How do they manage? A qualitative study of the realities of middle and front-line management work in health care

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

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Scientific summary

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Background

Management is a role traditionally defined in terms of activities, which include 'POSDCoRB': planning, organising, supervising, directing, co-ordinating, resourcing and budgeting. Human resource management responsibilities must also now be added to this list of activities, as these have been increasingly devolved to line management along with change and service improvement roles, which may or may not involve responsibility for staff and budgets, but which involve planning, organising, co-ordinating and other traditional management activities, as well as carrying accountability for change outcomes. For the purposes of this project the term 'middle manager' encompassed all hospital staff with roles that included some or all of these management responsibilities, with the exception of board members. The management function was thus found to be widely distributed, with >30% of hospital staff either holding full-time management posts or combining managerial responsibilities with clinical or medical duties. The latter group, 'hybrids', outnumber full-time managers by four to one, but most have little management training, and some do not consider themselves to be managers.

Objectives

This project was designed in response to a call for studies of management practice in health care, and addressed three sets of questions. First, how are middle management roles in acute settings changing, and what are the implications of those trends? Second, what problems arise when implementing change following the recommendations of investigations into serious incidents, and how can those problems be effectively addressed? Third, how are clinical and organisational outcomes influenced by management practice, and what properties should an 'enabling environment' possess to support and strengthen those contributions? Evidence shows that most management contributions are change and improvement oriented. Implementing change in the aftermath of serious incidents can be seen as a special – and valuable – category of contribution.

Methods

Data were gathered from 1205 managers in six acute trusts, including two foundation and four non-foundation trusts, through set-up and case incident interviews, focus groups, management briefings and a survey that generated over 600 responses from five of those trusts. Qualitative information from interviews and focus groups was analysed using standard content analysis to identify recurring patterns of issues and themes. For the serious incident case studies, event sequence narratives were developed, based on temporal bracketing and, where appropriate, accompanied by mess mapping to generate visual representations of the antecedents and aftermath of such events in addition to the properties and causes of the incidents themselves.

Results

Interview, focus group and survey evidence shows that middle managers are deeply committed and highly motivated but have to cope with increasing demands and diminishing resources. They also have a negative stereotype, reinforced by politicians and the media, devaluing their contribution. The extensive and constantly changing nature of acute trust management agendas appears to have created 'extreme jobs', which are characterised by long hours, high intensity and fast pace. This job profile can be exciting and

rewarding, but can also have adverse implications for stress and work–life balance. Other main findings with regard to the three sets of research questions are as follows.

Realities

- Counting 'pure plays' and those in 'hybrid' clinical-managerial roles, around one-third of hospital staff have managerial responsibilities. This contrasts with NHS Information Centre data, which categorise only 3% of NHS employees as 'managers and senior managers'. This discrepancy is explained by the nature of the Information Centre's coding matrix rules, which categorise middle managers and supervisors as 'administrative and clerical', and which count those in hybrid roles with their occupational groups – typically doctors and nurses.
- Most hybrids have had little or no management training, hold part-time managerial roles and do not think of themselves as managers, preferring the term 'leader'. Some even feel that being described as a 'middle manager' is demeaning, especially with government ministers and the media repeating disparaging comments about the value of health-care managers.
- Acute trusts have lengthy, complex, 'multiloaded' change agendas, with multiple priorities that compete and conflict with each other, in which all items are always priority. A key concern thus lies with the managerial capacity to cope with this workload.
- The institutional context of health care is highly regulated and prescriptive, with constant structural change and micromanagement from central government. Even a policy to encourage innovation in service delivery was accompanied by a new oversight body, a compliance framework and fines for non-compliance – conditions that are known to stifle innovation.
- Middle managers are deeply committed and highly motivated but their roles and responsibilities have continued to expand, along with rising expectations to maintain and improve quality and safety of patient care, in the context of ongoing cuts in resources.
- A variation on the 'extreme jobs' phenomenon, first met in highly paid international professional roles in finance and management consulting, now applies to many middle management roles in health care, with long hours, fast pace, constant demands and high intensity of work. Exciting for some, extreme jobs can lead to fatigue, burnout and mistakes.
- Management and leadership capabilities at a premium include political skills, resilience and mental toughness, developing interprofessional collaboration, addressing soft complexity and 'wicked problems', performance management capabilities and financial management.

Changes

- Experience in health care and elsewhere suggests that it cannot be assumed that findings from investigations into serious incidents and 'never events' will automatically be implemented. There are often many individual and organisational barriers to change in such contexts.
- Problems with change following serious incidents are traditionally conceptualised as organisational learning difficulties. Evidence from the cases developed in the course of this project suggests that this approach could potentially be strengthened by adding a change management perspective, managing change in 'wicked situations' and driving 'defensive' rather than 'progressive' agendas, in which conventional guidelines do not necessarily apply.
- Widely used in the analysis of serious incidents, root cause analysis is a valuable tool. However, in seeking to fix the immediate causes of individual incidents, this approach is limited in terms of establishing wider-ranging change agendas and has been criticised as leading to 'root cause seduction'. In other sectors, systems-theoretic methods are now more commonly deployed on the grounds that systemic problems require systemic solutions.
- A maintenance model of sustainable change emerged from the experience of one acute trust that successfully contained a dramatic rise in the number of cases of *Clostridium difficile*, a health care-associated infection. Success endured long after the short-term crisis management phase, suggesting an approach that other trusts facing similar problems could usefully adapt.

- Managing change in 'wicked situations', visual tools such as end-state mapping, 'mess mapping' and multilevel future planning can be helpful in understanding the dimensions of a problem, identifying and potentially reconciling competing perspectives and developing action plans.
- High-reliability organisation concepts have seen limited application in health-care settings. Going well beyond the concept of 'safety culture', this should be an important topic for the development of practice, and of evaluation research.

Contributions

- Contradicting traditional stereotypes and contemporary media imagery, middle management contributions to clinical and organisational outcomes are multifaceted and include maintaining day-to-day performance, 'firefighting', ensuring a focus on the patient experience, translating ideas into working initiatives, identifying and 'selling' new ideas, facilitating change, troubleshooting, leveraging targets to improve performance, process and pathway redesign, developing infrastructure [information technology (IT), equipment, physical equipment], developing others and managing external partnerships.
- Middle managers often find themselves in a 'low-trust – low-autonomy' environment in which the ability to make independent decisions concerning the effective running of their service is constrained by the perceived unnecessary interference of senior colleagues.
- The attributes of an enabling environment for middle management contributions are common sense: good communications, timely information, streamlined governance, autonomy to innovate and take risks, information sharing not constrained by 'silo working', interprofessional respect, supportive support services, teamwork, adequate resources. These characteristics may indeed make sense but they do not appear to be common.
- Many of the problems facing middle managers are 'wicked problems': understood differently by different stakeholders; not amenable to rational, linear, reductionist problem-solving methods; with no 'right or wrong' answers; and with only 'better or worse' solutions. Examples (arising in this project) include winter contingency ward planning, managing complex discharges, and staff performance management. The managerial contribution in such contexts is key, as medical staff training in particular emphasises diagnostic and problem-solving approaches that are not applicable to 'wicked problems'.
- Whereas current commentary emphasises radical transformational change, this project identified a methodology, 'sweat the small stuff', demonstrating how a deliberate focus on small problems, with direct staff ownership, and fixing these rapidly, could generate significant gains for patients, staff and the organisation as a whole at minimal cost, laying the foundations for collaborative approaches to tackling larger-scale changes. This approach won an innovation award in the trust where it was first applied, where its application was extended successfully to other services, and where training for other staff in this approach was introduced.
- Actions to build and maintain an enabling environment to support management contributions include suggestions for individual capabilities and behaviours, divisional practices, corporate issues and recommendations for the top team such as 'do not meddle in operations', avoid 'panic of the week' and 'listen to middle managers who know more about operational issues'. Steps such as these could potentially generate significant gains, and most are cost neutral.
- In a context characterised by conflicting and changing institutional priorities, increasing workloads, diminishing resources and 'extreme jobs', management capabilities at a premium include political skills (influencing and negotiating), resilience, developing interprofessional collaboration, performance management, financial skills and addressing 'wicked problems'.
- One feature strengthening the management contribution concerns the power of clinical–medical–managerial collaboration, also described as 'paired learning'. This can be a low-cost or cost-neutral approach to innovative service improvement. One feature weakening the management contribution concerns the silo working that is reinforced by the service-line management structures which foundation trusts in particular have been encouraged to adopt.

Conclusions and research priorities

1. *Management capacity*. This study highlights the significance of the concept of management capacity and one research priority would be to develop better theoretical and practical understanding of the factors that influence that capacity. This issue is significant for at least three reasons. First, the widely distributed management function in acute trusts is dominated by untrained, and in some cases reluctant, clinical hybrids with part-time managerial responsibilities, often responsible for large numbers of staff and multimillion pound budgets. Second, acute trust management agendas are extensive, and 'multiloaded', with a wide range of strategic issues, all of which are always priorities, placing increasing demands on the management function. Third, despite financial and other resource pressures, the service is expected to be creative, innovative and commercially oriented, improving simultaneously the cost-effectiveness, quality and safety of patient care. These issues present management challenges that clinical staff are often unwilling or unable to address working on their own. At a time of financial constraint, how can management capacity be assessed and strengthened?
2. *Extreme jobs*. A second research priority concerns the nature and incidence of extreme jobs among the health-care management population, and the individual and organisational implications of such roles. It appears that some managers find work of this nature challenging and rewarding, to the extent that they have 'crafted' this role deliberately, and for them the extreme nature of the role may not be problematic. However, the existence of such roles may also be symptomatic of inadequate resourcing and training, and sustaining an extreme job can have adverse implications for work–life balance and stress, and may increase the incidence of errors. For hybrids in extreme jobs, this profile could potentially compromise patient safety (although this project generated no evidence for that outcome). How could such roles be redesigned, to make them less extreme, or 'positively extreme', and/or what forms of support can be developed for extreme job holders, perhaps including resilience training?
3. *Service-line silos*. A third priority concerns understanding the advantages and drawbacks of the service-line management structures that foundation trusts have been encouraged to adopt. Service-line management involves restructuring a hospital around clinical business units, each operating as a 'business within a business'. The advantages of this approach include relative service autonomy, closer clinical engagement in service planning, strategy and improvement, and greater transparency with regard to income and costs. Evidence from this study suggests, however, that these structures entrench a 'silo mentality', generate tension and hostility between divisions, reduce the sharing of information and the exchange of good practice and also reduce cross-divisional understanding (a problem for duty lead nurses in particular). What is the balance of gains and disadvantages in service-line management structures, and how can the disadvantages be overcome while the gains are sustained?
4. *Incident investigation*. A fourth priority concerns the development of methods to understand the causes of serious incidents, and to link these with appropriate change agendas. Root cause and timeline analyses are widely used and valuable tools for identifying the cause or causes of an incident, leading to recommendations for action to prevent or reduce the probability of a recurrence. These methods, however, tend to focus on what can be learned from an individual incident, concentrate on proximal causes and preclude those involved in an incident and its aftermath from a role in determining the changes that should be made. It may also be useful to consider 'what can be learned from *incidents like this*' and to include those who were implicated in the investigation and change planning, exploring systemic causes and other contributory factors through 'mess mapping' and related visual tools. This perspective would be consistent with the system-theoretic accident models now used in other sectors. What would be the advantages and limitations of this systemic approach to incident investigation and change?
5. *High reliability*. Based on studies of aircraft carriers and nuclear power installations, the qualities of high-reliability organisations include a mindful preoccupation with failure, reluctance to simplify and deference to expertise, which may, depending on circumstances, reside with junior staff who are closest to the flow of events. There have been reports of attempts to develop pockets of high reliability in health-care settings. With the continuing priority attached to improving the quality and safety of patient care, while reducing costs and increasing productivity, it would be valuable to consider the more systematic application and evaluation of high-reliability methods tailored in particular to acute health-care settings.

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