words, under Critical Action Theory 'management' concepts are ideological when they promote the reproduction of particular social and economic relations. In studies of healthcare management, for example, a Critical Action account would not treat concepts such as 'choice,' 'Lean' and 'quality' as unproblematic, but potentially as ideological elements whose accepted definition and maintenance can operate to the benefit of wider political interests, associated perhaps with a neo-liberal epoch.

In fieldwork, therefore, a Critical Action study would entail more than accounting for wider macro-level forces that influence the local domain being investigated. Instead Critical Action would suggest that such external factors are a fundamental part of the internal composition of that domain, and should be recognised as such even at the most micro level of interaction. A Critical Action approach suggests that the social production of meaning in work organizations is intrinsically linked to economic and political concerns, and that the ideological character of organization is habituated in the infusion of such economic and political interests in 'everyday' knowledge, elements of which may take reference to MOS knowledge itself.

Finally, in some respects Critical Action Theory resonates with what Fairclough(96) has described as the 'macro' and 'meso' level concerns of Critical Discourse Analysis, notably through concern with language, social context, and issues of political ideology and how power relations are reproduced. Critical Action Theory, however, through its primary recourse to ethnographic rather than textual investigation, offers a more anthropologically-oriented analysis, one which places the social subject - rather than just language forms -at the centre of the sociological stage. This reflects its origins in ethnographic and interpretive sociology, rather than in critical linguistics. Further, at the 'micro' level of analysis, Critical Action Theory is far removed from the focus on syntax, metaphoric structure and other elements of linguistics characteristic of Critical Discourse Analysis. Above all, under Critical Action Theory the human subject is 'thrown into the world alive and kicking,' rather than being - under genres of postmodernism, for example - philosophically 'dead'.

4.4 Critical action in healthcare research

In this chapter, we have offered a general introduction to the assumptions underpinning theory and method in forms of research conducted. The aim has been to introduce the research philosophies at the heart of our examination of managerial work in four healthcare settings: an Acute Trust, an Ambulance Trust, a Mental Health Trust, and a Primary Care Trust. In the chapters which follow we explain these investigations into the 'realities, 'roles and behaviour' and 'interactions' of healthcare managers in greater detail, notably in terms of how they deal with the demands of a neo-liberal economic agenda, and specifically with the policies and practises associated with the New Public Management.

For each case organization our research has been framed by the theory and practice of our preferred Critical Action Theory, a hybrid approach developed from Action Theory and Critical Theory. In terms of fieldwork, this has seen the development of an ethnographic approach to investigation, one founded on two qualitative research techniques based on interviewing and observation. Our interviews have been based mainly on a semi-structured instrument directed at addressing issues related to the aims of the project (see Appendix1). In addition, we conducted a small series of interviews that were largely unstructured, this being the case, for example, with some recently 'out-placed' healthcare managers interviewed near the end of the fieldwork. The interview process generally saw managers interviewed at their place of work, and commonly in their offices, or else a private room if a manager worked in a shared office or open-plan setting. Exceptions were for our out-placed managers and interviews with academics who are experts in a certain field of healthcare management research (which were all held at Manchester Business School). The duration of interviews was generally between 60-90 minutes, although in some exceptional cases they could last for over two hours. The process of interviewing generally saw one or two members of the team meeting with a single interviewee and recording the discussion on a digital recorder. These recordings were transcribed subsequently by an external agency. On one or two occasions however interviewees were reluctant to have their views digitally recorded, and so the interviewer(s) took detailed notes by hand. On other occasions informal interviews were documented by hand as appropriate. In total 80 recorded interviews and 39 unrecorded interviews were conducted during the period of field investigations.

In addition to semi-structured interviews, our fieldwork also involved periods of qualitative observation, specifically non-participant observation. This research concerned, in the main, observations of managers at work, team meetings, board meetings, and training sessions. Data were recorded mainly by hand-written notes, made either at the time of observation or in the period immediately afterwards. These notes represented the direct description of events, plus reflections and comments on particular issues and incidents. During the fieldwork, the team conducted 53 periods of non-participant observation (319 hours in total), with a period, in terms of duration, lasting anything from a one hour meeting to an all day training

session, to a day spent 'shadowing' a manager. We must note, however, that while such observational research had been envisaged at all four case sites, due to the government's healthcare White Paper of summer 2010, access negotiations resulted in this only being feasible at three - the Acute Trust, the Ambulance Trust, and the Mental Health Trust. In the case of our Primary Care Trust (the last of our case organizations to be researched) it was felt by our access gatekeepers that, at this time, observation of managers and meetings would be too sensitive, and notably so given that the Human Resources Department was one of the areas to be studied. As such, an agreement was reached that access would be permitted to the organization, but that we must restrict our analysis, almost exclusively, to interview-based research.

Therefore, in the chapters which follow we describe our research is terms of four case study accounts. As noted, these accounts reflect our preferred theoretical and methodological approach of Critical Action Theory. In addition they also reflect elements of the approach to qualitative case research and theory building described by Eisenhardt(97). To provide a logical explanatory structure, in each case we present our data in terms of three areas of investigation: managerial context, managerial roles, and managerial behaviour. This structure is adopted so as to discuss our main research themes at three levels of analysis: macro, meso and micro. Thus our analysis of managerial context deals with macro issues of ideology, policy, and governance; of roles with meso issues of responsibilities, domains, and practices; and of behaviour with micro issues of attitudes, experiences and perceptions. Although such categories offer a basic guide for analysing relevant issues of policy, practice and perception, as this research is based on the qualitative analysis of ethnographic data, we do not suggest that these levels of analysis are hermetic or discrete. Rather, they frequently reflect overlaps in terms of influence, meaning and understanding.

Thus the he process of analysis has largely been that of traditional ethnographic interpretation in organizational settings (Turner(98); Van Maanen(99); Watson(100) and(101)). Although all members of the team undertook Nvivo training in the early months of the research, rather than deploy a qualitative software package, exclusively, for the coding and classification of data, the research team has also generated its own grounded criteria relevant to the project. It can be argued that this approach is more closely aligned with the interpretivist philosophical assumptions (ontological and epistemological) of ethnographic organizational enquiry and with those of Critical Action Theory in particular.

Finally, we should also note here that our methodology is not without its logical shortcomings. Common criticisms associated with the style of research we have adopted include for example researcher bias in data collection, subjects affecting the outcome of the research, and subjects themselves being affected by the presence of researchers. In adopting an ethnographic method that is underpinned by a Critical Action Approach we have attempted as far as possible to ameliorate these problems by

appropriate research design and professional research practice. There are however additional methodological limitations linked specifically to the nature of this research project. Notable here are problems related to location and temporality, especially with regard to the PCT case. As explained later, in this case study the initial aims and objectives of the research were in some ways undermined by political events emanating from a change of government and notably the impact of a White Paper. In the case of the PCT therefore the aims of the research were adapted to contextualise the changing political and strategic environment and the potential influence this would have on the roles and behaviour of healthcare managers.

4.5 Conclusions

The aim of this chapter has been to introduce the nature and philosophy of the research process undertaken in the course of this series of investigations. In particular we have described various theoretical and methodological issues reflected upon vis-à-vis meeting the aims of the project. This has seen a largely chronological description of our activities - from our early discussions of the epistemological options (or paradigm research domains) available to us, through developing a formal position on theory and method ('Critical Action Theory'), to realising this research approach methodologically in ethnographic fieldwork investigations.

5 Case study – Acute Trust

The acute trust, which we refer to as 'Millford Foundation Trust'[3] was the main provider of secondary health care services for the people of 'Millford' as well as some parts of 'Millshire'; a catchment area of around 350,000 people. The main site was around 2 miles from the centre of Millford, itself a large town. The inclusion in the catchment area both of urban and rural, affluent and deprived areas, meant that Millford served the needs of a diverse population. The trust had an annual budget of £188,000,000 and employed 4100 staff across 4 sites. There were 873 beds at Millford, allowing for treatment of 305,000 patients during a typical year.

Situated in a suburb of Milltown, Millford Foundation Trust could be accessed through a myriad of roads, walkways, gateways and doorways, giving visitors the impression that it was physically, as well as organizationally, embedded in the local community. Reinforcing the impression of local embeddedness was the fact that many staff lived locally and could be seen walking to and from work. Staff and patients who were not fortunate enough to live within walking distance had to take their chances either with the bus, or with a hotch-potch of surface level, and hastily constructed steel alloy two storey parking areas. At busy times such as visiting hours, private cars and taxis crawled around looking for free spaces.

Like many historically established acute trusts, Milltown's estate was a mix of late twentieth century, Victorian and post 2000 buildings, presided over by the looming forms of the laundry, boiler and incinerator chimneys. Following an expansion in government funding for NHS capital projects during the years 1997-2009, it was the new buildings that now dominate visually, many replete with reflective glass and automatic doors. The heart of the hospital remained a large Victorian building, albeit one which was now mostly obscured by the modern editions that had attached themselves to what was once its exterior; they comprised a virtual case study of the development of architectural trends from the 1960's to the 2000's. For patients and visitors, the hospital was bright, clean and as welcoming as one would want. In the main building, the oldest part of the hospital, there was a new cafe, a small shop and a (deservedly) popular canteen which was open to both staff and visitors. Staff offices were predictably functional, even at senior level. For many middle managers, it had to be taken as read that one's office was less than permanent; this was particularly the case for managers working on one, or a series of, 'projects' – a group which was expanding.

[3] The names of participating organizations, participants and role titles have been substituted with fictional names to comply with the terms of consent. The name Millford indicates health organisations operating in overlapping health economies. In addition, certain particulars, such as job title or department, have been adjusted to ensure that the identities of participants and organizations remain obscured.

Having considered the trust as a site within the local community, we began to explore its characteristics at the macro level in the sense of its relation to national policy frameworks, and the tenor of its organizational ideology. As one of 10 hospitals to become a foundation trust in 2004, Millford was a healthcare organization very much steered by the concepts embodied in the foundation trust model; most notably, a 'business' orientated approach. The organizational - that is to say corporate – culture at the trust emphasised the need for financial awareness on the part of managers and non-managers alike. The trust was focused on the reduction of waste as a way of reducing costs, and this was reflected in the Lean Hospital Program (a local expansion and adaptation of a national initiative). Whilst the issue of finance was an ever present one in discussions with, and observations of, managers from executive to junior level, it was embedded in the context of patient care. That is to say, cost savings were seen as both a way of managing resources effectively in order to deliver continually improving patient care, and concomitantly, minimising the impact on patient care of shrinking resources in both the medium to long term. In turn, the trust had to maintain a level of patient care and medical outcomes that ensured continued funding from commissioners, at the same time as avoiding financial penalties for failure to do so. These dynamics were explicitly understood at all levels of management at the trust.

The top management team at Millford were highly strategically aware and prioritised the dissemination of strategic priorities (such as the introduction of Lean management systems). For the level beneath that of the Chief Executive, Secretary, Trust Operations Manager and Directors, strategic priorities were disseminated at fortnightly briefings for middle managers at the more senior end of 'middle' – Associate Directors and other key figures from the four main business groups. These presentations, delivered by the Chief Executive and trust directors, centred on a presentation by the Chief Executive covering the trust's present and future financial position as well as key issues such as staff sickness levels and monitoring procedures, waiting times and infection reduction targets, patient satisfaction levels and so on. These might be elaborated upon by other senior managers, for example the Director of Human Resources.

The top level of management at Millford had been notably stable over the last 15 years, during which period the Chief Executive, Operations Manager and Trust Secretary remained the same. In terms of organizational structure, the trust had a number of directors at senior level. Each of these directors was responsible for the key strategic functions of the trust, and although not involved in the day–to–day operational matters within their remit, these directors represented the penultimate level in the hierarchical reporting structure. The delivery of patient care, broadly conceived to include diagnostics, occupational therapy and so on, was organised through business groups, in fitting with what was often known as 'business line management'. Reflecting both the size of the organization as well as the extreme complexity of what it was expected to deliver, actual lines of reporting were often less clear than they appeared on organizational charts. To further complicate matters, organizational structures at the trust were in

an almost constant state of flux. For instance, areas of responsibility within the business groups had recently been expanded to accommodate a reduction in numbers of middle managers as a result of financial pressures.

5.1 Acute case study; fieldwork design

We interviewed the following people, shown here grouped into broad role categories.

5.1.1 Clinical managers

Lois (Nurse Manager – Head of Nursing for Trauma and Orthopaedics)

Kay (Paediatric Nurse Clinician)

Barbara (Matron)

Keely (Matron and Project Manager – spans boundary with research managers; see below)

Annette (former Head Occupational Therapist)

Gabrielle (Ward Manager [a role previously known as Sister])

Dawn (Children's Services Manager and Lead Nurse for Paediatrics)

Trevor (Doctor – Clinical Director)

Rose (Clinical Nurse Lead for Intermediate Care)

5.1.2 Research managers

Shannon (former Audit Manager at the trust)

Elaine (Audit Manager)

Jason (Research and Development Manager)

Keely (lifestyle research Project Manager and former Matron)

5.1.3 Business group managers

Eddie (Associate Director, Human Resources business group)

Shirley (Associate Director, Diagnostics and Clinical Support business group)

John (Associate Director for Emergency Medicine)

5.1.4 Trust directors

Megan (Associate Director for Quality)

Ruth (Director of Human Resources)

Katherine (Director of Nursing and Midwifery)

Kevin (Director of Communications/Trust Secretary)

Speaking to managers across the organization both 'vertically' and 'horizontally' was necessary in order to provide valuable contextual and historical information, as well as material on how the work of middle management was viewed at the trust more widely. Notwithstanding this, readers may find that the focus in this case study tends to be on clinical managers. This was the group we spent the most time with in terms of observations, and it was numerically the largest. It was also the group that most clearly fitted in to the 'middle and junior' category of manager. Space here is limited, necessitating a more focused presentation, but our analysis of findings would not have been possible without input from colleagues across the organization that provided valuable insights.

We sought to determine the roles and behaviours of middle and junior managers. At the meso level we considered both the formal roles of middle and junior managers, and the functional outcomes associated with fulfilling this role successfully. We wished to capture the ways in which managers achieved their goals and fulfilled their roles. Focusing here on the micro level, we looked at how managers work, the strategies and tactics they employed - their behaviours. Also at this level, we explored managers' own perceptions of their role and the related issues of identification and identity. Beyond this we situated NHS middle and junior managers within the wider organizational structures, with which they interacted and had to negotiate – the meso level once again. These local organizational structures and dynamics were themselves in constant interplay with national policy and ideology – the macro level. Thus interplay was perhaps the watchword; our analysis moves between levels the better to show the relationships between them.

5.2 Roles, definitions and identities

Come into this strange world..... (Dawn, Children's Services Manager)

In broader, formal terms, the role of clinical managers was to manage staff reporting to them in order to deliver good quality care for patients 'on the wards'. For research managers and business managers, their roles related less directly to delivering patient care, although their roles were understood very much as part of an organizational delivering exactly that.

Beyond the level of formal job titles, the managers we spoke to often had their own concise understanding of their role. Rose was able to give a summary of her role which covered two levels – that of the manager within the organization, and the manager of the unit for which she was responsible:

So I work in a small unit. My day or my diary is made up of; I attend professional meetings based up at the acute sector, I

> *attend workforce meetings, I attend the modern matron's lead meetings, so I get all of my, and that happens within* [the acute trust]*, within that support structure. Then within the unit I oversee the day to day running of the unit, monitor the bed capacity, liaise with my partners in intermediate care and primary care. I manage the budget and I organise staff meetings and support training for the team that I manage. Does that make sense?* (Rose, Clinical Nurse Lead)

This description certainly did make sense. Rose's description was a good summary of the work of more or less all the nurse managers we spoke to, and we could see that it really did place this manager in the middle of the organization. Like her counterparts, this NHS middle manager and senior nurse worked to connect the different levels of the organization, both vertically upwards (senior colleagues), horizontally (colleagues such as matrons and other senior nurses) and vertically downwards to junior colleagues – '*the team that I manage*'.

In terms of role conceived of as constitutive of an identity, medical managers we spoke to were often ambivalent. Lois, working at a similar level to Dawn, was responsible for nearly 200 nursing staff. For her, defining her own role was made difficult both by its inherent complexity – the range of functional roles that she had to perform, as well as cultural factors surrounding the nurse, the clinician, as manager. When asked to define her role, she said:

> *Well I'm a nurse manager I would say in terms of 'who am I?'... I'm a nurse manager, but then there are some people who would define me as an operational manager. The person that's on the ground, doing the stuff... middle manager. Some people see you as a senior manager, but I would say nurse manager, operational manager.* (Lois, Nurse Manager)

We are reminded of Anthony and Reed's conception of nurses as 'reluctant middle managers'(45). In the end then Lois opted for a definition of her role that encompassed multiple identities. The managers we spoke to (for managers they were, objectively) sought to emphasise their concern for and sometimes proximity to, patient care. Trevor, a Clinical Director;

> *came in to medicine to treat patients, If I wanted to become a manager I would have gone to do a management course or whatever and gone down that training route.* (Trevor, Clinical Director)

Ultimately however, Trevor did concede that while the key driver of his role was to improve clinical care for patients, '*how to achieve that involves a lot of management.'*

For Eddie, a more senior Human Resources manager, his role was defined in organizational terms – that is, as embodying HR as an organizational unit which in turn had the role of '*Being the independent little person between employees and businesses* [business groups]*.'*

Despite some ambivalence then, around how to define their roles in terms of identity, we have seen that managers were usually able to give a concise definition of the functional thrust of their role.

Our exploration of managers' roles did not, of course, extend only to the level of organizational or individual definitions. Rather we were able to hear and see for ourselves what roles NHS middle managers had to perform in order to deliver their services.

5.3 Roles and behaviours: What do middle and junior managers at the Acute Trust do?

5.3.1 Leadership by example

> *I see management as the bicycle and leadership as the light on the front* (Rose, Clinical Nurse Lead)

Leadership was a quality recognised and promoted by both the NHS as a national organization, and by individual trusts. Doctors and managers were encouraged to see themselves as leaders as well as, or perhaps rather than, managers. For clinical managers in the acute trust, as for many of us, leadership might be something of a nebulous concept. Managers like Rose were able to conceptualise the management and leadership as distinct features to an extent. She used the metaphor of NHS management as a moving machine, a bicycle:

> *management is about sort of like the nuts and bolts of the movement of the actual whole machine, leadership is about having that light on the front* [of the bicycle] *and actually knowing where you're going and how to get to it'* (Rose, Clinical Nurse Lead)

Spending time with clinical managers at Millford, one quickly became aware of their desire not to appear detached from the realities of work as carried out by their junior colleagues. This was the case from the most junior manager in this cluster, Gabrielle, to more senior managers such as Dawn

and Lois. We have already heard from Dawn, for whom leadership was a key element of her role. We can say that it was a key constitutive role (one that, with others, came under the 'headline' role of a formal management position). Leadership was one of a number of roles that clinical, and other NHS managers, had to carry out in order to achieve their overall goals effectively. While leadership for Dawn was a key element of her overall role as defined both by the trust and by herself she, like many of the clinical managers we spoke to, sought to adopt the role of 'leader by example'.

Perhaps because of negative implications around management being detached from the realities of medicine, many clinical managers reported that they aimed to be 'hands on' on the ward. Barbara, a Matron, would '*go down and make a bed...and quite happily do bits and pieces*.' This, Barbara saw as helping and supporting staff, perhaps practically as much as in terms of leadership and motivation. Gabrielle mentioned that, although she tried to be as visible as possible on the ward, time for her to engage in 'hands on' patient care was limited. She rarely got to wash a patient anymore, for example, but this was due to the '*volume of other things you've got to organise*.'

5.3.2 Problem solving

You've got the fire fighting every day. (Lois, Clinical Nurse Lead)

Lois was keen to emphasise the operational element of her role: '*At this level because it's very operational we tend to do a lot of fire fighting.*' It was clear that by 'fire fighting' Lois meant 'problem solving': '*Well, I could be phoned now and somebody will phone me up with a problem and it's literally down sticks and you have to resolve that problem.*' This fire fighting or on the spot problem solving, took up around 50% of Lois's time. If we assumed that a similar situation pertains in the case of many other managers with an operational element to their role, we could say that this was a key role of the middle managers in this trust. Managers sometimes saw staff themselves as constituting 'problems'. Elaine, the Audit Manager, solved the problem of a somewhat recalcitrant 'problem child' by positioning them within the office in a way that allowed effective surveillance of their work station.

We were clear that these problems were not trivial, and could be seen as symptomatic of stresses in the systems within which these managers work. Problem solving could be seen as managers 'plugging the gaps' in the system. Our observations provided ample illustrations of the problem solving role. Walking around the wards with Keely, we came across senior nurses, heads of services, cleaning a linen cupboard on a newly refurbished ward; the reason? The tradesmen had been behind schedule and yet the time and date of the ward opening remained the same. Snagging, the final stage of the refurbishing, had concluded at 10.00am. The ward was scheduled to open at 12.00noon. Thus it was a matter of *'all hands to the*

pump'. Denise, the head of nursing, at the time wearing a plastic apron and wielding a cloth, noted that: '*when you're working with people* [you get] *crisis'.*

On another occasion we spent time with Lois on a shift as an 'on call manager'. This was almost a 'role within a role' for many of the clinical managers, although it was taken up by nurses rather than doctors. Senior nurse managers were expected to do an 8 hour shift as an on call manager 3 or 4 times a month, and this could be on any day of the week, at any time. The on call manager or 'bleep manager', was, during their shift, responsible for operations for the hospital as a whole. In practice this meant the on call manager dealt with untoward or unpredictable events such as intruder alarms, deaths, complaints, police enquiries, breaches of accident and emergency four hour targets, media enquiries, bed numbers and bed planning, and once again, 'plugging the gaps' as required.

Here we encountered the figure of 'manager as bed maker'. In order to perform their problem solving role, the manager had to use their initiative and practical skills, acquired through experience. Faced with a bed shortage during a Sunday night bleep manager shift, Lois opened up a ward usually used for day patients and coordinated a group of porters to bring in the appropriate type and number of beds. She then made the beds and checked the relevant equipment (oxygen cylinders etc.). When asked how such a situation – managers doing basic tasks such as bed making – was viewed within the trust and the NHS more widely, Lois explained that it is *'part of the culture.'*

5.3.3 Arbitration

Arbitration and, connectedly, conflict management were, like much of the work of the operational managers we spent time with, a form of problem solving. Although this role did not come across strongly in interview discussions, it was clear from time spent observing the work of clinical managers that this was a role that they needed to carry out in order to maintain a properly functioning system. Clinical managers, particularly those with operational responsibilities that covered staff across different units, were required to deal with conflicts between staff and patients, usually in the form of administering complaint procedures, between individual staff, and between organizational units of staff who were competing for limited resources.

On an 'on call' shift with Lois at Millford, we observed as she took phone calls in quick succession from two groups of junior managers. The issue at stake was access to a cupboard containing medical scrubs, with one group wanting access and the other wishing to retain the stock for itself. Lois fulfilled the role of arbitration in the first instance by preventing the conflict escalating any further and in the second by attempting to find a solution that would satisfy both parties. However, in the end a direct intervention proved to be the most expeditious behaviour, and we found ourselves once

more back on the wards, or in this case, very much in the 'backstage' area of the hospital, amongst storerooms and cupboards, with Lois retrieving the necessary scrubs herself. These were handed over to the junior nurse managers who required them, thus removing the element of negotiation – and conflict, from the equation. It should be noted that in some cases, the most appropriate form of arbitration was for the clinical manager to remind their junior staff of their professional duty, ultimately, to resolve the conflict themselves. We saw earlier how the Associate Director in HR viewed arbitration as central to their role.

5.3.4 Coordination and planning

Much of a manager's job is coordination, and for managers in the NHS this was certainly the case. We have already seen examples of this within other key roles; the porters needed to bring beds to a ward that needed to be opened, the staff who would need to be found, contacted and brought to work on the ward unexpectedly, and so on. Much of the problem solving role, in a sense, was about coordination. There were other contexts, often more structured and formally systemic, where coordination took place. Often, this coordination had much of the character of planning, and so we deal with these key roles together here.

Many key elements of coordination took place in meetings, which occurred on both a scheduled and ad-hoc basis. A clinical manager such as Lois had up to 13 meetings in a week; the number of meetings per week tended to increase the higher up the hierarchy one went. Some meetings were focused on information management and decision making. For example at the scheduled meeting for the key management staff in Trauma and Orthopaedics issues were raised, discussed and compared; decisions were made, although we should be conscious of the fact that these were decisions within a restricted sphere – focusing on operational, rather than strategic matters.

At another meeting we observed the Associate Director for Emergency Medicine making operational decisions about bed spaces at a very fast pace. Numbers, names and places flew back and forth:

> *Gynaecology is OK because you don't get a lot of GP admissions…*
>
> *B5 is moving to B2, which gives me 2 extra beds*
>
> *C2…C5… Plan E… 8… identification from medicine or DMOP* [Department of Medicine for Older People] *ward… got a nice 'med reg.' coming in 9-9 on Saturday… A12 situation is difficult…*
>
> *Bottom line across the trust?*
>
> *3 beds over what we need.*

We can see here managers co-operated in order to ensure that patient flow and necessary resources were coordinated across the trust. This was coordination in a very immediate, very focused sense.

In terms of planning as an element of coordination, this tended to centre, for middle and junior clinical managers, on two sets of resources; firstly, human resources in the sense of staffing, and secondly, financial resources in the short and medium term. Often, the two were closely connected. Gabrielle placed the coordinating of staffing with her given budget, at the centre of her role and identity as a manager:

> *I'm given the title of ward manager because you get a budget basically... You have budget meetings and... have to make sure the staffing's balanced and so on and so forth.*(Gabrielle, Ward Manager)

For all of the managers we spoke to, the issue of budgets and finance was an important one. Managers had to negotiate, both ontologically and practically, the tension between resources, that is financial resources in the sense of both material and staff, and care. This was true at all levels. Katherine (Director of Nursing and Midwifery), saw herself as almost a *'thorn in the side of some business developments'*, and Shirley, Associate Director of Diagnostics, saw the role of NHS manager as redolent of *'multiple personality disorder'* - reflecting the tension between business management and the ever present focus on patient care. Interestingly, Shirley was able to see patient care as compatible if not with cost savings directly, then with greater efficiency and consistency of systems, in that this would lead to expeditious care with consistent quality. Cost saving was part of the equation, but was not expressed as the highest common denominator.

For middle managers such as Lois, they not only had to coordinate budgets as they currently stood (as in the case of Gabrielle, a more junior manager), but had to plan further into the future. In today's NHS, which as Dawn noted, has a *'business ethos'*, this could mean, as Lois said, *'putting together a business case.'* With staffing the primary resource issue for managers at this level, it was not surprising that these business cases tended to relate to workforce planning. We took the foregoing example from an interview with Lois: *'So I've just had to write some proposal papers for the strategic health authority, because I need some more advanced practitioners.'* For Kay and Barbara, rotas had to be done at least two months in advance - it was, according to Kay, a *'nightmare.'* Kay was able to draw on Barbara's experience and assistance, even though, formally, Barbara as a matron did not have responsibility for staffing issues. Kay, who said that doing the *'off duty' rota used to take her 8 hours'*, suggested that, of the challenges facing clinical managers, particularly nurse managers;

Staffing is the biggest; I think staffing is the biggest one.(Kay, Nurse Clinician)

In order to co-ordinate the work of those around them, the middle managers we spoke to sought to cement their ability to do so by being visible 'on the floor' and cementing their leadership role along the way. Other behaviours reflected differing approaches to managing relationships. Gabrielle, for example was conscious of the need effectively to manage relationships with doctors. It is fair to say that the majority of the middle and junior clinical managers we spoke to had a rather negative view of doctors, or at least the attitude of doctors and their willingness to work in concert with managers. Doctors apparently were able to wield a certain amount of power by way of an unspoken understanding that they, more than almost anyone else in the NHS system, were able to withdraw their labour. This apparently gave them the status of some sort of rare commodity that had to be handled carefully. Gabrielle found that;

the amount of time we spend chasing after doctors to do things is incredible. Weekends is an absolute nightmare, in the evenings, but just getting them to do... just to come and book the take-homes for the patients and they can't leave without it so...(Gabrielle, Ward Manager)

5.3.5 Monitoring

Keely had spent the foregoing nine years of her nursing career as a matron. In contrast to what one might think, matrons at Millford did not have a formal management role in the sense of managing people. Rather, they were expected to have an information gathering and monitoring role. In practice they remained within the culture of nursing and continued to be seen by others in a senior nursing role. As such they were a source of advice and mentorship for their colleagues, who were able to draw on their extensive experience. Mirroring coordination in being something that relates to both resources and people, monitoring was a role that managers were required to perform in order that service delivery ran smoothly. Matrons played a key role here; often acting as the 'eyes and ears' of other managers. The official role of matrons at this acute trust related to 'quality'; what this meant in practice was that matrons had a monitoring role based on collecting 'audit' information from across an area of the hospital over which they had been given responsibility. This related to issues such as infection control, hygiene, falls, patient lifestyle and so on. This information gathering role, together with their highly experienced position and tacit knowledge of both the sub culture of nursing/clinical care and the organization as a whole, meant that matrons at Millford seemed able to glean information from colleagues on what was going on across the Trust. The following notes were taken whilst accompanying Keely as she went

from ward to ward checking on the implementation of a project that she had initiated. In the corridor, we stopped and spoke to a matron, Denise:

> *Ward B13, all sisters have resigned…no sisters there…big problem…but you don't get support from management… 'disaster zone'…[!]…Various people off sick. Leanne back today but looks like she should still be off sick. Builders not very good, job which was meant to take a week has taken eight....*(Denise, Matron)

Visibility on the wards, as well as strengthening leadership roles and so on, gave managers the chance to monitor both the staff and the patients on the ward, first hand. In terms of the staff, monitoring was not necessarily in the sense of surveillance. It could focus more on informal discussions with staff in order to hear the issues currently affecting them. Visiting the wards further allowed managers to monitor (at least in a superficial sense) the condition of the patients there – clearly an important factor in the performance of a healthcare organization. Lois, for example, spoke of visiting a ward where the patients *'looked somewhat unkempt and perhaps not as clean as they should have been'*. On other occasions, junior staff reported concerns (such as staff members being rude to patients) to clinical middle managers and it was the responsibility of the middle manager to investigate these concerns. This was usually done in two ways. Firstly, the middle manager might spend a shift working with junior colleagues in the relevant context, in this case a particular ward. Whilst this had the advantage of allowing the middle manager to see things first hand, it had all the obvious disadvantages of overt observation. Another strategy employed by clinical managers was to place a trusted colleague within the unit that required investigation, and have them report back.

5.3.6 Information management

Information gathered either formally in the sense of audit statistics or informally in what Keely called *'gossip pathways'*, the conversation in the corridor, for example, was useful only if it was managed in a productive way. Thus a key role of the clinical managers we spoke to was information management. Many elements of information management in the sense of collection, was mandated by national and trust governance procedures; hence the need to audit for 'quality'. Once collected, information was then discussed at scheduled meetings. Observing with Lois, we attended a senior nurse meeting. This meeting was chaired by the Head of Operations for the business group, and was attended not only by Senior Nurses such as Lois but by Matrons, an HR Manager and a Governance Manager. The range of issues was extremely broad – from a dentist hitting his head on a lamp, to accusations of bullying, to swine flu. Also notable was the pace at which the succession of topics proceeded. Managers in this setting had to be able to

assimilate and make use of a significantly high volume of information; in the case of middle managers with responsibility for large numbers of staff, effectively all of the topics discussed in meeting such as this were relevant. If the manager was not expected to remember everything they heard, such discussions did form the backdrop to their work as a manager, and they had to be able to process this information in order both to prioritise tasks and to maintain their oversight of the operation of their area of responsibility. We could clearly see here that the monitoring and information management roles were intrinsically linked. It was here, also, that the monitoring role of matrons intersected with the role of information management, as they fed back both their formal findings and their informal observations.

As Gabrielle explained, scheduled meetings served to facilitate a flow of information both up and down the hierarchy of the organization:

> *It's just basically a* [forum] *that gives us a chance to say what we think, you know. And it's also a venue for people* like [the Associate Director of the business group] *now, who can come in and give us an overview of what's going on in the organization. So it's a way of the organization being able to get in contact with all the Sisters* [ward managers*] together and actually feed-back, share information to pass it down that I can then pass on to my staff.*(Gabrielle, Ward Manager)

In the case of statistics related to governance, information was often presented in settings such as this in the form of 'traffic light' or 'dashboard' tables. This was intended both to make assimilation of the information easier and also to give a sense of 'performance' against governance targets. Indeed, information pertaining to actual targets such as waiting times or infection rates would tend to be a key feature of managers' discussions in scheduled meetings with an operational remit. In the case of mandated targets, managers, in performing their information management role effectively, were in a sense monitoring themselves. They were aware that in doing so they risked making a rod for their own back, since targets at Millford were taken very seriously. To quote Lois: *'you get hung, drawn and quartered if you let a patient breach their eighteen week pathway'*. These pressures could have a negative impact on patient care, according to Kay, who spoke of patients being moved around to accommodate others at risk of breaching their four hour waiting target. This, according to Kay, was *'heartbreaking'* for the nurses involved, who were aware of the negative impact on quality of care for the patients being moved around (to three different wards in one week, in Kay's example), and yet had no choice but to move them; such is the power of targets to influence management decisions.

Information was a crucial resource for managers in the NHS, where the need for monitoring had significance greater than that in many other organizations. That is, information relating to matters of patient care, and

sometimes, life and death itself. But while many middle managers had to be able to assimilate and manipulate data effectively, and understand its significance in the round, they, along with junior managers, medical and administrative staff on the ward were also responsible for the actual collection and inputting of patient data. Many managers we spoke to complained, in simple terms of an excess of 'paperwork', much of it related to collecting audit data (including information on individual patients) and inputting it either on paper forms or onto a computerised database. Other elements included governance around risk assessment, for example. This paperwork seemed to many managers with whom we spoke, to be ever increasing. Barbara and Kay, like many others, raised this issue;

> *Barbara(Matron): lots of things have to be done now that you know five years ago didn't have to be done...*
>
> *Kay (Nurse Clinician): It's a lot more paperwork... infection control, risk. I suppose it's very linked isn't it, and they have a major impact on our work now, don't they?... sort of with nurses on the wards and audits.*

5.4 Conclusions

Our findings were in line with those of researchers such as Anthony and Reed(45, p28) and Oroviogoicoechea(50, p1275-1276) in that we were able to conceptualise the broader role of NHS middle managers as made up of a number of individual, though not fully discrete 'sub roles.' NHS management therefore could be seen as highly diverse within each formal role or job title, and this was particularly noticeable in the case of medical managers such as nurse managers. Medical managers in particular were expected to be both operationally and, increasingly, strategically aware.

Though Sergeant has argued that NHS management, and in particular middle management remains, '*untouched by the commercialism that transformed business in the 1980s'*(102, p37), we found that this was far from the case. Managers at all levels had come to conceptualise their role within the wider organizational context of an acute trust as a business. This was reflected not only in their language but in their ontological negotiation of their role – their identity. For clinical managers Duffield's observation held true: '*the transition in nursing from the role of a clinician to a manager can result in role confusion and conflict'*(49, p1248). Be this as it may, managers were keen to engage with development opportunities (should time allow), and showed an often entrepreneurial approach to negotiating sources of funding, and even the path of their own careers.

Managers at the acute trust were motivated by an almost always explicitly stated sense of service to patients and the wider society, and sought to reconcile this with an ethos of economic rationality. Thus there was a broad, though sometimes wry acceptance of new management strategies such as

Lean management. While targets were seen as having some benefits for patients in terms of waiting times, they were seen, alongside other audit type data as placing an ever greater burden on managers' workload. Our findings were broadly in concert with those of Cooke(62) in that they point to work intensification for NHS managers. This was particularly apparent in the case of the medical/nurse managers we spent time with, who were often required to work at high levels of pace and intensity in sometimes emotionally and interpersonally challenging circumstances.

A key challenge faced by all managers at the acute trust was limited financial, and thus human, resources. At times, the operational challenges caused by limits to resources allowed a sense (though not an extant situation) of low level crisis develop. More senior managers faced resource challenges on a no less immediate basis in the sense that this provided the backdrop to much of their role. More senior managers tended to be able respond strategically by developing new management processes and initiatives, and with a greater awareness of future policy developments.

Managers faced both strategic and operational challenges, as we have shown, with a sense of professionalism and commitment to their role.

6 Case study – Mental Health Trust

This chapter concerns a mental health trust, 'Millfordshire Care Foundation NHS Trust' or 'MCFT'. As this chapter will show, the organization played a somewhat hidden role in the local health economy. The mental health trust had close links to social care, housing, police and acute hospital services. It offered services to people who had serious mental illnesses (e.g. schizophrenia), common mental health problems (e.g. anxiety) and dementia. In spite of the complex inter-organizational needs of patients, mental health services have struggled to maintain funding even in the years of increased health spending. As one director put it;

> *We've never had good times. We've had reductions each year. We've shut loads of stuff in the last five years. We've never had any more money...We've got a lot of expertise in bed reduction; we've reduced our beds by about 30% in the last four years.* (Robert, Director of Operations)

Mental health services are often called Cinderella services because of the difficulties they have in attracting funding and attention. In spite of this, at the macro level, MCFT had managed to expand year on year by acquiring additional services and reducing overall management costs. Unlike other health services, mental health services were not subject to significant national targets and continued to be funded by block contract rather than payment per treatment making it easier for purchasers to chip away at funding.

MCFT was formed in 2002 as a result of a national move to create specialist mental health organizations from acute and community services and it became a Foundation Trust in 2008. Many managers had worked at there since its formation being employees of the original mental health services that formed the trust. At the time of the study, MCFT covered a population of 1.2 million people in five towns in the north of England. Unlike other health services, patients may not welcome the mental health care they receive and may be held against their will. As a result some of the challenges for staff arose from the patients themselves. The work involved offering the full range of mental health treatments, protecting patients and others and containing patients who were a danger to themselves or others. The trust encompassed 40 square miles and covered affluent and deprived, rural and urban areas. It provided services from four hospital sites and many more community locations. The full range of mental health services provided by the trust is shown in Table 4. The trust had an annual income of £140m and employed over 2,600 staff.

Table 4. Millfordshire Care Foundation Trust services

Type of service	Description
Working-age adult mental health	In-patient and community services for adults of working age including crisis resolution, home treatment, assertive outreach and early intervention
Older people's mental health	In-patient, day services and community mental health services for older people including assessment, care and treatment
Child and adolescent mental health (CAMHS)	In-patient, out-patient and community services for children and their families
Drug and alcohol services	Information and treatment for drug and alcohol users and training and consultancy for other agencies
Psychiatric intensive care units (PICU)	Secure units, non-secure intensive rehabilitation and prison mental health services

Our research revealed that MCFT was in a state of almost constant change aimed at increasing size, achieving economies of scale through reductions in management numbers and diversifying the services provided. By the end of the fieldwork (April 2011) MCFT was about to double in size again by taking on non-mental health community services from disbanded primary care trusts. New mental health developments were targeted at high value services such as secure in-patient services and new units were being built to house these types of patient. The demands being made on managerial and front-line staff were increasing in variety, intensity and complexity with the result that many managers were working long hours. The remainder of the chapter will illustrate why this was the case by examining the daily lives of middle and junior managers. It will demonstrate that organizational changes included attracting new business, management restructuring, devolving management responsibilities and increasing central services such as human resources and finance. Furthermore, it will argue that these changes were affecting management roles leading to a disconnected hierarchy as new business management roles impacted on historic clinical managerial roles. We begin by providing details about the five main organizational challenges facing MCFT managers and how they were trying to adapt and modernise. We then move on to explore management roles and behaviours in greater detail thus providing an account of the realities of managerial work in an under-researched type of NHS organization.

6.1 Managerial context

Our investigations at MCFT revealed five main challenges that provided the context for managers within the organization: 1) regular expansion of mental health service provision, 2) management restructuring and delayering, 3) business and clinical management arrangements 4) emergent centralised management roles and disconnected hierarchy, and 5) attracting new business.

Firstly, MCFT had expanded rapidly to provide a diverse spread of services from over 60 locations. The growth of the trust was almost matched by the increase in diversity of employees, their management arrangements and the number of locations from which services were provided. For example, some services were jointly provided by MCFT and council services whilst others were taken over by MCFT. Each service had a distinct local culture and MCFT had struggled to find a simple management hierarchy to cover the disparate services. Nevertheless, rating scores for the trust, awarded by the Care Quality Commission, were consistently high and it was one of the highest performing foundation trusts of its type. The trust headquarters were located in a town centre towards the middle of the area covered by the trust. The modern, glass offices stood alongside the headquarters of several other NHS and charitable organizations, in contrast to older hospital buildings on acute hospital sites. The trust modernised a number of in-patient buildings on two of the five hospital sites. Nevertheless, estate still included Victorian in-patient buildings and some dilapidated community buildings. The delivery of services was fragmentary many types of services were provided in each of the five boroughs through numerous locations both on and off hospital sites. There was no main centre to the trust and each of the five locations had strong local cultures. Each had mental health services that had evolved locally and many of the staff had worked in the same buildings providing mental health services for many years whilst the organization expanded and renamed. An additional management challenge concerned the complex management arrangements for services as they were provided in co-operation with many other partner organizations: six local authorities, three acute hospitals, general practitioners and independent sector organizations. Nationally, there had been a drive to reduce the number of in-patient beds and to provide community services instead and commissioners of health services had continued to require cost savings. As mental health services generally did not benefit significantly from increases in health spending in previous years, they were suffering severe resource shortages. They were focusing service developments in areas that attract better payments such as in-patient secure units.

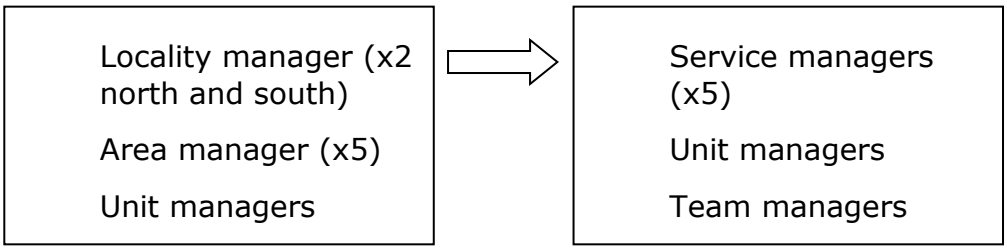
Secondly, and following on from the first challenge, the trust had undertaken several management restructures in recent years. For example, in 2009, as a result of management restructuring, it reduced management costs by over 30%. This trust had cut management costs significantly before national cuts were announced. The management of services was being reconfigured during the study. Rather than being organised by geographic area the organizational hierarchy was moving towards being

organised by service (see figure 2). This was thought necessary because of changes to national payment systems as well as the desire to reduce management costs further. The move to service line management arrangements was, at least partially, driven by the fact that performance data related to service type rather than area and that future arrangements for payment of services would be by type rather than in the form of a block contract. During the majority of the study there were dual management systems in place with single managers occupying a role in both hierarchies. This dual system as well as the regular restructuring of higher level managers gave the perception that managers did not stay around for long;

> *The doctors say that they tend to take a job for life and managers have a two or three years cycle and they're off. People are gone before the smell gets out from under the office door.* (Anthony, Service Director)

This was the latest of many management reductions in recent years and, in common with restructuring in other industries (Hassard et al 2009(1)), it left managers with rapidly increasing spans of control managing different people under the two simultaneously operating management hierarchies.

Figure 2. Reconfiguration of service management hierarchy



Thirdly, reductions in overall numbers of managers meant that management tasks were being devolved down the hierarchy. These devolved management tasks were overtaking traditional clinical management tasks, for example, clinical supervision was replaced by performance management reviews. A senior nurse manager explained:

> *M who did my job before me was more like an expert clinician...it would have been alright three or four years ago whereas now you're calling on a whole range of managerial skills. In a way it's a different personality type as well as a different skill set.* (Hamir, Community Services Manager)

Senior managers at the trust said that the trust lacked a body of trained managers at the middle and lower reaches of the organization and had

instituted internal management training programmes for team leaders and for middle managers. This training was aimed at increasing professional management skills within the organization and developing a group of managers who could be called upon in the future. Alongside the rapid expansion of the trust and reductions in management costs, on-going initiatives included national programmes to introduce Lean management ideas – 'Productive Ward' and efforts to improve the comparability of performance information – service line reporting. These initiatives drew upon national NHS programmes and derived from business management ideas.

Fourthly, management roles were changing as will be seen in the following sections of the chapter. There were emergent corporate and business roles. As the trust expanded, new corporate management roles developed whilst other more traditional activities were being passed down the management line adding to the pressures faced by more junior managers(1). Alongside the rapid changes to management structures noted above, there were few linkages in the middle of the organization. One human resource managers asked '*Can I be the only manager who's not in charge of anyone?*' Whilst those offering frontline services answered to a line manager and those in the upper reaches had clear lines of accountability, there were disconnections in the middle leaving some business managers with no direct authority and/or many lines of accountability. One service director explained that management roles were clear at the top and bottom of the organization but were much more opaque in the middle;

> *You go a layer or two below* [the board] *and that will become vaguer and then it becomes clear at operational level because they know what the targets are...You've got the management hierarchy and you've got the business partners that come in from headquarters...So you've got IM and information, HR business partners, finance business partners, so it's more opaque.* (Anthony, Service Director)

Finally, MCFT was undergoing so many rapid changes that it has been difficult to present a static account of managerial work at the organization. By the end of the study MCFT had virtually transformed its business by taking on services from disbanded primary care trusts. As the research ended mental health work accounted for less than half of the income of the newly expanded organization. The latest addition of community services both doubled the size of the organization and diversified the operation to include services outside of mental health, such as, community nursing[4]. This led to a paradoxical situation, where front-line services were largely

[4] These newly acquired community services are not included in this report. Community services, for the purposes of this report, refer to community mental health services specifically.

unchanged whilst the organization itself constantly mutated, taking advantage of opportunities for growth and trying to limit the effects of spending cuts through reductions in management costs. The trust was remarkable adaptable in winning contracts, at times, at the expense of any clear business focus. The sense that the organization would continue to reconfigure rapidly in response to circumstances was widely held. At the same time, it was argued that the front line work barely changed;

> *Reorganization's been almost constant since I joined and at the lowest level we have domestic staff and portering staff who've been doing pretty much the same job for 20 years, and they're working for their fourth organization by now.* (Peter, Head of Facilities)

To summarise the above, MCFT was facing a wide array of management challenges and its governance structures were being rearranged in line with anticipated changes in funding. These multiple and simultaneous governance structures had significant effects upon the way managers went about their work. The remainder of the chapter examines firstly the formal *roles* (the responsibilities) of managers, then their *behaviours (*the actions they took). The chapter concludes by summarising the main themes.

6.2 Middle and junior managerial roles at MCFT

At MCFT we found that whilst many management roles were common to most managers, aspects of the role differed between clinical/operational services and central services. Managers of central services formed two groups – established and dwindling management groups such as estates and rapidly expanding groups such as human resource management. We therefore explored the roles and behaviours of three groups of middle managers, shown in table 5.

Table 5. Management groups

Group	**Location**	**Middle managerial job titles**	**Junior manager job titles**
Acute Services	3 geographical areas	Unit manager, community service manager, service manager, locality manager	Team leader, therapy manager, ward manager
Human Resources	Corporate headquarters	Associate director, head of HR, head of OD	HR manager, OD manager
Estates	Corporate headquarters	Director, Deputy director	Head of estates, Head of facilities

The acute services group of managers covered three geographical areas and involved managers from community mental health services, therapy services and in-patient, acute ward services; in effect forming three subgroups. The work of fourteen managers was studied in depth, to encounter the variety of management roles. The human resource group of managers were based mainly in the corporate offices and four managers were studied in depth. The estates group was the smallest group of managers encountered. The middle managers were located at corporate headquarters and junior managers were located at particular hospital sites. Three estates managers were studied in depth. We describe management roles generally and identify where differences between managerial roles were noted.

A good place to start our evaluation of management roles is with observations of a management training programme aimed at junior managers on the first rung of the management ladder. Fieldwork at Millfordshire offered considerable opportunity to understand the roles and behaviours of junior managers. These were managers who were responsible for managing small teams of staff (or a particular function like complaints for example). Job titles included; team leader (for a clinical service), ward manager, therapies manager, human resource manager, finance manager, complaints manager. The training was taking place at an out of town hotel and involved 10 days of study over the course of six months (6 days of teaching, action learning sets and a feedback session). The managers were asked to describe their roles, what they expected of themselves, what their team expected of them and what MCFT expected of them. Their descriptions of their roles were similar to those seen at the acute trust and were characteristic of what we observed and were told at interview. They are captured in Table 6.

Table 6. The role of a junior manager/team leader

A team leader is	Teams expect their team leader to	MCFT expect team leaders to
Organised	Mediate, listen and consult	Balance the budget
Responsible	Have answers – guide and clarify	Use resources effectively
Confident, professional	Be honest and straight talking	Provide a safe/quality service
Leads by example	Explain how changes will happen	Deliver on strategy and apply Enact MCFT policies
Sets standards	Be both supportive and firm	Promote services
Good communicator	Challenge senior managers	Supervise and recruit
Supportive, loyal, fair	Be consistent and fair	Reduce absenteeism
		Act as a small ambassador

This first line manager role was recognised as being particularly difficult, not least because these managers rarely had any previous specific management training or experience.

> *I mean, first line managers, it's the worst job in the world...I remember being one, but it's not something I'd want to go back to* (Brian, Estates Manager)

The trainees were drawn from across the trust and included clinical and central service managers. They used the sessions to develop management skills and to focus on particular problems they were facing such as dealing with a difficult staff member or implementing a change programme. These first line managers were taught about situational leadership, learning styles, change management and were encouraged to develop their own management style. The training included opportunities for coaching which was used as a development tool throughout the organization. The training programme was opened by the chief executive who emphasised the importance of being profitable and added '*the key phrase is more for less*'. He described how he liked to recruit from within and asked who wanted to be in a senior management position in 5-10 years? None of these managers did. Instead, they answered the question about where they wanted to be in five years as follows: *no idea, doing something I enjoy, managing a bigger team, have a better IT system, be a ward manager*. The junior managers offered their attachment to the front-line aspect of their work as explanation. They also indicated that these junior management roles seemed less precarious than those higher up.

There was a divide between junior and middle/senior managers generally. For example, in the estates department, there were divisions between middle managers and the frontline staff that derived from blue collar employment relations;

> *I don't like to think of 'us and them' but it still works like that. Whether we like to think it or not, at certain levels it stills works like that, and the supervisor is in the middle if you like of what you would call 'us' and 'them', because they don't see themselves as being, sort of, well up the management chain, but equally they don't see themselves as one of the tradesmen and the people doing the physical work.* (William, Deputy Director, Estates)

The estates department had an extremely flattened hierarchy (see table 7 for summary of estates managers). Their work was target-driven and they normally dealt with requests in seven to ten days and received 150-170

requests per week. Work was classified as immediate, urgent or routine and repair targets were set by the organization;

> *What we do is we classify work in terms of immediate, urgent or routine. Anything that is immediate has a response target of a response within three quarters of an hour and completion within two hours. If it's urgent it has a response within four hours and completion within eight, and if it's routine it has a response within three days and completion within five. Those are the targets, and then what we set ourselves is to meet those responses in 85% of the cases for the routine, 90% for the urgency and 95% on the immediate.* (William, Deputy Director, Estates)

Table 7. Estates managers

Group	Name	Job Title	Brief biography
Estates	Brian	Director of Estates	Working for another mental health organization, he won an award for estate strategy developments. Consequently he was seconded for two years by Millfordshire to act as director of the department and to develop their estates strategy. Hotel services (catering, portering and domestic services) also brought under the control of Estates as management costs are cut.
Estates	William	Deputy Director of Estates	Worked for the NHS for forty years. Developed the maintenance services for this organization. Previously Director of Estates, William was supplanted by a new director, with different management skills, seconded to the organization for two years.
Estates	Peter	Head of Estates	Worked for NHS for 22 years mostly in middle management roles. Has been head of performance and risk and has managed estates. Now manages facilities specifically catering, portering, linen and domestic staff.

As the span of control of the Estates department expanded several of the remaining managers were effectively demoted as they were doing similar work at a lower management level within the organization. Estates

managers were extremely pressured because of the constant flux between acquiring new sites and closing some of those sites down to reduce estates costs. At the same time staffing had been slashed by 75%.

> *It* [the organization] *had more than quadrupled in fact, in terms of size. You had four organizations then at senior level that had to squash into one. So you ended up with one Chief Executive. And you lost three quarters of the senior staff. And a similar thing happened in Estates. You still ended up with four people, doing what previously probably sixteen were doing.* (William, Deputy Director, Estates)

For acute service managers the pressures were different. This group of 14 managers covered in-patient and community services, nurse managers, service managers and directors. Many service managers in this group were working in two roles at once (covering both a service across the entire organization and a locality). The organization was operating two management structures – one geographical and one by type of service and the management job was almost impossible. These service managers negotiated with each other to offset workloads. A further level of management was being removed whilst more management responsibility was being pushed down the line, not only from HR but from all corporate functions. Several of these managers had been demoted in recent restructuring or had taken on vastly expanded spans of control. The emerging management roles for each level of manager in the acute group are described below.

New management roles were emerging at three levels:

- Service directors were now directing large, dispersed businesses and were responsible for income targets, problem solving eg miscosted services, being proactive in planning new profitable services, protecting junior managers
- Unit managers were responsible for all day-to-day management requirements for their unit and, with the exceptions of holidays abroad, were always on call or on duty. They dealt with complaints, breeches of security, bullying, suicides, staff sickness, arbitration with doctors. At the same time they were concerned to be seen to be hands on in order to lead by example.
- Team leaders, ward managers and HR managers had different roles. They were at the receiving end of responsibility within a disconnected hierarchy. This meant that the HR manager, for example, had no-one to manage but had to influence organizational development across the trust in co-operation with other team and unit managers. Ward managers carried responsibilities for day-to-day staff management – appraisals, return to work interviews, organising staffing rotas and replacement posts for new staff. All of this management had to be balanced against a requirement to fulfil a clinical role.

It was within this group that managers were working at many levels – clinician, team leader, standing in for unit manager, leading a management project for the board. The job was highly fragmented and no-one occupied a fixed managerial role. Ward managers were seconded into position and then asked to lead projects for the board. There was a move towards project work so that each task was graded and paid on different pay bands. This task-based work allowed for less emphasis to be given to clinical expertise. In addition, managers were given partial promotions as they were paid on different grades for different aspects of their work. At the same time, and as noted in the previous section, performance management replaced clinical supervision. Long-serving managers sustained vast networks of contacts across this dispersed organization and this allowed them to find shortcuts and to get things done through informal routes.

Managers were introducing national initiatives from the private sector such as the 'productive ward' which derived from Lean management principles. Ward managers were uncritical of these initiatives, being more concerned about how they might use them to gather more resources to their area of work. There were numerous examples of hybrid managers who came from a clinical background and were working at a service manager level combining what they saw as the best of business ideas to fulfil public sector values. There wasn't always an easy fit between these two competing demands. For example, paradoxically, it made business sense to keep patients in longer to improve occupancy rates.

As has been noted many management responsibilities had been devolved to junior managers. At the same time there was an increase in centralised control sometimes delaying relatively simple tasks. So, for example, a ward manager struggled to organise to fill vacancies as each stage of the process had to go through a centralised HR system, which had replaced the local administration and which was not running smoothly. All the pressures resulting from these delays were experienced by the operational managers as they continued to work with staff shortages. The following summary of observation notes illustrates the many simultaneous management tasks undertaken by one ward manager. She had come to work two hours before her shift officially began;

> *Gail arrived at 7.00am. All morning, she was trying to complete the off-duty rota, but was constantly involved with liaising with outside authorities such as the police. She was talking about patients with outstanding warrants and one who had burnt out a room on the ward. She spoke to HR about a post that had been empty for three months as the paperwork relating to a replacement had been lost. She had to start from scratch with this. She had three further vacancies to fill. She organised the off-duty so that willing nurses would be free to do additional shifts. 'I'm cunning, I schedule the staff who will do bank to be off for shifts where I'm short so I can ask them to cover later'. She told me about staff who have been followed home and*

threatened by patients (and their relatives). She booked in performance reviews with some nursing staff. She worked a ten hour shift and in that time she was involved in all the roles noted of nurse managers at the acute trust - fire fighting, leading by example, arbitration, co-ordination, communication, planning, negotiating.(Fieldnotes MCFT)

Whilst the service managers were under pressure because of increasingly devolved management tasks and pressures to reach income targets, the HR managers were also working under intense pressure as they had to work with many disparate groups of staff many of whom did not recognise their authority. The HR department was expanding but not in pace with the expansion of the organization. New staff had been recruited from the private sector and Tesco in particular mirroring appointments at the Department of Health. The department was introducing private sector policies that were much more aggressive about sick leave, absences and limiting recruitment. New HR staff were struggling to deal with rapidly expanding organization that was changing its line of business. They had little direct control within the organization and HR were off-setting responsibility to, already overloaded, team and unit managers leading to difficult relationships outside of head office. The HR department was a very unhappy work place and middle managers were experiencing stress-related illnesses and sickness except at the level of HR manager. HR managers were responsible for supporting many service managers but had no hierarchical relationship within the organization forming a disconnection in the system.

6.3 Managerial behaviour

In order to fulfil these roles there were common patterns of behaviour. Managers routinely worked extremely long hours. The culture was described as being one where '*going beyond the deadline isn't really an option. You have to do the best you can within that deadline*' (Peter). As a result it was common for managers to work long hours;

We routinely do nine to ten hours a day. That's the normal day. Occasionally it can be longer than that. But nine to ten hours a day is the normal day...I would just prefer to stay here 'til half seven and get it done. (Peter, Head of Estates)

It's stressful because of sheer volume of work...I usually work here until 8 o'clock at night when the security locks it up, go to the hotel, grab a bite to eat and then start working probably until 11 o-clock, but I try to make sure that its only three nights a week. So when Thursday night comes I travel home, I don't do anything Thursday night. I work from home on the

Friday. Once Friday, 5 o'clock comes I make sure I don't do anything on Saturday or Sunday and that's a hard thing to keep to. (Brian, Director of Estates)

In common with many managers, working long hours was described as a choice. Managers felt that they were not compelled to work those hours but that it was necessary to put that time in to complete tasks.

Observations of a service managers' meeting showed that rapid, large scale changes were being implemented by this active group of middle managers. At this meeting there were 14 managers including five service directors, HR, finance and estates managers. The responsibility for action continuously fell on the operations managers. Service managers seemed to carry much of the responsibility for getting things done whilst HR business managers, finance and estates offered a supporting role. This excerpt from one of the meetings dealing with an immediate need to reduce estates costs shows how the managers switched rapidly between short term goals and long term potential for changes in rapid fire exchanges;

Peter, the director of estates introduces an agenda item about estates costs; 'This is so fundamental, this is bread and butter stuff and it can't wait. I want an action plan from Tanya, Carol and Anthony [service managers] in two weeks time. We need to reduce the number of buildings because it is costing too much...move to purpose built buildings...use hot desking... more efficient use of resources... sell H house to generate funds for capital development.

Anthony; 'if we reduce buildings we can maintain staffing?...we need culture change as well, when you move people to a new building they are more amenable to changing the way they work...IT systems are key to using estates effectively' [there seems to be a consensus that IT systems could work better.]

Peter jokes;'it's my aim to eliminate estates'

Carol; 'we need to get a group together and scope, we need to talk to Robert [Director of operations], we need to get a vision and push the initiative and get some early wins to take to the board.'

Anthony; 'there's got to be something positive for staff with new buildings, decent drinks machines, breakout spaces.'

Ella, HR manager; 'the biggest problem is clinicians, they want their own rooms.'

Brian, Director of Estates; 'Where your paper bin stands, that's probably costing nearly £200 a year for that bit of space, so if

you use that space more effectively, then that all starts racking up'.

Carol; 'we are looking at new ways of working. Now back to the agenda'.

By this stage a date has been set for the service managers to develop a plan. The meeting moved rapidly on to the next item. The short meeting dealt with many agenda items including the development of new IT systems, new senior appointments, estates planning, Lean recruitment processes. Whilst the service managers had to devise and implement service changes the supporting managers were taken to task, for example, why it takes so long to recruit new staff? In spite of the temporal and financial pressures there was much good humour between managers;

Tanya; 'the recruitment system is so un-lean'

Ella, HR manager; 'we'll put it on a diet'.

All the managers had to report at these monthly meetings against dashboard targets for sickness absence, staff appraisal rates and other organizational and national measures. The focus of the agenda items was to keep dashboard items at green.

The level of scrutiny has gone through the roof since becoming an FT. When I first started, for example, our budgets were pretty vague and not very accurate, whereas now 80% of it is year-end forecast and stuff. (Anthony, Service Director)

Mental health work could be unpredictable affecting all management groups, for example, when patients caused damage to property or a risk to patients was identified. If one patient could harm themselves on the property then all properties had to be adapted urgently. More often work could be scheduled and was co-ordinated via scheduled meetings. Observations of managers meetings showed that they dealt with many issues in rapid succession and were '*business, business, business*' (Peter, Head of Facilities).

Because of the wide spread of sites and jointly provided services, both junior and middle managers spent substantial amounts of time on the phone or in meetings sharing information and trying to get things done. For example, estates managers had to deal with in-house and contract staff;

> *For most of our headings we have multiple providers, whether that's on the maintenance side or facilities; catering and laundry. We have multiple providers so managing them can be time consuming. Email has been a fantastic initiative. I don't know how we could do our jobs without email.* (Peter, Head of Estates)

> *Where it's in-house* [staff]*, generally I can get things sorted out pretty quickly if there's a problem. If it's a contractual arrangement, sometimes we're one step removed from the contract, where we might have a service level agreement with a partner NHS organization who then subcontract to a company like Isis, Mediclean or Initial and we then have to raise it with the partner trust, who then raise it with Isis and it just feels like you are too far away from the staff.* (William, Deputy Director of Estates)

Service directors were responsible for specific income targets related to new services under rapidly expanding spans of control. Their performance was measured in terms of how well they were able to achieve these targets. This placed them under considerable pressure as the targets, at times, appeared to them have been plucked out of thin air;

> *Sometimes the execs have a habit of just drawing up plans, then we have to deliver the plans, then the plans become my problem if they don't get delivered....I was told we were doing a 15 bedded unit and I had an income target of if being full for 90% . It wasn't based on any market analysis but I had to make it work. That happens quite a lot. If it didn't work it would totally become my problem and I would be performance managed and judged by that...they say 'well let's put in that we'll do four new units and make a million or two and we'll worry about it later'... but what happens is, we don't worry about it later. It becomes my problem.* (Tanya, Service Director)

Within this trust, there was recognition of two types of manager. Firstly, the home grown, NHS worker who progressed into management and, secondly, the graduate manager brought in for their specialist business skills. At times it seemed surprising that there was little antagonism from those who were being replaced. Rather there was a tacit acceptance that this was necessary;

> *I think they are both valid. Looking at our directors here, for example, our Chief Exec, our Director of Ops, our Director of Nursing have come up from being basic grade nurses at one point. They were all mental health nurses who've worked their way up. But we have other people on the director's team and the management team who've entered as graduates, entered through the management training programmes, and they bring a good set of abilities and they contribute a lot as well. I think it's probably best to have a mix of different talents and different skills.* (Peter, Head of Estates)

So, in contrast, the new director of estates saw the old style manager as outdated and harmful for the organization. They were criticised for having a 'relaxed', 'that will do' attitude. He outlined how managers who could not keep up were moved into *'a siding'* to allow *'the express train to come through'*;

> *There is a point in time when you have got to say 'well okay what we need to do is move them into a siding for a period of time' because we can't afford the organization to slow down because their speed of development is slower that the organization's requirement for speed so we can actually, not necessarily get rid of them but to put them into a siding in order that we can allow the express train to come through.* (Brian, Director of Estates)

In reality, Brian warned of a change in approach towards managers who were not keeping up. He described how managers outside of head office were thought to be unaware of the extent of the cuts required where as there was a *'war mentality'* at head office that was forcing through previously unthinkable changes;

> *I use the word war-mentality, the amount of money that we are going to be forced to have to save, there isn't going to be any opportunity to say 'oh I don't like playing with you because I don't think I can trust you'. It will be 'well we've got not choice so let's agree, you know, whatever the Geneva Convention or the equivalent is, let us agree the rules of engagement and actually put them in to place'...and it might mean a new building somewhere, if it means that we can get rid of three or four old and inefficient buildings.*

The war metaphor continued in a changed attitude to managers who could not adapt quickly enough;

> *We haven't got time to spend on nurturing them. There are times when you will pick somebody up and carry them on your shoulder, you know, pick the wounded up, but there are times when you've just got to shoot them in the trenches. I think we are getting into that position where we might have to be shooting more, you know, then 'there are no wounded soldiers here'... You've got to be 100% performance here. So if you can't run then you will be shot, there is no carrying people.* (Brian, Director of Estates)

Brian, a newly appointed director, described the purpose of his two-year secondment to the organization as being to put *'systems and structures in place to move forward'*. He described how management capability had not been able to keep pace with the rapid growth of the organization and argued that this created stressors for established managers;

> *A lot of organizations have grown quite significantly over the last five, six years and some of them have grown their management structures but possibly some of the management capabilities have not grown to cope with the growth of responsibility. The sort of effects where businesses suddenly grow...they might have been superb at managing the small business but when it becomes a bigger business it's a different challenge. As a director it's very easy to go back to the comfort zone, doing what you originally trained to do, your original profession and you start reverting back to that. But you should be saying 'hang on a minute, my job is to direct so I've got to let other people' ...when it becomes a certain size actually there is a different style of management and different skills that you probably need to do that... and I think some of the stresses that you see around people in this building are probably because they are trying to actually run a small business even though it's a lot bigger than that.* (Brian, Director of Estates)

Whilst some managers described how dashboard reporting (red, amber, green) was a great improvement on previous information systems;

> *You can scan through quickly and pick out where your problems are...I was sat in meetings a number of years ago where there were reams and reams and reams of written reports, which are hard to scan through. So yeah, the idea of*

the dashboard is it, kind of, picks out the key things for you. (Peter, Head of Estates)

On the other hand, this quick reference system meant that staff were able to prioritise their maintenance job by rating it a high risk (scoring 15+ out of 25) then it would go straight to the board for action. There was a suspicion that staff used the numerical system used to over-rate risks to bring their jobs to the top of the list. Estates managers were engaged in trying to assess the real level of risk and negotiate these ratings down.

You sometimes wonder...is this really a 16?...have they given it that just to make sure that it goes in front of the board, and then it'll get some attention, it'll get some resource? (Peter, Head of Estates)

In the future, and in response to the cuts, the estates managers were going to have to half their numbers of properties in conjunction with a further service reorganization and the constant changes continued and those who could receive services were redefined;

At the moment we have 500 in-patient beds across eight locations, and we have community staff at 60 community locations and to achieve the savings they are talking about we can change that configuration, so that, perhaps we go down to four sites and instead of having staff at 60 community sites we go down to 30 or 40. You have to just keep reprioritising your services so that everything's targeted at the most acutely ill. Perhaps some patients that aren't as ill don't meet that threshold anymore. So we would just realign our services, our estates and facilities services to match that service reorganization. (Peter, Head of Estates)

Brian described how the balance of managers would shift as new managers, able to manage a larger business were grown or recruited and those who could grow would be *'restructured'* or *'retired'*;

Recognising that you are not going to grow the skills in everybody in the time scale and we are recruiting people with those skills and that broader aspect to actually help fill that gap. But eventually through succession planning we'll probably increase some of the staffing but eventually flatten that off again once we've dealt with the restructuring and take into account succession of those people as they retire because

we've got two or three people that are coming to the end of their working life. (Brian, Director of Estates)

6.4 Conclusions

You can't take managers out of the structure and still expect all the management to be done. (Carol, Service Director and Locality Manager)

We found that all managerial roles at MCFT were changing significantly. This was partly because of the management requirements of an organization that had expanded significantly and reduced management costs by more than 30%. Managers were experiencing increasing pressures of work through expanded responsibilities and increased demands in terms of workload as management tasks were passed down the ladder. There were particular pressure points where work demands were almost limitless and areas where work demands could be controlled. Unit managers and ward managers experienced very high work demands whereas community services were slightly more limited. Most managers were working extremely long hours although many believed that they had a choice about it. Most managers came in early to have 'a quiet hour to deal with emails and prepare for the day'. Opportunities for remote access went beyond on-call arrangements to mean that managers of high pressure areas were available for work at all hours. All management roles involved increased requirements for business management skills such as understanding budgets, competitive strategy, meeting targets etc, and there was some conflict between business and clinical values. As with the other trusts studied, middle and even junior managers at MCFT were expected to have significant levels of strategic awareness, although their ability to shape strategy tended to be limited.

MCFT offers an instructive case study, having undergone both significant changes to organizational form and extensive reductions in management costs, in advance of management cuts being faced by other NHS organizations. The effects of this restructuring were evident within the case as the varying challenges facing managers played out in changing management roles and behaviours. It remains difficult to attract funding to mental health services and there is, perhaps, no little irony in the fact that the trust was no longer, predominantly, a provider of mental health services by the end of the study.

7 Case study – Ambulance Trust

This chapter explores our third case study, 'Combined Counties Ambulance Service', or 'CCAS'. As this chapter will explain, this organization plays a critical role in the healthcare economy of the region of England under study. But it also seems to occupy a rather low profile in discussions of policy development in the NHS and has little influence over debates that affect it. This is something of a paradox - CCAS emergency vehicles are a highly visible and common sight throughout the region, threading through traffic with lights flashing and sirens blaring as they respond to emergency calls. Nationally, ambulance trusts represent the only NHS services that are genuinely available to any person 24 hours per day, 365 days of the year. Anyone in the region can call 999 and expect a CCAS vehicle and emergency crew (in various configurations) to respond quickly, according to nationally-mandated target response times. (For the most serious, potentially life-threatening, emergencies the target response time is 8 minutes timed from the second the call is connected to emergency control to the arrival of the crew). This theme, of intense, demanding, immediate, 'always-on-call' work emerged regularly during our time researching this organization, raising considerable challenges for managers, employees and patients of CCAS.

CCAS essentially operates two 'lines of business' – the well-known emergency ambulance service (known as 'Paramedic Emergency Services' or 'PES') and the much lower-profile non-emergency transportation service for patients to and from care episodes usually at hospitals or specialist treatment centres (known as 'Planned Care'). CCAS is a provider rather than a purchaser – it is contracted by local PCTs to provide PES and Planed Care services across a population of 7 million and a geographical area of 5,500 sq miles. This makes it one of the largest ambulance services in the UK and, by extension, one of the largest 'free at the point of need' ambulance services in the world. As of 2011 it employed 5,100 staff, and owned and maintained nearly 1000 vehicles operating out of 114 ambulance stations. It has one headquarters and four regional offices, in addition to three paramedic emergency control centres. It responds to around 780,000 emergency calls per year, and typically completes around 2.4 million planned patient transportations per year. The organization was formed on 1 July 2006 by a merger of three separate regional ambulance trusts into CCAS. It is, therefore, an organization that has undergone very substantial growth in scale the last five years.

Our research revealed that CCAS usually operates under severe financial and temporal pressures. It is also tackling substantial challenges associated with organizational change. The demands being placed on its front-line and managerial staff are growing in their complexity, variety, and intensity. In a somewhat ambivalent fashion, CCAS is becoming both more sophisticated in its clinical and logistical capabilities, while also struggling to fulfil all of its basic duties and responsibilities. The following text will explore why this is the case by exploring the daily lives of CCAS middle managers. It will focus

on how organizational changes toward decentralization, devolving of authority to line, and patient choice (Andrews et) (40) are difficult for managers to realize in the face of acute resource shortages and intra-and inter-organizational conflict.

We begin by providing details on five main organizational challenges that provide the context for what managers in CCAS are faced with, and how it is trying to adapt and modernize to face increasingly complex and challenging environments. We then move on to explore their roles and behaviours in great detail in order to provide a clear and robust account of the realities of managerial work in a vital and under-researched organization.

7.1 Managerial context

Our investigations at CCAS have revealed five main challenges that provide the context for managers in the service. Namely, these challenges are: 1) relations between management and front line staff, 2) a punishing regime of performance targets that relates to many areas of CCAS' operations, 3) severe resource shortages, 4) the changing demands of government policy, and 5), the legacy of the 2006 merger of three previously independent ambulance trusts into CCAS. The remainder of this section explains all five of these challenges in turn.

Firstly, working relationships between managers and roadstaff across the service were often conflictual and problematic. In keeping with other ambulance trusts around the UK, CCAS is also going through a major, long-term organizational culture change. This is moving it gradually away from the traditions of centralization, hierarchy, command and control, a uniformed culture, and a somewhat hostile industrial relations climate, to a more decentralized, competitive, and 'professional' identity. Paramedics have been recognized since 2000 as Allied Health Professionals regulated by the HPC. This means that traditional forms of hiring, training and career development in CCAS have had to change, with all newly-registered paramedics trained at universities on diploma programmes. This has changed how CCAS staff may gain promotion to management positions, away from the centralized, uniformed traditions of seniority and length or service. (This typically involved an internal career ladder through Patient Transport Services, then to PES, then into supervisory and managerial roles). Such traditional career paths are changing, and the OL & D team in CCAS runs a wide range of managerial training and development programmes designed to increase the capacity of its managers (especially in general management issues such as people management, performance management, budgeting, and even commissioning). This, it is hoped, will devolve traditionally centralized managerial tasks downward onto middle and junior managers, freeing senior leadership to concentrate on more strategic matters.

Another hugely important issue facing managers in CCAS, and one that arguably conflicts with the drive to improve the sophistication, professionalism, and complexity of the service, was the dominant role of performance targets that were set for all manner of the services' areas of business. The most famous and controversial of these is, of course, the 8 minute and 19 minute response target times for PES crews to respond to emergency callouts[5]. While these targets seem likely to have played a major role in reducing patient waiting times(103); (104), they are something of a blunt measure when it comes to understanding the impacts of ambulance trusts' operations on patient care. Targets are notoriously unpopular with roadstaff, who often point to how they encourage 'goal displacement' by instituting a way of working that prioritises speed of response over all other goals). Hitting time targets arguably becomes an end in itself, relegating actual patient outcomes to a secondary interest(105); (106, p25-6). Response time targets have a long history in UK ambulance trusts, and date back to the 1974 'ORCON' standards. (The New Labour government's enthusiasm for targets and performance metrics led to the introduction of similar measures across all manner of ambulance services' operations.) The drive to meet response times clearly has the potential to put a great deal of pressure on call handlers, dispatchers, and roadstaff. When responders arrive late, they often have to explain themselves to control managers. At the top of the chain, the Chief Operating Officer of CCAS meets to discuss target performances on a weekly basis with the Chief Executive of the region's Strategic Health Authority.

A senior HR manager explained the situation in an interview, noting the overlapping, contradictory demands of the multiple target regimes in play. With resources stretched CCAS cannot satisfy target 'x' without missing target 'y':

> *If we are below target it is not easy to remedy it. We can't poach staff from other NHS organizations. We train in-house [for several roles], and there is a minimum of four weeks, probably longer. There's driver training also. Some of them fail the tests and have to retake. Ordering new ambulances takes time. You can't just go and buy them, they are bespoke […]*
>
> *We have a management development programme. We release staff and managers for this where we can. CQC criticized us for not being up to date on clinical training. But we can't take people off the line easily. We're damned if we do and damned if we don't* (Senior HR manager)

This brings us onto the third issue that managers faced – perhaps the most critical – that of chronic resource shortages. Managers in CCAS provided us

[5] The 19 minute target response time for category B calls was dropped in 2011, as research showed that it has no clinical value (AACE 2011: 12).

with overwhelming evidence of shortages across the organization including the unavailability of personnel (including roadstaff, supervisors, and managers, largely through sickness absence and insufficient posts around whom to share the large workload), and vehicles (through such issues as breakdowns, or downtime for deep cleaning). The trust had a robust system of targets for capacity utilization of staff and vehicles and for handling sickness absences. Just 'keeping the show on the road' was a major challenge for CCAS managers, and the processes required to maintain adequate service coverage (arranging rosters, juggling crews) were themselves major, time-intensive undertakings for managers.

CCAS was currently contracted to undertake emergency and planned transportation of patients for a combined annual total of £250 million. The contract for emergency work for the entire CCAS region is £190 million. At the time of the research this contract was negotiated centrally by one PCT which acts as the 'lead commissioner'; in effect a sole customer which acts on behalf of the hundreds of thousands of possible organizations and members of the public across the region who may at one time require unplanned emergency care. The Planned Care contracts add up to around £60 million and are all negotiated separately with individual contracts from PCTs, and the hospitals and specialist treatment centres themselves; a total of 79 individual contracts. There is also one very large contract with the PCT in a large city. According to a PES Sector Manager, '*If we don't meet the care package, we don't get paid. It's becoming more ruthless if you like, more cut-throat.*' It is quite possible that CCAS will lose some of these Planned Care contracts. Indeed this has happened in the past, where other NHS or private ambulance providers have managed to secure contracts instead of CCAS, by promising to provide a cheaper and/or more reliable service. The risk of losing contracts to competitors was clearly 'on the radar' of many managers we spoke to. The larger contract for emergency care, at the time of writing, is obviously less vulnerable to competition, but in PES resource shortages were just as much an issue as they were in PC.

A fourth element of relevance to CCAS managers was the impact of national policy changes. In recent years, the traditional model of emergency ambulance care, of 'taking the patient to the hospital' has been changing. There has been a major national drive towards 'taking the hospital to the patient' and widening the range of treatments ambulance responders can perform. Research has shown that 70% of patients who receive an ambulance response are conveyed to A&E departments. It is estimated that around 50% of these transports are clinically unnecessary(107, p13). If patients' needs could be better identified and treated by ambulance call-handlers and roadstaff responders, this could obviate the need for onward transportation and costly hospital admissions. Ambulance trusts are also being asked to augment their capacity to handle forward planning, for handling major planned events (such as sports events)[6] or major unknown

[6] Provision of standby emergency healthcare at large, planned public events is increasingly being met by private operators, such as Ambuline and MedSoc.

emergency incidents (such as terrorist attacks). Ambulance trusts have introduced Hazardous Area Response Teams (HART) and new managerial posts in the field of Emergency Preparedness. Ambulance services face considerable pressures to increase the sophistication and complexity of their systems, even as they struggle to meet growing demands for the more everyday forms of emergency and planned care provision. In the words of a senior HR manager at CCAS:

> *When it comes to responding to genuine emergencies the staff are excellent, it's a case of 'all hands to the pump.' People work exceptionally hard and think on their feet. We are good at this - this is what we are best at. But certain other things that we have to plan for, we are not so good at, we're not used to doing it. Take the flu pandemic for example. This is all new to us.* (Richard, Senior HR Manager)

New policies have also affected Planned Care operations. Planned Care managers and supervisors are now forced to schedule patient journeys across geographically wider regions because the drive towards patient choice (in the form of 'Choose and Book') gives patients more power to choose the facilities where they will be treated.

Fifth and finally, the merger of three previously separate ambulance trusts in 2006 has caused considerable difficulties and has massively increased the size of the new organization. During our fieldwork visits, we often noted that all three areas still showed signs of pre-merger 'legacy' systems,[7] and several staff informed us that different organizational subcultures existed in regions, some of which had very complicated effects on service reorganization, such as the differing constitution of trade union representation across regionally-dispersed workforces.

To summarize the above, CCAS is facing up to a wide array of organizational challenges, and its governance structures tend to focus around numerical and temporal targets, many of which are nationally-mandated. These governance structures had powerful effects in structuring the ways in which managerial work was carried out at CCAS. The remainder of this chapter explores this issue in more detail, focusing first of all on the formal *roles* of managers, then on their actual *behaviours*. In other words we first describe their responsibilities, then explore the actions they take as they attempt to meet these responsibilities.

[7] Data taken from CCAS annual report

7.2 The roles of middle and junior managers in CCAS

This section will provide detail on the responsibilities of junior and middle managers across the areas of CCAS that we researched, namely the areas of PES, PC and OL & D. A good place to start our discussion is by describing, using our observation fieldnotes, the range of issues being dealt with in a PC senior management team meeting, which covered such diverse issues as policy compliance, patient complaints, organizational change, and staff training. This meeting ran for nearly two and a half hours with all present being highly disciplined and focussed. Our fieldnotes read as follows:

> *The meeting is taking place in a well-appointed room in CCAS HQ. Large flip-chart pages are stuck on the walls, windows, or hung from the picture rail. There were around 15-20 of these pages. They included text such as:*

- *Roster Reviews*
- *Vehicle Business Case*
- *Web Bookings*
- *Site Strategy*
- *Contract Management*
- *Employee Ts & Cs*
- *IR issues*
- *Quality*
- *Demand Tolerances*
- *Management Information/Quality*

> *[…]*
>
> *The chair of the meeting, [head of Planned Care] quickly called the meeting to order and explained that the meeting is taking place during what has been a two-day session working on a new commissioning process, hence the paper over the walls. […] 'These things needed to be sorted out very quickly, we're under a lot of pressure.'* (Fieldnotes from observation of Planned Care Senior Management Meeting)

Under discussion were such issues as compliance with CQC demands, complaints from patients (said to be small in volume - about 0.1% of the two million patient transport episodes per year), staff training, and staff conflict issues. A dominant issue throughout CCAS was performance management, again involving targets to hit in terms of the percentage of staff taken through procedures such as KSF. People management problems were common, partly due to difficulties releasing staff for training events. This caused morale problems (sometimes grievances) when staff had their requests refused. Below are some further observations from the meeting:

A senior HR manager moves on to talk about performance management in Planned Care. There is a weekly performance meeting where KPIs were shared. […] 'What we are facing is 'exceptionally challenging' she reports. […]

'Our targets on KSF and mandatory training is 90% through mandatory training by the end of March. This will go by the wayside. We've committed to 35%.'

Other middle managers (mostly heads of geographic sections) discuss this for some time, saying they cannot release staff from their teams easily for mandatory training or for KSF review. A consensus comes out that we should all 'Under-promise and over- deliver.'

The chair of the meeting mentions that 'What gets monitored gets done.'

[…]

A middle manager warns that 'We should not raise expectations too high. Taking a lot of people off the road for review is not sensible.'

[…]

'We're getting towards Christmas and New Year. We're running all these pressures in parallel. KSF is in there, but it will have to wait till January.

[…]

HR manager: 'Four or Five staff had to be swapped out of training. This does affect individuals but we have to manage some of the damage, the effect on staff motivation. […] Anyway, this individual should be put into training in January. This should take some of the heat out of it.'

Someone asks: 'Is this the one that's gone to a grievance?'

HR manager: 'No, that's someone else.' (Fieldnotes from observation of Planned Care Senior Management Meeting)

Our observations and interviews demonstrated that a significant amount of mangers' time involved handling staff rotas, accounting in minute detail for the hours worked and jobs completed of road crews, attempting to make cost savings wherever possible. It was a difficult task to maintain coverage of all the patients and areas while at the same time juggling crews and vehicles to cover sickness absence, training, vacancies, and vehicles unavailable, while also coping with the legacy issues inherited from the large-scale merger of 2006. An Operations Manager in Planned Care

explained the work involved in handling such tasks; ones quite typical for middle managers in charge of operational, front-line staff around CCAS.

> [I have] *Four CSM's* [Customer Support Managers] *reporting to me and 110 road staff across the north, central, south and 24 hour services. Primary responsibilities are ensuring we have sufficient resources out on the road, we're meeting our rota requirements, we're doing that within budget. […] Monitoring and managing sickness within defined parameters, so our sickness at 5% or what have you. […] offering support, advice and guidance to Customer Support Managers, […] liaison with the hospitals; dealing with complaints, queries from patients, carers, hospital Trusts. […] investigating those […] our responsibility is to ensure that we have a rota which is fully staffed and we aim to put out 98% of our staffing resource on weekly basis.* (Neil, Operations Manager, Planned Care)

He explained that about a day per week would be spent in direct contact with his four CSMs meeting individually on a weekly basis and monthly as a team. These meetings typically involved organizing rotas and handling absences while trying to maintain a family friendly working environment. Managers are continually juggling resources (human, financial, and physical) in order to keep to CCAS's contractual obligations. Managing sickness absence was again a major issue for junior and middle managers in this Trust. There were some fairly clear procedures (involving targets) designed to aid managers in handling this. (Sickness absence was a particularly serious problem in CCAS. Lifting injuries are especially common in CCAS, leading to a lot of difficult, long-term, and recurring problems such as back injuries.) Neil went on to explain:

> *Within our Key Performance Indicators we have a target around our resource at 98%. […] no more than 15% of our resource off at any point in time on annual leave. […] We're working to 5% or less as a sickness target.*

We interviewed and observed one of Neil's direct reports at work – a CSM called Amanda. This gave us some very useful insights into what is involved in accounting for and juggling rotas and crews. The observations revealed a great deal of micro detail on the everyday difficulties and frustrations with trying to run the service in the face of seemingly constant staff and vehicle absences and an increasingly complex and demanding case load of patients to transport to and from a wider range of locations. In the following fieldnotes, the researcher is sat in Amanda's office in a corner of a major city-centre hospital:

> *We are in a small room with no windows and walls painted yellow. The room is cramped, probably about 4ft by 10ft, with two very small PCs on desks along one wall. There are bits of paper pinned all over the walls, containing telephone numbers of hospitals and PCTs all around the CCAS region and beyond, and details of what needs covering in forthcoming training events.*
>
> *I am sat with Amanda, a Customer Support Manager, and Darren, a former Planned Care roadstaff member moving into a supervisory role. Both are dressed in the bottle-green CCAS uniform with 'AMBULANCE' written across their backs. […]*
>
> *'I'm doing all the figures from last week's work. I've got last week's rota which has everyone's hours that they've supposed to have done, and then this - the OCT240 which records what actually happened. Things run over, people move into unplanned overtime. […] One frustrating thing is that we do duplicate some paperwork. Having filled in the OCT240, we then have to upload it to the Dashboard Tool. So it's duplication, from Excel onto the dashboard.' […] 'recently, with all that's going on, we're now being told to watch every penny'.* (Fieldnotes from observation of Planned Care managers at work)

Managers had to manage not only increased *volume* of demand but increased *complexity* of demand. 'Karen', a supervisor in charge of scheduling planned care journeys, explained her work this way:

> *'Postcodes fit into either 'north' or 'south' and from there I can schedule them to appointments anywhere in the country.' Her PC monitor shows in total for tomorrow she's got 139 inbound trips and 141 outbound trips to organize.*
>
> *'The vehicles can take 3 patients at a time. So I have to juggle around and try to work out how to do this in the most efficient way. I currently have 18 wheelchairs, these take up more space on the vehicles.'*
>
> *'Sometimes it's 'a strangling day'' she says, and makes a gesture of having hanged herself - head to one side, tongue hanging out.*
>
> *'Is this normal,' I ask, '140 trips?' 'Yes, it is. The load has grown steadily in recent years, but we don't have an increase in resources to cope.' […]*

'[Patients] *have much more choice about where to go these days and that can mean going much further away than simply your closest hospital. People chose to go to some quite faraway places and that means bigger distances to travel.'*

''Choose and Book' does mean a better service for the patient, but it makes life harder for us. We have set higher standards, but then these standards are not achievable. Let's say you've got 5 patients in north [City]*, they might all chose four or five different places, rather than just around the corner, so […] I put them in 4 separate vehicles. The service hasn't expanded to cope. At times I'm down on vehicles, too. For repairs or cleaning, or down on crews with sick leave or whatever.'*

'I'm four crews down today, its sickness mostly. […] The other day I had just 8 vehicles. Also there used to be a cut-off point whereby if you've not booked in your journey by 2pm there's a cut-off and you're moved to next day's scheduling. But now I'm taking bookings up till 6pm. Anything we can do to secure the contract is good for us, but then we have to make the best of it.' (Fieldnotes from observation day of Planned Care crews and managers)

This excerpt ends with a very instructive phrase - *anything we can do to secure the contract.* Such talk was common throughout the study. Managers are acutely aware of the need to make their service as attractive as possible in the face of increasing competition. Yet with such resource constraints, the promises being made – to patients, PCTs, hospitals, CQC and the SHA - cannot always be achieved easily, or at all.

On the PES side, the forces of overstretch, incomplete information, and physical and emotional pressure on staff were magnified by the unplanned nature of PES work, which derives from 999 emergency calls rather than planned elective surgery or regular treatments. The work often involved severe, life-threatening accidents and medical emergencies, so the consequences of errors, bottlenecks, information failures, and delays are potentially calamitous.

Managers in PES also face a large and growing burden of information collection, interpretation, and reporting, often including having to explain what has happened out on the road following complex incidents. One Ops Manager moved from PES to PC partly because the demands of PES managerial work were becoming extremely burdensome, especially having to be on call for one 24 hour period per week on top of the normal working week.

All sorts of incidents [can happen] *from medical gas incidents to large scale road traffic accidents […] I was on call for when they called a major incident when the weather was bad and it*

> *snowed […] My first time on call: 'Naomi I think you better go out to this.' […] it was an RTA with an ambulance and a car, and the car was in someone's front garden. […] You get called out for lots of incidents. Some you can deal with quite quickly but in the main if you're called out you're probably three or four hours at minimum […] paperwork needs doing, you know statements off staff, etc. I've worked all day, been on call, been called out and then met my senior managers […] with part of the investigation.* (Naomi, former PES Ops Manager, now PC Ops Manager)

While working as a PES Operations Manager at one of the busiest ambulance stations in the country, she was faced with a multitude of stressors:

> *I did find the PES job stressful because I was the only 'real time' manager for the 150 staff - high workload - Senior Managers requesting detailed information at the 'eleventh hour' - responding to emergencies (big time lapse since putting clinical knowledge into practice and no time for refresher training and not put as a priority by senior managers) - resource issues created by high levels of staff sickness - long term sickness of Administration Officer for Group - various roles introduced i.e. constantly required to attend A&E departments due to delays for ambulance staff as A&E departments 'full'. Even with good planning of your days' work it would be constantly interrupted by demands of Paramedic Emergency Control and PES Staff i.e. attend incidents, deal with staff issues, station issues, liaison required. […]*
> *[I worked] ten hours at least per day and sometimes 6 - 8 hours at weekend (4-6 hrs taking work home which needed concentration to complete as at work there were constant interruptions).* (Naomi, former PES Ops Manager, now PC Ops Manager)

It seems to be a very serious situation where managers are given such huge spans of control over such a complex population to manage. Bear in mind that these 150 staff are paramedics and EMTs, who deal with some of the most stressful and exhausting work done in the whole of the NHS, and a working population with a history of troublesome industrial relations. PES managers were also frequently at odds with managers and staff of other NHS organizations, especially local hospitals where limited bed capacity meant slow handovers of patients. This would often tie up ambulance crews for 30-40 minutes when they were supposed to be 'clear' and back on the

road ready to respond to the next emergency call. Obviously this has knock-on effects on CCAS' ability to hit target response times.

Managers elsewhere in the service have little or no people management to contend with. We also interviewed and observed managers working in the Organizational Learning and Development team. Their role is to encourage changed behaviour and values of managers across CCAS, running a wide range of managerial and training programmes. As we shall see in the next section, this exposed them to a lot of workplace conflict and, at times, resistance from professionals and managers who would argue that genuine change in workplace practices is practically impossible with such stretched resources.

Other managers (often more senior) agreed that the culture change at CCAS was needed and that the traditional uniformed hierarchy had to be replaced with much wider understandings of the healthcare business as a whole. Take, for example, a story recounted by a CCAS sector manager:

> *The culture that's changed in the ambulance service, and needed to change […] it used to be a rank thing: planned care, A&E, supervisor, and work up, and it was almost a kind of hereditary thing, you'd get through and eventually become a manager without any managerial skills […] I always remember going to a meeting where this particular [CCAS] manager from years ago went and was holding court with senior police officers, senior PCT, senior fire, and really was well out of his depth.* (Sector Manager, PES)

Another middle manager mentioned that decisions about managerial career progression were 'entirely clinically focussed' and that CCAS:

> *have always been and probably still are the classic example of, 'you're a good clinician and you make a name for yourself,' that's going to get you into management positions.*

Question: […] has that changed over the last years?

> *'Not enough.'* (Workforce Development Manager, OL & D)

To summarize, the roles of CCAS managers varied widely according to their areas of responsibility. PC and PES managers had large amounts of people management to handle (involving organizing rotas to ensure maximum resource allocation), and were faced by robust governance regimes, usually emphasizing inflexible performance targets. PES managers, due to the work's unplanned nature, had the added demands of having to manage the

ramifications of serious incidents, often involving investigations. It was hard for PES managers to get time to complete their people management and performance management duties, which we will explore in more detail below. OL & D managers also faced a troublesome time trying to implement the organization-wide culture change.

How do CCAS managers cope with their wide and diverse workloads? The next section explores how they go about meeting these demands, emphasizing the themes of managerial overstretch, resource shortages, and handling difficult working relationships. As we shall see, at times managers' reports of overload, exhaustion, and management-frontline conflict had concerning implications for staff morale and wellbeing.

7.3 Behaviours of middle and junior managers in CCAS

The above section has highlighted the wide range of roles that managers in CCAS are responsible for. Resource shortages mean that these roles are demanding and unforgiving. Middle and junior managers in CCAS have learned to live with shortages, and talk of having to *'take it on the chin'*, *'just get on with it'*, and *'make the best of it'*. Managers try to find time to attend staff training and development events, but have become used to having this refused – for them, and for staff reporting to them. They also regularly experience blockages and failure of coordination across other NHS organizations (such as hospitals) and private sector providers (such as independent urgent care centres).[8] A large part of managerial work in this context involves improvising in order to get past blockages and shortages.

The impact of such bottlenecks and conflicts on patient care and staff morale and relationships are serious. Occasionally, description of these problems morphed into complaints about senior management, who were often described as not really prioritizing training needs. Instead, meeting the targets and the numbers is the dominate priority, and innovations that bubble up from the ground are sometimes not allowed to flourish. Below is an excerpt from fieldnotes taken while observing a KSF reviewer training event:

> *A PES Clinical Team Leader mentions an idea that people had on his station to set aside a specific training vehicle to use for clinical training. 'But […] our idea was just bombed out by management. It's now a core vehicle on the roster for call outs.'* (Observations from CCAS HQ KSF Reviewer training day)

[8] Similar stories of inter-service conflict are recounted by Reynolds (2010) who is especially critical of psychiatric and maternity care in London.

Inadequate resources - time and again - seem to stand in the way of allowing middle managers to be able to handle their complex and growing work demands. Also on this theme, our fieldnotes from observing a training day on commissioning indicate that the growth of demand volume and demand complexity (in this case involving private healthcare providers in the form of 'Independent Specialist Treatment Centres') has generated further pressures to adopt 'businesslike' practices:

> *A PES Regional Manager says: 'We're up against the private sector all the time. We are tendering against so much other stuff out there.'*
>
> *[…]*
>
> *A Planned Care manager talks about the growth of new specialist centres for renal or oncology that are 'springing up'. At present CCAS planned care is contracted to provide patient transfer to and from these centres, but 'they might want to offer private sector services of their own, or contract from elsewhere.' […]*
>
> *A PES Regional Manager adds: 'we don't have a monopoly any more. Who can do it for the best price, best feedback, best reliability? We have to be accountable for all that we do.'*
>
> *The training facilitator puts up a PowerPoint slide entitled 'Challenge Vested Interests'. 'We can't afford to be unresponsive,' she says.* (Observation from Commissioning Training Day, CCAS HQ)

Resource shortages make it difficult for managers to adapt their parts of CCAS services to meet new demands driven by this emerging competitive, business-driven environment. Many staff were apprehensive about, and critical of, the creeping marketization of the healthcare economy in which CCAS operates.

Another theme that emerged strongly across PC, PES and OL&D was the culture of roadstaff, and how this sometimes manifested itself as obstruction, rudeness, and even militancy and aggression against managers. Tara, an OL&D middle manager, while clearly stating that most staff are committed and approachable, described a significant minority that acts out of what she described as *'a mob mentality'*. While observing PC managers at work, one CSM, known as Emma, was very outspoken on this issue:

> *Amanda's been out on the road, Darren's been on the road, I've not. There's a real difference to it - in how you're seen.*

[…] Emma says that once she was at [District] *Ambulance Station and someone left notes on her car. ''Don't **** come here telling us what to do.' It was like the mafia!'* (Observations of Planned Care managers at work)

A PES clinical team leader put it this way:

Old hands here don't like change, they see it as being stuffed down their throat. Younger or less experienced staff accept it more. They're more eager to try new things, willing to accept them more. Others see it somehow as an attack on them. I've worked in emergency services for 25 years in different organizations, and I've listened to a lot of moaning. But I often think 'why are you complaining? Maybe change is good?' People are passionate, and that's ok, but sometimes they get aggressive. They react so funnily and sometimes I'm like: 'what was that all about?!' It's a weird response - a disproportionate response.

Perhaps one explanation for these reactions is the emotionally stressful nature of emergency work. The stakes can be very high. Front line responders take pride in what they do, and do not take kindly to what they perceive to be intrusive management behaviours. Where resources are spread so thin, the effects of such emotional intensity are likely to be higher than they perhaps need to be. The busyness of all staff means less time to discuss and work through problems with other managers. Prior research has shown that a lack of 'face time', or 'development time' is often a major problem which prevents employees from looking out for each other and passing on experience(1).

Tara, the manager in OL&D, drew attention to the need to change this unpleasant culture of blame and conflict. At times she described it as *'crazy'* and *'venomous'*:

What we're trying to do through our management development programmes is actually give managers the confidence to be able to manage again. Because what we've got now is a load of managers who don't manage performance because they're scared to, because it usually ends up as a grievance.

Control in [region] *is particularly rife with conflict. […] one of the mangers asked somebody to do something and they said, 'Well you can't ask me to do that unless I've got a trade union rep with me.' […] so it's this kind of culture that's bred, that's crazy. […] well, if you're setting somebody objectives, you've got every right to say, 'This is the standard I expect. If you're not meeting that standard then I'm going to give you some*

feedback and we're going to work out how you can.' […] that keeps us in a job because we've got loads of managers out there who haven't got the confidence to be able to manage effectively. (Tara, Manager OL&D)

A PES manager working in Emergency Preparedness described a worsening culture of *'back stabbing'* because of resource shortages, uncertainty around the service, and mounting threats of cutbacks and reorganizations. While much of the conflict seems to focus around 'overstretched' roadstaff versus 'out of touch' managers, such criticism was often unfair. We found many examples of managers under intense pressure whose duties no longer involve (or have never involved) working on the road. Managerial workloads in Paramedic Emergency Control centres, for example, could be particularly severe. We observed managers in two of CCAS' three control centres. Below, we report our observation notes from a day spent with Neill, a PES control manager:

Neill's role is to coordinate emergency ambulance response across a geographically and socially diverse area that encompasses two counties and hundreds of thousands of people. […]

Large LCD screens are mounted on the walls of the dispatch room showing statistics on call handling performance targets in real time. Neill, like those around him, uses a number of advanced computer systems to monitor staff performance, ambulance response times, and a range of other metrics; he switches regularly between different screens.

[…] The phone rings approximately every 120 seconds. When not on the phone, Neill is walking around the office helping colleagues with their decision-making choices, offering encouragement. At 10.23 Neill is dealing with 10 vehicles off the road due to mechanical faults, at 10.24 possible criminal proceedings against an ambulance crew and at 10.25 conflict between ambulance crews and hospital staff. Throughout the day disjointed accounts come over the airwaves and on the computer system, of a 'double fatal' car accident. At around 10.30 Neill notes that 'it's starting to build up'.

In the time we have to discuss organizational issues, Neill says that change has been 'non- stop' since the Trust was reconfigured in a merger some years ago […] At 10:40 I ask him to place this level of work intensity on a scale of 1-10, and I am surprised to find that we have reached only 5 or 6. Something appears on Neill's screen which catches his attention: a junior colleague is dealing with a case where a Doctor has apparently called in an MI (Myocardial Infarction)

*and then left the scene '**** hell'… He offers guidance to this colleague. Someone needs to go to [city] and there is no-one to take them. Elsewhere, a situation is developing which may call for the air ambulance to be scrambled.*

By 11.45 […] Neill no longer has time to walk across the room to talk to a colleague so he phones her instead. Throughout, Neill remains calm and professional, and tells each person he's called to 'have a nice day'. Still, the intensity level has risen to 7/10, Neill tells me, unprompted.

[…]

Someone is trapped and injured in their car but the ambulance can't reach them because of ice. Elsewhere there are reports of someone hit by a train. Someone else is caught in an industrial saw. By now, when Neill puts the phone back on the hook to make another call, it immediately rings with an incoming call. While he is on the phone, a junior colleague approaches his desk and asks about overtime…. By 14.10 Neill tells me that the intensity level has reached 9/10, but 'sometimes we go up to 11!' (Fieldnotes from observation day at Paramedic Emergency Control)

With the volume of unplanned emergency work coming in, basic managerial duties simply fall by the wayside. It was very common to come across the managers (junior and more senior) who don't have the time to perform managerial duties because of the intensity and unpredictability of front-line demands. The following observed discussion, at a KSF Reviewer Training day at CCAS HQ, highlighted this issue very well:

Kenny comes straight out with it: 'I'm a Clinical Team Leader, but I'm not really leading a team. We're all out all the time on 2-man crews. Really I'm a paramedic with admin duties. This won't ever change.'

Tara (OL&D Manager) – 'No it will. Team leaders are the key to sorting this whole organization out. […]. We devolve things like KSF to the line, and we get it moving, we can then behave as a team.'

Kenny – 'yeah, Tara, but we've done that. I'm in the real world. It's not gonna change. It always comes down to pressures. The situation won't change.'

Tara – 'No, if I thought like that I'd have gone mad!' […] 'You can't say it will never change.' (Observations from CCAS HQ KSF Reviewer training day)

It was interesting that Tara mentioned '*you can't say it will never change.*' It is disheartening to hear staff having given up on the prospect of things improving. The demands of the targets culture seem to consume all available time. Later conversation at this training event continued this theme:

> *Alan says 'The demand has gone crazy. Its nowhere near covered as it is.'*
>
> *Someone says: 'You can't maintain this level of demand, the morale will collapse.'*
>
> *Several say 'It already has, yeah…'*
>
> *Alan: 'We try to think of what we can actually do. Certain troops won't come in for KSF, it falls by the wayside. So you split up the crew, try to get it done, but they get sent to a call in [town] and you never get 'em back.* (Observations from CCAS HQ KSF Reviewer training day)

Such data, in keeping with our other three cases, reveal distinctive identities and subcultures. CCAS was somewhat on the sidelines of 'core' NHS organizations, and the specific workforce culture of uniformed, emergency services seemed to lend it a rather 'blue-collar', sometimes 'macho' feel, where some staff refuse to comply with bureaucratic demands, such as *'certain troops'* who *'won't come in for KSF'*. A paramedic by the name of Rachel, who was just moving into a supervisory role at CCAS, had this to say:

> *I used to be a nurse, and one thing I can't get over is the attitude of some people in the ambulance service. They seem to think it's ok to simply refuse to do things. We'd never do that as nurses. […] If a manager says you do it, you're doing it!* (Rachel, Supervisor)

This obstructive attitude coexisted with huge dedication and personal identification with the work. Alongside the complaints and conflict, many spoke of emergency medical work as 'the best job in the world'. For example:

> [Being a paramedic] *It's a hard job. There's no doubt, it's a hard job. But I wouldn't want to do anything else. If I got injured and couldn't do this job anymore I'd be destroyed. My life would be destroyed*. (PES Clinical Team Leader)

Such views were common, and they shed light on the high levels of staff dedication to patient care that was abundantly clear across the trust. But major conflict about managerial priorities was also highly visible. There was a widespread feeling felt that ill-designed performance targets and severe resource shortages got in the way of delivering genuine patient care, and created considerable strain for CCAS managers and staff. The final section of the chapter will summarize the case study and bring out its key thematic contributions to the overall study of roles and behaviours of NHS junior and middle managers.

7.4 Conclusions

According to national reviews of ambulance trust performance, patient satisfaction in general, is very high(104, p39). But our research also reveals some clear indicators of where CCAS cannot meet the demands made of it. In the words of a Performance Manager in PES, *'[e]verything has been trimmed so near the knuckle, […] there's no support, there's no safety net any more, everything is taut, and without flexibility'.* It seems in this case that the flexibility promoted as part of the reform process of New Public Management has been cancelled out by another – the drive to 'do more with less' -this situation is the result of the continual squeeze on costs and resources that is stretching CCAS to, and in some cases beyond, breaking point as people and systems struggle to function. Sickness absences then create further strains in the shape of wider work demands for others to cover. Managers in the trust typically have a very wide range of work tasks, and many reported long working weeks needed to keep on top of it all. Almost all managers reported having to improvise frequently when demands were particularly severe (such as bad weather or serious incidents that require investigation). Spans of control were variable, and there were some situations in which the span became barely manageable when certain other staff were absent or unavailable. Managers in CCAS appeared to work with great commitment and energy, but there are also strong indications of areas where they are unable to overcome certain entrenched problems. Morale appeared to be low due to feelings of constant overstretch and frequent interpersonal conflict. In keeping with general trends in public service delivery(40), CCAS is moving from a centralized, Weberian structure of uniformed hierarchy, to one of decentralization, emphasizing patient choice and devolution of managerial decision-making. But there seems to have been little thought given to how - or if – CCAS can actually achieve this change, or indeed whether or not such a change is desirable. As regards paramedic crews there have been some obvious performance improvements, such as faster response times, more sophisticated treatments and the opening up of more diverse and appropriate patient pathways(104). But much less is known about ambulance service managers and their working lives. Our study suggests that CCAS managers perform key roles in keeping the service running, but that they face very high levels of pressure, stress, shortage, and conflict.

In such a situation it is hard to imagine strategic changes, such as 'Bringing Healthcare to the Patient', emergency preparedness, or the Health and Social Care Bill, being carried out successfully, or without major organizational trauma. The OL & D team is attempting to put in the groundwork for allowing such changes to occur, but they too, were short on resources. For instance, CCAS holds training days where managers can learn more about how policy changes will affect the organisation at a strategic level, for example, changes to commissioning. While the middle and junior managers we spoke to evidenced a high degree of strategic awareness, this was sometimes tempered with cynicism and an awareness of how strategies tended to actually play out 'on the ground' rather differently from how they were intended. Middle managers, as was the case at the other trusts, need strategic awareness in order to translate strategy (formed by senior managers) into practice, but this translation took place, like many other activities, in a context of high pressure and indeed, constant readiness for the *next* set of strategic imperatives. There is clearly an urgent need for increased resources at crucial middle management positions among whom to share out the workload and to provide some respite from day to day fire-fighting in order to have any chance of increasing the sophistication of the service or changing its orientation.

8 Case study – Primary Care Trust

> *I've come from an organization that's going to be abolished to an organization that going to be abolished … I introduced myself as the Director of Workforce Reduction and Organizational Demise* (Senior HR Manager, Millford PCT)

> *The current disengagement evident across key groups like healthcare professionals and managers represents a serious challenge to the reforms. It would be a mistake to assume that these groups will simply come to accept the reforms in time*(108)

This chapter concerns, primarily, the changing roles and behaviour of middle and junior managers in a Primary Care Trust. The chapter also notes, however, the singular environment in which the research was progressed. Initially envisaging an analysis of managerial roles and behaviour in changing economic times, not long in to the prescribed period of empirical investigation the researchers found they were also analysing an organization that was to be delayered out of existence. Of our four case organizations, it was the PCT that was most drastically affected by the healthcare White Paper of July 2010 ('Equity and Excellence: Liberating the NHS', 109) and the subsequent Health and Social Care Bill, 2011(110). Such policies would make significant structural changes to the NHS, under which PCTs were to be abolished by 2013 with GP-led Commissioning Consortia assuming most of the commissioning responsibilities they formerly held. In addition, public health aspects of PCT business were to be taken on by local councils. The Millford PCT (MPCT) case therefore discusses how managers attempt to make sense of their organizational roles and behaviour in times of uncertainty and change. On the one hand, the case reflects the influence of political uncertainty, with ideological forces seeming to pave the way for private commissioning and franchising in what are traditionally public sector domains. On the other hand, the case reflects issues of personal uncertainty, with Millford (a 'pathfinder' organization in the restructuring exercise) struggling to make sense of what the future for its staff will hold. As one senior manager at MPCT suggested, *'to be a junior or middle manager must be awful at times'*.

8.1 Managerial context

> *We're half way through a re-organization when nobody seems to know what the outcome of the reorganization will be* (Sir Gerry Robinson, Newsnight, BBC, 8.5.11).

> *So that's when the restructuring came about. And they said to me, 'half of what you do is going over there and half of what you do is going over there'. So you [say], 'so where do I go'?*

'Am I with that way or am I that way'? [And they reply] 'Um, well, we don't know'… So for the last year I've been floating. (Middle Manager - Clinical, Millford PCT).

In Chapter 4 we noted how over the past three decades the pace of health care reforms in Britain has increased markedly. Within such reforms Primary Care has received extensive attention and forms of policy making have varied significantly(111). Links to other public sector bodies (e.g. education, social services) signals the importance granted to Primary Care and its central place in the transformation of health services(112). Indeed there have been a range of reforms of Primary Care in a drive to improve the quality of care provided and enhance cost efficiency.

With the 2010 White Paper, however, Primary Care in the United Kingdom was about to witness a particularly dramatic set of organizational changes. To establish a context for our case account of change at MPCT, we shall briefly discuss therefore the structure and management of PCTs prior to the White Paper and then consider broadly the changes brought by the latest round of reforms. By illustrating the reaction to recent changes within PCTs we establish a context for our ethnographic analysis of roles and behaviour.

Traditionally PCTs have been multifaceted organizations with different roles, responsibilities and duties (Primary Care Trust Network NHS Confederation, 2010). There are different ways of considering PCTs. From a patient's perspective, the definition given by the National Health Service (NHS) appears to be the most relevant. The NHS, on its website (http://www.nhs.uk), defines Primary Care Trusts (PCTs) as being in charge of '*the care provided by people you normally see when you first have a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test or a trip to a pharmacist to buy cough mixture'.*

This definition outlines the roles of PCTs in the daily lives of patients and justifies the attention they receive. In terms of a managerial perspective, PCTs have historically intervened in a threefold process which consists of the planning, commissioning, and delivering of health services to local communities(113). PCTs have been charged with providing primary care services and commissioning secondary and tertiary care(114). The 'shifting [of] the balance of power within the NHS(115, 116) a decade ago led to a relocation of the public health function and infrastructure from Health Authorities to PCTs(114).

With the 2010 White Paper, however, a plan emerged to put an end to PCTs by 1 April 2013, with much of their management responsibilities being transferred to GP consortia(117). From then on, GP consortia would be conferred around £80billion and be the main referents in terms of the commissioning of care. Much of the philosophy behind the White Paper was that significant efficiency should be gained from implementing the new management system, as it would reduce the level of organizational bureaucracy, which it was argued served to slow down the care process. The proposals in the White Paper would increase the efficiency and quality

of care provided and reduce the overall operational costs involved(118). In so doing, the dismantling of PCTs would represent an attempt to foster a more competitive system. This would represent another step in the political and economic liberalisation of the NHS, which was given major impetus with the National Health Service and Community Care Act (1990), which directed the NHS towards more market-based philosophies and policies. It was argued that the dismantling of PCTs would represent a positive phenomenon in that GPs would be more effective at setting priorities and making informed choices. Although the changes suggested would undoubtedly lead to cases of redundancy and demotion, as Carole Taylor-Brown (Chief Executive of NHS Suffolk) argued they would also create new opportunities, fostering the development of skills and experiences that would promote efficiencies on a larger scale(119).

At the time of writing (end October 2011, with the Health Bill approaching its second reading in the House of Lords), reactions towards the dismantling of PCTs remain mixed. There is still a dearth of consensus on the utility of this measure and particularly as to whether the changes initiated by the reforms will significantly contribute to the de-bureaucratization of NHS and reduced management costs. There is doubt in particular as to whether the reforms will improve the quality of health and care services delivered while saving money(120). In addition, there is a concern over the ability of GP consortia to manage a PCT budget without management help from that PCT. The Nuffield Trust for example suggested a longer stay of execution for PCTs in order to guarantee a smoother administrative transition (see O'Dowd, 2011(121)). Likewise, some senior NHS managers have suggested retaining PCTs - as a sort of 'Plan B' - in the event of things not turning out as planned, or simply in order to pass on their operational knowledge to GP consortia, whose potential weakness may be a lack of managers and managerial experience (see West, 2010(122)).

Given the nature of this context, which under current political proposals sees PCTs slated for closure, for our case study of roles and behaviour at MPCT the main managerial challenge appears clear – how do you maintain morale and keep operationally focused amidst incipient organizational decline? Framed by explicit political ideology and focusing on acute managerial experience this is the context within which our 'critical action' study of PCT managers' roles and behaviours is set.

8.2 Roles of middle and junior managers at MPCT

> *And the idea that you don't need management, I mean for goodness sake it's the lifeblood of an organization* (Middle Manager - Patient Advice and Liaison Service, Millford PCT)

MPCT was established in April 2001 and currently has funding and spend of just over under £450 million. It serves a population of just under 300,000,

which is an ageing one with 18% being 65 years or older; the projection is that this will rise by a further 10,000 people in the next decade. The trust covers one of the most polarised areas of wealth and deprivation in the UK, with those in the most deprived area on average having 12 years of ill health whereas those in the wealthiest only 6. On average, however, Millford is one of the healthier places to live in its geographical region, with life expectancy for both males and females being above the average. In recent years it has also ranked above average in the National GP Patient Survey.

In terms of organization structure, the trust was originally based around 6 main departments - Corporate Services, Finance & Estates; Commissioning; Public Health; Human Resources; and Provider Services. In recent years however it has operated a 'shared' HR service with another local NHS authority. Also in recent years these functions have been joined by 'Millford Direct Care' (MDC), the GP commissioning consortium. MDC was set up in 2007 by over fifty GP practices in Millford. It was chosen as one of the first national 'pathfinders' in order to spearhead NHS reforms. As such it was within the first phase of the development of GP commissioning nationally, placing its GPs at the forefront of the development of local health services.

In terms of workforce, at the start of research the complement was around 1200 of which 900 represented whole time employees. The vast majority of employees are female, in fact making up around 90% of the workforce, which is a common pattern for this UK healthcare sector. At the start of our research 56 staff were defined as 'senior managers'; that is, Band 8A and above (or 4.7% of the workforce population). Just over 30% of senior managers are male, as compared to 10% of the entire workforce; the vast majority (97%) work on a full time basis.

Data for the MPCT case study has been collected primarily through semi-structured interviews with middle and junior managers from both the provider and commissioning wings of the organization. Essentially the research remains 'ongoing', due to the rapidly changing nature of the political context surrounding this area of UK healthcare. Given the atypical nature of this case - a process of organizational closure and staff dispersal - the research team decided to extend the empirical research beyond the official period of funding, given the need to trace the employment fortunes of those displaced through restructuring. Thus although a large number of research interviews have been undertaken with middle and junior managers at MPCT (on both provider and commissioning sides) there are agreements with a number of interviewees to re-interview them in the months to come (and also plans to interview other potential informants). Indeed methodologically the case has involved a multi-stage research design in which certain managers have been interviewed on more than one occasion in order to account for the changing nature of the reform process. As a result, in terms of data, much of the material collected before the announcement of the White Paper in May 2010 focussed on the changing roles of PCT managers, whereas that collected afterwards on managerial

behaviour and organizational culture in the midst of the slated closure of PCTs. A final idiosyncrasy of this case is that (as noted earlier) the data is virtually all extracted from interviews. Although the original plan was to base the MPCT case on a mixture of semi-structured interviews and non-participant observations, during the late-spring/early summer of 2010 the research team decided against conducting the latter given the sensitive nature of ongoing political and organizational changes.

Our early interviews therefore focused on issues of the changing roles of PCT middle and junior managers. In carrying out theses interviews the researchers used a common interview schedule but one that allowed respondents to shape their own agendas in terms of the issues of importance to them (rather than have an information structure imposed, as with a structured questionnaire). This research approach was adopted in line with the preferred theoretical perspective of Critical Action Theory.

Much of the data collected on changing work roles has focussed on issues of accountability, expansion and intensity. This was frequently in relation to the history of large-scale organizational change in the NHS, and in recent times the adoption of specific management techniques, such as the Lorenzo system of task accounting or the philosophy of 'Lean' operations. Given the nature of this healthcare sector, many of the managers interviewed were what we would term 'hybrid managers', in that part of their work had come to involve a management element on top of a dedicated clinical role. This was frequently the case for those we interviewed on the 'provider' side, where this integration of managerial and clinical roles could sometimes itself require managing, for there could be conflicting pressures. As one of our informants explained, for example, in the following exchange:

> *So I manage the team, coordinate the sort of service that we're going to give. So some of it is in groups; well a lot of it is groups. Then there's some that's one to one. So I split the team up and tell them what they're doing from term to term, look at the [patient's] who are waiting, split the* [patients] *up. So I do all the day to day management of that but I've still got a clinical role as well, so I assess most of the new* [patient's] *that come in.*

Question: Right, so the role is how much clinical and how much management?

> *Well from last year, as I said, my boss has just come back from maternity leave,* [so] *it was very much half and half…* [But] *it's now gone to point 3 management, officially…*
>
> *But we're sort of getting dragged and sucked in to kind of, I suppose, justify our grades into a lot of the strategic stuff over*

there. So we're having to be quite protective of our clinical roles at the moment.

In explaining their changing roles many of our middle and junior managers emphasised the increasing level of accountability they encountered in carrying out their work. One of our respondents suggested that training in management techniques originally derived from industry or commerce, especially 'Lean' management, were important in order to *'justify all the higher grades'* within the NHS. However our interviews suggested contradictory pressures being placed on middle and junior managers in this respect. On the one hand, managers had to be more business-like and *'streamline* [their] *services and what they had'* amidst a climate of increased efficiency and economy. This was accomplished for example by adopting efficiency philosophies and systems such as Lean management, based on the Toyota system, in which many Millford NHS managers had recently been trained (with members of the research team also attending Lean training courses within Millford NHS). On the other hand, however, as a result of an emerging 'blame culture' within the NHS - in which 'everything has got to be justified' -there were simultaneous pressures of increased role accountability. This saw technologies directed theoretically at creating efficiencies in role performance seemingly bringing about short-term inefficiencies in practice. As one manager remarked in this respect *'there's just so much extra paperwork over the last five, ten years. The amount of paperwork and documentation has just got ridiculous'*.

One of the instruments regularly discussed in this respect was the introduction of the Lorenzo system of task and event recording, which was aimed at *'justify*[ing] … *literally every minute of every day'*. As one of our managers explained:

So we're spending a good proportion of our time typing in that we're on the phone and it's got to that ridiculous situation where we're losing so much face to face clinical time because everything has to be documented, down to what sort of phone call it was, so they can actually break down now every minute of every working day.

Managers understood, in general terms, that underpinning the system was a theory of economic efficiency, notably in terms of determining that the optimal type of work was being undertaken by the optimal level of employee. In this sense the system appeared reminiscent of the early role and task efficiency philosophies of scientific management, such as the *'separation of planning from execution'*(123). The formal aims of the system however often appear not that clear to our sample managers, even to fairly senior or experienced managers. A respondent with over 30 years in the NHS suggested for example that *'we assume it's just being stored by the*

PCT to [confirm] … that managers aren't doing stuff that could be done by somebody a lot lower'. This manager offered as an example the sending out of appointments,

> *[W]hy do I have to send my own appointments out? Not that I object to sending my own appointments out, but actually it's an awfully expensive use of my time that could be done by a Band 3 in the office. So that's one of the reasons they're doing it and they're trying to justify, well if we looked at Grades 4 to 9, what's the pattern that's emerging when they're putting all this information on Lorenzo? And obviously the lower grades should be doing more of the administrative, routine-type preparation of equipment that they're not doing because they have… they're being sucked into it all. They're actually doing a lot more clinical-type work.*

However rather than the information gathering being a single event, mangers felt it was instead a *'rolling programme' that was ultimately 'going to take over'*. One manager suggested there was potentially a *'huge mismatch'* between the time being taken up in collecting the data and the future efficiency savings. Other elements of the system concerned record keeping and target-setting, with again responses being mixed in terms of the perceived value of the system. So while on the positive side, the system, a nationwide operation, was potentially useful, for a clinician or manager could now *'type in a* [patient's] *name and see who the last* [clinician] *that ever saw them was and what other professionals are involved'* with the result that *'it's actually a really good tracking mechanism'*, on the negative side *'a lot of the information that we have to put in is just ridiculous and it's having a huge effect on morale across all grades'*. In relation to a suggested climate of poor morale at MPCT, one manager suggested, *'over the last few years it is probably Lorenzo control, I think,* [that] *has affected people most'*. Another manager, similarly, noted that Lorenzo was reflective of *'a culture in that … you can be blamed'* - one in which *'you're in a no win situation … almost as if you're guilty until you're found innocent'*.

The same manager linked new role demands associated with the Lorenzo system to wider issues of role expansion and the philosophy of Lean management,

> *When I first became a team lead it was very much just, 'Right, this is the number of* [patients] *you've got* … [and] *this is the number of* [clinicians] *you've got, this is the number of sessions you've got. Just work out who's going where and when.' So it was very pertinent to the job that I did. Whereas the role has now … expanded phenomenally. And we have to*

> *look more strategically at 'Leaning' [philosophy of Lean management and services and, you know, attending meetings that you think, actually, this has got nothing to do with the department that I'm working in, which again affects morale because you think this isn't what I trained to do. I don't mind managing a service that's pertinent to my training but the role has broadened and all the HR-type issues that in the past we wouldn't have had to deal with they've been now put down into our layer.*

This area of MPCT had also experienced decentralisation of some tasks in a manner that served to create greater administrative 'distance' between various roles and layers. One of our middle managers noted for example how,

> *Our manager has moved up, so she's now much more distant. She used to do all the HR stuff, all the annual PDRs, performance reviews. They were all done by her. Annual leave cards, those sorts of day to day things. She approved the annual leave and the [in] lieu time, whereas she has now totally distanced herself from that and that is very much down to us. It sounds quite a petty thing but it's, you know, we are doing much more of the day to day management of the whole department now and our manager's definitely moved a step higher in terms of, not in terms salary, but in terms of the sort of job she has to do.*

Middle managers suggested to us that the Lorenzo system also had implications for working hours. Informants noted that it served to clarify in particular the difference between 'official hours and non-official hours' in carrying out the managerial work role. As one manager put it, under Lorenzo *'you should be able to see how many hours people are doing, which you can do'*. She continued that this was *'the interesting thing'* for *'you log in everything you've done for the day'* in a system where, in her specialism (to bring it in line with normative official hours in other areas of the NHS) *'we're supposed to be* [on] *a 36 hour week, slowly building up to 37.5 through the Agenda for Change'*. However this is the 'official' working period, for the same manager noted how under Lorenzo *'you can look at your hours and think, 'Oh I did 54 hours last week''*. Although this middle manager suggested that in terms of additional hours *'there isn't an expectation that you do them'*, she also admitted *'but you've got to get your job done'* with the result being that she was *'tending to do at least two hours a day over and above what I get paid, easily'*.

This manager went on to explain how most of her 'unofficial hours' were completed in her PCT office rather than at home – *'I only log on Lorenzo the hours I do here and I don't put them on in lieu cards or anything'*. However she admitted also that she was known on occasions to *'come in on the holidays'* and on these occasions she would *'put that on my [in] lieu card'*. She admitted further that *'in reality … I very rarely take that time back. It's only if I have to for funerals or whatever then I would take that back. But I have got a remote laptop. Most of us have got remote laptops'*. Indeed it was common for many of our sample managers to regularly work 'unofficial' hours over the weekend. Another of our respondents suggested how she tended to *'clear emails at weekends'* and that *'if I've got a report to do at home, then rather than staying here 'til half six at night, I'll take it home'*. As she no longer had as many domestic commitments as when her children were growing up, in fulfilling her role she now tended to *'do a lot more work at home'* and assumed that *'even lower levels are doing the same'*.

Many of the sample managers interviewed in this case cited the impact on clinical and managerial roles of the 2004 NHS Agenda for Change. Part of the Agenda saw a set of national job profiles agreed to assist in the process of matching posts to pay bands. On the positive side, one of our managers described a process by which *'the NHS looked at everybody's job and everybody had to rewrite their job description'* with the result that *'it supposedly brought everybody's terms and conditions in line'*. So instead of '[her clinical specialism] *being on Whitley council pay and dentists being on whatever', those who worked for the NHS 'were put on the same pay scales, from cleaners up'*. Subsequently each job description was *'put to an Agenda for Change Board and evaluated on a particular scale'*. Although managers responsible for writing these role descriptions suggested it *'took a phenomenal amount of time'*, because *'we had to make sure we got everybody's job descriptions correct'*, they suggested it also had the affect of *'address*[ing] *all those anomalies of people who didn't have a specialist role but were actually doing one'*. The Agenda thus, in an equitable way, *'gave them credit for what they did'*.

Some informants suggested further that the Agenda for Change had a positive effect in terms of role development and career progression. One of our respondents noted for example how,

> *Whereas a* [clinical role], *traditionally, used to be on something called Senior 1, Senior 2 and Basic Grade and they only had three incremental points, so once you got to the top of your three you had no career progression; you were stuck there. So I'd been stuck on the Senior 1, which was the top one for eight, nine years, knowing that unless I became a full time manager, there was nothing to do, whereas with Agenda for Change, it gave you a much broader band of increments. You couldn't move right to the top but it gave you a broader band and it made career progression a lot better.*

As a result of this restructuring however some respondents also remarked that the exercise had also cost the NHS a *'phenomenal amount of money'*. In particular it was felt that the Human Resources planners and advisors to the exercise had been frequently over-generous in terms of the positioning of role descriptions in relation to the remaining increment levels available in salary bands. As a result, *'what the NHS didn't realise was actually how much it's going to cost them, because even though we are assimilated across on what we already got paid, they didn't realise that most people then had another four or five increments to go'*. This manager went on to suggest that a problem has now arisen in that Human Resources is *'now back-tracking a lot of them'* and saying *'oh your job description needs rewriting'* with the result that *'there's been quite a few downgrades'*.

In a process that involves input from both the clinical department and Human Resources there remained the potential for influence from both directions. Indeed the system seemingly allows for a situation where *'the odd member of staff … says that they now want their job descriptions rewritten because they feel now they're doing a much, a more defined role'.* The problem however is that in the current economic climate *'there's no money to pay them'* and thus *'if they do get* [their] *jobs upgraded we haven't got the funding because funding, as public sector, of course, at the moment is dire. And the restraints are very, very frightening this year'.* Indeed a general policy of 'job freezes' had existed for a while with respondents suggesting that this caused particular problems for relatively small clinical departments within the PCT. Given the high percentage of female employees this could be particularly acute in situations where staff took maternity leave, *'for anybody who goes off on maternity leave, jobs aren't being covered, and in a small department like we have that has huge repercussions if a member of staff goes on maternity leave and isn't filled'*.

8.3 Behaviour of middle and junior managers at MPCT

> *Erm, it's gruesome, honestly ... They set targets and every month you get how many patients you've seen in that month. And that is on line for you to reach your target at the end of the year, because it's that points make prizes. So the PCT gets paid depending on activity.* (Middle Manager - Clinical, Millford PCT)

In fulfilling such changing roles we also enquired about the ways in which managers routinely met increasing work demands in terms of changes to practical work behaviour. Again discussion with middle and junior managers often turned to examples of increased work intensity when asked about the structure of their 'normal working day'. Expanding on the earlier

theme of role expansion, we were surprised by the regularity with which our managers reported that they were often in the office about a half an hour or an hour prior to the official start of the working day, reportedly to 'clear the decks' so that they could begin 'proper work'. This frequently meant doing administrative work prior to starting a round of meetings, telephone conversations or direct clinical tasks. As one informant suggested, she was regularly *'in about half past seven in the morning, clear*[ing] *emails if I haven't cleared them at the weekend or the night before'*. Another reported similarly, *'I tend to get here about half seven, quarter to eight in the morning and will try and deal with any emails that have come through'* this being useful because *'the staff here don't tend to come into the building till about half past eight, so at least I've got an hour of quietness where I can deal with some of the emails'*. Doing administrative work outside of 'official' office hours seemed totally natural to our managers and considered just *'part of the job'* in a situation where it was often difficult to manage the round of daily activities given current financial constraints.

Managers also reported how much of their work behaviour could be devoted to trouble-shooting or resolving issues of confrontation with clients, this often being linked again to the general climate of economic restraint. One respondent, for example, described how much of her work behaviour was *'dedicated to troubleshooting'* and frequently to,

> *Trying to pacify [relatives] who want extra [treatment] therapy for their [relations] and we can't provide it. Because we haven't got the staff. So a lot of that front-line confrontation.*

This was considered a regular part of contemporary work behaviour in this healthcare sector, for in reality,

> *It's all right saying, 'Oh yes, but refer that over there because they're [the] ones who've caused the cuts. It doesn't make any difference because I'm the one that gets that awful phone call from [a relative]. You know, 'I want more [treatment for the patient]. But, yeah, actually I want more [treatment for the patient] as well, but this is the situation we're in. So a fair few of those in a day.*

The same manager reflected further on how in the current economic and political climate *'trying to keep on top of* [the daily work demands] *with decreasing staff is very difficult'*. She noted for example how,

> *You get in a quandary. So, what do I do? Do I really bust a gut and work every hour I can and keep on top of this 18 week*

waiting list, which then actually doesn't tell the powers that be over there that we've got a problem. Well actually if we see those [patients] within the 18 week timeframe what do we do with them after that? We haven't got the staff to see them. But which is best? Do we see them and then know the problems we've got on a waiting for [treatment] list; or do we not see them and we let our waiting list grow. And then they'll complain over there at Royal House and then we can say, yes but you've cut our staff. You know, you've taken two full time equivalents out of my team in the last three months who've gone on maternity leave and aren't being replaced. So you've got to expect that my waiting list's going to increase, but then you get more complaints … You're in a no win situation really and that's what I think we're going to do at the moment is, you know, I'm going to see as many as I can see, but that waiting list is going to rise over 18 weeks.

A related, theme that emerged regularly within our discussions of work behaviour with middle and junior managers at MPCT was that of dealing with 'monitoring' and the nature of 'targets'. Discussion of this theme was again frequently linked to reactions towards the Lorenzo system, which had begun to have an increasing impact on the nature of our managers' work behaviour. Problems could arise here if there was a mismatch of expectations between clinical and managerial functions within MPCT. As one manager commented about work being monitored through Lorenzo,

We have annual targets that we have to meet and that in itself poses a massive problem because the person who sort of devises our quota for the year actually doesn't know what we do. So they can say, right well you know if you look at [clinical specialism]*, they can see I don't know how many thousand people in a year and they can say, you know, the appointments are five, ten minutes each, in out, in out. How come* [my clinical staff] *are only seeing six* [patients] *in a day?*

Respondents in some clinical areas remarked that monitoring problems could arise in situations in which there was a lack of sensitivity on the part of some management functions (notably HR) to the qualitative difference between the nature of, and demands on, different clinical areas, which some managers felt was not always appreciated by those managing the monitoring systems. As one of our respondents commented,

Well we're a bit different to somebody with a [minor medical problem]*. You know, and every* [patient of ours] *is very different… So I've had arguments with the guy over there* [in

> HR] … [who] *said, 'So, looking at your diary on Lorenzo, you see one* [patient] *for half an hour but your next* [patient] *you see for an hour?' Well yes, the half an hour is a review of a* [patient] *that I gave a home programme to, so I'm just checking him. Actually a new one is a lot more complex and needs an hour. And* [HR say] *how come with some* [patients]*, you can see them in a group? So why don't you see all* [patients] *in groups because that way you can see six in an hour? But [we say] not every* [patient] *fits in a group. So you're working with mathematicians* [in HR] *and we're working with real people here.*

Another manager noted how this could result in the setting *of 'sometimes very bizarre targets for us that we're expected* [to meet]'. Reminiscent of well-known target-setting practices at General Electric(1) and reflecting seemingly a neo-liberal agenda in healthcare provision, she described how *'every year we've got to increase our productivity by ten per cent'*. Commenting critically on this system she queried, *'how can we increase our productivity with (a) increasing numbers of* [patients] *and (b) less staff?'* And it's those sorts of pressures, which are very unrealistic'. This 'hybrid manager' elaborated on how the provider-commissioning split in MPCT can affect such practices,

> *Because we're a commissioned service from the PCT we have to achieve that otherwise they won't give us the money next year'. It's one of the few things they actually look at, is how many contacts we've had and it doesn't matter what quality that contact is. If you can just tick the box that you've seen ten [patients] in a day, that's fine…And they can't, they just cannot see how we work and that they're very unrealistic. The target for this year is something like 12,500 contacts. Now, you just need to get some extremely complex [patients] who take, you know, one [patient] could take a whole morning.*

Given a wide variation even in related clinical work, some managers felt that a lack of sensitivity towards the demands on different areas could be dysfunctional for the service as a whole. One manager commented on how a clinical service related to her own - due to the complex nature of their patients - was working on only *'one and a half contacts a day'*, this being due to the fact that for each case *'you're not just offering treatment' but* instead *'you're liaising, you're assessing, discussing the case history, putting programmes into place'* etc. So in comparison to areas such as this, our informant remarked that *'my team … looks super-efficient, because we're working on six or seven a day'*. This manager suggested however that when confronting such Lorenzo averages the response from wider managerial functions tended to be *'oh we'll have more of you, but we don't*

want any more of that one because that's a really expensive service'. In contrast the reality was that, in being linked services, *'we couldn't do without them because they're working with very complex* [patients]*. But they can't see that over there'*.

A similar logic was apparent in discussions over other recent management practices within MPCT. One informant suggested for example that in the new managerial discourse *'we're expected to produce this 'how much an episode of care''*. To arrive at this estimate,

> *One of the questions was, 'how many times do you need to see a [patient] before you cure them'? You know, I saw a [patient] last week who I cured there and then on the spot. Finished. [But] another [patient] you think, I'll have him until he's sixteen.*

This informant elaborated,

> *But that's what the management don't realise … And that is what is so frustrating in our role that we want to deliver a service but actually we're having this made more and more difficult.*

Under the logic of Lorenzo, information could potentially be made available for various clinical functions on *'how many contacts do you see a year and so on'*. As such, by extension of a market based approach in healthcare,

> *They could actually say, right well, we've looked at how much you provide for 15.5 full time equivalent* [clinicians] *but actually* [name of PCT in adjacent authority] *have 15.3* [clinicians] *and they're providing an extra 2,000 contacts a year. We're going to buy* [treatment] *from* [the adjacent authority]*. In which case we'd be out of a job. So we've got to make ourselves marketable, which is why 'Lean' happens and why we've got to keep a check on how many* [patients] *we can see, what sort of packages of care.*

The same manager suggested that to make their services look economically attractive some clinical areas had adopted a practice of not listing certain tasks as part of a 'package of care' – *'not including things like report writing and programme writing'*. The response of her department when confronted with such comparative data was to say *'well that's not fair because, yeah,*

you can do five packages of care if you're not including that in your bit but actually if you're going to do a real package of care, it costs X amount … But we've got to prove that we are worth basically what they give us as a service'… The danger of that is they could go to [local city] or [local town] or buy in private [clinicians]. Our informant concluded,

> *That's what these Lorenzo contacts are, right, you've got to provide us with 11,000, 12,000 contacts a year. And they don't really care what quality it is, and that doesn't sit with a, sort of, a [clinician] who wants to do their best for the [patients]… I was talking to a colleague at lunchtime who's the same age as me and she said, you know, we're churning that many [patients] through that there becomes a fine line to where you make a difference. And if we see too many [patients] we're not making a difference.*

In certain clinical functions within MPCT in order to achieve a greater measure of resource flexibility and also balance the budget they have started to behave 'somewhat entrepreneur[ially]' in aspects of 'income generation'. Managers suggested to us that Millford NHS was now *'very, very good at income generating'*, with one of our middle managers offering a personal example of such behaviour and how it related to resource management,

> *For example I produced a couple of intervention tools which we got published and are used nationally, so we get royalties from those and I go round the country delivering training on that. So obviously we income generate my time, we charge for my time. So all that money we income generate we put into staffing. So we pay for fixed term staff, who help support the waiting list and what have you.*

For this manager, however, a potential problem with such income generation was that, over time, it can become incorporated within target estimates. She explained how *'unfortunately those figures get absorbed, so Royal House think, oh we're doing really well because we've got 25 members of staff here but actually, they're only paying for 20 of them and the other five, myself or another couple of* [clinicians] *are income generating … So basically what they're saying is all my income generation is going over there now as* [part of] *our target'*. With the tightening of targets and that *'we've got to make ten per cent savings financially'*, this manager suggested that as a knock on effect,

> *We're having to lay staff off. Fixed term staff, we're not able to keep. So those targets they gave us become unsustainable. The fixed staff tend to be cheaper because we tend to take on assistants who can work with a therapist by pooling the numbers of* [patients] *we see, or they can work with individual* [patients] *with a very definite programme that we give them. So actually they are very, very cost effective because they're cheaper and they can through a lot of [patients], but we're not giving them the complex* [cases]. *So we're in this awful situation that, you know, I'm going off to do training but actually the money I'm producing is going over there to plug some deficit over there. So again, that affects morale because there's fixed term staff* [that] *are holding up a core service.*

Our sample managers reported other examples of entrepreneurial behaviour and the development of a business-oriented narrative, as when one informant commented that her boss was *'very good at income generating and seeing gaps in the market'*. In fact the manager in question was so adept that *'you can see her ending up in business'*. This example of entrepreneurial behaviour was similarly related to generating income from external training and the subsequent employment of fixed term staff,

> *She's a national* [brand name of clinical technology] *trainer, and she does training that brings in the money that then pays for fixed term contracts. And you know … as a manager we're constantly now looking for gaps in the market. You know, what can we provide? What could we actually sell?*

One of our respondents explained that whereas earlier in her NHS career such external offerings would more often than not be provided on a *pro bono* or *gratis* basis, the contemporary climate in MPCT had seen the emphasis change from a 'public' to a 'business' service. She offered as an example of this new professional behaviour working with groups in the local community,

> *So I had a phone call from somebody last week, could you do some evening, twilight sessions to [groups in the local community]? And whereas in the past, I'd go yeah just let me get my diary. Yes, when do you want me? It's [now], right, well, we'll have to charge you. And even now I'm in that mind-set now and it doesn't cause me any problems. So we charge. And obviously then that money comes back into the department. So there's a huge need to do that.*

Other services provided outside of the clinical setting could be arranged on the basis of regular contractual agreements with local bodies, although within the domain of public services in Millford these services were based increasingly on business logic. As the same manager noted, *'we've got three or four what we call service level agreements with outside agencies … So they're buying in a contract with us for so many sessions'*. The same manager commented on how the custom and practice in this respect had changed significantly, as had the mindsets of individuals within MPCT, for,

> *A few years ago, if you'd have said to me that all that training you do in [Millford public services] and things, you're going to have to be paid for it, it would have sat very uncomfortably because as a [clinician] you're there to provide a service'. But the culture is [now] that the ones who want the training haven't got a problem. They know that they're going to have to pay for services because … well, we are still super caring, but it's not this, you know, we can open our arms and take anybody on board anymore.*

Finally, discussions of the onset of a more business oriented culture within the recent history of MPCT could regularly return respondents to reflect on 'Lean' management and operations within the organization and particularly of conducting management training to this end. So prevalent was this cultural ethos in internal management and staff development that as one respondent remarked *'in any training you go on they start to talk about Toyota'*. Another manager suggested that although the Lean logic had not yet fully *'cascaded down'* it was certainly beginning to happen. She suggested this was not just about *'tidying your desk'* but in her department had seen the re-evaluation of roles with a view to placing some duties within lower skill bands, with her department being an early adopter in this respect,

> *When anybody leaves or goes on leave and comes back part time, we actually re-look at their job and think, right, well we're saving three days' worth of a Band 6. Do we really need a Band 6 or could we use a Band 4. So we've done that constantly. So we're totally skill-mixed now, so we've got lots and lots of Band 4s and lots and lots of… So we are mixed. So I think we have been, as a department, very, very good at 'Leaning' wherever we can'.*

8.4 Conclusions

These brief examples of data from our ethnographic analysis highlight trends associated with a perceived intensification of managerial work within PCTs. Such examples relate the expansion of occupational roles to increased intensity of work and techniques for greater role accountability. They also describe ways in which middle and junior managers within PCTs have reacted to such changes in a period of heightened organizational uncertainty and occupational pressure.

In addition we have noted how role expansion and intensification has also been linked to behaviour consistent with an increasing emphasis on business culture in health services. Many of our managers had adopted behaviour patterns consistent with images traditionally associated with private sector organization. Examples have included working long hours, developing activities reflective of commercial entrepreneurialism as much as public service, setting and meeting operational targets, and establishing organizational relations based on a contractual or commodified logic. Although only scratching the surface of the extensive interview data produced in the course of this case research, our analysis demonstrates the changing culture and symbolism of healthcare management in an era defined increasingly by neo-liberal philosophies and private sector business techniques, albeit that such an era is not universally perceived as positive by all professionals exposed to it.

Finally we have also noted that in addition to our formal research on managerial roles and behaviour this case study was affected significantly by the announcement (in May 2010) of the Government White Paper on healthcare reform, which ostensibly heralded the termination of PCTs. Given this situation, our study of MPCT managers began to focus increasingly on how they were managing within a context of 'workforce reduction and organizational demise'. Although additional to the original research aims, we have assessed the behaviour, attitudes and roles of managers at MPCT as they attempt to keep staff motivated and operations stable in a period characterised by demoralisation and decline. Indeed in many ways the MPCT story became an acute one as staff began to assume that the organization had closed from the day the White Paper was announced rather than from the date officially projected for closure.

9 Analysis and discussion

This chapter draws together the analysis of the four cases to produce a combined discussion of the overall findings from the project. It addresses the main research question of the project concerning the effects of the New Public Management ethos on middle and junior management roles and behaviour in UK healthcare. This encompassed an examination of the realities of managerial life for middle and junior managers in healthcare organizations. Within this we included comparisons of the various roles and behaviours of middle and junior managers in respect of competing organizational governance regimes, an exploration of the interactions between managers and frontline staff and their impact on service delivery, and the building of knowledge relevant to the practice of managers in healthcare organizations.

We speak to this research agenda by extracting and describing five central themes that are common to all four cases. These themes are summarised as: 'The constant flux'; 'Narrative management'; 'Cost control'; 'Conflicted role identity'; and 'Struggle for workplace dignity'. In explicating these themes, the discussion reflects our particular approach to critical ethnographic analysis - Critical Action Theory – which highlights the interaction of interpretive and ideological forces.

9.1 'The constant flux': A shifting governance/organisational framework

Our research data demonstrate that the roles and behaviours of middle and junior managers must take place in the context of a more or less constantly shifting policy framework. We found that managers at all levels were aware of current political and ideological machinations in Westminster, although these were of most strategic relevance for senior managers at director level. Having said that, middle and junior managers had their own views on government policy, with some predicting the privatisation of the NHS and others (accurately, as it turned out) predicting job losses, particularly amongst their own ranks.

National NHS policy in a less overtly political sense exerted a powerful influence on middle and junior managers; this tended to be manifested most significantly in the sense of governance, with its implications for monitoring, information collection and management. For many managers, complying with governance policies through information management was a significant draw on their time. Aside from the actual burden of data collection, when asked about the fact that NHS policy seems to operate in something of a state of flux, managers we spoke to tended to agree with Rose, a manager in the Acute Trust, that:

it increases the pressure. It decreases the potential satisfaction for people. It does impact upon patient care because you can't have your eye on both at the same time, potentially.

Rose's ambivalence, which is expressed succinctly here, was widely shared:

Having said that, within that […] there's some really positive things, you know, I really applaud governance.

And Dawn, Children's Services Manager at the Acute Trust, expressed her views on the implications of governance thus:

Thinking back to when I was first a nurse and even into the nineties you had a Directorate Manager and then you had Ward Managers, and then the Matron sort of evolved out of Clinical Nurse Manager and then this huge amount of work landed on us around targets, around governance, benchmarking, quality indicators…

While it was recognised that additional managers were employed to help deal with ever growing and ever changing governance, managers generally viewed it as something that added to their workload. This situation may be one that was exacerbated since, as Dawn noted, the NHS had now *'realised'* that extra layers of management were not affordable. Indeed, as our fieldwork at Millford was coming to a close, the role of Matron was eliminated. Similarly, Lois - another nurse manager with whom we spent time at the Trust, was 'restructured' into a less senior project management role. She was moved to ask: *'who is going to pick up all this other stuff...?'*

This constantly shifting terrain was perhaps even more apparent at MCFT, the mental health trust, to the extent that mental health services formed but one part of the service provision by the end of the study. The organisation had doubled in size by taking on non-mental health community services from disbanded PCTs, thereby diversifying both the business and the demands upon managers. In addition, new business developments were targeted at high value services such as providing secure in-patient units which could command higher payments than standard services. Mental health services had struggled to maintain their income, even during the preceding period of increased investment and, as a result, MCFT had recently reduced management costs by 30%. This meant that the responsibilities of the remaining managers were increased considerably and senior managers worried that many middle managers at the trust were not able to cope with their expanded roles. A further pressure facing remaining managers was the dual structure. As a result of on-going management restructuring many managers occupied a position in effectively, parallel hierarchies. The first, historic system organised services by geographical

area and the second, new system was organised by service type. The new system anticipated changes to payments for mental health services which had yet to be announced at a national level.

As levels of management were eliminated across the NHS, these vacuums were expected to be filled by other providers, such as private contractors, a system which had the potential to make interorganizational relationships in the NHS more complicated, based increasingly on arms-length market relationships, and possibly harder to coordinate. This issue surfaced in the ambulance case study. In April 2011 CCAS was nearing the end of negotiations to secure one new contract for the next three years across all the PCTs that need CCAS Planned Care contracts. This would have simplified the contracting and commissioning system considerably, but the announcement of the government's White Paper 'Liberating the NHS' which scheduled the PCTs to be closed by 2013 meant that CCAS' contracting arrangements had to be put on hold. CCAS was forced to redraw the contract to just one year for the time being, waiting to see how the system changed before entering into a wide array of new contracts with the range of customers wanting to purchase CCAS services. This was but one example of the ways in which constant change was making it hard for trust managers properly to plan ahead; to get beyond the discussion stage and on to implementation.

Another example in the ambulance trust was of a change process that was badly handled. Here, both CCAS and others contracted in from the private sector appeared to lack adequate resources to handle a change effectively, leading to failure with obviously severe impacts on staff morale. History seemed to be repeating itself, as this story replicates the highly problematic introduction of a new computer-aided dispatch system at the London Ambulance Service back in October 1992, of which the subsequent inquiry revealed that neither LAS staff who were to operate it, nor the new Computer-Aided Dispatch system was ready for full implementation. This major adverse incident revealed a 'deeply ingrained culture' among roadstaff, a 'climate of mistrust and obstructiveness', and where management 'misjudged the industrial relations climate so that staff were alienated to the changes rather than brought on board'(124, p3).

The following are observation fieldnotes taken from a training day at CCAS on commissioning, which highlight managers' frustrations with the fragmentation of NHS services across multiple private providers:

> *A PES manager starts to complain about the private company that has won the contract to run the administration/front desk/reception for the A&E at a hospital in a nearby town. They also run a medical centre in the area. 'Up to 40% of our A&E patients are supposed to go to their Urgent Care Centre. This is creating conflict – they are a private company running A&E reception. They're jammed up, the 4 hour waits are about*

to trip, they're snowed in, and we bring more patients in. We're the fly in the ointment. They want us to take them elsewhere.'

A Planned Care manager tells a sad story about the place. 'It was also there where we had the disaster of the new electronic patient record forms. We trialled it at that hospital and it was a disaster. Paperless PRFs. The project manager cried. There was a lack of research into what was needed. We were running […] there was basically 4 systems running. The one supplied by [private telecommunications contractor] was supposed to be a paperless PRF, but it didn't work with the other three systems.'

The PES manager continued 'The worst bit was that the manager went to Costa Coffee to get takeout for everyone, but only bought coffees for her immediate team! Everyone was incredulous. I went out and bought some Caramel bars from the vending machines to try and placate them…' (From observations from Training Day on Commissioning, CCAS)

Of our four case studies, however, it was the PCT that was hardest hit by issues of change and restructuring. We have described how much of our analysis of roles and behaviour at MPCT was conducted against the backcloth of such organizations being slated for closure under the proposed Health and Social Care Bill. Even before the announcement of the 2010 Health White Paper, one of our middle managers in the Human Resources department, Gladys, noted how at MPCT: *'It's a constant programme of restructuring and service modernisation and service redesign'.* Another MPCT manager noted how *'it's certainly not the NHS that I came into. I've probably been through five or six different reforms, you know, Griffiths and all that sort of stuff. I've been through all of that. And you come to a point where you're sort of battle weary really'*.

There was not a little irony however when Gladys extended her analysis of flux and change to offer her views on the likely scenario for MPCT in the years to come:

Well … I've worked in a number of organisations [where] these kind of crises come up all the time don't they? And unless an organisation disappears completely, which they do sometimes - I haven't worked in an organisation that's ever disappeared completely - they are accommodated in some way and life continues, doesn't it. That's my view. And so I don't know how it's going to pan out in reality. I think things will definitely change. I don't think this department will be sat here like this in 12 months' time; definitely not. But my view is that things, you know, things just go on, don't they?

A few months later, in wake of the announcement of the 2010 White Paper, the incoming new Head of Human Resources, Jonathan, in paraphrasing his official position, felt able to introduce himself to MPCT staff as *'the Director of Workforce Reduction and Organizational Demise'*. Noting how large private sector organizations had a reputation for managing significant programmes of change, he felt that a CEO of a major global corporation however:

> *Wouldn't be saying … Let's reduce management costs. Let's get rid of a lot of people. Let's bring in clusters. We'll bring in the GP consortia as well. And that's on the back of TCS as well; there's TCS going on isn't there? What else are we doing? We'll change all the MP stuff, all the IT stuff. We'll stop all that and we'll start something else'. You just wouldn't do it … They're trying to fix something that largely isn't broken*

The frequency of organisational restructuring at all four cases gave observers, and perhaps managers themselves, an impression of almost constant change. In the Acute Trust, for example, having moved to a system of managing different areas through business groups, some associate directors had begun to feel that such a system encouraged 'silo' working, limiting collaboration across business groups and potentially impacting on coordination more widely. The original intention of the move, to allow managers to focus on their areas of specialism, appeared to have had some negative consequences. Some middle managers sensed that this structure would change yet again. During previous restructuring exercises, some middle managers had to go to *'little interviews for our posts'.* Asked about how they coped with this state of ever present uncertainty, managers tended to respond that they had become used to it during their careers in the NHS. For some, the only sensible response was to *'keep your head down'* and not worry too much until actually summoned to the associate director's office. Since the strategic decisions around restructuring were beyond the control of middle managers, such a response was understandable.

Decision-making and organizational reforms were not all driven in a 'top-down' fashion. Our research also revealed trusts developing change initiatives of their own. The acute trust was responsible for both reacting to and implementing policy and framing the way in which it was managed. An acute trust as an organisation did have the option of developing its own initiatives. One such was the Lean Hospital Program encountered at our research site. Initiatives such as this provided another frame within which managers had to perform their role. Learning about, being trained in, and implementing the Lean Hospital Program was not a negligible draw on the managers' time and energy, and for some, it was an initiative too far. Whilst

on observations we heard of two wards 'dropping out' of the initiative through lack of resources – that is, staff and time.

9.2 Narrative management

We found that Millford Foundation Trust placed a heavy emphasis on communicating narratives about the hospital's strategic direction to all members of the organisation. While any member of staff might see a poster encouraging them to save money by turning off lights (cost, or 'waste' reduction being a key narrative), it was middle and junior managers who were entrusted with actually implementing initiatives, and it was they who were the focus of senior management's efforts to instil a sense of these initiatives' importance.

The Lean Hospital Program, for instance, included 'in-house' and professionally delivered training, visits to factories operating using Lean manufacturing principles, and importantly, a series of Lean Hospital Awareness events. These events allowed managers who had successfully implemented Lean practices in their units to showcase their achievements. The managers most active and engaged in the Lean Hospital implementation strategy were given the title of 'Lean Trailblazers.'

Lean practices were framed in the Trust's narrative as practices that, while necessitating some commitment of time and resources on the part of managers and junior staff alike, had the potential, ultimately, to make their work easier. This was to put it simply of course, but it is true to say that narratives of Lean management at the trust played to many managers' desires for more simplified systems (on the ward, in the office), whilst at the same time offering potential time efficiencies that would allow staff to have more contact with patients. While some nurses did buy into the vision of a more efficient and smoothly functioning hospital that the initiative created, some nurse managers were somewhat sceptical about the Lean program, and viewed it as yet another transitory initiative *'like all the others'*. Others viewed it benignly, even positively, but retained their sense of humour. During one Lean training session a horse and cart passed close by the ground floor window, heading in the general direction of accident and emergency, prompting one nurse manager to quip; *'look – a Lean ambulance.'*

Narratives about management at MCFT, like those at Millford, included the adoption of national programmes promoting Lean management ideas such as 'the productive ward'. Junior and middle managers used these programmes pragmatically. They tried to serve the stated aims of improving quality and reducing cost, but also tried to use the programmes to gain scarce resources as part of 'productive ward' improvements. The managers were uncritical of these programmes, instead using them as a further opportunity to try to obtain basic supplies for their department. What the clinical managers noted was the shift in the language they used from a focus on patient need to attention to business goals. This had real

implications for manager's roles as the development of clinical expertise via clinical supervision had been replaced by performance management meetings. Rapid expansion came at the expense of a specialist mental health business focus and so the common goal became to bring in more money in the form of new contracts. In common with the acute trust, management ideas formed the basis for good humoured banter between managers; *'the recruitment system is so un-Lean'* (Tanya, Service director) *'We'll put it on a diet'* (Ella, HR manager).

Likewise at MPCT a middle manager commented that *'any training you go on, they start to talk about Toyota'*. Again managers were not so much critical of the Lean approach per se, as of the fact that that, despite widespread training opportunities, it had not been fully *'cascaded down'*. The range of Lean applications also appeared quite wide, or else in certain instances at variance with the original philosophies applied in the automotive industry. In a department that had been *'very good at Leaning'*, one MPCT middle manager discussed this wide range of applications - from *'basic things like … organising rooms, organising your desks'* to the reappraisal of roles in cases where staff may take maternity leave and return on a part-time basis. Here the goal appeared to be better 'skill mixing', through a process in which a department would re-examine a job and ask *'do we really need a Band 6 or could we use a Band 4?'* Here elements of a job could be re-designed so that *'we're saving three days'* worth of a Band 6' and thus reducing departmental costs.

Similar issues arose in the ambulance case study about the penetration of managerial ideology. Some managers expressed a certain cynicism about the 'badges' that were being placed on many polices, which was sometimes described as getting in the way of the job in hand. For example Tara noted that:

> *I went to a talent management forum where there was a lot of HR directors and, you know, OD leads and things like that […] And one of the things I said, […], 'We're just so keen to badge everything. Instead of just getting on with the job,' […] We, kind of take something and we go, 'Right. This is a whole different ball game now. You need to do this, you need to sign a statement to say that you're doing it...' And it is an NHS thing. I don't know whether it's a public sector thing generally, but certainly an NHS thing. That we just like to take that much and make it into a massive, great, big project. We just badge everything so easily. […] But we tend to just, kind of, go, 'Oh, that's that, and that's that, and that's that.' And then, you know, just not think about it logically really. That actually, you're doing all of those things already. Stop! Do you know what I mean?*

9.3 Cost control: constant battle to secure resources

The managers we spoke to were acutely aware of the importance of managing their budgets effectively, and financially planning for the medium term. They were also very aware that financial resources available to them were tightly controlled by more senior managers and ultimately, by an apparently general shortage of money at their trusts and across the NHS as a whole. They were sometimes faced with difficult dilemmas, having always to balance patient care with limited available resources. An extended quote from Lois illustrated the situation extremely well:

> *But for example today I am asked, I have got to save money. We've got cost improvement programmes and we have to save money and you've heard about the NHS and the debt that they have, £2 billion or whatever it is… So I am asked as a nurse/manager, Lois, have you looked across your budget statements? Can you save any money? … Yes, I can look at that and I can say I can make a saving. But now we've been asked to look at nursing posts and that's very, very difficult… It's very difficult because in your mind you've got quality issues, delivering care issues. The hospital see it very much as the business we've got, all these patients that come through the system, the activity we know has increased and the acuity of the patient has increased. […] But these people have to be looked after safely on the ward. So where you've got dilemmas like that, for me it's a real dilemma.*

The mental health trust had experienced cost pressures for longer than the other three trusts, they maintained their income level by expanding service provision and cutting management costs. They were suffering severe resource shortages and were focusing developments on areas that attracted better funding. Income targets were being allocated to service managers as a means of managing costs. These targets were said to be somewhat arbitrary but once itemised at a performance management meeting, it became the managers' responsibility to meet the target. These targets were said to be 'back of the envelope' calculations that bore little relation to market prices or demand. Service managers, middle managers with little discretion then had to find a means of achieving the target. In one case this meant redesignating a newly built facility to provide services for patients that attracted higher payments. The drive to focus on cost containment and bringing in new payments resulted in conversations, such as the one reported in the case study chapter, where the director of Estates reports how much the space for a paper bin costs; *'costing nearly £200 a year for that bit of space'* (Brian, Director of Estates). These conversations extended to clinical care, so that nurses were acutely aware of the costs of treatment decisions and were aware that the need to reduce costs was paramount.

A middle manager in the ambulance trust put it well with a very simple phrase: *'you can't do both – something will give*':

> *We haven't got the resources to go out and deal with the jobs the way that we are doing. So things need to change for that but, we've still got the same targets that we had, you know, we've got targets to make, I think quality and performance need to be dealt with separately in the Trust because we're trying to meet performance and that's up here, where, actually we're supposed to be a patient care and quality type organisation and the two things don't always… […] You can't do both, something will give.* (Vicky, Manager, Emergency Preparedness, CCAS)

And in the case of MPCT we discussed the impact of targets and target-setting at length. One clinical manager described the *'very bizarre targets*' that could be set for her department in a financial climate where *'every year we've got to increase our productivity by ten per cent'*. This manager commented on how increasing *'productivity' in line with this target was extremely difficult because of '(a) increasing numbers of* [patients] *and (b) less staff'*. As a result, this could lead to 'unrealistic' targets being set for clinical departments. Other organizational changes at MPCT related to the goal of being more cost effective saw departments encouraged to be more 'entrepreneurial' and thus to generate income from offering services – such as training - to outside bodies. Informants described how training for local voluntary bodies, previously offered on a *gratis* or *pro bono* basis, was now charged through formal contracting. As such the contemporary climate had changed from that of a 'public' to a 'business' service. A potential problem arising from such entrepreneurial activity however was that, over time, the income generated could become incorporated within a department's target estimates.

9.4 Conflicted role identity: carer or businessperson?

In fact, so pervasive was this sense of tension between care and cost, that it in itself can be considered a key theme. This conflicted sense of identity was expressed by a number of the clinical managers, as well as some of the business and senior managers with whom we spoke. It is a conflict in the very roles that middle and junior managers in the NHS must perform. They were, as we have seen, financial planners, yet at the same time, had to prioritise patient care.

Dawn, as we saw earlier, was *'fairly comfortable'* with having to balance cost concerns with patient care, and yet had a sense of *'constant tension'*. Like all of the medical managers we spoke to patient care was the priority for Dawn, and again, in concert with many others, she was in no doubt that

the NHS had 'a business ethos.' Gabrielle was similarly cognisant of this ethos, acknowledging that the NHS operated as a market:

> *It is actually a market we're talking about. It's talking about generating income to make improvements. I understand all that and I know the general public, they don't; they wouldn't like to hear that. And for us I do understand about balancing budgets. I know what they're talking about when, you know, they want you to get the patients in and out and I will work with that but there's also the other side of me that, you know, I see the caring side and that's not to slip either.*

The use of the phrase *'the other side of me'* neatly conveyed the sense of tension within a healthcare manager's identity that was created by the necessity of fulfilling two key overarching roles; managing scarce resources, and delivering the best patient care. The pull on middle managers to move to wholly business orientated role identities was described by Hamir, Community Services Manager at MCFT;

> [The person] *who did my job before me was more like an expert clinician..it would have been alright three or four years ago whereas now you're calling on a whole range of managerial skills. In a way it's a different personality type as well as a different skill set.' Mental health service middle managers were operating primarily as business managers. In HR, many managers had been recruited from the private sector and were introducing private sector HR practices to manage business performance. For middle and junior managers in other areas, additional areas of work were divided into projects. Each project could attract a different rate of pay depending on how the work had been graded. Managers were identified as 'home grown, NHS managers' or 'graduate, business managers'. Although the trust had managers who had worked there a long time, the trust had moved to bring in business managers at a senior level, for example, in the Estates department. These managers then restructured the levels below with a preference for business-minded managers.*

In CCAS, the phrase *'patient care has gone out of the window'* was twice used by separate staff members we had observed and interviewed. On one occasion, a junior manager in Patient Transport Services used this phrase when describing the large volume of patients they had to transport (who were often vulnerable people) with limited resources per patient.

> *What concerns me is the way we treat patients now, it's like they want them to be treated like we're transporting boxes. Patient care has gone out of the window. There's so many people to transport, so much to do, the human element gets lost. You have to make recommendations in your report – more money!* (Fieldnotes from observation day of Planned Care crews and managers)

At MPCT many managers described a shift towards a move business-oriented culture within PCTs. As Gladys, a Human Resources manager, explained (in the period prior to the Health and Social Care Bill):

> *In the last 12 months the provider arm has gone through a massive restructure in terms of management structures to align services, and they're actually in business units now which, you know, I pushed because it is a business. You know it's not some kind of happy* [family]*. I'm not saying it's an unhappy place but, you know, we need to get the focus here that our business is delivering health care.*

The same manager noted the potential for role conflict inherent in moving towards *'business line management'* and how for many staff adopting a management role:

> *that is a big jump … because what you have to also bear in mind is a lot of our managers also still deliver a clinical input. So you know our service managers, even at quite senior levels, still run clinical service. You know, they still turn up and run a clinic. And that must be quite hard, I think, for them to do. And it also, you know, it tugs them in two directions.*

This tension between caring and cost-control was perhaps manifested most concretely within the occupational culture of nursing. This may explain why increasingly, more senior middle management roles were being filled by people with a private sector business background; people who, in Lois's words, *'had the business knowledge, but not the nursing knowledge.'*

Our research revealed, however, that business managers also had an acute sense of the importance of patient care – indeed, like nurse managers, it was often what motivated both their choice of career and their daily work. Perhaps selecting managers with a business background was primarily a pragmatic strategy for embedding business knowledge and skills into the management framework; skills that would be expensive and time consuming for the trust to impart to clinical managers to the same extent.

9.5 The struggle for workplace dignity

The roles of middle and junior managers across the four NHS trusts constituted a demanding array, and managers had to employ a range of behaviours in order to fulfil them properly. We found that for some managers, the behaviours employed in order to complete their work centred on two strategies. Firstly, managers were required to work at a high level of intensity. This ranged from meetings where issue followed issue with (for the observer at least) dizzying rapidity. Even here, middle managers with a more senior role might be required to check their beepers for important messages, and respond if necessary. Clearly, the ability to multitask was a key prerequisite for many middle and junior NHS managers. During 'on call' shifts, we observed phone call following phone call, beep following beep, task following task, problem following problem. Even on a standard shift, there was often little time for breaks and lunch, where it was taken at all, might be a ready meal heated up in the office microwave and eaten at one's desk; a chance to catch up on the considerable volume of administrative work, at the very least. Not every day was manic and even the on call shift can be a 'famine' as well as a 'feast', but performing work at a high level of intensity was often the only solution to a middle manager's workload.

Other, more junior managers spoke of *'monkeys'*, as in *'monkeys on my back'.* Ward managers and other senior nurses spoke of being accosted by an almost constant stream of requests as they attempted to make their way from one end of the ward to the other. These are 'monkeys', issues brought to them by colleagues that could mount to unmanageable levels. Senior managers at the trust encouraged middle and junior managers to try and avoid taking on other people's 'monkeys', but this was easier said than done.

Not only was this workload tough to manage in terms of its volume and rapidity, it was often emotionally draining. Emotional stressors were derived from the 'life and death' nature of much of the work they were involved with, but they also derived from some unpleasant forms of workplace conflict. In the ambulance trust, for example, several managers recanted stories of resistance and obstructiveness by front-line roadstaff amid a highly traditional and conflictive industrial relations climate. Such stories included *'roadstaff resenting managers'* visits to 'their' ambulance stations, and dealing with sicknesses, complaints, grievances, and investigations were common, and often stressful, tasks for CCAS managers.

Staff shortages were a large feature of all four cases. While usually episodic, absences have also become effectively systemic, encouraging managers to 'firefight' and improvise in order to manage day-to-day patient and task demand. According to Gabrielle at Millford Foundation Trust:

> *I mean, for example, in an emergency situation, they may open another ward and to cover that ward, they will take staff from, say, here or somewhere else, leaving us down with our staff numbers, to have to manage with less staff, to deal with*

the same number of patients and that happens constantly. That's not just an odd thing. That happens all the time. Another ward's got, there's somebody off sick, so you have to take somebody from your ward to send to their ward.

Work intensity was apparent at MCFT among ward managers, for example. Many managers described their extended working hours as a choice or a result of their own lack of time management*;*

I probably still spend quite a bit of time with patients but that's because my time management's really poor... at the same time there's the requirements from, from the Trust perspective and from legislation that, you know, we have to be achieving certain targets and audits have to be completed and the documentation that goes with that and the administration, so you're, kind of, you're very much split, really. (Gail, Ward manager)

In CCAS, a manager spoke of how the sheer intensity and volume of work was essentially unmanageable, leading to staff burning out and become unable to cope. She highlighted the dangers to work dignity in serving as a manager in Paramedic Emergency Control centres.

Day by day, not only the workload, but the fact that they're all in that room constantly […]

They're in there and do not move, yeah, they'll go for a quick break, when they get in there, they're sucked in and they live it and it, you know, health wise, it's not great for you. […] I've been here seventeen years, I worked in the control room for, I would say, for the first twelve years of that, we had a general manager that turned over every two years. Now, I think I probably worked under six general managers because they burn out. […] when you're that involved you can't see straight, you know, so things, performance starts going really bad, which is where we're at again at the moment, you know, you've got a senior manager in there who has been there and, again, this isn't something I could say out…outside of here, you've got a senior manager who has been in that post for nearly three years and desperation starts setting in, they've been off sick now, they've been put on a little project because, two or three years in that sort of environment is so unhealthy. You know, the pressure, the amount of change …

> *And their managers are always on top of them […] the sickness there comes up and then the managers are battling back down […] being a manager in that area, at the moment, isn't comfortable, you know? It's not a nice place to be in.* (Vicky, Manager, Emergency Preparedness, CCAS)

In order not to compromise patient care, the staff that remained, including middle and junior managers, faced a higher workload and intensification of their work. Such a situation was part of the culture of 'normalized intensity'(11) that was evident all across the four cases.

The second strategy employed by managers was to work longer hours and take work home. This was reported in every case study, by almost all managers we interviewed. Informants in the MPCT case were typical in this respect with managers regularly reporting that they were in the office long before the official start of the working day in order to *'clear the decks'* before they began the *'proper work'*, which on the 'provider' side usually referred to carrying out a clinical role during the 'normal' day. A manager in a clinical specialism was typical of many when reporting that she was regularly *'in about half past seven in the morning, clear[ing] emails if I haven't cleared them at the weekend or the night before'*.

But higher workloads had consequences – sometimes resulting in bullying and sickness, which were, of course, linked. The latter led to further staff shortages and further work intensification. So how did managers cope with normalized intensity? We uncovered substantial evidence of managers simply accepting these conditions 'as part of the job', stating that they *'just have to get on with it'*. Connectedly, they also drew on their own senses of professionalism. They were motivated *to cope* by their professed commitment to patient care. This came through strongly in almost all individual cases, whether managers had a clinical or non-clinical background.

It was helpful for us to view these managers as *professionals*, who faced highly complex compromises between business demands and patient care on a daily basis, striving to make their organization as effective as possible, amid major strains and resources shortages. For many, especially those with clinical backgrounds, middle and junior management might not have been 'a calling' or 'vocation', but once staff found themselves in such positions, they typically expressed a desire to carry it 'professionally.' This meant a desire to execute their roles to the best of their abilities, to make a difference to front-line care, and to contribute to their organizations' attempts to hit their various and, at times, ambitious and contradictory targets.

Such hard work and commitment at junior and middle management levels was a world away from the often caricatured public perception of NHS manages as wasteful timeservers in privileged public sector positions. It was most common to read newspaper headlines about overpaid, wasteful

managers, such as a recent front-page article in *the Telegraph* that claimed that New Labour *'wasted billions of pounds on […] bureaucracy and inflated salaries for managers'*.[9] *The Observer*[10] reported the Liberal Democrat's health spokesman describing NHS managers' pay as *'utterly scandalous'*. '*People will be disgusted by the extent to which fat cats in the public sector have been enriched at a time when the NHS has denied people drugs that they need and access to treatments such as mental health*'. Based on the findings of our study NHS managers, rather than being self-serving, highly-paid bureaucrats, play critical roles in the day-to-day organization and delivery of an increasingly complex and resource-starved NHS. Instead of further cuts and downgrading, they deserved additional support and resources with which to carry out their increasingly large and stressful workloads.

[9] 'Cancer cash wasted on NHS Salaries', *The Telegraph*, 28 November 2011
[10] 'This NHS manager was paid £68,000 in bonuses over three years – on top of a six-figure salary', *The Observer*, 25 April 2010

10 Conclusions

This study focused around one question: 'What are the effects of the New Public Management ethos on middle and junior management roles and behaviour in UK healthcare?' It has generated rich and detailed accounts of how middle and junior managerial roles in the NHS are changing. Overall, and in common with managerial roles in other industries, the roles and behaviour of middle and junior management in health organizations appeared to be increasingly complex, with the interactions between different levels of management and across different functions of the organization becoming increasingly diverse. Managers', interpretation of, and reaction to, change measures were increasingly business-like, and, while they could not simply be 'read off' a formal list of top management goals they did have some characteristics in common.

Management roles were changing because implementation of some New Public Management related measures contributed to shifting the ethos of the NHS manager from that of a public servant towards that of a commercially-oriented businessperson. As we noted in the executive summary at the start of this report, this is not something covert or epiphenomenal, but a stated aim of New Public Management. Rarely considered by the policymakers and senior managers implementing the changes associated with New Public Management are the tensions, both ontological and in terms of work intensification, that such changes produce, and which are reflected in our findings. In chapter 3 we saw that other researchers in the field of NHS management have have picked up on these tensions and contradictions, which seem inherent to New Public Management as a system (to the extent that it can be considered a system rather than a set of imperatives). Our research has examined the effects of these contradictions on the lived experience of NHS managers.

We found that changes to middle and junior management in the NHS were very similar to those experienced by large organizations across the world in commercial and public organizations(1). Many NHS managers had come into management from clinical roles, and often occupied hybrid clinical-managerial positions. External hiring of professional, generalist managers also appeared to be growing, with new middle managers brought in from commercial organizations such as retail, engineering, financial, or other public sector organizations such as police or local government, once again reflecting one of the key aims of NPM, to inject private sector 'dynamism' into public bodies. Organizations were tackling financial pressures through headcount reductions and flattened hierarchies. While this amounts to 'doing more with less', a key goal of the New Public Management, we found that this has human consequences in terms of work intensification. There were some accounts of upskilling as managerial tasks were forced down the hierarchy. Middle managers in particular faced specific pressures as they formed the target for cuts at the same time as being responsible for implementing change. This had consequential effects of increased workload, increased spans of control and increased performance demands. Junior

managers were able to draw, to some extent, upon their specialist clinical or functional area for identity and job security. However, we found consequent negative effects on careers, job tasks and responsibilities and quality of working life.

We began by tracing five eras of management in the NHS associated with the evolution of government policy and the New Public Management. Our study suggests that rather than forming distinct managerial types in distinct time periods, elements of each managerial role remain and co-exist. The newer roles, such as manager as business-person and manager as entrepreneur, were, however, gaining in cultural capital.

- Manager as administrator – reactive, problem solving, inward-looking
- Manager as bureaucrat – responsive to government demand, financial controls and monitoring
- Manager as business person – Increased managerial control, competitive, business culture
- Manager as leader - decentralized control e.g. Foundation Trusts, individual payments for treatments, leading change, setting direction
- Manager as entrepreneur – competing for individual business units, winning contracts , doing what pays

We found considerable similarity between management roles outlined in the literature such as; managing financial resources, crisis management, strategic planning, co-ordination, developing personnel. In the case of strategic planning, his tended to be fairly localised in extent, and in temporal terms, to focus on the relatively short term - issues of staffing and occasionally, succession planning. Managers across all trusts evidenced considerable strategic awareness, and saw their role as implementing strategy formed by senior managers. However, many (though not all) managers we spoke to were to some extent cynical about high level Trust strategy, in that it tended to reflect government policy and thus would in fact be short term and prone to replacement for political reasons in the future. The overarching strategic drive to a more business oriented approach that emphasised efficient use of resources (associated with NPM) was however universally understood as the permanent context of operation.

There was considerable similarity between managerial behaviours and those noted in the literature, such as; using networks of relationships, personal skills, personal obligation, acquired wisdom, formal and constitutional authority. However, we argue that the sum or aggregate of managerial behaviours has changed in ethos, from public service towards business management in keeping with international reform trends often labelled New Public Management. We identified five key themes contributing to or accounting for this overall trend. They were:

1. Constant flux – the need to change direction rapidly and regularly

2. Narrative management – making use of management ideas such as 'Lean' pragmatically
3. Cost control and limited resources – move towards winning contracts even when they are in new lines of business
4. Changing/conflicted role identity – from public servant and/or clinician to business person
5. Effects on workplace dignity – middle managers encouraged not to complain or raise problems, rather to be compliant and cope

We argue that these changes to middle and junior management roles and behaviours were of a radical rather than a gradual nature. The study presents an account of middle and junior management roles immediately prior to and during a period of increasing fiscal pressure. As these pressures look set to continue the findings are likely to be of interest to other health service organizations. Moreover, as further changes to NHS service organization and delivery are implemented, these findings offer some insights which may be of value to those responsible. These include;

- NHS organizations are increasingly operating like businesses, adopting commercial organizational forms and philosophies such as Lean and Six Sigma, taking a robust approach to cost control, increasing their efforts at managing external relations, and operating with very limited spare capacity
- Attitudes to business are entrepreneurial, with NHS Trusts increasingly encouraged to bid to win contracts for new or different services.
- Middle and junior managers are experiencing work intensification, increasing demands and increased spans of control as a result of headcount reduction, upskilling and flattened hierarchies
- Managerial responsibilities are changing rapidly with occasional gaps in experience and ability
- NHS middle and junior managers play a vital and at times, underappreciated role in their organizations. They have a wider understanding of the entire 'business' of their trust and beyond, and their engagement is essential in the everyday running of trusts, plus in the form of 'plugging gaps', where possible, in service provision regardless of whether it is formally part of their role.

  NHS managers are not obstructive or wasteful. Rather they are committed employees, who strongly identify with the NHS and with patient care. Many emphasised the importance of trying to put patient care at the top of their agendas in spite of severe resource and time constraints. They play vitally important roles in keeping NHS trusts functioning and evolving. They reported being on the

receiving end of unfair criticism and having a lack of avenues for advocacy and representation for their interests.

- Further research is suggested in the following areas:
- The use of extended periods of contact with managers provided rich data and deep understanding about the realities of managerial work, and we would strongly advocate the continued use of such methods if we are to fully understand and articulate the life-world of managers in a changing NHS.
- Whilst this study used cross case comparisons to arrive at common findings, further studies could usefully examine specific roles and behaviours in more depth by organisation type or management group.
- This study has highlighted the impact of increasing demands for monitoring information from middle managers. The extent to which this continues and is affected by organizational change could be usefully explored.

Finally, it is important to acknowledge that, broadly speaking, each of the four NHS trusts were performing relatively well amid very challenging circumstances, perhaps the most challenging since 1948. Working in the NHS was a source of pride for most of the managers we met. However, many managers (especially, but not exclusively, those with clinical backgrounds) stressed to us the importance of trying to put patients' needs above all others, and expressed deep concerns about the increasing salience of the tension between patient needs and financial/business needs. In keeping with Madeleine Bunting's famous study of white-collar workers under intense work pressure(125, p208-245) we noted in places a 'deficit of care' whereby managers face their working challenges alone, without help and support. When resources are stretched so thinly and with managers at times struggling to cope, NHS patients may also experience a 'care deficit' in their experience of NHS services.

While the richness and depth of data collected is a strength of this study, the results cannot be easily generalised. However, whilst the findings may not be exhaustive, they do provide an important account of middle and junior managerial roles immediately prior to, and during, a period of increasing financial pressure. As these pressures look set to continue, the findings are likely to be of relevance and importance to other health service organizations and indeed to other public sector organizations.

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Appendix 1

Interview Schedule

This research project focuses on the realities of working lives of middle and junior managers in the NHS.

This interview schedule is designed to examine the views of middle managers as to the contemporary nature of their employment. It is intended as a rough guide to the sorts of questions asked, and will not be rigidly adhered to. The interviews are intended to operate in a conversational fashion, with the managers being allowed the freedom to discuss any aspects of their working lives that they feel are relevant.

The interview is divided into three sections:

1. What managers do (roles, behaviours, subcultures and identities)

2. Organizational forms (governance modes and the navigation of competing logics)

3. Organizational dynamics (relationships between senior managers, managers and frontline staff as they affect wider organizational performance and service delivery)

1. What managers do (roles, behaviours, subcultures and identities)

- How would you define your role here?
- Please could you describe a typical day at work?
- What tends to be the main focus of your work?
- Still thinking about your day-to-day work, are there any parts of it that are more rewarding than others?
- Is your work monitored by the organization? If so, how?
- Do you find the amount of work that you have to do is manageable?
- Would you describe your job as stressful?
- To what extent, if any, has your role changed since you have worked here?
- How do you feel about the way your role has changed?
- Is there anything about your role and how you work that you would like to see changed?
- Do you feel a sense of loyalty to your work unit, to the wider organization, to the NHS?
- What is the most rewarding aspect of your job, and the least?

2. Organizational forms (governance modes and the navigation of competing logics)

- During your career, have you experienced any changes in the way your organization is structured?
- Have organizational changes affected the way you work?
- Are the goals of NHS strategies for your sector, clear?
- What role do national NHS strategies play in shaping your work?
- What are the priorities for this organization?
- Have the priorities for this organization changed over time?

- How are the priorities reflected in the way you work?

3. Organizational dynamics (relationships between senior managers, managers and frontline staff as they affect wider organizational performance and service delivery)

- How much autonomy do you have at work?
- Can you tell me about your relationship with senior managers in this organization?
- How would you describe your relationship with the people you yourself manage?
- Do you feel that you work as part of a team?
- Does the way people are managed here help with service delivery?
- Is there anything about the system of management here that you think could be changed?
- In your opinion, how is your role viewed by colleagues in this organization?

Appendix 2

SDO project 08/1808/241 Roles and behaviours of middle and junior managers: managing new organizational forms of health care

Management fellowship report

Overview

A three year management fellowship was awarded to Dr Charlotte Haynes linked to this research project. The fellowship was designed with three aims: first, to improve the quality and relevance of the research; second, to enable a managerial fellow to develop managerial research skills and third, to contribute to knowledge mobilisation in respect of the study findings. The award was used to increase the research capacity of the fellow for using research evidence by providing training and direct experience in managerial research methods, direct involvement with the project and concurrent projects, knowledge exchange with Manchester Business School, and knowledge mobilisation activities coordinated by the SDO. The management fellow – Dr Charlotte Haynes brought an NHS insider perspective to the project and the research team were able to develop the study and refine their ideas as a result of having direct access to a subject matter expert (a practicing NHS manager) and from the existing research skills of the management fellow. The study was enhanced by having a management fellow dedicated to knowledge mobilisation activities arising out of this study, thereby improving the quality and relevance of this research to a broader community. To this end a series of three management research reports were prepared and disseminated to participating organisations and stakeholder groups and a stakeholder meetings were held at each participating Trusts and at other venues. The management fellow was located at the Acute trust (one of the four case study organisations). Unfortunately, the fellowship ended prematurely at the end of the second year when the management fellow took up a full-time post with the National Institute for Clinical Excellence. The decision was taken to terminate the fellowship as there was little likelihood of a suitable replacement being found.

Introduction and aims of the fellowship

This management fellowship was one of the first twelve to be awarded by the SDO. The fellowship has provided a valuable adjunct to the research project in line with the three objectives detailed below.

There were three key objectives for the managerial fellowships:

1. To improve the quality and relevance of the research itself through greater managerial involvement;
2. To develop capacity in the managerial community for accessing, appraising and using research evidence; and
3. To encourage greater engagement, linkage and exchange between the research and practice communities in healthcare management.

Dr Charlotte Haynes formally joined the project team in April 2009, having already helped with access to her employing NHS organisation. She also consulted on the development of the research protocol. Dr Haynes worked on the project for 1 day/week until April 2010 and was seconded for 2 days/week beyond the first year. Achievement in relation to each of the three aims is summarised below.

1. Engagement in the research project

Charlotte participated in the majority of team research meetings, during which she contributed to the research design by

- Suggesting that all 4 NHS sites were based within/linked to one area so that one health economy might be fully explored;
- Providing suggestions as to which groups of middle managers would be suitable for the observational side of the project;
- Being integral to the discussions concerning the use of "middle manager" as a descriptor when contacting potential participants, as the research team discovered that, regardless of job function, many people did not accept "middle" and/or "manager" as acceptable descriptors for their job.
- Several Trusts had a strong focus on implementing LEAN methodology and she contributed to the group discussions concerning the implementation of LEAN, its efficacy, and changes in staff's perceptions of the merits of LEAN.
- Advising about the practicalities and feasibility of the research design within NHS settings.
- Assisting the research team in gaining access to the acute and primary care trusts involved as participant sites in the project.

Charlotte has contributed to the research analysis by

- Designing an anonymisation template for transcripts and field notes,
- Arranging for a 2 day training course in NVivo8 for the research team,

- Sharing views of the emerging themes with the group,
- Discussing the implications of the latest policy developments emerging from the coalition government, in particular the impact of the white paper "Equity and excellence: liberating the NHS" on the structure of the NHS and for the findings of our research,
- Attending conferences, e.g. Primary Care Live 2010 and relaying pertinent findings back to the research team.

Charlotte participated in both group away days, which were very productive in terms of work outputs and team building. The group discussed that one of the outputs of the project should be a publication aimed specifically at an NHS audience; and Charlotte was working on that, but it was not possible to achieve this by the end of her contract.

2. Developing research capacity

During the first year of the study Charlotte enrolled on the "Management: Leadership & Teams" masters in public health personal professional development course (University of Manchester). The course provided details of management theory, and in particular focused on the people side of management. Participation in the course provided Charlotte with a good understanding of different leadership and management theories, which has assisted her when undertaking observational work and analysis on the research project. In the second year Charlotte participated in specific courses offered to doctoral candidates at Manchester Business School, namely day-long courses on qualitative data methodology and analysis.

Charlotte also familiarised herself with literature on how field notes are written up and read seminal ethnographic works in order to assist her in undertaking fieldwork; and the principle investigator and research associate also provided her with practical guidance on undertaking ethnographic research.

During the first year Charlotte ensured that she had a good understanding of the project objectives and she was fully integrated into the team, operating as an equal member. Her input as an NHS "insider" was highly valued, as were her pre-existing research skills. Charlotte's initial input to the project was to provide practical guidance and assistance on gaining access to NHS settings and potential participants. In particular, within her own organisation she identified individuals that the team would benefit from interviewing, and suggested appropriate people to be participants of the observational work. Charlotte introduced the researchers to several key people and kept them up-to-date with internal and external events taking place that would be relevant to the project. At her own organisation she also provided the research team with the following:

- Internal communications and policy documents, as appropriate, which provided an insight into the organisation's culture,
- Organisation charts for each division,
- Lists of job title and contact details in order to identify particular management groups and individuals within them,
- Access to meetings, and
- Arranged times for meeting with senior managers.

Building on Charlotte's theoretical understanding of ethnographic and managerial research, in the second year she was directly involved in undertaking interviews and observations at one of the study sites. She was involved in 9 interviews and 2 days of fieldwork at the mental health trust. Following these interviews/observations she wrote detailed notes summarising interviewees' roles, emerging themes and highlighting key quotes.

Charlotte helped to develop drafts and suggestions for the development of a promotional poster for the project to be distributed to stake-holders feedback sessions scheduled for late 2011. In particular, she explored how the main themes were inter-related and what appropriate thematic titles were, developing a graphical representation of the themes for use in the poster. She also contributed to managerial briefing documents. She contributed to a half day meeting exploring how the study findings could be disseminated to practitioners and what the relevant findings were. Charlotte used NVivo8 to identify appropriate quotes, undertook additional research to expand on key points identified in the meeting, and liaised with Dr Hyde on how to progress the briefings. Following drafting of the briefings, these were adapted by the research team in order to develop 3 briefings for stakeholder feedback; and Charlotte was in the process of developing a third briefing on "relationships" that would mirror the style of the first two briefings. These briefings were completed by the research team after she left and are appended to this report.

As Dr Haynes was able to advance her career before the end of the project a practitioner summary on the theme of "Quality of working life" went unfinished. As did an article she was preparing, focusing on the roles and behaviours of a cluster of hybrid managers whom she has interviewed and observed – she had reviewed the literature on hybrid healthcare managers, identified themes and developed an outline for a paper. There is some hope that this paper may reach fruition following the conclusion of the research project.

3. Engagement with stakeholders

Dr. Haynes helped with the organisation of, and participation in, the stakeholder meeting. She contributed to the design of the day, invited practitioner contacts and contributed to the post-event review.

Charlotte assisted in the process of contacting the HR departments at each participating research site in order to determine the format of feedback sessions to take place in 2011 and she was involved in an initial feedback meeting to the HR Director at one of the study sites.

Charlotte found that her involvement in the project provided her with an opportunity to engage more directly with senior managers within her trust as she was able to act as a broker - ensuring that the researchers could gain access to senior management.

Dr. Haynes is now a member of the newly formed IHS healthcare workforce research network at University of Manchester.

Charlotte participated in all the SDO management fellows' workshops; and attended the SDO conference in 2009 and 2010. Charlotte also presented at the SDO conference on 2nd June 2010, collaborating closely with her co-presenters, Chris Smith and Jo Partington in order to deliver a presentation on their personal experience of being management fellows.

Knowledge mobilisation

The management fellowships were focused on developing knowledge mobilisation in health care management research. Charlotte's participation in the August 2010 and February 2011 management fellows' meetings provided some useful insights into knowledge mobilisation techniques. It was only once the study findings were emerging, that Charlotte's knowledge mobilisation role became apparent: contributing to the preparation of appropriate written materials, organising meetings with stakeholders and sharing findings in a constructive way. It was envisaged that much of this work would occur in the third year of the project.

Dr Haynes familiarised herself with the SDO funded scoping review on knowledge mobilisation; and acquainted herself with literature on change management, in particular, the work of Argyris.

Charlotte resigned her management fellowship with effect from 31st May 2011 having completed just over two years of the appointment. The fellowship had been successful in achieving the majority of aims for the first two years of the project. Her progression to work for a national organisation (NICE) in a role that involved disseminating research evidence illustrates how the fellowship has contributed to her professional research development and to building capacity generally.

The three management research reports, which Charlotte had begun to prepare, were successfully completed and were well-received at the stakeholder event and other feedback events which took place after her departure. PDF versions of the management research reports are provided alongside this report.

Appendix 3 Management briefings

The University of Manchester
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Management research report

New management roles: What middle and junior manager do

"... almost by default managers are seen as an unnecessary cost and management costs have got to be driven down. But, at the same time we're expecting these managers to deliver on the government's agenda, the HR agenda and every other performance management agenda and every other agenda under the sun ... You can't take managers out of the structure and still expect all the management to be done." Senior Manager

Roles and behaviours of middle and junior managers: managing new organisational forms of healthcare

http://sdo.portals.mbs.ac.uk

Original Thinking Applied

Roles of managers

Our study showed that NHS managers

- were *highly committed* to doing a good job
- had a *sophisticated, complex set of responsibilities*
- had many *competing pressures* on their time and
- they often worked *very long hours*

This was a common pattern across different types of NHS organisation and across all levels of the hierarchy from senior, middle-managers to junior, front-line managers. It was also common to managers from different backgrounds – for example, clinical, human resources, finance.

This report explores the issues raised above in more detail and identifies what organisations can do to enable managers to work more effectively in a rapidly changing environment.

Public images of middle managers

Public perceptions of middle managers are generally not always positive, and this affects organisational functioning. This poor public image arises because:

It is not clear what middle managers' role involves – a complex role.
Necessary meetings and paperwork can be perceived negatively, despite being crucial to the smooth running of large, highly specialist organisations.
Middle managers are sometimes perceived as 'bureaucratic' and resistant to change.

NHS managers have received negative coverage in the media and in political rhetoric.
Portrayed as somehow less useful by dint of not being on the so called 'front line', and again, because of opaque nature of the role.

Positive views of middle managers

However, managers make important contributions to organisational functioning and this has been recognised in the media:

"Health systems the world over are unstable and struggle with improving quality and safety, being responsive to patients, providing easy access, and staying affordable. Managing a beast like the NHS is difficult in the extreme... and NHS managers are part of the solution not part of the problem."
Richard Smith, guardian.co.uk, Monday 24 April 2006

And in research:

Granter, E. and Hyde, P. (2010) 'What have NHS managers ever done for us?' London Journal of Primary Care, December 2010.

Hassard, J., McCann, L. and J Morris (2009) Managing in the Modern Corporation: The Intensification of Managerial Work in the USA, UK and Japan, Cambridge University Press

Huy QN. In Praise of Middle Managers. Harvard Business Review. 2001; September: 72 - 9.

Merali, F. (2003) NHS managers' views of their culture and their public image: The implications for NHS reforms. The International Journal of Public Sector Management 16:7, pp. 549-563.

What do NHS managers do?

Our findings based on observations of managers at work and in-depth interviews showed that managers contributed to organisational performance in the following ways:

- **Problem solving**: plugging gaps in the system such as getting wards open on time
- **Planning: Workforce planning, rotas, budgets, improvements to productivity**
- **Organising systems:** The 'lean' office, the Productive Ward, integrating IT systems
- **Leadership (by example):** Presence on the ward/on the road, bed making by managers
- **Investigation:** Untoward incidents, patient complaints
- **Information management:** collecting and disseminating information, both up and down the organisation – much of this activity was mandated by Trust and outside organisations
- **Arbitration and conflict management:** Between different groups having to share resources, between staff or staff and patients, e.g. Mental health managers working to resolve opposing viewpoints
- **Coordination:** often at the centre of a fast moving situation, e.g. Ambulance Service Control Centre

Challenges and rewards of NHS management

Work of NHS managers is both **challenging:**

"I think it comes with the territory. I think it would be really naïve for somebody to come into a job like this and not understand that there are certain things that they must do. And if you don't do [them] then you're going to be in trouble." (Acute Trust Manager)

Challenges included:

Resource constraints – pressures to cut costs
Multiple demands – clinical and managerial workloads
External demands – for information and to comply with regulation
Relationship management – with those inside and outside the trust

Managers were, at times, almost overwhelmed by the sheer volume of demands made upon them and had to work at a very high level of intensity to do so.

...and rewarding:

"I enjoy what I do. I like the people that I work with and it's feeling that I'm actually doing something worthwhile... despite all the problems and all the concerns that it is a worthwhile job. It is something that is valid and valued." (Ambulance Service Manager)

Rewards of the job included:

Making a difference to the local community
Colleagues and informal networks
Improving life for staff and patients
Seeing things through – a sense of professionalism

While the rewards of the job clearly help motivate managers, the demands do have consequences in terms of rates of stress and sickness absence. We found that managers worked extremely long hours to get the job done, and often took work home.

New management roles

Managerial roles in the NHS are extremely diverse but we found that managers across NHS organisations were involved in:

- Essential activities related to patient safety but...
- That managerial aspects of the role are still a hidden function
- The work is high stakes – literally matters of life and death
- Managerial work was as high intensity – rapid fire and long hours
- Sustainable intensity?

Developing a new generation of NHS managers

Middle and junior managers were motivated and willing to adapt to change. In fact, managers were essential, in some cases, to ensuring continuity of care. In these straitened times trusts can:

- Continue investment in internally provided management training and development programmes – there were examples of this across all the Trusts. These programmes helped managers to network and to encounter the trust culture
- Involve managers in problem solving at all levels
- We found an increasing managerial role in project-based work
- Managers had innovative ideas for cutting costs and coping with change

Project summary

This ethnographic study focused on the reality of working life for middle and junior managers across four types of health organisation. As well as being based on extended observations with middle and junior managers, the findings are based on interviews with managers at all levels of these organisations and a review of relevant documentation.

The study examined the realities of working life for middle and junior managers in health care organisations by looking at three features of managerial life:

1. What managers do
2. under different forms of governance
3. in establishing the dynamics of managerial relationships

Participating organisations

The participating organisations provided services to overlapping health economies. They included one of each of the following type of organisation:

Acute Foundation Trust
Ambulance Trust
Mental Health Foundation Trust
Primary Care Trust

Project team

Dr Paula Hyde, Dr Leo McCann, Dr Edward Granter, Professor John Hassard, Manchester Business School, The University of Manchester

Professor Jonathan Morris, Cardiff Business School, Cardiff University

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The University of Manchester
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Management research report

Beyond management: Managing after the cuts

"We're looking at 'what do we absolutely have to have a form for and ones we don't' ... ideally we could get rid of two thirds of all paperwork." Senior manager

Roles and behaviours of middle and junior managers: managing new organisational forms of healthcare

http://sdo.portals.mbs.ac.uk

Original Thinking Applied

Project 08/1808/241

What is the problem?

The first health policy statement of the coalition government in 2010 outlined cuts to management costs of 45%. These would take place over four years and involve radical service restructuring affecting all parts of the NHS. Most notably, Strategic Health Authorities and Primary Care Trusts would be abolished. These structural changes mean that commissioning of services will change radically at a time when management capacity is being reduced. Few people object to cuts to management costs as managers are often cited as sources of inefficiency and bureaucratic waste and reducing management costs is expected to free up money for front-line services.

This report describes how health policy towards managers has changed over time with consequent effects upon the self-esteem and activities of managers. It explores the challenges trusts might face and discusses how trusts might cope with these major structural changes whilst reducing their managerial capacity.

The evolving identity of the health service manager

Government policy has come almost full circle since the introduction of general management in the 1980s when managers were expected to improve service efficiency and governance arrangements. We highlight five eras of management in relation to government policy each casting managers in different roles. Remnants of these identities continue today, shaping managerial behaviours and attitudes towards managers.

1. Manager as administrator: 1948 to 1982
Before general management, health services were run on consensus lines where consensus was achieved between administrators and lead doctors and nurses. Here the manager had a specific role as an administrator and tended to be inward looking.

2. Manager as bureaucrat: 1983-1988
The Griffiths Report recommended the introduction of general managers to all levels of NHS organisations. Managers were introduced to improve efficiency and ensure consistency across diverse systems. Here the manager was cast as a bureaucrat, with more of an eye to national and external forces.

3. Manager as business person: 1989-1996
The quasi-market reforms of the early 1990s introduced the idea of health services as businesses operating in a market environment where services were bought and sold. Purchasers and providers formed separate organisations and business values were promoted. During this period business values became important and came into potential conflict with public service values of health workers.

4. Manager as leader: 1997-2009
The new labour government of 1997 dismantled market reforms and later reintroduced them via the formation of partially independent Foundation Trusts and the introduction of payment by results. Primary Care Trusts had commissioning arms specifically designed to shape service development. Targets, regulation and performance management meant that managers, using the language of leadership, had to be cognisant of externally driven requirements.

5. Manager as entrepreneur? 2010 onwards.
The coalition government announced the intention to cut management costs by almost one half at the same time as radically changing the ways in which health services are commissioned. In this rapidly changing environment managers, as entrepreneurs, need to secure service contracts in changing organisational contexts and with increasingly limited resources.

Changing directions, roles and identities

The legacy of changing managerial roles in the NHS has, in some ways, shaped the way health service staff relate to each other and the way they understand their roles. We found three areas of rapid change and potential conflict between groups of managers and between managers and staff: changing directions, changing roles and changing identities.

1. Changing directions

Most managers valued their ability to fulfil a public service role where they contributed to patient welfare in some way. However, for some managers there was a perceived discrepancy between **public service values** – doing good for the local community and **business values** – recognising the costs of the decisions that are made. We found managers who struggled with these competing values as well as managers who were able to find a match between business and patient needs.

"I really wish somebody would write a manual on how to be a good health service manager and say this is how you do it, without compromising yourself... And people say, I have never compromised my principles of being a nurse while being a manager, and that's a lie because you cannot get through this job without being in a position where you have to do that." Nurse manager

2. Changing roles

These radical changes alongside management cuts seem to indicate a new era of health service reform where management happens, to some extent, below the radar. Managers came from very different backgrounds and as a consequence were able to occupy exceedingly diverse roles as they brought with them different areas of expertise. These included:

Hybrid roles

Clinical hybrids whereby managers drew upon clinical as well as managerial expertise.
For example, an operations manager, who had worked at the acute trust for many years was able to draw upon her clinical knowledge to manage the clinical service and to develop innovations with clinicians.

Specialist hybrids where managers with specialist knowledge from non-health disciplines in the public or private sector were engaged specifically to tackle organisational problems. For example, an estates manager at the mental health trust was employed to bring specialist management expertise to the organisation.

3. Changing identities

We found that managers in the middle and junior ranks made different contributions to organisational performance and that there was the occasional failure to value or recognise the contributions of managers from different groups such as:

The co-ordinators: Long-term middle ranking managers who had wide networks and focused on maintaining internal cohesion and consensus
The guardians: loyal to the organisation and work hard to protect the organisation from external criticism by enforcing formal rules and meeting external and internal measures of performance
The elders: Managers of long-standing who have many internal contacts and understand the underlying reasons for why things are done in particular ways
The outsiders: On a temporary sojourn into the NHS, these career managers brought expertise, contacts and knowledge from outside the NHS.
The specialists: building specialist departments and concerned with external evaluations of these specialities

Read this: Hyde, P. Granter, E. McCann, L. Hassard, J. (forthcoming) 'The lost health service tribe: In search of middle managers'. In Dickinson, H. Mannion, R. (Eds) The reform of health care: shaping, adapting and resisting policy. Basingstoke: Palgrave Macmillan

What can you do to maintain management capacity during the cuts?

STOP the criticism. Managers make a vital contribution to organisational functioning which at times goes unrecognised.

Identify the full range of management contributions. There can be a tendency to focus on high flying managerial groups. When making cuts, there needs to be a focus on those managers who quietly protect the organisation by filling in the gaps.

Recognise the mix of managerial and other work. There were few pure managers in middle and junior positions. Most people had a range of responsibilities at junior, middle and senior levels. These mixed roles offer some potential for new forms of management activity.

Bring different tribes of managers together. Managers from different backgrounds, commonly clinical or business managers have different sets of expertise to work with.

Review and reduce requirements for management information. Many managers had to provide similar sets of information many times. Where possible, review the need for and purpose of management reporting data.

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The University of Manchester
Manchester
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MANCHESTER 1824

Management research report

Managing across organisational forms

Roles and behaviours of middle and junior managers: managing new organisational forms of healthcare

http://sdo.portals.mbs.ac.uk

Original Thinking Applied

Project 08/1808/241

Organisational forms of governance

The NHS has a history of significant reorganisation and restructuring. Restructuring has involved three types of organisational model or form of governance: hierarchical, network and quasi-market. Each change to the NHS has introduced structures, even within organisations, that demand different approaches to management, and health service managers have to find a way to navigate between them. Good management relationships and connections are important to successful management of mixed organisational forms.

1.Hierarchical organisational forms emphasise top-down performance management against specified targets. Management involves communicating decisions through command and control within vertical line management systems.

2.Network organisational arrangements emphasise partnerships and collaboration across organisational boundaries and they require high-trust relationships. Management involves consensus formation and joint action as a result of bargaining between autonomous parties.

3.Quasi-market forms emphasise diversity of providers. Pricing acts as the signal and incentive to decision making. Managers need to restrict release of business-sensitive information. There is a reduced flow of information across organisational boundaries.

This report describes how the changing structural context of the NHS affects middle and junior managers. It explores the management challenges trusts were facing and discusses how organisations might enable managers to cope with these structural challenges.

Changing context for NHS organisations

Recent experimentation with different organisational forms has meant that few managers are now subject to simple line management arrangements. Different aspects of work are associated with different managerial connections.

Experimental trends have included:

- Managers as managers of reform and change
- Reform focused on using restricted resources efficiently
- Increasing use of 'managerial' approaches from the private sector and business schools
- Increasingly 'business' oriented organisations, for example, Foundation Trusts
- Increasing importance of information
- Challenges to medical dominance

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Organisational design differences specific to NHS organisations

Type of Trust	Number of Sites	Range of specialities	Geographic spread
Acute	Low	High	Low
Ambulance	High	Low	High
Mental Health	High	Medium	Medium
Primary Care	High	Medium	Medium

Organisational design differences, shown above, give rise to particular management challenges, for example, managing staff at distant sites or managing staff who were on the move. The economic situation and contemporary changes to national policy affected each trust differently; see below.

Type of Trust	Management challenges at time of study
Acute	Changes to income streams Pressures to reduce costs Different contracting arrangements Increased competition Diverse professional interest groups
Ambulance	Pressures to meet targets Pressures to reduce costs Rapidly outdated buildings, plant and technology Employment relations Increased potential for competition
Mental Health	Rapidly expanding organisation Pressures to reduce costs New specialist services and new provider organisations to be assimilated Diverse professional interest groups
Primary Care	Radical restructuring of NHS removing this organisational form Rapidly changing commissioning environment Rapidly changing service provider environment

Managing competing demands

Managers were able able to develop their skills and knowledge for managing across organisational forms in the following ways:

Broadening informal networks Few managers had simple line management arrangements they built up networks through maintaining contact with other managers they met at management training events, meetings and other social networks.

Organisational communication Trusts encourage 'buy in' from managers through written materials such as newsletters and management briefings. Conference style meetings, along with smaller scale regular briefings, allow senior managers to explain the trust's direction of travel for the coming period.

Formal training Managers at all levels welcome opportunities for training to enhance both skills and knowledge. Training encompasses knowledge of key governance issues such as commissioning or appraisal, as well as wider leadership and people management skills. A significant number of managers undertake external training and study, often to advanced levels; MA, MSc, MPhil and so on. Accreditation from bodies such as CIMA and CIPD is also achieved by a significant number of managers.

Using management language and concepts Across the four trusts, the use of 'managerial' approaches and concepts from the private sector and business schools, can be observed. The use of technical management terms is widespread; a key example of this is discourse around the concept of 'lean' management. Lean management has, in various forms, become part of the language used across managerial levels to achieve goals and engage in dialogue about improvements.

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