

# Being a manager, becoming a professional? A case study and interview-based exploration of the use of management knowledge across communities of practice in health-care organisations

Mike Bresnen,<sup>1\*</sup> Damian Hodgson,<sup>1</sup> Simon Bailey,<sup>1</sup>  
Paula Hyde<sup>1,2</sup> and John Hassard<sup>1</sup>

<sup>1</sup>Manchester Business School, University of Manchester, Manchester, UK

<sup>2</sup>Durham University Business School, Durham, UK

\*Corresponding author

Declared competing interests of authors: none

Published May 2014

DOI: 10.3310/hsdr02140

## Scientific summary

### Being a manager, becoming a professional?

Health Services and Delivery Research 2014; Vol. 2: No. 14

DOI: 10.3310/hsdr02140

NIHR Journals Library [www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)

# Scientific summary

## Background

Managerial capacity development is considered integral to the UK government's strategy for implementing programmatic change connected to public service modernisation, particularly within the modern NHS. Reform in the NHS has closely reflected some broader trends in the private economy as market-based and performance management incentives have been introduced and competition has increased.

In this context, understanding how managers in the NHS access and use management knowledge to help improve organisational processes, and so promote better service delivery, is of pressing importance in health-care research. Given the expectations we have of managers in the NHS to improve performance in the face of constant pressures for change, and the grave consequences of poor management, it is important to know that managers are at the leading edge of thinking in management theory and research. For this, there is a pressing need for more research into the uptake of management research and innovative practice by NHS health-care managers and how this relates to their professional development as managers.

Yet, despite a good deal of research that has begun to look in-depth at how managers in the NHS perform their roles, we have only limited understanding of how managers access management knowledge, how they interpret it and how they adapt and apply it in their own health-care settings. There is also very little research that has tried to understand how the use of management knowledge relates to managers' individual learning and development and how this ties in with their own development as 'professional' managers among different 'communities of practice' (CoPs) across the NHS. Similarly, we know relatively little about how the managers' organisational setting influences the ways in which managers access, make sense of, select, adapt and apply relevant management knowledge.

## Aims and objectives

The aim of the research was to investigate how NHS middle managers encounter and apply management knowledge and to examine the factors [particularly organisational context, career background and networks of practice (NoPs)/CoPs] that facilitate or impede the acceptance of new management knowledge and its integration with practice in health-care settings. It recognised, of course, that there are different groups within management that have their own needs and perspectives and that draw upon different types of management knowledge (e.g. operational, financial), that management knowledge itself is often the subject of considerable debate (particularly when transferred from different contexts, such as the manufacturing industry) and that managers are part of wider communities and NoPs within the NHS and beyond that influence approaches to professional training and development.

Following on from this were three specific objectives:

1. to establish how occupational background and career influence knowledge receptivity, knowledge sharing and learning among health-care managers
2. to examine how relevant CoPs enable or obstruct knowledge sharing and learning
3. to ascertain which mechanisms are effective in supporting knowledge receptivity, knowledge sharing and learning/unlearning within and across such communities.

Therefore, the emphasis was on understanding flows of management knowledge and learning as heavily influenced by the social and organisational context within which managers and their work are embedded

as these contextual influences were expected to have an important effect on the ways in which managers access and use management knowledge and how they apply it to their management practices.

This study complemented and built on existing studies concerning managers' ability and motivation to access and use management research, managers' information seeking behaviour and managers' use of evidence in making management decisions. By identifying modes of professionalisation in communities of practising health-care managers, the study further aimed to illuminate the realities of managerial practice in the middle reaches of health-care organisations. The project also complemented existing studies that have focused on managerial roles and behaviours.

## Methods

Middle managers were here defined inductively as those who were defined as such in the organisation, part of a clear chain of line management and located with at least two hierarchical levels of management above and below them. Our approach aimed to capture the subtleties of how different groups of managers go about accessing and using management knowledge in their everyday work. We therefore adopted a comparative case study approach, allowing for the in-depth examination of important similarities and differences between and within cases and managerial communities.

Three types of NHS trust were selected to provide variation in organisational context. These were selected to provide quite distinct cases with regard to the diversity of services provided and, consequently, the knowledge requirements faced by managers and the networks likely to be available to them. The three trusts were:

1. **Acute trust**, which offers a wide range of acute services centralised mainly in one location and covering a fairly limited (local) geographical area.
2. **Care trust**, which delivers a diverse range of mental health and community services with operations distributed in many locations over a large (regional) geographical area.
3. **Specialist trust**, which offers a limited range of specialist services mainly from one central location to patients spread across a very wide (regional and national) geographical area.

To capture differences across managerial groups in each trust, a selection framework was developed in the early stages of the project that was refined as the project developed and allowed us to differentiate between cohorts of managers that could be selected in each trust on the basis of their managerial and clinical orientation.

- **Clinical:** included those with managerial responsibilities in medical and nursing areas (e.g. clinical directors, modern matrons and lead nurses).
- **Functional:** included those within specialist areas such as finance, human resources (HR), marketing, information technology (IT) and estates.
- **General:** included service, operations and general managers.

The main characteristics and derivation of this framework are explained in more detail in the methodology chapter.

After an initial phase of the study involving interviews with 13 selected key informants (e.g. from NHS employers and NHS Confederation) and members of the project advisory group, the main empirical phase consisted of semistructured interviews with selected cohorts of managers combined with ethnographic observation methods. A purposive, non-random sample of approximately eight managers was identified for each of the three cohorts of managers in each trust, yielding a total target sample size of around 72 managers across the three trusts for interview (in the event, 68 were actually interviewed). With repeat visits and follow-on interviews, up to 100 interviews were planned.

Access to potential participants was arranged through each trust's lead collaborator and HR department. Selections were made on the basis of meeting the need to generate sufficient numbers of interviews in each broad group (clinical, general and functional) while allowing some variation in their work position and context (e.g. different clinical/functional specialism or service operations). This would allow appropriate analytical (as opposed to statistical) generalisation. The final sample actually consisted of 68 interviewees across the three trusts (20 at Acute, 25 at Care and 23 at Specialist).

Interviews were semistructured and carried out by two members of the research team. They ranged across seven key themes, which included background information, occupation/career, leadership/management, knowledge, networks, organisational context and change. Interviews lasted between 1 and 2 hours (the majority lasting around 1.5 hours) and all were recorded and transcribed. When possible and appropriate, meetings and other forms of management event (e.g. training workshop) were also observed in cases in which these managers were involved and in which knowledge processes would be expected to be most critical. All interviews and observations followed a standard research protocol that was based on the explicit agreement of managers to be interviewed or observed.

All the data collected were transcribed, collated and stored centrally for coding and analysis using NVivo 9 (QSR International, Warrington, UK) qualitative data analysis software. A coding frame was inductively developed and applied to the interview transcripts by two of the research team (to ensure inter-rater reliability). The coding framework was used to structure the analysis and presentation of the data into four areas: context (institutional and trust), management (including leadership), knowledge and networks.

## Results

The first aim of our empirical research was to set the examination of management in context and this was achieved by situating management activity in the context of wider institutional processes and changes, and also in the context of the particular structures and cultures of the trust organisations of which they were a part.

Our analysis of management then focused on three key features: the nature of management and leadership, the clinical–managerial interface and the responsibilities and skills required of managers. In exploring conceptions of leadership, managers made a consistently clear distinction between visionary, strategic and transformative leadership (which was highly valued) and a more procedural, operational and bureaucratic approach to management (which tended to be denigrated). Our analysis then explored the ways in which managers' responsibilities related to this emerging emphasis on leadership in practice.

Our focus on the clinical–managerial divide identified key differences in the nature of that divide within the three trusts as well as differences in the mechanisms used to bridge that divide (structural, relational or through personal embodiment). The analysis of managers' responsibilities identified a highly diverse set of roles and skill requirements, but a common strong emphasis on interpersonal skills.

Regarding knowledge, our analysis drew upon a classic differentiation between explicit and tacit forms of (management) knowledge and between abstract learning and learning that is situated in practice. This enables us to distinguish between different types of knowledge and learning in our study and how they may be translated into practice through processes of socialisation, externalisation, combination and internalisation.

As well as charting the difficulties of translating abstract management knowledge (e.g. 'lean' thinking) into practice, our study also highlighted the challenges of translating local and embodied solutions and innovations into generalisable and transferable knowledge. We were also able to identify particular barriers to this knowledge mobilisation process. The pros and cons of formal training and development, as opposed to more experiential forms of learning, were also examined.

Our analysis also focused on the impact of the influential body of professional knowledge associated with clinicians, against which managerial knowledge and understanding is often juxtaposed. Management knowledge was often perceived to be in competition with, or judged against, the standards of medical bodies of knowledge. At the same time, as many of our managers were also (or had been) clinicians, the performance of their role often relied as much on their clinical or other professional knowledge and experience (and the credibility it gave them) as it did on their managerial know-how.

Regarding networks, we considered the various NoPs and CoPs to which managers belonged and explored the diverse range of inter-related purposes served by networks, including not only knowledge acquisition but also career advancement, influencing policy and practice, and personal/emotional support. Striking in this regard was the variation that existed amongst groups of managers in their access to, and use of, networks for knowledge and support. Clinical and functional groups of managers had much greater access to wider networks and professional CoPs than did their counterparts in more general managerial roles.

The comparative absence of wider networks for general managers to readily access and draw upon different forms of knowledge also reinforced the likelihood that existing ways of operating and managing would become self-reinforcing. In other words, managers were not only focused on responding to local managerial challenges but also more isolated than the other two groups from sources of knowledge and learning potentially accessed through networks of peers.

## Conclusions

This research set out to investigate how NHS managers encounter and apply new management knowledge, examining the organisational and extra-organisational factors that facilitate or impede the acceptance of new management knowledge and its integration with practice in health-care settings. Our research differentiated between three broad groups of managers, in terms of their routes into management, roles and responsibilities, and their diverse orientations towards management knowledge, its acquisition, translation and application.

The main findings of the research stress the heterogeneity of management and the highly diverse sources of knowledge, learning, experience and networks drawn upon by distinct management groups (clinical, general and functional), the particular challenges facing general managers in establishing a distinct professional identity based around a coherent managerial knowledge base, the strong tendency for managerial knowledge – particularly that harnessed by general managers – to be more ‘home grown’ (localised) and experiential (as opposed to abstract and codified) and the tendency for this to be reinforced through the difficulties facing general managers in accessing and being actively engaged in wider networks of professionals for knowledge sharing, learning and support.

The research underlines the challenges of overcoming fragmentation across a diffuse managerial CoP in health care, exacerbated by the effects of organisational complexity and differentiation. The research highlights the importance of specific training and development initiatives and also the value of NoPs for knowledge sharing and support of managers.

## Recommendations

1. **Valuing management as well as leadership:** the research points to a widespread tendency to denigrate management in favour of heroic conceptions of leadership. There are benefits to be gained from a clearer recognition of the contribution of effective management and the necessity of explicitly presenting management and leadership as equal partners in managing complex and changing organisations.

2. **Balancing experiential learning:** the research indicates that the challenge of codifying and translating management knowledge leads to an over-reliance on experience and localised, situated knowledge and/or a tendency to privilege other forms of knowledge such as clinical or financial. The evidence underlines the value of networks and other social modes of engagement to overcome these epistemic boundaries and assist the circulation of knowledge.
3. **Facilitating clinical–managerial relations:** the challenge of managing the relationship between clinical and managerial communities is pervasive across health-care organisations. Our trusts each adopted distinct structural, relational, or personally embodied means to manage this relationship, each reflecting their organisational contexts. The research suggests that there is no universal solution and that trusts need to tailor their ways to manage this divide.
4. **Enabling reflective learning:** in light of the evidence on translation gaps in health-care organisations, our research suggests that receptivity to management knowledge, and the innovative or creative use of this knowledge, are enhanced by training and development that allows space and time for reflection and knowledge translation. This applies across all managerial groups but especially to general managers.
5. **Encouraging strong network ties:** the research indicates that networking for knowledge acquisition/ sharing, support, career-development and influence are closely inter-related. Therefore, recognition of the embeddedness of knowledge processes in social networks points to the importance of supporting the formation of strong network ties to enhance knowledge sharing and learning.
6. **Extending general management networks:** given the evidence pertaining to isolation and inward-looking tendencies among general management groups in health care, trusts may consider the advantages of providing greater opportunities for internal and external networking to assist knowledge sharing and learning.
7. **Strengthening professional CoPs through leadership development:** the research underlines the challenges posed by the extreme diversity of managers' responsibilities and skills owing to task and organisational differentiation and the fragmentation this creates within managerial CoPs. This supports the value of a widely available management and leadership development programme that meets the needs of the whole spread of middle managers more effectively.

## Funding

The National Institute for Health Research Health Services and Delivery Research programme.

# Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) ([www.publicationethics.org/](http://www.publicationethics.org/)).

Editorial contact: [nihredit@southampton.ac.uk](mailto:nihredit@southampton.ac.uk)

The full HS&DR archive is freely available to view online at [www.journalslibrary.nihr.ac.uk/hsdr](http://www.journalslibrary.nihr.ac.uk/hsdr). Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: [www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)

## Criteria for inclusion in the *Health Services and Delivery Research* journal

Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

## HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: [www.netscc.ac.uk/hsdr/](http://www.netscc.ac.uk/hsdr/)

## This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its preceding programmes as project number 09/1002/29. The contractual start date was in September 2010. The final report began editorial review in March 2013 and was accepted for publication in September 2013. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

© Queen's Printer and Controller of HMSO 2014. This work was produced by Bresnen *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Published by the NIHR Journals Library ([www.journalslibrary.nihr.ac.uk](http://www.journalslibrary.nihr.ac.uk)), produced by Prepress Projects Ltd, Perth, Scotland ([www.prepress-projects.co.uk](http://www.prepress-projects.co.uk)).

## **Health Services and Delivery Research Editor-in-Chief**

**Professor Ray Fitzpatrick** Professor of Public Health and Primary Care, University of Oxford, UK

## **NIHR Journals Library Editor-in-Chief**

**Professor Tom Walley** Director, NIHR Evaluation, Trials and Studies and Director of the HTA Programme, UK

## **NIHR Journals Library Editors**

**Professor Ken Stein** Chair of HTA Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

**Professor Andree Le May** Chair of NIHR Journals Library Editorial Group (EME, HS&DR, PGfAR, PHR journals)

**Dr Martin Ashton-Key** Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

**Professor Matthias Beck** Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

**Professor Aileen Clarke** Professor of Public Health and Health Services Research, Warwick Medical School, University of Warwick, UK

**Dr Tessa Crilly** Director, Crystal Blue Consulting Ltd, UK

**Dr Peter Davidson** Director of NETSCC, HTA, UK

**Ms Tara Lamont** Scientific Advisor, NETSCC, UK

**Professor Elaine McColl** Director, Newcastle Clinical Trials Unit, Institute of Health and Society, Newcastle University, UK

**Professor William McGuire** Professor of Child Health, Hull York Medical School, University of York, UK

**Professor Geoffrey Meads** Professor of Health Sciences Research, Faculty of Education, University of Winchester, UK

**Professor Jane Norman** Professor of Maternal and Fetal Health, University of Edinburgh, UK

**Professor John Powell** Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

**Professor James Raftery** Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

**Dr Rob Riemsma** Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

**Professor Helen Roberts** Professorial Research Associate, University College London, UK

**Professor Helen Snooks** Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

Please visit the website for a list of members of the NIHR Journals Library Board:  
[www.journalslibrary.nihr.ac.uk/about/editors](http://www.journalslibrary.nihr.ac.uk/about/editors)

**Editorial contact:** [nihredit@southampton.ac.uk](mailto:nihredit@southampton.ac.uk)