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Allied health professionals and management: an ethnographic study

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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

AHP (allied health profession/professional)

CHC (Community Health Care)

CI (Chief Investigator)

CLCF (Clinical Leadership Competency Framework)

CPN (community psychiatric nurse)

CSM (clinical services manager)

CT (computed tomography)

DH (Department of Health)

GM (general manager)

HCPC (Health and Care Professions Council)

HEI (higher education institution)

HPC (Health Professions Council)

HR (human resources)

MF (Management Fellow)

MHCOP (Mental Health Care for Older People)

MRI (magnetic resonance imaging)

OT (occupational therapy/therapist)

PCT (Primary Care Trust)

SLT (speech and language therapy/therapist)

SR (superintendent radiographer)

TCS (Transforming Community Services)

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Roland Petchey (Professor, Health Services Research, and Lead Investigator) was responsible for strategic management of the project, and jointly responsible for design and execution of the project, data analysis and writing the final report.

Jane Hughes (Research Fellow) was responsible for organising fieldwork and data collection at three sites, and jointly responsible for data analysis and writing the final report.

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Executive Summary

Background

The Department of Health (DH) in England recognises the following types of professional as Allied Health Professionals (AHPs):

- Arts therapists (music art and drama)
- Chiropodists/podiatrists
- Dietitians
- Occupational therapists (OTs)
- Orthoptists
- Paramedics
- Physiotherapists
- Prosthetists/orthotists
- Radiographers
- Speech and language therapists

The English National Health Service (NHS) workforce includes over 85,000 staff who are classified, according to the DH's definition, as AHPs.

They are a highly heterogeneous group of professions, varying in terms of their power and status, professional organisation and public visibility, professional ethos and practice. In common with other health professionals, AHPs have been exposed to a plethora of policy initiatives since 1997 which have required them to: work more flexibly; develop extended roles that cross professional and organisational boundaries; and to engage with service and role redesign in order to increase capacity and improve service delivery. Despite this, AHPs have lagged behind medicine and nursing in terms of their involvement in management. Their relative underdevelopment thus represents an under-exploited managerial resource for the NHS.

Aims

We set out to investigate the following research questions with regard to a variety of AHP clinician managers in a range of organisational types and settings:

1. Their lived experience and how they make sense of their role(s).
2. The identities they construct (both for themselves and others), and how these vary by management level.
3. The career narratives they construct and the factors they perceive as promoting or restraining their engagement in management and their career progression.

4. The narratives they offer regarding their relationships as managers with members of their own profession, and with other professions and lay managers.
5. Their strategies for managing relationships with other sectors (such as education or social services) and the narratives they construct regarding these.
6. Their strategies for managing the relationship between central policy imperatives and local needs and the narratives they construct around them.

Methods

We undertook ethnographic fieldwork at four sites, purposively selected to provide a range of size, organisational type and setting as well as a spread of AHPs.

Vanguard

Vanguard Healthcare NHS Trust is a large multi-site hospital trust. It is one of the largest NHS trusts in England, treating more than a million patients every year and employing around 10,000 staff. It is internationally renowned for the quality of its clinical research. Fieldwork was carried out with diagnostic radiographers in the imaging departments of two of Vanguard's hospitals between late September 2010 and February 2011.

Whiteford

Whiteford NHS Trust is a small district general hospital, serving a medium-sized town in South East England, and the surrounding area. Fieldwork was carried out in the therapies department between May and July 2011.

Greenshire

Greenshire Community Health Care provides community health services for Greenshire (population 1.3m), which is a large and demographically diverse county in South East England. It was formed by the merger of multiple Primary Care Trusts (PCTs) into a single county-wide PCT and is responsible for a wide portfolio of services, including more than a dozen community hospitals. Fieldwork here was carried out with AHPs (mainly physiotherapists and OTs) working in adult services between December 2010 and July 2011.

Cloffaugh

Cloffaugh Mental Health Care for Older People (MHCOP) is part of an NHS University and Foundation Trust. It is situated in one of the UK's most deprived inner city areas, with high rates of mental ill-health, poor housing, and high levels of under- and unemployment. Field work here was carried out with arts therapists between April 2010 and July 2011.

We collected data from a wide range of sources using multiple methods. These included observation (both scheduled, e.g. of formal meetings and also opportunistic e.g. of informal interactions between staff) and informal conversations as well as formal interviews. Formal interviews were audio-recorded, transcribed in full, and uploaded to a password-protected website to which all members of the research team had on-line access. Notes were taken of informal interviews, meetings, other conversations and fieldwork observations. For each of the case studies, the researcher concerned produced a series of preliminary summaries that sought to identify emerging themes from the heterogeneous data they were collecting from interviews, conversations, observations and documents. These tentative syntheses were shared via the website, and presented, robustly questioned, defended and negotiated at regular team meetings. The frequency of meetings increased as fieldwork progressed – from monthly at the start of fieldwork to fortnightly as the project moved into the report writing phase. Between meetings there was constant email interchange of drafts, comments, responses and re-drafts.

Findings

Six broad and intersecting themes emerged from the case studies:

The problematic nature of clinician manager identity

Clinician managers' identity work was a complex and ongoing process, only transiently accomplished and constantly undergoing revision for different audiences and purposes. Both components of their identities – the clinical as well as the managerial – were problematic. A key process in identity construction was 'discursive positioning.' This involved differentiating themselves and their profession from others, and representing the others as less worthy. It also entailed resisting or defusing others' attempts to define them. Consequently, *power* was a crucial element of identity formation; identity claims and ascriptions were frequently adduced in defending or challenging the status quo. 'Allied Health Professional' as a collective appellation was adopted by only a minority of clinician managers. While a few embraced it as a means of asserting their distinctiveness vis a vis other professions, others saw it as implying interchangeability, hence threatening their professional status. Insecurity of professional identity was particularly problematic for members of the smaller and lower profile professions, who, in the face of modernisation, were vulnerable to having their *raison d'être* called into question.

The variability of clinician management

Both across and within our four case studies we found multiple styles of clinician management, rather than a single style. Clinician management was not just complex and variable, but also highly situational, contextual and

contingent. Although clinician managers faced a common set of national policy imperatives, these played out differently in each of the cases we studied. A key factor shaping the local context was the complex web of inter-professional relationships that clinician-managers were situated in. This shaped their managerial work and constrained their autonomy. Clinician managers had not been exempted from the denigration of management that has accompanied the 'turn' towards leadership in official discourse and policy.

The variable and complex relationship between the managerial and the clinical on the front line

Clinician managers found the boundary between the clinical and the managerial difficult to pin down, elusive and shifting over time and according to context. Management was not a 'back office' function; much of it took place on the front line. Consequently, the two were inseparably intertwined. The strains and stresses that this could occasion was a constant theme in their narratives. Significant 'bridging' was required to enable them to maintain credibility with staff, other professionals and managers.

Clinician management as a problem to be managed

Managerial work constantly threatened to 'take over', so needed to be contained and subjected to careful and continuous management. Thus, 'keeping a balance' and 'fitting it all in' were constant concerns. Clinician managers adopted a variety of stratagems to help them in their struggle (not always successful) to achieve this. Demarcation involved segregating clinical sessions from managerial ones, or signalling roles through dress. Management could also be kept within bounds by downplaying managerial achievements, or redefining it as non-managerial.

The significance of emotional labour in clinician management

The two way permeability of the boundary between management and the clinical arena meant that the clinical could spill over into the managerial. The clearest expression of this was the value placed on emotional labour as a component of management. One narrative saw this as an expression of the gendered nature of the professions concerned. Another saw it as an expression of clinical values.

The problematic transition from clinician management to clinical leadership

Leadership featured in clinician managers' discourse only rarely and incompletely; narratives were far more likely to be framed in clinical and managerial terms. A traditional model of leadership predominated; leadership was associated with exceptional, heroic individuals occupying positions of formal authority. It thus diverged from the model of post heroic, distributed leadership currently advocated.

Research recommendation

Our findings point to an association between management/leadership style and their gender and professional values among the clinician managers we studied. Further research is needed to investigate whether and to what degree this association obtains among a wider selection of clinician managers/clinical leaders, and to identify ways of promoting their engagement.

Implications for policy and practice

Four findings in particular may have implications for policy and practice on clinical leadership. These are:

- The inherently politicised nature of clinician-management and the unequal distribution of opportunities to exercise leadership
- The continuing potency of the traditional model of leadership, which associates leadership with heroic exceptional individuals in positions of formal authority.
- The existence of multiple styles of management, which appear to be associated with gender and professional values.
- The importance of emotional labour in management.

These complexities may limit the take-up of current initiatives to promote a universal model of distributed, post-heroic leadership throughout the NHS.

Our findings may also have implications for the design and delivery of education and training of AHPs in management/leadership at pre-and post-registration levels. They suggest that an approach to AHP leadership education and training that acknowledges the diversity of professional cultures and builds on their existing leadership/management achievements may be more likely to be productive.

The Report

1 Background

1.1 The Allied Health Professions

The Department of Health (DH) in England recognises the following categories of professional as Allied Health Professionals (AHPs):

- Arts therapists (music, art and drama)
- Chiropodists/podiatrists
- Dietitians
- Occupational therapists (OTs)
- Orthoptists
- Paramedics
- Physiotherapists
- Prosthetists/orthotists
- Radiographers
- Speech and language therapists (SLTs)

As of September 2010, the English National Health Service (NHS) workforce included over 85,000 staff classified as qualified AHPs (1).

A number of features make the AHP workforce a potentially fruitful ground for research into clinician-management. The most striking of these is their heterogeneity as a group of professions. Despite having been subjected to a common regulatory regime by the Health Professions Council (HPC) (since 2012 the Health and Care Professions Council (HCPC)), they continue to differ along a number of important dimensions:

- In terms of *size*, they range from physiotherapists (c.22,000 employed within the English NHS), and occupational therapists (c.18,000), through speech and language therapists (c.7,500), down to arts therapists (c.700) (1).
- These differences in size are correlated (although not consistently) with significant variations in *professional organisation, power, status and public visibility*. All of these might be expected to be relevant not just to opportunities for involvement in management but also to the kind of narratives that individual AHP clinician-managers might be able to construct, and to the success of their storytelling.
- Their *professional ethos, education and practice* vary in terms of the extent to which they conform to the biomedical paradigm, with radiographers and physiotherapists at one extreme, and arts therapists at the other.

- The complexity of the task of *inter-professional boundary management* that they are exposed to also varies. For example, radiographers operate largely (if not exclusively) in the context of a (generally subordinate) relationship with a single profession (Radiology/Medical Physics/Oncology). By contrast, physiotherapy, occupational therapy and speech and language therapy interface with a much wider range of health professionals as a consequence of their involvement in a variety of multi-professional pathways, such as stroke recovery.
- The extent of *inter-sectoral boundary management* that AHPs are required to negotiate. Thus, occupational therapy and speech and language therapy are expected to operate (and potentially manage) across important sectoral boundaries, such as social care (OT) and Speech and Language Therapy (SLT), housing (OT) and education (SLT). By contrast, radiographers' and paramedics' practice is effectively confined to clinical settings.
- Finally, the variety of *organisational contexts* in which they operate creates the potential to identify and explore management arrangements that diverge from the 'industry standard' doctor-nurse-lay manager triumvirate.

Table 1 (below) presents for selected AHPs some of the characteristics that might be expected to be significant for them in terms both of their management practice and also (from a narrative standpoint) of the range of audiences and the complexity of their storytelling.

Table 1. Key characteristics of selected AHPs

Profession	**Key characteristics**
Physiotherapy	Numerically the largest AHP; high biomedical orientation; highly effective national organisation; high public visibility; multiple inter-professional interfaces; practice in wide range of health settings; limited inter-sectoral working (greater for community physiotherapists).
Speech & Language Therapy	Medium-sized; mid-range biomedical orientation (strong psychology research tradition); effective national organisation; high public visibility; multiple inter-professional interfaces; practice in wide range of settings (health, rehabilitation, education/SEN); extensive inter-sectoral working (especially with social services, education, voluntary sector).
Radiography	Large; high biomedical orientation; moderately effective national organisation; limited public visibility; highly restricted inter-professional interfaces; practice

	restricted to secondary health settings; minimal inter-sectoral working.
Occupational therapy	Large; low biomedical orientation; moderately effective national organisation; lower public visibility; multiple inter-professional interfaces; practice in wide range of settings (health, social care, education, residential); extensive inter-sectoral working (especially with social services).
Arts therapies	Very small; low biomedical orientation; weak national organisation; low public visibility; multiple inter-professional interfaces; practice in wide range of settings (education/SEN, social care, mental health, prisons); extensive inter-sectoral working (especially education, voluntary sector and prison/probation service).

Nevertheless, regardless of these internal differences, as a group of professions AHPs share a number of common characteristics that differentiate them from medical, nurse and lay managers and enhance their potential interest to clinician management research. For instance, as professions that are intermediate between nursing and medicine, and have (in general) lower public visibility than them, AHPs might be expected to experience particular problems in managing the multiple boundaries between the *professional subcultures* (and even *nanocultures* (2)) that characterise health care organisations.

There is good evidence that doctors in management rely primarily on their professional status and clinical expertise and networks as sources of managerial authority. Although firm evidence is lacking, we hypothesise that nurses, by contrast, will rely less on professional status and more on *managerial* network power, by virtue of the 'colonisation' of management by significant numbers of nurses who have sought career progression within management. At junior levels where they are responsible for managing teams consisting exclusively of nurses, they are likely to rely on clinical experience and expertise. As they move up the managerial hierarchy it is likely that they will rely increasingly on managerial expertise as the basis of their authority. Lay managers are likely to rely on a combination of (managerial) expertise and (managerial) network power. It is unclear, however, how AHPs in management function without the status power of medicine, or the network power of nursing, or the expert power of the professional manager.

1.2 The policy context

In common with other health professionals, AHPs have been exposed to a plethora of policy initiatives since 1997 which have required them to work more flexibly and develop extended roles that cross professional and

organisational boundaries (3-5). They have also been actively encouraged to engage with service and role redesign in order to increase capacity and improve service delivery (6). A number of AHP-specific policies have built on these general initiatives. *Framing the Contribution of AHPs* (7) built on the ambitions of the *Next Stage Review* (8) by setting out the contribution AHPs could make to service development. It was supported by *Modernising Allied Health Professions (AHP) Careers: A Competence-Based Career Framework* (9), which sought to develop the AHP workforce to enable them to make that contribution. In line with the *Next Stage Review's* emphasis on clinical leadership, developing AHP leadership capacity had already been identified as a priority by the Chief Health Professions Officer (10) and two rounds of the National AHP Leadership Challenge in 2009 and 2010 set out to promote this aim. Despite these initiatives, AHPs have lagged behind medicine and nursing in terms of their involvement in management. Their relative underdevelopment thus represents a significantly under-exploited managerial resource for the NHS.

1.3 Clinician management in the NHS

Consideration of clinician management in the NHS needs to be prefaced by a number of observations and caveats. First, the literature on clinician management (and, we would suggest, the policy on it also) is dominated by a single health profession – the medical profession, and the small minority of its members who occupy senior management roles – medical directors and chief executives. More often than not, this focus has been implicit, but even where it is explicit (e.g. (11)) it has seldom addressed the structural and cultural uniqueness of medicine as a profession that differentiates it from other health professions and is likely to limit its generalisability to non-medical clinician managers. Fulop is one of the few to acknowledge this 'blind spot' and its implications for understanding the broader relationship between managerial and clinical work in health care organisations (12). She suggests that it may have helped to perpetuate the heroic model of leadership, reinforced as it is by constant mass media headlines of extraordinary medical interventions and treatment breakthroughs, which are invariably presented as the achievements of 'lone warriors' (13) rather than (as is generally the case) of multi-professional teams. We would point to further 'blind spots' that this preoccupation with medical managers may have helped create. First, concentration on senior managerial roles is likely to result in exaggeration of the distinctiveness of management work (strategic, proactive, transformative, organisation-wide, outward-looking) and clinical work (individual patient-focused, routine, specialty-specific). At middle and junior management levels, where responsibilities are more operational, the managerial and clinical components of the clinician-manager role are likely to be less readily distinguishable. In its turn, this is likely to have implications for the identities of more junior clinician-managers. Second, the overwhelming majority of the medical managers who have been studied have been male; it is noteworthy that only one of the 22 medical chief executives studied by Ham and colleagues (11) was a

woman. As a consequence the potential significance of gender as a factor in clinical-managerial work has invariably been neglected. Finally, preoccupation with senior medical managers has contributed to a concentration of research on clinical management in acute service provider organisations. Much less is known about clinician management in other types of health service organisations. Rather than treating clinician-managers as an undifferentiated entity (or generalising from a single category), we contend that research needs to be sensitive to differences between them – whether in terms of gender, level of seniority, profession or position in the healthcare division of labour.

The history of efforts to engage clinicians in management in the NHS has been well documented and analysed elsewhere (e.g. (14,15)). While accounts such as these are useful in outlining the broad sweep of changes in governance, they are less helpful in capturing the nuances of policy change, especially of the more recent changes and particularly as they shape the lived experience of the clinician managers who are on the receiving end of them. We identify two recent developments which might be expected to influence the lived experience of clinician managers.

The first is the perceived turn in policy discourse away from management towards leadership (16) or from managerialism to 'leaderism' (17). It is suggested that the emergent discourse of (clinical) leadership/leaderism draws on certain elements of both professionalism and managerialism, but simultaneously constitutes a radical critique of them. Specifically, it rejects the association of leadership with formal technical expertise and occupation of formal positions of authority. In its place, it offers a more charismatic vision of leadership as a generic resource that is distributed not just throughout the organisation (including front-line staff) but, crucially, also beyond the organisation by reconceptualising service users/consumers as (at least) equal partners in service transformation or ultimate arbiters of service performance. In privileging service users, it simultaneously differentiates itself from both managerialism, which is seen as being accountable primarily upwards, and professionalism. Whereas traditional professionalism is associated with a custodial relationship with *individual* patients, leaderism has a custodial relationship with the 'local' (17) (p.1091).

The rise of leadership/leaderism has been accompanied in political discourse by mounting denigration of management as the well-spring of the dysfunctional consequences of bureaucracy – 'remoteness', 'targets and terror', 'audit culture', 'gaming of performance measures' and the like. Buchanan cites media characterisations of NHS managers as 'bureaucrats', 'administrators' and 'pen pushers' (18). Against this backdrop, the Coalition government came into office committed to reducing NHS management costs by more than 45% by 2015 (the 'Nicholson challenge'), by cutting layers of management and handing control back to front line clinicians and patients (19). Representation of the NHS has been encouraged as locked in a Manichean struggle between the 'back office' (bad) and the 'front line'

(good). Management's fall from grace has occurred with remarkable speed. As recently as 2004, under *Agenda for Change*, managerial responsibilities constituted grounds for professional advancement. By 2010, they were becoming a source of jeopardy. Because of their hybrid role, clinician managers are likely to have found themselves in a paradoxical position vis-à-vis these developments. On the one hand, as front line clinicians, they could be ideally positioned to exercise clinical leadership. On the other hand, as managers they may be vulnerable to denigration (and worse) as 'mere' administrators.

1.4 The nature of identity

It has been claimed that the formation of individuals' identities is a dynamic, continuous and iterative process, in which a variety of resources are deployed in order to develop a sense of 'self' in interaction with their social environments. This 'permits the simultaneous construction of their personal identities as human beings and their public identities as social actors' (20) (p.300). The concept of 'identity' may thus be seen as a crucial 'bridge' between individual and society, its mediating quality lying in its dual nature – 'it refracts what can be seen as a 'permanent dialectic' between the self and social structure' (*ibid*.). The social processes involved in identity formation are complex and unstable, which implies that ascriptions of identity are provisional and continually negotiated and contested (21,22). Ybema *et al.* therefore suggest that

> ''identity formation' might be conceptualized as a complex, multifaceted process which produces a socially negotiated temporary outcome of the dynamic interplay between internal strivings and external prescriptions, between self-presentation and labeling by others, between achievement and ascription and between regulation and resistance' (20) (p.301).

Accounts of the identify-formation process within organisational research have, however, been criticised for often failing to pay sufficient attention to this duality and complexity, tending to focus on either internal or external processes, definitions and ascriptions (23), rather than the complex interplay between these phenomena, and the rich variety of organisational structures and discourses, in which identity is created (24).

The analysis of language and discourse has come to be seen as crucial in making sense of the complexities of the identity construction process within organisations, since it helps facilitate socialisation and the internalisation within individuals of their rules and practices. Furthermore, the close and detailed analysis of individual, organisational and social discourses – of 'how language filters experienced realities' (20) (p.304) – should help to reduce the ever-present temptations of essentialism, that is, of isolating a particular identity as an individual's or organisation's pre-formed and objectively existing true nature (25), which can be observed or 'read off' in a straightforward way. Rather, we should, according to Goffman, pay attention to how social actors present themselves in everyday situations,

and to what this reveals about how their identities are constructed (26). This involves attending not only to language, but also to the rich variety of other phenomena and symbols, such as actions, rules and habitual behaviours, and the use of objects. Because identity work is situation specific, identity research needs to place equal emphasis on situation and context in relation to it.

The notion that identities of individuals are constructed or fabricated through discourse, action and the use of symbols and objects is often, however, at odds with how those individuals themselves perceive their own identities, and express them in everyday situations. Such perceptions and descriptions are frequently essentialist in character, and assume a core inner identify or self constituted by fixed and stable characteristics, even though individuals may at times experience doubt and conflict concerning their 'true' identities. This way of conceptualising and asserting identity is of considerable practical and social importance, since it can legitimate - indeed mandate - certain types of behaviour, i.e. that associated with or expected of certain roles, and can in turn serve to maintain one's status and acceptability to self and others, defend one's interests, and so on. According to discourse-analytic approaches, however, such essentialist ascriptions should be interpreted as 'stabilized moments in an on-going process of identity-formation and re-formation', with identity being 'a matter of claims, not character; persona, not personality; and presentation, not self' (20) (p.305-6).

A fundamental mechanism in identity construction involves invoking similarities and differences in order to establish and assert who we (and others) are and who we (and others) are not (24). A common way of achieving this is via what has been termed 'discursive positioning' (27,28), the setting up of simplistic binary oppositions (weak versus strong, saint versus sinner) which serve both to differentiate oneself or one's group from other individuals or groups, and to represent them as, for example, inferior, less acceptable or less powerful (29). Such positioning is commonly used to establish or preserve a coherent sense of oneself as a good or morally worthy person (30), but may also serve to defend positions relating to race, class, gender or other supposedly relevant categories and can, naturally, be highly normative, emotive and divisive. It also, therefore, highlights the salience of *power* to identity formation, in that identity claims and ascriptions may be used to defend or challenge the social or economic status quo (31).

1.5 Researching identity

We adopted a narrative approach to understanding the experience of AHPs in managerial roles in health and social care settings, that is, to understand them through the stories that they tell, both as tellers of stories and as the objects of the stories they tell (*Homo narrans narratur*). The history of the narrative tradition in organisational research has been summarised by Bruner (32), but builds on theoretical and methodological contributions from

(among others) Gabriel and Boje (33,34). It maintains that our understanding of the world is built up through the creation and exchange of narratives, which serve to construct social order, and give substance to organisational culture. However, we produce these narratives not solely for others, but also for ourselves - as means of creating (and recreating) our identities and making sense of our lives. To date, there have been few examples of narrative research in health care settings, but those that have been carried out (e.g. (35-37)) confirm its potential as a methodology for exploring the identities of managers in health and social care settings (38).

1.6 Research questions

We set out to investigate the following research questions with regard to a variety of AHP clinician managers in a range of organisational types and settings:

1. Their lived experience and how they make sense of their role(s).
2. The identities they construct (both for themselves and others), and how these vary by management level.
3. The career narratives they construct and the factors they perceive as promoting or restraining their engagement in management and their career progression.
4. The narratives they offer regarding their relationships as managers with members of their own profession, and with other professions and lay managers.
5. Their strategies for managing relationships with other sectors (such as education or social services) and the narratives they construct regarding these.
6. Their strategies for managing the relationship between central policy imperatives and local needs and the narratives they construct around them.

2 Methodology

Our original research plan involved a flexible three phase design, in which the detailed design and execution of subsequent phases would be informed by the outcomes of preceding ones. Phase 1 (Orientation) included interviews with a number of key stakeholders, the purpose of which was to inform our understanding of the characteristics of the AHP workforce, the context of the research and recent developments in NHS policy affecting AHP clinician managers (reported in 1.1, 1.2 and 1.3 above). Phase 3 was to have consisted of a policy Delphi, involving a panel of relevant experts, to finalise and prioritise conclusions. Delays to fieldwork arising from difficulties in negotiating access to case study sites resulted in fieldwork and analysis having to be extended into the period allocated to the Delphi, meaning that this phase of the research had to be abandoned.

As far as fieldwork (Phase 2) was concerned, our original intention was to elicit the narratives of a series of individual AHP managers at up to 15 sites. Although we recognised the necessity of situating these narratives in context, at that stage we conceptualised context essentially as the interpersonal networks of our 'index case' individuals. The number of case studies we envisaged and hence the length of time allowed for each of them meant that our exploration of this context would perforce have had to be brief, opening us to the accusation of 'drive-by' ethnography (39). As we prepared for fieldwork, we became increasingly conscious of the limitations of a methodology that fore-grounded the individual and back-grounded the organisational context. Two sets of considerations informed this growing realisation.

The first was a progressive refinement of our approach to research into organisational identity from thinking in terms of narrative-*and*-(shallow) context to narrative-*in*-(deep) context, in response to Ybema and colleagues' insistence that we see organisational identity formation as a process of 'negotiating between social actors and institutions, [and] between self and others' (20) (p.303). In so doing, we accept their stipulation that it is imperative for organisational identity research not just 'to place equal emphasis on situation and context' (*ibid.,* p.313), but to be capable of following this process over time.

The second set of considerations was more pragmatic and practical, in the shape of a dawning realisation that we had significantly underestimated the difficulty of accessing our intended case study sites, and the time this would take. We initially approached four potential case study sites (which we describe below). In two cases (Vanguard and Cloffaugh) a member of the research team already had personal contact with the site. The other two sites were approached at the suggestion of the relevant AHP Lead, who facilitated the initial meeting. The initial response of all of the sites was uniformly and encouragingly positive, and agreement in principle to

participate in the research was rapidly forthcoming. However, at just four sites, and even with the benefit of personal introductions, translating this agreement in principle into meaningful access proved to be far more difficult and time consuming than the three months we had built into our original timetable. Scaling up to the number of sites envisaged in the original protocol would have eaten significantly into the time we had allocated to fieldwork. It was striking that the process of gaining access was so different and had such diverse outcomes at each of the four sites we approached. We could find no single or simple recipe for success, but, in general, we seemed to make more rapid progress where we relied on interpersonal channels and informal processes, at middle management levels, rather than on top-down, formal chains of command.

The reasons for this are hard to pin down. Organisational size may have been a factor; larger organisations were more difficult for us to navigate as newly arrived outsiders and were also possibly more likely to respond to unusual requests by slotting them into formal systems and processes (e.g. 'research governance') that were designed for clinical research involving patients rather than ethnographic research involving staff. This was certainly our experience at Vanguard (see Box 1, below). We speculate that participation in research for a research intensive trust (like Vanguard) normally generates tangible benefits both for the trust and for its staff (income, facilities, reputation and the like), which means that the potential beneficiaries can be relied on to drive the project forward through the research governance procedures. Where (as in our case) the benefits are uncertain or negligible and the trust and staff were participating as subjects of the research rather than researchers, the normal dynamic could not be relied on. Instead, impetus had to be sustained by us, who, as outsiders, were both relatively powerless and also less familiar with the workings of the organisation. We were also constrained (like all ethnographic researchers) by having to tread a narrow line between securing short term access ('getting in') without jeopardising the longer term relationships ('getting on') that would be crucial to the ultimate success of the research.

Box 1. 'Getting in'

Our initial contact at Vanguard was with the Head of Therapies and agreement to participate was immediately forthcoming, with detailed arrangements being agreed to ensure that all AHP staff were informed about the research via the Trust newsletter. Shortly afterwards, however, when two members of the therapies management team were interviewed, it turned out they had not been primed about the project as anticipated. Other managers did not respond to repeated attempts to contact them by email. It became clear that AHP staff had not been informed as agreed. Groundwork for the project was suspended in early July, when the Head of Therapies decided that an honorary contract with the trust was required. Obtaining this took a further three months. The process was cumbersome and blighted by a series of errors and delays, requiring determined vigilance

to keep things moving (balanced by the need to remain diplomatic and to avoid alienating potentially useful contacts and gatekeepers). From initial contact in early May 2010 to fieldwork proper commencing in late September took a full five months and in excess of 50 contacts by email, telephone, letters and meetings.

This evolution in our methodology had clear implications for our methods. As Dingwall pithily observes, there are just three basic methods of qualitative social research – 'asking questions,' 'hanging out' and 'reading the papers' (40) (p.52-3). Ybema and colleagues develop this distinction, suggesting that, in organisational identity research, these three methods correspond to three differing views about the nature of identity and where it resides (20). Thus, asking questions is appropriate if we assume that identity is some kind of individual property that researchers can access through interview accounts. By contrast, hanging out sees identity as situated in organisational practice and responds to the need for access to what people do as well as what they say. Finally, reading texts sees identity formation as an essentially cultural process. It should be noted that, as Ybema and colleagues point out, 'texts' in this context include not just the 'standard' range of textual representations, but also artefacts, such as offices and dress, that can be read as revealing identity.

2.1 Methods

In light of our developing understanding of organisational identity and the problems of negotiating access that we encountered, we decided to abandon recruitment of individual AHP clinician managers at multiple sites in favour of recruiting a smaller number of sites, at each of which a variety of AHP clinician managers could be studied. Concentrating on fewer sites offered considerable benefits to the research. First, it allowed for a more in-depth consideration of the organisational context in which our AHP clinician-managers were operating; from vague background it was, if not fore-grounded, at least promoted to equal status with the accounts we were collecting from our managers. Second, it gave us the opportunity to track actions and developments more systematically and over much longer periods of time instead of the 'snapshots' that would have been possible under the original protocol. The merger at 'Whiteford' and the move at 'Cloffaugh' are instances of the kind of developments we were enabled to incorporate into our narratives. Finally, it offered more sustained opportunities for observation and informal interaction in place of the formal interviewing that the original protocol was so reliant on.

2.2 Case study sites

We undertook ethnographic fieldwork at four sites. These were selected partly for reasons of convenience, in that we had pre-existing contact with them or else a formal introduction (e.g. from an SHA Regional Lead), but

principally because they offered a good spread of organisational type, size and location. Thus, Vanguard and Whiteford are both hospital trusts, but the former is a very large, internationally renowned, teaching hospital trust, while the latter is a small, provincial district general hospital. Greenshire and Cloffaugh are both community health service providers, but in entirely different settings. Site selection was also influenced by our desire to research a spread of AHPs. Thus, Vanguard afforded an opportunity to research radiographers, while Cloffaugh enabled us to study arts therapists from the other end of the AHP spectrum. Thumbnail sketches of the sites follow. Further detail is included in each of the case study chapters.

2.2.1 Vanguard

Vanguard Healthcare NHS Trust is a large multi-site metropolitan hospital trust. It is one of the largest NHS trusts in England, treating more than a million patients every year and employing around 10,000 staff. It is internationally renowned for the quality of its clinical research. Fieldwork was carried out (JH) with diagnostic radiographers in the imaging departments of two of Vanguard's hospitals between late September 2010 and February 2011.

2.2.2 Whiteford

Whiteford NHS Trust is a small district general hospital, serving a medium-sized town in SE England, and the surrounding area. Fieldwork was carried out (JH) in the therapies department between May and July 2011.

2.2.3 Greenshire

Greenshire Community Health Care provides community health services for Greenshire (population 1.3m), a large and demographically diverse county in South East England. It was formed by the merger of multiple Primary Care Trusts (PCTs) into a single county-wide PCT and is responsible for a wide portfolio of services, including more than a dozen community hospitals. Fieldwork here was carried out (JH) with AHPs (mainly physiotherapists and OTs) working in adult services between December 2010 and July 2011.

2.2.4 Cloffaugh

Cloffaugh Mental Health Care for Older People (MHCOP) is part of an NHS University and Foundation Trust. It is situated in one of the UK's most deprived inner city areas, with high rates of mental ill-health, poor housing, and high levels of under- and unemployment. Field work here was carried out (RPi) between April 2010 and July 2011.

2.3 Data collection

Across these four sites we undertook ethnographic fieldwork, collecting material from a wide range of sources using multiple methods. These included observation (both scheduled, e.g. of formal meetings and also opportunistic e.g. of informal interactions between staff) and informal conversations as well as formal interviews. The precise balance between these varied between sites, and also over time, since organisational ethnography has to be sensitive to the rhythms and routines of the organisation being studied. For instance, after a few months at Cloffaugh, an impending move to open-plan offices emerged as a focus for management activity. Tracking the move over the eleven months stay there allowed the researcher (RPi) to follow the classic anthropological approach of concentrating on an event and working outwards from it. Ethnographic fieldwork is also inescapably conditioned by place and space, and hence varied hugely from site to site. Thus, the foyer and adjacent kitchen at Cloffaugh's 'Old Place' and the staffroom at Whiteford offered scope for unobtrusive sustained observation (a process characterised by Geertz as 'deep hanging out' (41)), but similar spaces were not available elsewhere, which meant that opportunities for hanging out were correspondingly limited.

Formal interviews were audio-recorded (with interviewees' permission), and transcribed in full, and contemporary notes were taken of informal interviews, meetings, other conversations and fieldwork observations and written up in full by the researchers on leaving the field. All of these materials were uploaded to a password-protected website to which all members of the research team had on-line access.

2.4 Data analysis

Unlike purely inductive research designs where understanding is developed exclusively bottom-up through grounded theory, our design mixed deductive and inductive elements. The partial literature review we had conducted while developing our research proposal had identified a number of broad initial concepts (such as boundary management and hybrid role) which shaped the research questions which we were setting out to investigate and also informed our initial analyses. Data analysis proceeded concurrently with data collection. Our approach to analysis was informed by Miles and Huberman's 'tactics' for generating meaning (42). It consisted of the following processes: *noting patterns and themes; making initial sense;* identifying connections by *clustering* concepts; *making metaphors*; *making contrasts and comparisons*; *shuttling back and forth* between data and concepts; *identifying relations between concepts; moving towards conceptual/theoretical coherence* via comparison with referent constructs in the literature. In operational terms, this involved the following procedures. For each of the case studies, the researcher concerned produced a series of preliminary summaries that sought to identify themes emerging from the

heterogeneous data they were collecting from interviews, conversations, observations and documents. These tentative syntheses were shared via the website, and presented, robustly questioned, defended and negotiated at regular research team meetings. The frequency of meetings increased as fieldwork progressed – from monthly at the start of fieldwork to fortnightly as the project moved into the report preparation phase. Between meetings there was constant email interchange of drafts, comments, responses and redrafts. In addition to accommodating criticisms and suggestions generated in team meetings, repeated rewriting of interim accounts also allowed us to incorporate additional material as fieldwork progressed. The whole process was one of treating the case study as 'a landscape that is explored by 'criss-crossing' it in many directions' (43) (p.178). Also, as we approached the end of fieldwork, we updated and expanded the initial literature review, in order to improve our understanding of referent constructs that had emerged from our sense making and would enable us to refine our analysis. Sense making thus consisted of moving progressively from the descriptive to the explanatory and from the concrete to the more abstract. In addition, whereas in the early months of fieldwork we were concerned primarily with searching for themes within case studies, subsequently we focused more on searching for differences and similarities between them.

In terms of validation, our extended involvement with the case study sites offered frequent opportunities to check out, develop and refine our understandings as they emerged. Informally, we were able to check out our thinking in the course of naturally occurring conversations during fieldwork. More formally, we adopted the technique of respondent validation (44), by feeding interview transcripts and draft vignettes back to the individuals concerned for validation or comment. Finally, towards the end of fieldwork, we undertook in-depth interviews (JP) with four AHP graduates from a one-year clinical leadership programme commissioned by NHS London. This was a further opportunity to check out with an entirely new set of subjects our emergent understandings and to reassure ourselves that we had not missed anything of major significance. In fact, it was these interviews that alerted us to the fact that 'leadership' was missing from our case studies. Through these various processes we aspired to the standards of rigor specified by Greenhalgh and colleagues:

> '…achieving immersion (i.e. spending enough time at the field site to understand what is going on), collecting information meticulously and analyzing it systematically, encouraging reflexivity in both researchers and research participants, developing theory iteratively as emerging data are analysed… defending one's interpretations to both the research participants and one's academic peers' (45) (p.397-8).

Finally, a couple of points regarding the presentation of our case studies. First, in keeping with Alvesson and colleagues' injunction to preserve the authorial voice, we have deliberately eschewed any attempt to pursue monological authority (46) by imposing unity of writing style on them.

Second, while writing up, we were principally concerned with maintaining the distinctiveness and the differences that characterised our case studies. However, we also make use (see 'Discussion' below) of cross-case comparison in order to explore how the same processes (such as identity formation or discursive positioning) played out in different contexts.

2.5 Research ethics

In terms of formal ethical approval, East London & The City Research Ethics Committee (REC) determined that the project was service development and hence it did not require formal approval by a NHS REC. Ethical approval was obtained from the City University REC. All local research governance requirements were complied with at each of the study sites.

There has been much debate about the fit between ethnography and the formalised systems of research ethics and governance that have developed in health services research over the past decade or so. Our concern here is not to rehearse that debate, but to present and justify the particular approach we adopted. Even so, some reference to it is required.

Much of the debate concerns the concept of anticipatory informed consent, which forms one of the corner-stones of medical research ethics. A number of features of this approach have been identified (e.g. (47)). First, it presumes that the implications of the research, its methodology and its methods, as well as benefits and costs it offers to participants and the potential risks it poses to them can all be specified in exhaustive detail before the research has begun. Consent is conceived as a one-off event, which is prior to (and indeed a pre-condition of) the creation of an individualised quasi-contractual relationship between researcher and subject, in which the rights and obligations of each are spelled out explicitly in an inflexible and pre-determined research protocol. It is suggested that this model of consent is inapplicable to ethnographic research, which is based not on a pre-specified research protocol but 'on the tentative development of research questions and analysis in the context of emergent relationships of trust' (47) (p.2252).

From this standpoint, rather than being an event that precedes a relationship, ethnographic consent is seen as 'a relational and sequential process' (48) (p.2226). Consent is not a one-off contractual agreement; it is constantly being negotiated, re-negotiated or reconfirmed. It is almost invariably implied and enacted, rather than explicit and documented. It is dependent on the researcher's ability to establish and maintain their trustworthiness and to sustain the goodwill and cooperation of the research participants.

Our solution to this ethical conundrum was a hybrid based on principled pragmatism (or 'ethical situationism' (44)). Where we were able to specify our methods, and the costs, benefits and risks of participation in advance (e.g. with formal interviews), we complied with the practices associated with anticipatory informed consent. Otherwise, we adopted the

ethnographic approach to consent. With observation of meetings, for instance, sponsors advised us that formal anticipatory consent of each individual participant was not necessary or appropriate. Instead, they offered to facilitate our attendance with colleagues in advance. Similarly, we found that, although people were familiar with interviews and even shadowing as research methods, they were much less certain about what ethnography was. In order to conform with the spirit of informed consent we therefore produced a short explanatory leaflet explaining our approach.

A further ethical issue we grappled with at the analysis and writing-up stage was that of safeguarding the confidentiality of our participants. This was not in the usual sense of protecting them from the risk of being identified by outsiders (what Tolich terms 'external confidentiality' (49)). For this we could avail ourselves of the standard techniques of removing identifying details and using pseudonyms for locations, organisations and individuals. What concerned us was the problem of internal confidentiality – the possibility of identification by another *insider*. Due to the interconnectedness of their working lives and social relationships, and despite pseudonymisation, there was a real possibility that individuals might be recognisable by colleagues because we could not change details of their situation or biography that were crucial to 'rich description' and analysis. As organisational ethnographers, this problem was compounded by the existence of hierarchy and the potential repercussions for those who had been openly critical of aspects of their organisation or colleagues.

As Kaiser observes, ethical guidelines for safeguarding against deductive disclosure during dissemination remain much less developed than those that apply to data collection and cleaning (50). Indeed, conventions vary between disciplines. Among anthropologists, sharing findings with respondents and soliciting feedback is common practice; among sociologists it is not. Here again, our solutions were hybrid and pragmatic. In analysis and writing up, our primary aim was to avoid 'pointing the finger.' This meant (re)presenting our respondents not as idiosyncratic autonomous individuals, but as responsible social actors, endeavouring to satisfy the often competing demands of their organisations, their professions and their patients and to make sense of their complex working lives (51). Prolonged immersion in the field and the opportunities it brought of sharing our emerging thinking with respondents (particularly those with whom we had developed sufficient understanding and trust) gave us a degree of confidence that we would not say anything that would cause harm, but even so, the possibility remained of doing so inadvertently. To reduce this, we checked back where ever we felt we could do so ethically. Where a vignette involved a single individual, checking back was ethically unproblematic. Where a number of individuals were concerned, however, it was much less straightforward. Dismembering the vignette so that each individual saw only those sections that featured her/him would constitute incomplete feedback (as well as destroying the meaning we were trying to convey). The alternative (i.e. everyone sees everything) would mean that in trying to avoid doing harm we would be guilty of breaching our respondents'

confidentiality. We are confident that this process has minimised any risk to respondents that might arise from deductive disclosure (whether by insiders or informed outsiders). We are encouraged by the fact that responses we received were uniformly positive. For instance:

> "I am not concerned by anything you have written and disguised. I would stand by everything I have said to any one that recognised me. Thanks for giving me the opportunity to view it first." (Barbara, Therapy team leader, Greenshire)

3 Diagnostic Radiography at Vanguard

3.1 The setting

Vanguard Healthcare NHS Trust is a large metropolitan trust with several acute hospital sites. In partnership with a university and its medical school, the trust provides clinical education and training and maintains a strong academic research base. Vanguard is one of the largest NHS trusts in the country, treating more than a million patients every year and employing around 10,000 staff. Fieldwork was carried out with diagnostic radiographers in the imaging departments at two of the trust's acute hospitals.

Radiographers work closely with radiologists, the dominant profession in medical imaging, which differentiates them from other AHPs. The imaging workforce also includes nurses, clinical physicists, technical and administrative staff. Radiographers have traditionally been responsible for the technical production of images of injuries and abnormalities, which radiologists interpret, but this division of labour is increasingly complex and contested, and 'uneasy relationships' between the two professions are acknowledged (52) (p.169).More information about diagnostic radiography as a profession can be found in Appendix 1.

Each hospital's imaging department has a lead radiographer, who is clinical services manager (CSM) responsible for operational management of radiography services. CSMs are experienced radiographers, but do not usually work clinically with patients. The CSMs are managerially accountable to the General Manager (Imaging) and together with a clinical lead (consultant radiologist) form a management triad in each department. The trust has a directorate structure and imaging is within the largest of these, the clinical services directorate, which includes pathology, pharmacy, haematology, etc. The CSMs are the most senior diagnostic radiographers in the trust, but occupy a niche near the base of its management pyramid. Unlike doctors and nurses who have professional representation at all levels in the trust's hierarchy, radiographers are not represented at directorate or executive level: there appeared to be a particularly low ceiling in the Trust beyond which radiographer managers did not progress.

The imaging departments in each hospital are organised into 'areas', broadly reflecting the technologies used by radiographers: the 'imaging modalities' such as conventional/plain radiography (X-ray); fluoroscopy; computed tomography (CT); magnetic resonance imaging (MRI); ultrasound; and nuclear medicine. Each 'area' is overseen by a superintendent radiographer (SR), also known as the modality lead, an experienced clinician and first-line manager. The SRs are responsible for organising the services in their area: line management of the radiographers; relationships with radiologists, nurses and others; training

staff in the modality and on particular machines; liaison with clinicians who request imaging; maintenance of equipment; and communication with other departments such as estates, wards and porters. The SRs report to the CSM, in a uni-disciplinary line management structure, and one SR is designated deputy CSM, usually the 'general' (X-ray) lead, who has the most staff to manage.

Vanguard is a leading radiology research and training centre that has pioneered new approaches to diagnosis and treatment; its hospitals are equipped with the most sophisticated modern imaging technology. The status and reputation of the trust and the medical school enhance the standing of its radiologists, and being part of a leading edge institution with state-of-the-art facilities also holds an attraction for radiographers. There are radiographers in research posts and the work of diagnostic radiographers includes producing images for research purposes. However, Vanguard offers service diagnostic radiographers few opportunities for extended practice and there are no consultant radiographers in Imaging. This is not unusual in teaching hospitals, which give priority to junior doctors' training needs, but some respondents suggested that role development in radiography at Vanguard was opposed by powerful individuals in the medical hierarchy.

3.2 Fieldwork

The radiographer managers never referred to themselves as AHPs, and the term had little meaning or salience for them, although they knew they were considered AHPs and tolerated my naïve use of the term. They had little contact with other AHPs in the trust or even with radiographers in other departments. Radiographer managers saw little significance or advantage for radiographers in being "lumped in together" with other professions that they perceived as very different from radiography, particularly in terms of autonomous practice. I realised that using the term 'AHP' was inappropriate in this context, so abandoned it for the remainder of the fieldwork, substituting 'radiographer' for 'AHP' in project information sheets and other communications.

At the time fieldwork was carried out at Vanguard, the trust's management was several years into a programme of restructuring services and introducing initiatives to improve efficiency and quality that clinician managers were still coming to terms with. They perceived a steep management hierarchy; decision making that was remote and disengaged from the clinical front line; and top down autocratic management driven by targets and performance management. Increasing financial pressures on the trust had recently prompted reactive measures to reduce costs quickly, including budget cuts and staff headcount reductions, which had to be accommodated by all departments.

It did not feel like a good time to embark on fieldwork: radiographer managers were overstretched, with limited time and energy to give to a

research project, although access was readily granted by the CSMs. Some people were suspicious of me as an outsider and clearly guarded in how they presented themselves, while others used interviews as an opportunity to express their resentment and frustration. I experienced the 'brittleness' described by Mannion *et al.*(15) (p.146) in their study of an acute hospital trust with financial problems, where managers felt that they were bearing the brunt of a situation not of their making and were alienated by their superiors' attempts to impose control. The radiographer managers' experiences and views were coloured by the austerity measures that were being introduced; and the fieldwork material gathered at Vanguard is framed by the trust's financial crisis.

Thus it seems appropriate to begin this chapter with an account of how the financial crisis was affecting radiographers at Hospital A, drawn from observation at meetings and interviews with key informants. The vignette *'Radiography in a time of crisis'* is not intended simply as a factual account of what happened, but to convey the experiences and points of view of different players, and to highlight interpretations of events that sometimes conflict. Three themes from the vignette are then explored more fully: radiographers' status and position in the trust and their relationships with general managers and radiologists. The second main section in this chapter takes us to Hospital B, with 'cameos' of three radiographer managers at different stages of their careers and with varying levels of managerial responsibility. The cameos provide further insights into their experiences of clinical and managerial work, and the professional identities they construct for themselves. We go on to identify four narrative strands in radiographer managers' accounts of themselves – as clinician, technician, manager and leader – which are discussed in the commentary that concludes this chapter.

3.3 Radiography at Hospital A

Fieldwork at Hospital A was dominated by the 'crisis' and radiographer managers' responses to it. The vignette below, '*Radiography in a time of crisis'* (Box 2), was constructed from observations of management meetings and participants' accounts of the events that precipitated the crisis, how it was managed and its impact on the department. The vignette gives an indication of how radiographer managers experienced and made sense of managerial and professional cultures in the trust, and how this coloured their interpretation of operational issues in the department and influenced their work identities.

Box 2. Radiography in a time of crisis

The Lead Radiographer's office at Hospital A is tucked away along a narrow corridor in the Imaging Department lined with boxes, equipment and filing cabinets that have spilled out of overcrowded offices. The room is narrow and very full: piles of paper are stacked on every surface, including the floor

and both chairs. The door remains open to the noise and activity of the department and a procession of people appear for a word, a decision, a catch up later; on the desk phones, bleep and email compete for attention; the intercom's insistent demands punctuate conversation regularly. Nick, however, talks rapidly and fluently through all this.

This is an exciting but difficult time for the department. Nick has been involved in a major service development in A&E with substantial investment in new facilities and imaging equipment, along with an increase in radiography staff to provide 24/7 cover. It is evidently a source of pride that his specialist radiographic experience and planning acumen were eventually recognised by the high-powered project team, despite his lowly position in the trust's management ranks and professional pecking order. "I'm just pond life", he laughs, joking that after specifying imaging equipment costing millions of pounds, it took him several months to get approval from the Directorate's Head of Operations to spend £43 on refreshments for the official opening.

Nick joined the department as Clinical Services Manager four years ago from another teaching hospital, taking over the work of three managers, inheriting low staffing levels and a cadre of superintendent radiographers (SRs) whose priority was working clinically to "keep the service going" and waiting times down. Nick quotes figures and offers an analysis of problems and solutions but, running to keep up, has not yet turned things around sufficiently to meet all the trust's performance management targets, particularly for staff training and appraisal because there is "no resilience to release staff". His general manager has made it clear this reflects poorly on Nick's leadership: Nick continues to argue that the department needs additional resources, but also mentions possibly getting some more management coaching.

In recent months the trust has been set "challenging" cost improvement targets. After "headcount reductions" in every service, further savings had to be found. Senior managers in the trust directorate that includes Imaging decided that these could best be delivered by restricting the use of agency staff. Hospital A was reliant on agency radiographers, so Nick acted swiftly. However, his pre-emptive move to advertise for staff was confounded by the introduction of procedures to scrutinise recruitment, a further cost-saving measure, involving line managers making a case for filling every vacant post to senior managers, who then sought approval from the "Star Chamber" at executive level. Initially decisions were made quickly, but then "the goal posts moved" and Nick's submissions were returned for further justification. Nick rolls his eyes recalling the time and effort, but "it only delayed things by five weeks". However, in that time four more radiographers had left the department and the ban on agency staff was imminent.

A week before agency staff depart, at the fortnightly managers meeting, Nick reviews the situation for the SRs. Some appointments have been made, but the new recruits won't be in post for at least a month and

recently appointed junior radiographers are still not fully trained to work in all the areas. Supplication "up the food chain" to keep agency staff in the short term has received no response. News has also trickled down that staff rotas to cover the new service must be in place much earlier than anticipated, in two weeks, although the service doesn't go live for another three months. It's a case, Nick tells the SRs, of finding ways to maintain the service: "surviving for a month" with insufficient staff, being aware that there are "red flag risks". The atmosphere around the table is tense: eyes are lowered and lips are pursed. SR Joan can't believe "they" could really do this. SR Linda mutters petulantly several times, "you told me I can't close the scanner", but no-one responds. There is talk of alerting the Society of Radiographers to the situation.

Later in the meeting Nick urges the SRs to delegate clinical work to create more time for management, to "concentrate on improving quality". The women exchange looks of disbelief, bodies shift uncomfortably around the table, some sigh: this has been aired before. Linda speaks forcefully, "I can't do the basic admin, never mind do what you want. I'm never rota-ed for admin." Nick reasserts that they shouldn't go back to covering clinical work, being "beaten to a pulp" trying to do too much.

A month later, at the next meeting observed by the researcher, Nick pronounces the intervening weeks "utter hell". One trained agency radiographer was allowed to remain, leaving the department with nine vacancies. Keeping the service afloat was complicated by leave booked months ago and a workforce further depleted by sickness, but achieved by the SRs cancelling their leave, coming in for extra shifts, ignoring Nick's injunction against covering clinical work, and "really mucking in". There are tired and worn faces round the table, but thin smiles of acknowledgement as he speaks. "We're over the brow of the hill. I'm going to nominate the whole radiography team for a trust award." There's confusion about the name of the award – someone declares "that's for heroes!" and everyone laughs. A SR recalls they were told once before that the department had won it, only to discover the trust had confused them with Hospital B. The irony sparks more laughter; Hospital A is regarded as "the poor relation", often compared unfavourably with the trust's other hospitals and rarely singled out for praise.

Privately, SR Carrie is critical of how "the crisis" was handled, particularly the attempt to maintain a full service. Running all the CT scanners when the department was so understaffed was "such a bad decision … made by people who are target hunting … and we're still paying the price…".Much of the radiography workload is planned and routine, but unpredictable demand also has to be accommodated, for example being called to operating theatres: "there's no way you can say I'm not doing that". A radiographer has to be found and with insufficient staff this may mean disrupting a planned list of patients: "something has to give somewhere". A consequence of the crisis is that training has not progressed, continuing to limit flexibility in how staff can be deployed. Carrie thinks general managers

probably don't get enough feedback about the impact of their decisions on front line services and argues that to be recognised as a profession, radiographers should be more assertive, using their authority, knowledge and position to determine how services are run, despite the risk of being dismissed as stroppy "button pushers". "I don't feel we've got a voice." She worries about the effects on junior radiographers: "I should be standing up for them, protecting my junior staff".

Senior consultant radiologist, Richard, is clinical lead for Imaging at Hospital A. He has mixed feelings about the lead role: its demands encroach on his clinical time, but taking on the responsibilities was worthwhile for the chance to contribute ideas and "constantly draw attention to the deficiencies, until somebody takes notice". Richard puts the department's crisis succinctly: "more work … less staff … double whammy". Predictably, waiting times have increased and "now we're being told we need to get them down": it's a "Kafkaesque situation, which obviously frustrates people". Richard is disdainful of "the increasing bureaucracy" that's clogging up the trust and in meetings he sometimes appears dismissive of Nick's attempts to involve him in managerial decisions. Richard says he has little power, charting his distance "down the food chain" from "the higher echelons where the decisions are made", by people who "don't understand the minutiae of how a radiology department works". Despite the rhetoric of NHS policy, in his view "clinicians aren't really managing radiology". Richard sees Nick's job as "extremely difficult", with "a lot of pressure coming down from above" and resistance from below to taking on more managerial responsibilities.

General manager Douglas was new to Imaging eighteen months ago. He was surprised to find that radiographers and radiologists were "at each other's throats, not helping and supporting each other". Douglas instigated regular meetings of leads to "pull them together" to develop services, focusing on waiting times, sending out a weekly performance monitoring report, so they "know where the pressure points are". He agrees the last few weeks were tough for radiographers at Hospital A, but asserts that "nobody expected them to deliver the same service, at the same rate, with less staff". Surveys indicate that the radiographers don't feel valued. Douglas deplores "crisis management" at the expense of the workforce: "if we don't appraise them, give them management training, review them when they're sick" it will make things worse. In his view radiographers are "experts, who know their field, but sometimes they don't put things across in a way that gets heard". They complain, but are hesitant about pushing boundaries, unwilling to put up a fight.

Back in Nick's office, he says "luck and staff loyalty" got them through the crisis. With low staffing levels he describes the stark choice as between "delivery", responding to demand and meeting externally imposed waiting time targets, and "quality", ensuring that standards and safety are maintained. Both are important, but for radiographers at Hospital A the priority has always been clinical work, followed by "management if we can".

"You don't want to let your patients suffer, that's what radiographers don't like facing, making that patient wait longer for an X-ray, a clinic appointment … they're not going to cancel some of them so we can do the 'clean your hands' audit…". He admits he's been influenced by the department's culture of delivery, but feels making a stand for "quality" during the crisis by closing scanners would have been putting his "head in a noose". "Trying to balance things that are reciprocally related" is a dilemma, a no-win situation: he jokes wearily that when he meets general managers to review performance targets he is tempted to ask "which stick are you going to beat me with today?" Nevertheless, Nick has not given up on demonstrating that his department needs more resources; he's analysing data to compare productivity and argue for more rational distribution of radiographers across the trust's hospitals.

3.3.1 Status and position of radiographers in the trust

Nick's description of himself as "pond life" draws on the same ecological metaphor as "the food chain", a term commonly used to describe the trust's management hierarchy. With its connotations of predation and competition this seemed an apt way of describing the prevailing organisational order and norms of managerial behaviour. The dominant individuals at the apex of the managerial eco-system arbitrarily determine the fate of those below; those occupying lowly niches know they are essential to the hospital's continued functioning but feel vulnerable and insecure. This was a culture in which some clinician managers felt the need to look over their shoulders and censor what they said. In whispers and gestures ("not for the tape") the researcher was told about professionals in management jobs who had been consumed: summarily removed from the trust, their posts 'deleted' by senior managers. At Hospital A everyone in the Imaging department expressed a sense of being remote or disconnected from those with authority in the trust. The lead radiologist recalled the days when his profession and seniority would have given him "the ear of the chief executive", now he is less able to discern where power lies in the organisation, seeing only "the bureaucracy" he feels powerless to influence.

Speaking about their place in the organisation radiographers at both hospitals emphasised their insignificance and invisibility in a large and complex organisation: they were few in number compared to the larger professions and complained that they were "often overlooked". A number of respondents told stories about radiographers being "forgotten" when new facilities were planned. SR Carrie perceives the problem as "not having a voice": radiographers' experiences and views not being communicated to or not being heard by managers whose decisions affected them and the services they provided. SR Val agreed: "Our voice isn't even being registered, it's not even on the Richter scale", and linked this to there being no radiographers in senior management positions in the directorate. The views expressed in the vignette by SR Carrie and General Manager (GM)

Douglas, that radiographers themselves may be "part of the problem" and should do more to make themselves heard, were echoed by others. Some SRs saw their lack of voice as a failing of the lead radiographers to represent their views in the trust.

Radiographer managers seemed to have little confidence in traditional channels and methods of communication up the management hierarchy and appeared to be seeking alternative, preferably unmediated, methods that would not attenuate their messages. One example is the plea for managers to come and "see for themselves" what clinical radiographers had to deal with. Another example is the perception that DATIX, the system for reporting and managing clinical incidents, would make them and their concerns visible to decision makers. Radiographer managers frequently urged staff to use DATIX to report not only safety issues but also problems they experienced with providing a service, in order to generate "evidence" that would draw the panoptic gaze of senior managers towards radiography, especially if there were cost implications for the trust. A staff meeting discussion of difficulties being experienced in getting porters to take patients back to the wards was concluded by one of the CSMs saying: "I'll say again, fill in DATIX, it's the only leverage we've got."

3.3.2 Relationships with general managers

Imaging GMs changed relatively frequently at Vanguard: Douglas had been in post for 18 months before being promoted. One of the CSMs explained that imaging was considered "a good place for general managers to cut their teeth", then move on: it was seen as an easy option, with no beds, a clear management structure, few 'heavyweight' consultants and a well-defined budget. In this CSM's experience, most GMs arrived with little understanding of imaging or radiography and assumed that radiographers were "like nurses" who could be moved around at short notice to cover vacancies. Thus, the CSMs needed to "educate" their general manager that radiographers are highly trained specialists; sufficient experience in a modality is required for safety; and familiarity with particular equipment is required for maximum efficiency. Substitution is not always possible: "We are not a ward!". The new procedure for scrutinising vacancies described in *'The crisis'* vignette was particularly irksome to this CSM, who thought it should not be necessary to explain to Imaging GMs why staff were needed, or provide basic details about service organisation and how radiographers work: "They should know that!".

The other CSM saw this differently, pointing out that radiographer managers' specialised knowledge "gives them the edge" over general managers: "we could tell them anything, but of course we wouldn't because of our professional code of conduct." Nevertheless, this CSM gave an example of colleagues "trying it on" with the GM when estimating the time required for training staff on new equipment. A clinical physicist who worked closely with the CSMs to monitor radiation safety in imaging thought that general managers purposely avoided acquiring detailed information

about services because this might "get in the way of their policies". Professionals inevitably pointed out implementation problems and risks, as his own role required him to do, which brought them into direct conflict with the repressive 'can do' culture of trust senior management. He saw this as the reason professionals had been "stripped out" of the management hierarchy.

CSM Nick's narrative of the crisis has elements that are, as Richard observes, Kafkaesque: managerial diktat appears illogical and capricious; rules and expectations change without warning; Nick is isolated and constrained to comply with conflicting demands; and he conveys a sense of personal jeopardy ("putting my head in a noose"). The account of rigorous performance management, the various 'sticks' wielded arbitrarily by GMs, suggests that the regime of 'targets and terror' imposed on the NHS in the early part of the century continues to cast a long shadow over middle managers (53,54).

Some of his colleagues recognised Nick's precarious position as a middle manager, trapped "between the millstones" (55). Clinical lead Richard assessed Nick's difficulties sympathetically, perhaps because he also experienced similar 'pressures from above' and 'resistance from below'. SR Wanda described Nick as "stuck in the middle" between "the ones at the top running a business" and clinicians on the front-line, with all the problems "landing on his shoulders". But Nick himself imagined managing the department more like a business: he was adept at analysing information to explain and forecast trends in activity; he kept an eye on developments that would impact on radiography, not just within the trust but in the wider health economy; he had ideas about how the imaging department could generate income. GM Douglas was dismissive: CSMs should keep their eyes down, stick to doing operational management properly. The only broader responsibility in their job description was to take a "strategic", i.e. trust-wide, view of particular modalities. The rest was for general managers; CSMs should look after their staff, not aspire to be entrepreneurs.

3.3.3 Relationships with radiologists

The relationship between radiologists and radiographers is highlighted in the vignette by Imaging GM Douglas, who had tried to improve cooperation and teamwork. A discourse of teamwork, with its connotations of consensus and interdependence, was prevalent in imaging, but the 'institutionalised set of hierarchical relations' supporting different professional interests was also much in evidence (56) (p.1149). A consultant radiologist referred to radiographers as "the technicians", emphasising their subordinate position in relation to doctors, who were generally known collectively as "the clinicians". Radiographer managers argued vigorously that radiographers' clinical skills were comparable to those of radiologists, which warranted creating specialised or extended clinical roles in radiography, but shook their heads at the idea of challenging the status quo, "treading on toes", and direct conflict with radiologists.

In meetings observed while shadowing the CSMs tensions between radiologists and radiographers were apparent, but confrontation and outright conflict were rare. Radiologists tended to dominate discussion on some topics, during which radiographers would either sit in silence or indicate disagreement in muttered asides or barbed comments, not always out of earshot. On issues raised by radiographer managers, radiologists would signal their lack of interest by their body language and disengaging from discussion, contributing little even when specifically asked for their views. An extraordinary stand-off was observed at one meeting: a CSM made repeated valiant attempts to get the (radiologist) clinical lead's opinion on various issues affecting the department and to formulate decisions, but the clinical lead consistently ignored eye contact and direct questions and diverted the discussion to other topics. Radiographer managers' concerns about managing their departments, unless they impinged directly and immediately on medical work, could be dismissed as part of the "pointless bureaucracy" that wasted doctors' time.

Radiologists' privileged position allowed them to distance themselves from management and to avoid being subject to managerial authority. In contrast, radiographers, with their limited status power, operated within the managerial hierarchy, and relied on managerial systems for influence. Safety and risk featured strongly in radiographers' narratives about their work: they invested particular significance in the procedures and protocols designed to manage risks and ensure safety, such as DATIX, the system for reporting and managing clinical incidents. Radiographers and nurses saw it as part of their professional accountability to report adverse events. It was a bone of contention that doctors rarely used DATIX: their status and informal colleague networks allowed them to circumvent the system and act unilaterally when a problem came to light.

Another source of tension was doctors' attitudes to imaging machines and other equipment that radiographers regarded as their responsibility. At both hospitals equipment had been damaged by carelessness or neglect, and radiographers blamed doctors. One CSM had a £10,000 bill for repairing a broken state-of-the-art robotic machine; a lead apron had been "thrown on the floor" and damaged; and elsewhere equipment had been stolen because doctors "never locked doors". Asked about these incidents, the CSMs described doctors as irresponsible, "they're like teenagers", and told stories about doctors' casual attitude to using expensive equipment. "It's not their problem to solve and they're not held accountable." One CSM felt particularly strongly about the different standards of accountability demanded from the two professions, pointing out that radiographers are closely monitored to ensure they fulfil their responsibilities, while doctors are allowed to "behave as if they're self-employed", to the detriment of the service:

> "… radiographers are held accountable if they're late, if they haven't booked their leave properly, all this stuff that radiologists just (disregard) …. the prime example will be this Christmas … because the radiologists

here book their own leave. It's not managed at all. And they cheat essentially by telling the Specialist Registrar, "You're covering me aren't you?" And the rota looks quite populated, then you see it's got the same initials in three areas. I got so annoyed once …. I said if radiographers acted like consultants for one day, you watch how mad (radiologists) would get. "Where's my radiographer?" "Oh, they've chosen to take today off I think, I don't actually know because it's not recorded anywhere." "Where's the radiographer?" "Oh he's late, he's gone to a meeting." "Where's the radiographer?" "Well he said he'd do it; but, hey, been busy…" … they would just go apoplectic if they were subject to what they do to other team members."

The SRs said they had good relationships with the radiologists in their modality, describing only occasional conflict, typically over a radiographer's refusal to scan a patient immediately: "Clinicians (doctors) are used to having a tantrum and getting a patient seen." Radiographers following procedure can appear obstructive, said SR Wanda: "It's definitely something you come up against a lot in our roles: superintendents have to go, "No we can't do it, it's just not possible"." Wanda was so used to doctors questioning her judgment and sometimes being abusive that she had become "immune to it". She qualified abroad, where radiologists' training includes working as technicians: "They inject the patients, they clean the bums and everything else … that leads to a better appreciation of what we do." SR Sue had found more respect for radiography as a profession when she worked in district general hospitals: "people don't treat you as if you know nothing".

When they experienced conflict with doctors radiographers were circumspect in dealing with it, preferring to 'work around' confrontation, taking care to depersonalise issues and observe medical etiquette. Disputes between SRs and junior doctors were resolved through the medical hierarchy, the consultant being asked to "have a word"; referrals that did not accord with imaging guidelines were returned via a consultant radiologist; hospital policy was quoted in emails; and a recipient of verbal abuse was urged to "put in an incident form".

3.4 Radiography at Hospital B

Radiographer managers at Hospital B had not declared a 'crisis', although they were dealing with similar issues to those at Hospital A: the day-to-day problems of low staffing levels, heavy workloads, unreliable hospital support services and rigorous performance management, coupled with the additional demands of commissioning new equipment and implementing change. This section offers a different perspective on radiographer managers' experiences and views by focusing on three individuals at Hospital B. The first cameo is of Holly, recently appointed to a SR/modality lead post, who works clinically and manages a small team of staff (Box 3). Jennifer is an older, more experienced SR and as the General (X-ray) Lead deputises for the CSM. She is responsible for managing a large number of

staff and does little clinical work (Box 4). The final cameo is of Christine, the CSM and Lead Radiographer in the department, who has worked for many years at Vanguard (Box 5). These biographical narratives have been constructed mainly from interview data and use respondents' own words as far as possible. The various ways in which they resonate with each other, and with the views of colleagues, are explored to illuminate the narratives radiographer managers use to construct their work identities.

Box 3. Holly

Holly was appointed superintendent radiographer a year ago, about the same time as she received her master's degree and less than ten years after she first qualified. She would probably have stayed longer as a clinical radiographer, but the opportunity came up to lead her modality. Smiling, she says there's been a lot to learn. "I do love the job. There's job satisfaction, that's what keeps me going."

Holly works clinically and manages "the area", organising her three staff and patient bookings to ensure its efficient running, and going to multidisciplinary team meetings with the consultant radiologists and radiology nurses, "a nice bunch". There are, inevitably, pressures: "there's a lot of chopping and changing … as a manager you have to conform with all of the targets, the waiting times and the expectations of the other teams in the hospital. A lot is out of your hands, you know, consultants or managers decide that something has to be done, you don't have much control, you rearrange things around it".

"The biggest challenge at the moment is managing the area with the limited staff that we have. We're not at full capacity, unfortunately, because of all of the cutbacks. So I have to take myself out of my managerial role a lot more than I would like to, to facilitate the running of the rooms clinically." Holly has had support from her clinical services manager but she feels there are high expectations of modality leads. She's had in-house management training and other "bits and bobs", although it's difficult to get away because of clinical demands. She's booked on to some human resources (HR) courses next year.

Keeping up with advances in imaging technology is part of the appeal of radiography for Holly, and planning a new room with equipment costing £1.5 million has given her a taste of project management. She's organised visits to other hospitals and contacted companies for specs and quotes, discussing options with the team. "I don't really see what happens above, you know, I don't go to the business meetings and find out what the budget really is and where the money's going…". She says equably that she was happy with the choice of machine, but her preferences carry much less weight than the doctors' requirement to have similar equipment in all the trust hospitals. They're the ones with the power.

Holly sees herself being "a clinical radiographer for many, many years to

come. This is probably about as much management as I'd like to do. There's a lot of interaction with the patients, that's why I went into the job. My manager sits in the office all day, that doesn't interest me at all. If she has to deal with a patient, it's usually about a complaint, you know. I think management have a lot of pressure on their shoulders. I mean, I can't even imagine what my manager has to deal with. I much prefer being on the shop floor, mingling." She hasn't really considered becoming a consultant radiographer, knowing "it doesn't happen here" and sensing "a bit of animosity" from radiologists: "it's stepping on the toes of their training scheme".

Holly aligns herself with her radiographer colleagues as having pride in radiography and their own expertise, which amounts to "more than what appears to be pressing a button". She wonders what impression of radiographers comes across to senior managers in the trust. How do clinical services managers represent them? She suggests that non-clinical managers should spend a whole day in an area, rather than popping in for five minutes, so they'd get a better understanding, then they'd be able to convey that to people higher up. The best voice for radiographers, she says boldly, comes from radiographers and the superintendents on the floor.

Box 4. Jennifer

Jennifer is a superintendent radiographer with more than 30 years' experience, who managers 'core services' and deputises for the clinical services manager. She looks after the general (X-ray) area, theatres, mobiles, A&E (where there is currently a superintendent vacancy) and keeps an eye on the day-to-day running of the department. She has a calm authority and answers questions thoughtfully with an occasional dash of twinkling humour. Her job description includes clinical work but she doesn't currently do any. "I'm in and out of the general department all the time to see what's happening round there; I'll help out if there are any issues and to keep the workflow going. But to actually be rostered to a room on a day to be X-raying patients, in the present climate, there's just no time for it." She regrets this, especially because technology is changing constantly and it's unlikely that she'll get enough time to train fully on the new machines she's involved in purchasing. Buying new equipment gives her particular satisfaction and as she talks about new digital radiography equipment a huge smile lights up her face: "at the end of the day to be allowed to say "OK, we'll order this kit", I think, "Yes!"." She explains that her views count because "the general department is absolutely radiographer-led. All the radiologists are interested in is image quality." In her experience there's more conflict over IT systems, which may not be designed with all users in mind; that's when compromise is needed.

Jennifer laughs at the suggestion that she made a positive decision to go into management, describing how it happened "almost by default". But she finds her job rewarding, particularly managing staff, "keeping the service

running with happy staff - or as happy as they can be in the current climate". That may involve protecting workers from "issues that come down like a ton of bricks" from senior management in the trust: "whip cracking" to keep waiting lists down and increase productivity, or new systems with "a lot of box ticking". It's down to her to send messages back up the line if the demands are unrealistic. "I'd like to think I'm a buffer between [*senior managers*] and staff working extremely hard in the rooms, short-staffed."

In the last year the department has had to cope with a reduction in staff, an exceptionally high turnover of radiographers and management processes that effectively delay filling vacancies. Jennifer describes her job as "crisis management. I do not know what's going to hit me when I come in at nine o'clock in the morning. There are certain things I have to do but I know that most of my day is going to be spent juggling radiographers, dealing with theatre, clinics and portering because there are problems all across the board." As a consequence Jennifer has had to postpone some work on quality assurance, reviewing protocols and staff training.

Portering is a particular headache, sometimes preventing patients from the wards getting to Imaging for the same day service they aim to provide. "I've spent the last few weeks in meetings with the porters to present the case for improving or changing the service they give us; it's taken an enormous amount of time." Jennifer criticises the "lack of joined up thinking" in the NHS: "you have financial people calling the shots; all that's seen is numbers and financial issues".

Over her career, Jennifer has seen superintendent radiographers take on increasing managerial responsibilities. It's no longer viable to expect them to pick up management skills as they go along, as she did: protected time for management training is needed: "you can't really do it alongside your modality clinical lead role". Leaving the clinical floor to become a manager is "a big leap, you have to take a definite step". Being a manager, says Jennifer, requires "a love of dealing with people, you have to want your staff to flourish. If you're more interested in the clinical side and all these technical advances, stick to that, because there are amazing opportunities now."

Box 5. Christine

Lead radiographer and clinical services manager Christine has worked at hospitals in Vanguard Healthcare NHS Trust for most of her long career. She is confident and forthright, but sometimes sounds rather world-weary, especially as she lists the mergers and restructurings she has been through. Looking back, Christine counts herself lucky to have seen "exciting times" for radiography, such as the introduction of new imaging modalities, more sophisticated equipment and specialised IT systems, and she is proud to have taken a leading role in some of these developments. Advances in technology are what "fire her up": "I think all radiographers embrace technology and change, they're an adaptable group of people". And

innovation and change are the lifeblood of Vanguard: "we want to be the best". "That's what's driven me; my career has been shaped by technology!"

Christine's job is "entirely management". She manages six SRs, the modality leads, who combine clinical work with managing their teams, training, investigating problems and implementing changes in their areas that involve equipment and estates. One SR (Jennifer) deputises for her. Initially she "felt bereft" at not being clinically involved and for a while did MRI scans on Saturday mornings. She sometimes thinks she'd like to be a superintendent radiographer again, doing mainly clinical work, but she enjoys "having a say" in how things are run. Christine has resisted her office being moved away from the clinical floor because she likes to walk around and keep in touch with staff, although she grimaces at her inability to resist picking them up on uniform or name badges: so "old school", she laughs.

Managers and professional colleagues respect Christine's commitment, experience and sound judgment. In meetings, she is outspoken and authoritative. Although she is lead radiographer in the hospital, Christine describes herself as "a sidekick, not a lead, a good second mate". "I'm a radiographer by profession; I'm on the side of radiographers. That's my territory. I know my content. I can give good guidance. The other bits of general management aren't for me."

Christine thinks radiographers, as a profession, "are frequently overlooked" and she does her best to make sure their work is recognised. However, she concedes that radiographers themselves may be part of the problem, since radiography's now much more "bounded by procedures, policies, protocols and regulations, much more paper and protocol driven; radiographers don't think for themselves as much as they used to". Maybe she, too, could "sell things better".

Christine has an agenda for promoting and improving radiography in the trust and puts across her views vigorously. She has a personal commitment to a trust-wide project implementing a new order communications system that will link test requests and results to the single electronic patient record. She has seen two previous projects fail "with dire consequences for Imaging" and a trust "supposed to be at the forefront"; the waste of NHS resources makes Christine furious. The new system will be "life-changing" for clinicians, saving time and reducing risk with its inbuilt protocols for ordering tests and reporting results.

Despite her enthusiasm for this IT project, Christine confides that she no longer finds her work as rewarding as she used to. The current financial restraints and lack of support from senior management make it "harder to put a positive face on things. I can't pretend patients aren't suffering, but these are dismissed as emotional arguments". The important thing, she believes, is not to lose sight of the patient, to put the patient's needs and comfort first. "My [*general*] manager might say something different, but it

won't stop me doing it."

She's also concerned about the impact of cost reductions on her staff, who are coping with a high volume of patients and are under pressure to keep waiting times down. Recently a number of incidents were logged in which staff were considered to have "put patients at risk", although none were actually harmed. Christine explains "you've got patients booked at ten to fifteen minute intervals, but actually scanning the patient isn't the thing that takes the time, it's getting them on or off the table. And your next patient might be slightly disabled in some way, they can't move as fast. And then someone's trying to have a conversation with you about this urgent case they want done now. The concentration goes and they input the wrong data or something happens." Reviewing the incidents at a risk management meeting, Christine reproached herself: "Are we doing too many patients on a list? I'd left myself and the whole team open for something to go wrong … I feel most unhappy."

She sums up her situation: "The levels above me are driven by numbers but the numbers don't show you the stress that junior staff face. I sometimes feel I'm in the middle of a battlefield, I'm getting it from the bottom and I'm getting it from the top." She says she would like the directorate's head of operations to stand in CT for a day, to see what radiographers have to deal with. She knows it's what people always say about their managers, but she still sometimes thinks, "What are they doing up there? They haven't got a clue."

3.5 Commentary

The radiographer managers presented their work as complex and multifaceted: portraying it variously as being rewarding and challenging; concerned with securing stability and achieving change; subject to constraints and requiring agency; and aligned with organisational goals and conflicting with them. These accounts illustrate clinician managers' continuing efforts to 'impose order on the messy, deceptive, imprecise, social world they inhabit' (57) (p.254); and remind us that the stories they tell reflect themselves and their world but also have the potential to shape identities and events (55).

In interviews, the radiographer managers discussed their work broadly in terms of it being 'clinical' or 'managerial', but this was a dichotomy introduced by the research and, as such, possibly a form of 'narrative incitement' to use these terms in presenting their stories (58). However, as the cameos above demonstrate, they made it plain that the activities they perceived as important did not divide simply into 'clinical' or 'managerial', and their work identities were more nuanced than this dichotomy allows. The radiographer managers spoke vividly about their relationship with imaging equipment and technology, as a defining aspect of radiography and of themselves: equipment, as much as patients and staff, requires attention

to its needs and "looking after". Thus we have added 'technician' to 'clinician' and 'manager', to denote the technical and scientific aspects of radiographers' identities. Another aspect of their work, leadership, was rarely discussed explicitly by the radiographer managers, although it was enshrined in their job titles (lead radiographer, modality lead). Leadership, an official NHS discourse, announced itself in other ways. Therefore 'leader' is included as the final strand we found woven into the identity narratives of radiographer managers.

3.6 Identities

3.6.1 Clinician

The clinical aspects of radiography were generally equated with direct patient care and were foregrounded in radiographer managers' narrative identities. Holly says that she is a "clinical radiographer", aligning herself with clinical colleagues and distancing herself from managers. She links her choice of profession and her job satisfaction to enjoyment of working with patients, as did most of the other SRs. Jennifer and Christine see themselves as managers, but they both regret losing clinical contact with patients. Christine's attachment to working with patients clearly informs how she interprets the CSM role. She tries "not to lose sight of the patient" by emphasising professional values of patient care, putting "the needs and the comfort of patients first"; maintaining a presence on the clinical floor; and using patient-centred "emotional" arguments to counter managerial policy "driven by numbers". Jennifer's regrets about not treating patients are associated with missed opportunities to use new equipment.

At Hospital A, SRs giving priority to clinical over managerial work was perceived to be a problem, although it was their dedication to patients that, in Nick's view, enabled them to survive the 'crisis'. SRs were being asked to compartmentalise clinical and managerial activities, to differentiate them spatially and temporally, setting aside time in schedules and rotas to be "away from the floor" for management. This is a common approach to identity regulation in organisations (59), which also satisfies managerial needs to quantify and account for how time is spent (60). The SRs' reluctance to comply may not be just because they prefer patient care: the requirement to separate out activities was incompatible with the work flow in some areas and SRs' interpretations of their clinical responsibilities. Clinical work was described as pressured, fast paced and often unpredictable (see SR Carrie's account in the '*crisis*' vignette). In some modalities decisions to carry out a procedure depend on the clinical condition of the patient, making planning schedules extremely difficult, as SR Sue describes:

> "… (it) changes minute to minute …. you can have a request, but if it doesn't fulfil the criteria, then it's cancelled…. a list can be full and then by ten o'clock it can be empty, through no fault of wrong planning or

anything, just how it's worked out. Or you can end up with a list that is so full … you're going into out of hours with an emergency or something that really should be done before the next day."

The biological unpredictability of bodies can create periods of intense activity interspersed with 'baggy time' for body workers like radiographers (61). Body work[1] is labour intensive and demand is erratic; thus it is not particularly amenable to being standardised or rationalised to improve efficiency (62). Some SRs reported fitting managerial work around clinical work, filling in with suitable managerial tasks when things were 'baggy' clinically, or when they felt they could leave the floor safely, i.e. without leaving the team short of staff or juniors without access to expertise and guidance. Organising routines rigidly on 'clock time' was seen as inappropriate in some radiographic modalities.

Most of the SRs, like Holly, said they did not want to move away from clinical work, and they linked this to being "practical people", which was also how CSM Christine described herself. SR Wanda said:

"I'm a practically minded person, I like the human contact. So I don't think I'd ever push to go into a role where I would move away from clinical work, because it's what I like to do. So, the only change that I might make is move more to a research based area."

Being "practical" also draws attention to radiography as a craft, and the strong connection in practice between its clinical and technical aspects. SR Val expressed this as follows:

"Obviously radiographers love contact with patients and they love the technical element of being involved in quite high end equipment. … And there's nothing more satisfying than at the end of the day you know you've done a list of patients, you've produced an image that's of good diagnostic quality and there's going to be an outcome or an output, a report at the end of it. There's nothing more satisfying than that."

SR Jennifer's advice to the next generation of radiographers ("if you're more interested in the clinical side and all these technical advances, stick to that…") also links the technical and clinical and places them in opposition to management.

3.6.2 Technician

All three cameos show that the radiographer managers' close association with imaging technology was important for understanding their identities, and perceived as a positive and attractive aspect of radiography. All the SRs, like Val in the quote above, expressed an emotional attachment to the technical/scientific aspects of their work. The most striking examples from the cameos are SR Jennifer's delight at buying state-of-the-art "kit" and

[1]Body work involves 'direct, hands-on activities, handling, assessing and manipulating bodies' (61)(p.172).

CSM Christine's narrative of her career being "shaped" by her enthusiasm for technology. Ensuring that imaging technology was used to its full potential was a matter of professional pride; damage to equipment brought bitter recriminations. Equipment featured prominently in conversations observed during the project: the machines were central to the life of the department; they were characters in the narratives.

Claims to technical expertise, especially in relation to expensive, sophisticated equipment, hold the potential for increasing professional status, as in CSM Christine's account which aligns radiography with innovation and progress. But the technical aspect of radiography can be used by others to undermine radiographers' claims to professionalism, as in SR Holly's reference to the caricature of radiographers as "button pushers", simply machine operators following orders. Radiologists' positioning of radiographers as "the technicians" in opposition to themselves as "the clinicians" contrasts the two professions' relationship to equipment and, perhaps more importantly, to the patient, which legitimise inequalities of autonomy and status: radiologists make decisions that affect patient care, radiographers carry out technical procedures. SR Carrie spelt out this 'narrative of lack' (63) (p.132) and its implications for claims to professionalism:

> "I think radiography is [*seen as*] very similar to the pathology technicians. Request a test, we don't need to think about them. And they don't know anything, they're not specialists. … whereas physiotherapists can request X-rays. The nurses in A&E can request X-rays. They can interpret X-rays, they can plaster the patient, they can discharge the patient. If we had reporting radiographers, like I know they do in the North, "No fracture at the time of X-ray. This patient can be discharged". Or, "there is a fracture, this patient should be referred to the plaster room and discharged from there". Then suddenly you've elevated yourself to someone that's been referred to and can make a decision on the patient's care. I think that's why we don't identify with the allied health professions. We don't identify with physiotherapists, because they practice autonomously. They don't have the doctor that's in charge of their list. They are that person who treats that patient. It's the same with speech therapists, occupational therapists…".

Radiographers' relationship to technology is important in constructing their professional- and self- identities, but it is just one facet of how they would like to present themselves. However, when radiographers are attributed 'technician' as their only identity, it invokes a stereotype that diminishes them to unthinking machine operators. Lawler has pointed out narratives of lack are often accompanied by 'narratives of decline' (63) (p.136), which become mutually reinforcing. For example, when CSM Christine suggests that radiographers may be partly responsible for their invisibility, she goes on to say that "radiographers don't think for themselves as much as they used to", implying retrogression and a decline in their worth as professionals.

3.6.3 Manager

CSM Christine and SR Jennifer speak as managers, but make a distinction between themselves and general managers who have no direct connection with and by implication little understanding of clinical radiography. SR Holly identifies herself as a "clinical radiographer"; she emphasises that her managerial authority is constrained by the need to respond to demands ("conforming") and working around others ("you don't have much control"). The other SRs were similarly reluctant to be labelled 'manager': for example SR Wanda, "I don't ever say that I'm the manager". They also alluded to the tenuous control they had over their work, because "to get the patient on the table" they were dependent on staff and services over which they had no authority. SR Jennifer's account of her efforts to resolve the portering situation is a good example of this. Other SRs also spoke about having to remind, persuade or cajole others to achieve the co-ordination necessary to run their area efficiently and to meet performance targets.

It was difficult to elucidate precisely what 'management' meant to the SRs. Management could encompass everything that did not involve patient contact, although it was generally taken to mean managing staff, organising work schedules and managing relationships within a modality team and between the team and others. Activities carried out by the SRs that also required clinical and technical expertise, such as involvement in developments and training staff to use equipment, were generally left out of discussions about managerial activities. At Hospital A, some SRs talked about "admin" rather than management (see *'the crisis'* vignette, above), indicating their negative attitudes to "time away from the floor" for "doing the stats", monitoring and audits. However, all the radiographer managers valued radiography's systems of managerial accountability, which they associated with professionalism, comparing themselves favourably with radiologists, who were portrayed as irresponsible and unreliable as a result of not being managed.

All the SRs managed staff and they emphasised "looking after", "protecting" or "standing up" for them. SR Jennifer portrays herself as the link and "a buffer" between the clinical front line and general management, representing radiographers' interests and voicing their concerns to senior managers. CSM Christine expresses her sense of responsibility for her staff, reproaching herself for not doing more to alleviate the "stress" she knew they were under. In the cameos all three radiographer managers identify with their staff and express a sense of distance and disconnection between themselves and other managers "up there" or "sitting in an office", "driven by numbers", who have little idea of the reality radiographers deal with day-to-day. SR Holly "can't even imagine" what the CSM does, and CSM Christine in turn refers to unfeeling and unsupportive senior managers: "they haven't got a clue". Although SR Jennifer "sends messages back up the line", they all imply that communication upwards is ineffective.

The CSMs' position as middle managers, bridging clinical and managerial domains, was an important theme in their narratives. We have already discussed the conflicting demands and pressures on them in the general management hierarchy (Section 3.3.1) and tensions with their radiologist colleagues (Section 3.3.3). GMs' expectations of the CSMs privileged workforce management and meeting performance targets: friction was caused by Nick's entrepreneurial aspirations and Christine's advocacy for patients. The three CSMs were also in competition with each other for resources within the trust. Kippist and Fitzgerald describe clinician managers as 'embedded in a web of complex and pressurised relationships' (64) (p.645), which in Christine's words sometimes felt "like the middle of a battlefield".

Some SRs, like Holly and Wanda, were content with the current extent of their managerial activities, but others had an appetite for more management training and responsibility. SR Val was planning to study for a management qualification; others had less specific ambitions. The SRs were critical of the management training available (mainly in-house HR courses); how it was provided ("picked up as they go along"); and of CSMs for not delegating more responsibilities. SR Sue had taken her current post in the hope of getting more managerial experience and was disappointed at so far only being asked to monitor training: "… that's not management, that's just doing a list. I'm not saying it's not an important task, but really anyone with half a brain cell can manage a list…"

3.6.4 Leader

At Vanguard, 'leadership' was the language of general management and was rarely used by radiographers and other professionals, although most of those involved in this study had the term 'lead' in their job titles. The only time leadership came up spontaneously in discussion was in Nick's story of his general manger questioning his leadership of the department (in *'the crisis'* vignette). However, the fieldwork material reveals that leadership, its perceived absence and reluctance to claim it, was an important motif in narratives of radiography at Vanguard. Almost everyone - managers, radiographers and other professionals - mentioned radiographers' silence, invisibility and passivity: "lack of voice"; "unwillingness to put up a fight"; and a propensity to be "overlooked". Radiographers blamed others for their invisibility and subjection, but also found fault with themselves; they appeared to be looking to others for voice, representation and agency.

CSM Christine says she is "a sidekick, not a lead, a good second mate" and associates leadership with general management. However, she has the respect of colleagues and "does her best to make sure radiographers' work is recognised"; expresses her views vigorously; and is championing projects in the trust that will give radiographers more control over their work. CSM Nick emphasises the need for managerialist rationality and relishes combining his professional expertise with analytical and entrepreneurial skills, as far as he is allowed to pursue them. He too has earned respect

among professional colleagues for his part in a prestigious trust development, but the notion of leadership seems inconsistent with "Kafkaesque" narratives of life at Hospital A.

Fieldwork notes from Vanguard provide many examples of interaction and stories that could have been presented by radiographers as leadership, heroic and otherwise, but those involved did not construe them or claim them as such. Observing meetings at Hospital A, it became apparent that SR Carrie was regarded as a leader by others (radiologists and nurses) who worked with her: they sought and listened to her opinions, deferred to her when making decisions and co-operated with her plans. When this interpretation was tentatively suggested to her, she replied bluntly, "I don't see it like that", and diverted the discussion to the difficulties of working in a multi-disciplinary team.

That leadership appeared elusive to radiographer managers at Vanguard is perhaps not surprising, since they experienced the combination of professional and managerial subordination in the trust as disempowering and disaffecting. In this teaching hospital setting, radiology dominated Imaging, to the extent that radiographer managers could be described as working around rather than working with radiologists, despite egalitarian talk of "teams". Elsewhere in the NHS the division of labour between radiology and radiography is shifting towards role expansion and increasing autonomy for radiographers, but at Vanguard radiology's subordination of radiography appeared unassailable and it remained unchallenged. Although radiographer managers had assumed *de facto* leadership of some activities in Imaging, claiming leadership in clinical services risked confrontation with radiologists who saw leadership as an aspect of their professional authority. In terms of managerial accountability, failure to meet financial and performance targets was attributed by general managers to radiography's lack of management capacity and deficiencies in leadership; mobilising leadership was seen as a means of strengthening managerial control and aligning front-line professionals more closely with organisational goals. The managerial call to leadership had evoked little response from radiographer managers, who remained cynical about demands imposed from above; sought to resist being entirely "driven by numbers"; and wanted visibility and voice for radiography as a profession at Vanguard. Embracing leadership at the behest of managers held little potential for emancipating radiographers; and there were indications that leadership could become yet another stick to beat them with.

4 Therapy Services at Whiteford

Therapy Services are based in the County Hospital, a small district general hospital, perched on a hillside overlooking Whiteford, a medium-sized town in South East England. The hospital began as a grand Victorian redbrick building and now has a haphazard accretion of wings, extensions and out-buildings, connected by an echoing grey corridor. A small door gives access from the corridor to the therapy services department, which occupies a ward that has been converted into outpatient clinical areas and offices. The department is a bright, ordered world where green- and blue-uniformed therapy staff move around purposefully and calmly. Reception and an outpatient waiting area intercept a trickle of arriving patients. Clinical space and offices are side by side; patients and staff are not strictly segregated, although a 'staff only' sign deters patients from the staff room near the entrance. There is little noise as staff pass with a nod or word to the receptionist, most journeys taking them to or from a large room known as the 'team office', furnished with a jumble of desks, tables, filing cabinets, computers and notice boards, where the inpatient team is based. Further into the department are much smaller offices, interspersed with treatment rooms, an occupational therapy (OT) kitchen and a gym. In contrast with the clean and shiny but sparsely-appointed clinical rooms, the senior managers' office is slightly shabby and untidy, with just enough space for three old mismatched desks and files hastily stacked on shelves and the floor. The door is usually open, signalling not only availability, but also that it's hot and cramped in there and shutting the door is difficult without shuffling chairs around.

Physiotherapists and OTs have been based together here for some years, but the bustle and crowded feel to the department is a result of more members of the AHP 'family' joining them quite recently. There are now around 160 staff, the majority with professional backgrounds in physiotherapy and OT; a much smaller cadre of speech and language therapists, dieticians, orthotists and nurses; as well as clinical support staff and admin staff. They provide a range of services for inpatients and outpatients, and some teams treat people in the community.

A senior management team for the newly integrated department is being established, but plans must be suitably modest in view of demands for a reduced staff headcount, particularly fewer managers, and substantial savings to be made each year. Despite financial pressures, some service developments are going ahead, including rehabilitation for inpatients at weekends; plans for a pain service; and a pilot of therapies' involvement in A&E. The organisational landscape is changing, too: Whiteford is being "acquired" by a neighbouring foundation trust, Bootlington, which heralds yet more management restructuring and competition for senior posts.

4.1 Managing and morphing

The story of Whiteford told here is about the experiences of clinician managers in Therapy Services and their collective project of managing the department and the services it provides. It explores the narrative work that managers perform on themselves, their staff and the work of the organisation to meet external prescriptions and to better match ideals and aspirations. It illustrates the interplay between the evolving ethos and working practices of the department and the construction of work identities by clinician managers. Discontinuities, inconsistencies and tensions and attempts to resolve them are integral to the story. Some of the managers spoke of the need for "morphing", indicating the continuous alterations in presentation, persona or perception that they are required to make as the environment and expectations of them, as professionals, managers and leaders, changed.

We begin by introducing the Whiteford managers. The following section focuses on how the senior management team was attempting to re-form itself and accomplish management and leadership appropriate to their level in the organisation and in a way that reflected the department's ethos of integration and "quality". The two next sections, *looking after our staff*, and *styles of management* examine Whiteford's particular approach to managing staff, which places a strong emphasis on 'nurturing', privileging the emotional aspects of management. This is one half of a dichotomy that is apparent in other narratives, between the emotional work of developing staff on the one hand and a rational, strategic and business-focused stance on the other. The following section draws largely on interview material to provide clinician managers' accounts of their work, particularly how they combine clinical and managerial responsibilities; going on to consider attitudes towards management more generally. The chapter concludes with a commentary on the themes emerging from this case study.

4.2 The Whiteford managers

Fiona, a physiotherapist, has been Therapy Services Manager at Whiteford for about five years. She currently combines this job with a role at the SHA. She has a reputation beyond Whiteford and the SHA for vigorously championing the allied health professions' place in the NHS. She is also known for her ebullient personality. Fiona has that combination of intelligence, energy, vision and personal charm that in person is almost irresistible: she is a charismatic leader. When people talk about the department, their stories always include Fiona, referring to her with warmth, humour and appreciation; and acknowledging her for the political nous and entrepreneurial flair that have enabled the department to flourish. Encountering charisma can be troublesome for an ethnographer: not only is one subject to its fascination, it can be difficult to deal with in sociological writing. Following the lead of Law (65), we acknowledge the existence of charisma and its seductiveness; and we have tried to avoid hagiography.

Fiona features only as prominently in this account of Whiteford as she does in the life of the department.

She gives a persuasive and heroic account of inheriting a department that had fallen behind the times and spending her first two years "learning the game and how the business worked", stabilising turnover and recruiting "good people". She confesses she was battle-scarred from her previous job, but it was her good fortune that several colleagues fled the same punitive regime and joined her at Whiteford: "grownups who understood how it needed to be and could put their tentacles out and love and nurture, whilst pushing everyone fast in the direction of travel". The management group, "managers or leaders or whatever we call them", turned the department around and enabled her to "look up and out", to build the reputation of Therapy Services within the trust and ensure that the wider AHP group spoke with a voice that was listened to. "They were sick and tired of hearing us whinge … but now we can go anywhere and talk to anybody.' In the trust's most recent reorganisation, Fiona succeeded in getting therapies moved from the clinical and diagnostic services division, "because we were hidden, we weren't anyone's problem, we were stuck", to the division of medicine, "right into the pain of the organisation – incredible, the best thing we ever did". "It was a Trojan horse really, so we could infiltrate from the inside and offer solutions to their problems". Therapy Services has achieved visibility, respect and trust within the organisation such that the divisional general manager allows Fiona freedom to "just get on with things". She links the autonomy she is allowed to the small size of the organisation, its flat structure and informality.

Fiona has a close bond with Jean, her deputy and Lead OT, who oversees the day-to-day operational management of OT and physiotherapy services. Jean has a fund of knowledge about the hospital's people and processes and is acknowledged for "holding together" the department. But she is to retire very soon; "How we'll manage without Jean" is a pressing question, especially since the idea of replacing her with a business manager had to be abandoned. In the newly-integrated department, Jean's successor as deputy is Lead Speech and Language Therapist, Serena, an experienced clinician and manager, who seems confident about taking on a broader role. Serena and Fiona prepared for the professions coming together by meeting regularly over several years, observing other "integrations" and forming the view that it is possible to combine management, but imperative to retain separate professional leadership. They share a belief that joining together as AHPs is the best way to increase their influence in the NHS. Serena sees her new position as a "training ground" for AHP leadership. "I'm very fully involved in my own profession, and I'm learning about the day-to-day management issues of physio, OT and dietetics", although she quips "I'm a little old perhaps for this!" Nutrition and Dietetics is headed by Deborah, quietly-spoken and hesitant about moving into the senior managers' office.

Every Wednesday morning the senior managers hold a meeting to discuss management issues in the department and the trust with the OT and

physiotherapy services' "team leads": Band 7 clinician managers who spend half their time or more on management. Fiona says she attends these meetings to make sure she's "plugged in" and won't get caught out if managers or consultants ask her questions about particular wards or teams. "It probably sounds a bit laborious and far too operational, but it's the one hour in the week that I can suck up the detail of what's happening to make me safe for the rest of the time. And make them feel I care too, which is really important." The largest group of therapists and support staff, the inpatient team, is headed jointly by Lynne (OT) and Anita (physiotherapist), who oversee different specialist teams, providing professional leadership and supporting the predominantly clinical Band 7s who coordinate clinical activity (also, confusingly, called team leads). Lynne works full time, divided between management and her clinical specialty, stroke, and she is to become Lead OT when Jean retires. Anita works part-time and does not work directly with patients. Outpatient services are managed by Gail, a physiotherapist, who is 'home grown' and keen to progress further in management. An OT, Sarah, is team lead for the Re-ablement Service, which includes nurses and therapists; she has less management experience than the others and is mentored by Lynne. Both Gail and Sarah work full time, divided equally between clinical and managerial activities.

4.3 Shaping up as a management team

The department's senior management team is re-forming itself in order to accommodate the 'small professions', speech and language therapy and nutrition and dietetics, and to prepare for Jean's retirement. It is also an opportunity to reassess management and leadership in the department as a whole: for roles to be reshaped and responsibilities realigned, to demonstrate there is robust clinical and professional leadership. The merger with Bootlington adds impetus to the process: despite Whiteford's disadvantages in terms of size and status, there's fighting talk as Fiona urges the managers to position themselves "to go forward with confidence" and influence the new organisation.

The senior managers' meetings take place in their hot and overcrowded office, with the door firmly closed. Discussion is often intense: the managers lean forward, listening intently and weighing their contributions carefully. When the merger comes up, it feels slightly subversive: Fiona draws them into plotting and positioning, thinking in terms of taking the initiative, and second guessing the next move to stay one step ahead. It is "backstage" performance (26), a place where the managers can voice fears and doubts, develop a collective understanding of issues, reconfirm their belief in Whiteford's values and distinctiveness, "we're about quality", and rehearse arguments that Fiona may use later in negotiations. They are developing a shared narrative to underpin the collective leadership of the integrated department. Serena later describes it as a process of evolving "something that joins us all together", "an ideology", which can feel like

"clouds captured in a net … nebulous, moving", but she has no doubt that it is important in "shaping the way we move things forward".

Planning for Jean's retirement is also an opportunity to re-think and re-present management and leadership in the department. Jean is an approachable 'maternal figure' that therapy staff have come to rely on, knowing she will make time to answer their questions and give advice. Her facility for dealing with budgets, policies and staffing is much valued by her manager colleagues, who struggle with deficiencies in the hospital's corporate services, particularly Human Resources (HR), which has become "a barrier, an immoveable obstacle, not a support service". Jean tries to keep processes moving: "I'm chasing people all the time, checking up on what's been done." For managers in other hospital departments Jean has become known an authoritative 'single point of contact' for therapy services, someone who can answer questions and will get things done.

Among all the appreciative comments made about Jean and the stories that reaffirm her status as a pillar of the department - dealing with the finance department, filing outpatient notes, and more light-heartedly, washing up dirty cups - there are also hints that over-reliance on her competence in key areas has discouraged the 'growing up' that the managers expect from their staff and themselves, because "it's easier to come and ask Mum than find out for yourself". Gail, the least experienced manager in the team, asks Jean for time before she leaves to talk about "budgets and maths: I want to be able to look at my own budget". Fiona says thoughtfully, "I have to step up to more financial management, too".

Jean's workload has to be covered and cost savings made from her post. Fiona and Serena have ideas, but they are treading carefully because they feel Jean may be having difficulty reconciling herself to retirement. The three of them talk about how others' roles need to alter to absorb everything she has been doing for the department. Maybe the administration team could take some of the 'process driven' work that Jean has handled so efficiently for everyone: it's better than relying on clinical staff, who "get sucked back into the mire". Serena envisages flowcharts that will allow everything to be monitored, with someone responsible for progress chasing. Jean isn't sure it can all be simplified so easily: "Who will keep an eye on it and flag up the deadline? Sometimes steps have to be completed before chasing …". Serena's solution is more technology: "there are packages and apps we could use…". Fiona sees human benefits: making better use of the talents of the administrative staff would improve their job satisfaction. Jean accepts their suggestions with equanimity: "Long term it could all be in the admin office".

Recruitment is another process that puts strain on the team leads; Lynne and Anita do too much monitoring and chasing, says Fiona. "I can't have Band 7 staff running round the organisation with bits of paper!" There is increasing pressure to prove that clinician managers are "working to grade" and she knows the inevitable and invidious 'benchmarking' against nursing roles will disadvantage AHPs, who typically have lighter managerial

responsibilities. They need to up their game by focusing on clinical leadership, pastoral care and team management. "We need to develop their leadership skills".

Still other adjustments have to be made. Fiona admits she's not easy to work with and has relied on Jean to pick up "balls that are dropped". Serena says she's trying to get inside Fiona's mind, "so I'll be able to take a view … being in the same office helps". Serena later explains that she's not thinking about the changes in terms of "paperwork and form filling"; "any manager worth her salt will find someone else who can do that … it's about building leadership into management." To accommodate her new responsibilities Serena is reviewing her clinical work. She's an advanced practitioner, carrying out diagnostic tests and assessments: "If I said I wouldn't do my clinical work at all, I'd feel very anxious". Fiona responds: "So would I, because I told everyone all my managers are clinical!" Continuing to treat patients is not simply a matter of choice or personal and professional satisfaction; it has become a survival tactic for managers at this level, who risk being perceived as dispensable if they are no longer 'clinical'.

At the next senior managers' meeting, Serena pursues the flowchart idea. She turns her laptop so everyone can see "everything I want to monitor and data collection I want to audit: it's rudimentary but important information and one of the admin staff can update it and rag rate it, alerting team leads when items go amber". The processes can be summarised on a scorecard for senior managers. Serena is evidently enjoying this; the rest of us look slightly bemused, but try hard to keep up. The spell of the spread sheet is broken with laughter when Fiona says mischievously, "Who'd have thought we'd come to process ladies? Is it a sign of the times?" The discussion returns to what to include on the scorecard. There's so much to monitor, from patient safety to the temperature of the staff room fridge. They recognise they're getting carried away: "We don't want to scorecard everything!" But it seems the idea has taken hold. "I think this is Jean's brain!" says Fiona triumphantly, with a hint of irony, as she rushes off to another meeting.

Deborah has yet to move in to the senior managers' office. She casts her eye around the room and asks doubtfully about space for filing. The others make light of this, laughing about stacks of paper shoved under desks and offering to shift things around. The move is clearly non-negotiable, but she's dragging her feet, possibly not wanting to leave her pleasant office down the corridor. She's also dealing with a shortage of staff, "running all over the place covering GP clinics". Jean and Fiona each talk to Deborah, coaxing her involvement, asking for help and offering advice, gently drawing her into their circle and understanding of the world. Deborah's face lights up when Fiona mentions clinical developments and an opportunity to speak to commissioners about AHP input to in nursing homes. They agree that it would be good to show how joined up they all are. "Yes", says Fiona, "we all need to step up together for integration."

4.4 Looking after our staff

The Wednesday morning team lead meetings begin at 8.30am, with everyone bringing chairs and coffee and squeezing into the treatment room next to the senior managers' office. Unless Fiona has a pressing issue to discuss, the team leads begin with their reports, in which staffing and recruitment figure prominently. The inpatient team is coping with the most severe staffing difficulties, and Lynne and Anita outline plans to move people around to fill the gaps. Sarah, too, is having problems recruiting to some posts. As soon as one problem is solved it seems another emerges, in the form of sickness absence, a resignation tendered or a pregnancy disclosed; the managers must keep "all their plates spinning".

Members of staff are referred to by their first names only, sometimes with oblique or coded references to their jobs, relations with colleagues or personal circumstances that are sufficient cues for the managers, but make these rapid exchanges almost incomprehensible to the outsider. Quite frequently the managers share more detailed information about individuals' lives and career aspirations and make assessments of their capabilities, personalities and potential. Some deserve concern and sympathy – "we need to look after her"; "she's under stress so we must support her" - but troublemakers get short shrift:

> Sarah: "Maria is winding things up again."
>
> She explains that Maria sets the tone for the team's response to new ideas and plans, undermining her authority and stirring up resistance to change.
>
> Fiona: "She's a minx, I'm afraid".

The discussions illustrate how managers are 'juggling' their staff and, of course, budgets:

> Anita reports that Maureen (Band 6 OT) has been offered a job nearer to her home. She's been in post less than three months and HR say she only needs to give a week's notice.
>
> Gasps of surprise from the others.
>
> Anita: "She won't do that, the new job doesn't start for more than a month. I can turn that post into a whole time Band 6…"
>
> There's also a Band 6 respiratory post to be filled. Anita launches into a detailed explanation of shifting staff around and changing hours, waving her arms in the air as she outlines the complex plan…

In one sense the department's staff is a single resource, but individuals 'belong' to a particular team and manager, although some therapists work in several teams. Gail values the team lead meetings for insights into what's going on in other teams: "It makes it a lot better, although you can't always influence or help them out". The "harmony" she now sees between the different "camps", "inpatient and outpatient, acute and rehab", is the result of hard work to overcome the "us and them" divisions of the past. But even

now team leads' desperation about maintaining staffing levels can introduce an element of competition over staff that threatens the "generous spirit of close co-operation" Fiona says they have achieved. Non-specific requests for "help" are usually well received, but bids to "use" workers from other teams or to "trade" hours are treading on more dangerous ground, especially if bilateral deals appear to have been done. However, any resulting tension can usually be diffused by humour:

> Sarah: "I've got 20 applicants but I don't want to interview any of them. None has any community experience. I'm now on plan E or F and that involves Anita …" (*looking directly at Anita, who exaggerates surprise and fear*)
>
> Laughter lightens the atmosphere, although where this is heading seems clear…
>
> Anita: (*leaning forward and putting on an ingratiating voice*) "How can I help?"
>
> Sarah says one of Anita's part-time physiotherapists has expressed an interest in doing some days for her team.
>
> They discuss the details. It's the first Anita has heard of this: she suggests the physiotherapist's motive is to avoid the weekend rota now being worked by the acute team.
>
> Anita: "She's shafting us. I can't put it any better than that. She's trying to get out of the rota."
>
> However, she goes on to talk about possible flexible arrangements.
>
> Others chip in with ideas.

Discussions are most intense when clinician manager posts need to be filled, especially in teams that are considered to be "having a difficult time". A Band 7 predominantly clinical team lead going on maternity leave in several months' time will leave a critical gap in an already stretched team. No funding is available to fill the post, so 'cover' must be found from among existing staff. The problems are aired at two meetings. At the first, Anita suggests a "coalition" to temporarily lead the team, but when names are mentioned Sarah grimaces; they are not the right people to "keep it calm" and "give breathing space". The following week Anita reports on progress:

> Anita: "We're progressing with the coalition idea. The problem is where do I get the extra clinical from?"
>
> They discuss Molly acting up to the Band 7 post. She is friends with Leanne, who is going on maternity leave, but there is rivalry between the two therapists. There are doubts about Molly's potential, and how Leanne will feel about the arrangement.
>
> Fiona questions if Molly's just bored with her current post and could be a leader in the right post, or whether she hasn't got it in her. "I can't work it out."

> The others have firmer views and comments come thick and fast: "She's a loose cannon in her current post"; "It would be a risky experiment".
>
> The complex relationship between the two women is explained.
>
> Serena: (*wide-eyed*) "It's like a soap opera!"
>
> Anita: (*deadpan*) "It's better!"
>
> Lynne: (*speaking very firmly*) "She's a 6 demonstrating the skills of a stroppy 5."
>
> Fiona: "Lynne sees the harsh reality."
>
> Lynne: "At the moment she's not doing what she should. Not to the extent that I need to warn her, but she's draining the energy out of the team. She needs to prove herself."
>
> Fiona: "At least we need to help her to grow up. Is there a Band 7 she can link with, to give her the chance to understand where we need her to be?"

The managers must ensure their teams have sufficient staff and competent management, but leadership is considered crucial in team lead roles, and this is where some individuals are found lacking. Leadership is perceived to require emotional maturity and stability; it involves managing emotion in the team, particularly anxiety, to "keep it calm". It's a job only those who are "grown up", and hence able to manage their own emotions, can do well. Thus team leads portray developing staff as more than ensuring juniors gain the necessary variety of clinical experience; it is also about "growing them up" emotionally, to be ready for management and leadership.

The team leads emphasise emotional labour when talking about their line management responsibilities, using the terms "love and care", "looking after" or "nurturing":

> "My care is for all my workers, because if I can look after them and make sure they're okay and upright and well looked after … they'll do a good clinical job."

They often refer to ensuring staff are "upright", meaning functioning well and emotionally engaged with their work, and this physical metaphor reminds us that therapists are body workers. Their clinical activities involve "direct, hands-on activities, handling, assessing and manipulating bodies" - work which inescapably has emotional aspects that must be managed (61). Indeed, the goal of therapy could be envisaged as rendering the patient 'upright'. Using the term 'upright' emphasises the continuities between the team leads' clinical work and their responsibilities for staff, denoting the emotional component in both types of work. That it also has moral connotations may also be important for understanding team leads' construction of their work identities.

4.5 Styles of management

Parenting is a metaphor that informs clinician managers' discussions of managing staff, in some interviews with team leads it becomes more specific and gendered, and they refer to "mothering" by managers. One of the team leads uses "mothering" to contrast the previous service manager's approach to managing staff with Fiona's; and to illustrate how Fiona and the department's managers have modified their style to accommodate each other:

> "Our old manager was like your mum, you know, we had a very personal relationship … you could just go in there, sit down and cry … and Fiona came in, very strategic, no time for the niceties, no time to say hello. We didn't understand her language! I think actually we've converted her a little bit on that one. I do think she listens to you as a person more than she used to. So she has softened, but she's still strategic. We've changed our style towards being more business and strategic and understanding her. And certainly I think she understands that we're not that clear cut and cut throat. We need a bit of love and care."

Fiona also says she's changed since coming to Whiteford, describing herself as a "teaching hospital animal" who has adapted to a different environment, learning "a style that works at the moment, but I have to keep morphing as people change and we evolve as a department". She too speaks of "love and care" and a "supportive and nurturing environment" as important for getting staff to put in the discretionary effort required for services to run effectively. With a nod to the gendered nature of management at Whiteford, she says with irony and laughter, "and that's how we work as a group of laydees together…".

One of the predominantly clinical team leads describes her managers as combining caring for staff with a strategic approach:

> " … that's what I like about Whiteford. They're caring and supportive but actually it's got quite a strong work focus and 'where are we going' focus. As a team lead I can obviously be mothering to my team, that's not my strong attribute, I'm a bit more of a worker. Because we've all got mothers! Or mother figures. … I feel very well cared for, but actually what I wanted was a really strong management, and that's what I've got."

This 'heart and head' dichotomy in management is also expressed by another team lead, who sums up her view of Fiona as "she's got strategic vision but she's still got the heart of a caring AHP".

The approach to managing staff that was observed at Whiteford – the time and trouble taken over getting to know individual members of staff; attention to their physical and emotional well-being, the importance of "growing them up" to reach full potential - raised questions about whether therapist managers were recreating in management the type of relationship that therapists seek to establish with their patients. This suggestion was put tentatively to some of the team leads, who immediately made the

connection between managing patients and managing staff. The idea resonated for Lynne, who also suggests that her professional background explains her discomfort with the tougher side of staff management:

> " … we will have had Mrs Brown sitting on the toilet, sobbing into our shoulder about something that isn't working and the fact that they've needed two people to hoist them on the toilet. … I suppose you bring the skills that you're most comfortable using into the rest of your life, and how you manage things. And I think that's a plus, but it can also be a difficult thing when you perhaps, the idea of having to performance manage them potentially out of a post, frightens the living daylights out of me. … OT managers are always a bit too nice. Perhaps we don't bite the bullet soon enough."

An OT in another organisation made similar observations about the profession's approach to management, linking being "too nice" to paradigms of rehabilitation, internalised during training, influencing OT attitudes to interpersonal relations: "We never give up on anyone."

4.6 Combining clinical and managerial responsibilities

Fiona gives a vivid description of the complexity and difficulty of combining clinical and managerial activities at team lead level:

> "to be a brilliant clinician … keep learning, stay expert, teach people, nurture people clinically, as well as treating your patients , you could spend all week just doing that. To be the manager of a team of qualified and support staff, to get them to the right place, trained and competent, get the rotas done, feed parts of the managerial beast, service develop your area, keep up clinical standards, and be able to respond when a complaint comes in …. and we're short staffed and you're carrying a vacancy. … To marry those two worlds together and deliver on both counts is the hardest thing I ever did myself."

The team leads' own accounts of their work are less dramatic and tend to downplay the scope of their work, pressures on their time and conflicting demands, possibly because these busy and varied jobs constitute their everyday reality. All the team leads have a high level of clinical expertise, but their management experience is more variable, and some have also recently changed their job or the scope of their managerial responsibilities. However, they all draw a sharp distinction between clinical and managerial work, typically speaking about the different elements as though they were tightly bounded. Here we explore how the clinician managers presented their work; how they keep a balance between its different aspects; and their views on how their work is described and their job titles. Finally, we turn to the attitudes of clinical staff in the department to management and managers more generally.

4.6.1 Dual roles

Serena (Lead Speech and Language Therapist (SLT) and deputy to Fiona) is the most senior manager in the department who still does clinical work, although on assuming her deputy role in Therapy Services she reduced her clinical sessions to approximately one day a week. Serena describes the clinical interludes in her week as "light relief": in a clinical session, thinking about patients and nothing else, she is in her "comfort zone, relaxed", in contrast to the rest of her time, which is more pressured, "juggling, multi-tasking, trying to set aside time for in-depth projects". She finds managerial work challenging, "whereas the patient work isn't, so from the point of view of sanity, *[the mixture]* is quite good". Serena's view is that her specialised clinical work is "essential" to her role. Professionally, treating patients keeps her directly clinically involved with speech and language therapists and adds to her credibility and legitimacy when she speaks on their behalf. A specialist clinical role is also vital to maintaining job banding and her position in the organisation: "managing clinical services is viewed as something that could be done at Band 7 level, and I'm mid Band 8". Letting management "take over" her time and doing no clinical work would put her job at risk.

Serena also sees her job as providing leadership for the department, along with Fiona. She uses the term 'leadership' frequently and her identity as a professional leader is reinforced by work outside the department for her professional body and as an AHP representative. In contrast, the team leads refer to leadership as a skill rather than a role and do not mention anything they do outside the department as having a bearing on their work identities.

Asked to describe her work, Lynne speaks first about her role as OT clinical lead in stroke, a service for which the trust is renowned, adding, "that's what gets me out of bed in the morning … that's not to say I don't enjoy the departmental management bit, but it's because of the patients that I'm an OT". She lists her management activities as "recruitment, sickness management, the stats, development, all the information that supports bids for services and the rehab team", only later elaborating the key part she has played in most of the developments that have transformed therapy services in recent years. Lynne's management responsibilities and seniority in the department have increased incrementally over the years, and she describes her career progress as happening almost by default rather than the result of planning on her part. Taking over from Jean as Lead OT seems a natural progression, although she is not yet sure it will suit her. Stroke services are being redesigned and expanded, with increasing therapies input, and Lynne envisages "big opportunities in stroke management in the next few years … and actually I find that far more exciting".

Anita joined the department two years ago and describes herself as "bridging the gap between the clinical 7s and mission control (*the senior managers*)" - a role she sees as necessary to the department functioning effectively. She has stopped doing clinical work and is now "just a manager,

an operational manager", a job that makes full use of her skills in people management. She says she has reconciled herself to being a manager, but admits to moments of doubt, "when I think, "should I be a clinician?"". What forced her to face up to not being part of the clinical team was drawing up a rota for seven day working on the wards that included everyone except herself. "That bothered me … so I talked to staff about it … it wasn't an issue for them … just an insecurity on my part." She concludes, "I'm in the managerial camp, not in the clinicians' camp. That's where others see me, that's where I see myself, so that's where I am". However, in a climate where managers are considered dispensable, she is concerned about how best to present herself. "Am I putting myself at risk by saying I'm a manager?"

Gail has been a team lead for some time. She summarises her management responsibilities as "I oversee the [*therapy services outpatients'*] department, make sure that it's working efficiently and appropriately for the patients, and for the staff. I ensure the waiting lists are managed, look after service development, complaints, that kind of thing". She also manages the administration team. Gail wants to progress as a manager, but her plans for gaining a qualification had to be put aside when she took maternity leave, and she implies she may have missed her chance, although she is shadowing Fiona to learn more about her role. "I love treating my patients, don't get me wrong, but I couldn't do it day in, day out any more like my colleagues do. My passion is more for the department and service development than it is doing the day-to-day physio."

The title 'team lead' is popular with all Band 7 clinician managers, despite being generic and differentiating neither profession nor the extent and level of managerial responsibility. None of the Band 7 team leads in the tier with substantial managerial responsibilities object to being called managers, but some have qualms about being identified *only* as a manager. Lynne hesitates, saying "it doesn't feel like me"; she prefers to use 'team lead', "a softer term". She links her reluctance to not having a professional qualification in management, her skills have been gained through "courses, experience and being mentored, supervised, supported and coached by numerous able people. … but my degree is as an OT, not as a manager". The predominantly clinical team leads are much more wary of the label 'manager'. Jess, who relishes the managerial aspects of her role, thinks 'manager' isn't appropriate. "I'm definitely clinical, more than I am managerial … in my heart at the moment, I'm a clinician."

4.6.2 Keeping the balance

"Fitting it all in" is the main challenge the team leads identify, "without having to do too many extra hours, which can happen". Their work can be reactive and complex: "It's a bit of a jumble sometimes and my head feels a little bit too full of things … I have to clear space to see how to do it all in a very limited time." The team leads accept the division of time prescribed in their job descriptions as appropriate and fixed, and they seem to be striving

to make their work fit that pattern, although there was no indication this was rigidly enforced. They recognise the need for flexibility in apportioning their time when demands from one side or the other have to be met. The most pressing demands are often to 'cover' clinical work if there vacancies in their teams, but fixed management meetings or urgent work required by senior managers also have to be accommodated.

> "I'm 50/50 in my role, and I do try and stick to that, to make sure that I'm doing enough clinical and enough management. But there's the need to be flexible, to support staff in the team, particularly if we're staff down clinically, but also from a management point of view, if I need to review something or take time to deal with something" (Sarah).

Most of the team leads use the tactic of dividing their week into 'clinical' and 'management' sessions to achieve the right allocation of time to the different aspects of their role. Lynne divides her week "Monday and Thursday management, Tuesday and Friday clinical, Wednesday I split it: meetings in the morning, so the afternoon's clinical. And then I rob one to pay the other when there's home visits that I can't do any other time, or meetings dictated by somebody else". In her assessment "it doesn't work very well", partly because as a full timer she feels obliged to attend all the meetings she's asked to go to, "even if it means swapping all my clinical stuff around". Lynne's biggest problem is "having somewhere to retreat to" for managerial work that requires concentration. All she has at the moment is a "goldfish corner of the big [team] office, so people know you're in there", resulting in frequent interruptions.

Gail spends half her time on clinical work, doing an outpatient clinic every afternoon. This fixed clinical routine limits her availability for managerial activities and she finds it a particular constraint on her attempts to develop services, for example attending meetings at GP practices. "I find it really frustrating. You don't always have the time and energy to put into it. You start something and you're trying to get hold of the practice managers … then I've got a list of patients … so I have to go off and do that."

In contrast, clinical team lead Jess describes her role as "so multimodal and complicated, I've always found it hard to unpick my 30:70", and she prefers not to separate out her 30% managerial work into set sessions during the week. Her part time colleagues, with more restrictions on their time, tend to book management 'blocks' into their diaries and stick to them, but as a full timer she feels she doesn't have that "luxury", as she is expected to respond to clinical demands as they arise. On the other hand, being full time also allows greater flexibility: "you take a slot as and when you need it".

The team leads use their clothes to signal to others which role they are occupying. In clinical mode they wear uniform, indicating their clinical availability, and on managerial days they wear ordinary clothes. Sarah used clothing as a way of managing the transition from clinician to team lead, to

indicate her new role to colleagues and convey that she was no longer exclusively a clinician.

> "I'd wear my ordinary clothes on a management day and my uniform on a clinical day, partly as a cue to remind staff, so that they knew when they could interrupt or not. I always like to have an open door, but there are times when you need to have that peace and quiet. And I think it helped them understand my role."

Keeping staff and clinical work at bay on management days is, however, only part of the story. Some of the team leads emphasise that their ability to meet expectations depends on the capacity and willingness of clinical staff to give support by carrying out delegated management tasks or backfilling the team lead clinically. Gail, who manages a large team with a number of Band 7 clinical specialists, has delegated to them more of "the day-to-day stuff, the people management", to give herself time for strategic management of outpatient services and to develop management skills within the team. In contrast, Jess's team is small and several posts are rotational, and there are times when managerial demands on her can put the team under pressure clinically. She tries to plan and prioritise her work around essential management meetings, but her availability depends on having a Band 6 she can rely on.

Fiona also takes the view that the team lead role should be understood in the context of the team: the team lead coordinating activity to produce whatever is required by the service, be it leadership, clinical skill or management, but not necessarily doing it all themselves. She knows there's a tendency for clinician managers to view managerial and clinical work as separate and opposed activities, and to treat the role of manager as a 'jacket' to put on or take off at will. She believes that's unsatisfactory, "you've got to live and breathe it", internalise an identity as both clinician and manager, "it's got to become them, they have to see everything they do as clinical leadership, of which managing their team is just part".

4.6.3 Management and morality

Clinical staff typically introduce themselves in terms of their profession and clinical specialty, but even they are quite happy to talk about the managerial aspects of their role, since most have some involvement in management, such as managing staff or implementing service improvements. However, they say categorically that they are not managers and have little interest in management; sometimes making generalisations about managers as a group to distance and differentiate themselves from. There are certain aspects of managerial work that Whiteford clinicians perceive as distasteful, and comment on with undertones of moral repugnance: "politics" gets frequent mention, sometimes with a sneer, and financial or business management, too arcane or combative (echoing the team lead's comment "we're not that clear cut and cut throat").

A feature of staff room discussions about management was how often therapy staff turned talk about management in relation to their work into an opportunity to express their views on management in the commercial or financial sectors. This seemed to be a way of reinforcing stereotypes and questioning the morality of managers. Horror stories were told, citing the experiences of family and friends, that emphasised managers' competitiveness ("like vultures tearing each other apart") and self-interest ("only in it for themselves"). Of course, these accounts were rapidly followed by assertions that "our managers aren't like that!" Assurances were given about how well the department was managed, "they look after us well", and the virtuous qualities of the managers: approachable, kind, knowledgeable and hard working. In short, they were demonstrably still therapists at heart, putting as much emphasis on caring for their staff as caring for their patients. Even so, there were hints that "our managers" were vulnerable to becoming tarnished by the work they had to do, the people they had to deal with, or simply by being identified as a manager. Some therapists shuddered at the "politics" and "horse trading" that they imagined managers engaging in. Others spoke of AHP managers at other NHS hospitals who worked excessively long hours, insinuating that this was as much for personal gain as for the good of the service.

4.7 Commentary

Running throughout this chapter is the complexity and variability of the relationship between clinical work, management and leadership in the practice of clinician managers and the narratives they create about the department, themselves and their work. Fiona's story of the heroic rescue of a department in the doldrums set the scene by telling how she and new managers turned things around. This could be interpreted as an expression of the grandiose discourse of management and organisational survival that others have identified (46,66), but more positively it also demonstrated how belief in a bright future for the therapy professions and the value of good management for delivering high quality services had become part of the culture of the department (15). The clinician managers had developed a shared understanding of management and how it should be accomplished; and they had accommodated their practice to a style that suited them as therapists and "laydee managers" and met the needs of their clinical staff.

To a degree, the influence of the persuasive leadership discourse in NHS policy (16) is also apparent. It was enshrined in the department's structure and job titles, it was endorsed by the senior managers and informed how they presented themselves. Creating an 'integrated' department required identity work, and narratives of senior clinician manager roles were adjusted to place the accent more firmly on leadership, portraying it as encompassing managerial responsibilities and professional/clinical expertise. However, although leadership was central to Fiona and Serena's narratives, the discourse of leadership had not completely permeated the subjectivities of the team leads. Discussions about themselves, their work and aspirations

were framed by clinical and managerial narratives, in which leadership was less well articulated. Leadership qualities were also sought from first line managers, and in the context of clinical teams, leadership was associated with managing emotion in the workplace and keeping the workforce 'upright', in all senses.

Managerial work was acknowledged to be essential, but it also needed to be controlled and contained, so it did not 'take over'. A balance with clinical activity had be maintained within the department to meet externally imposed targets for numbers of managers and management costs; and within individual roles to safeguard jobs and gradings. Jean's role had expanded in response to increasing demands for monitoring and accountability and to fill gaps elsewhere in the organisation. Her retirement was an opportunity to regain control by redesigning roles and redistributing tasks: to sift administration from management, relocate it on computer spread sheets and delegate it to the admin team; for service managers to assume responsibility for the financial management they may have been avoiding; and for senior managers to elaborate narratives that (re)defined their main purpose as leadership. The team leads saw the challenge as keeping clinical and managerial work in balance and, although they admitted this could be difficult, most of them accepted the premise that a clear distinction could be made between the two and that they should aim to achieve the division of time specified in their job descriptions. They typically accomplished this by rigidly separating the roles in time and space; adopting dress codes that signified which role they were playing; and delegating work to their teams.

In the narratives of managerial work and clinician managers' roles we found a dichotomy between the emotionally engaged nurturing ("love and care") that was perceived as essential for managing people and the rational, strategic and entrepreneurial ("business") approach required to manage a service. This dichotomy has been commented on outside the health sphere, but has received little attention within it. A study of managers in an engineering company found similar themes in the 'antagonistic discursive resources' that they employed to construct work identities. The engineering managers are described as 'grappling with antagonistic demands to be unemotional yet emotionally engaged, neutral, rule enforcing professionals but politically astute and business-focussed while caring deeply for others and their own careers' (46) (p.344). At Whiteford the 'tough' type of management was seen as requiring shifts in thinking and behaviour that some of the team leads found difficult to accommodate. The 'caring' type was perceived as congruent with professional identities and values and clinical practice. The language team leads used to describe managing staff suggest that therapists extrapolated from their experience of performing body work on patients to accomplish management appropriate for their body worker staff. Perhaps most importantly the therapists' approach to 'doing management', like body work, is explicitly gendered and affective (61). The concept of body work has generally been limited to exploring relations between practitioners and patients; we believe it has potential to

provide insights into how clinician body workers, such as therapists, perceive clinical and managerial work and construct their managerial selves, although this is beyond the scope of the present project.

But identity work is sophisticated and reflexive and moral agency is fluid and negotiable (20). The managers recognised the necessity of authoring different versions of themselves to suit different situations: the manager who could survive and compete at strategic levels – the "teaching hospital animal", "clear cut, cut throat" – and the "laydee manager" - the softer, nurturing line manager, whose values were demonstrably those of clinical professional. If managers were ambivalent in their attitudes towards management, non-managerial staff were much more direct in questioning the moral basis of management. They wanted managers who had not lost touch with their professional values, who remained therapists 'at heart', and operated as emotionally engaged and morally appropriate guardians of their teams.

Thus the Whiteford team leads variously connected or demarcated clinical and managerial activities in their narratives of identity and practice. In general they preferred to maintain a distinction rather than creating a narrative that bridged the two. Most could think of themselves as a manager, as long as this was not the only identity they were ascribed. 'Team lead' was a convenient and acceptable label for clinician manager jobs, since it did not privilege manager over clinician. However, the concept of leadership seemed to have limited 'discursive appeal' to these clinician managers, or perhaps the necessary narrative resources were not (yet) available to them (16). Fiona was concerned about the disjunction between clinical and managerial work in practice and some clinician managers' inability to integrate and internalise both aspects of their roles. Gotsi*et al.*(59) have noted that managers often try to help individuals reconcile disparate roles by emphasising their interdependence and offering them an acceptable "meta identity". Despite Fiona's suggestion that the notion of 'clinical leadership' was a way of bridging the clinical and managerial, as well as of avoiding the negative connotations and moral jeopardy of identifying themselves as managers, this meta identity did not appear to have been incorporated into the team leads' narratives. They preferred work identities that emphasised compatibility and continuity with existing professional/clinical identities and represented 'authentic' selves, reflecting contemporary preoccupations with authenticity (63,67).

The team leads may not have needed to deploy leadership as an ontological category separate from management (16). They had secure professional status and clinical specialist identities that were uncontested in the department. There appeared to be little inter-professional rivalry or threat of domination by larger or more powerful professional groups. They had a strong sense of themselves as empowered agents in their clinical and managerial roles; they were actively shaping the department's values and vision and the services it provided. Indeed, Fiona encouraged their creative agency. Perhaps they did not perceive a need to re-author themselves as

clinical leaders. They also had a charismatic leader. Fiona had brought 'strong' management, the rational, entrepreneurial type, to a department that operated more comfortably on the softer, people-focused, emotional side. She embodied leadership, carried off performance as a leader that was thoroughly convincing in the department and outside it, such that most people were in awe of her ability to put across a compelling vision of the future, inspire confidence and co-operation and get things done. If this was leadership, it appeared extraordinary, unattainable to mere mortals (65) (p.116). That this might be a problem in distributing leadership more widely was acknowledged by Fiona and the other senior managers in asides about "wanting to move away from dependence on personalities", mentions of the need to build managers' leadership skills and give them opportunities to lead.

5 Greenshire Community Health Care

Greenshire is a large and demographically diverse county in the south of England. In 2010, when fieldwork began, Greenshire Community Health Care (CHC) provided community health services for a population of 1.3m, but did not cover the two largest towns in the county, Norton and Crestbury. The organisation had come into being following the merger of multiple PCTs into a single county-wide PCT and the subsequent division of commissioning and provider functions. Greenshire CHC inherited an extensive portfolio of adult and children's services and around 3000 staff, working from community clinics, GP practices, health centres and more than a dozen community hospitals with outpatient and inpatient facilities. The workforce included over 550 AHPs, in nine professions, with about 500 working adult services, at a total cost of about £12m a year. Despite being a large organisation, Greenshire CHC's management structure was relatively flat and most senior managers had clinical backgrounds, mainly in nursing, although there were several from the allied health professions.

Adult community services were the focus for fieldwork in Greenshire. Nurses were the most numerous profession, with AHPs (mainly physiotherapists, OTs and podiatrists) working alongside them and other professions in community care teams and community hospitals to manage patients with long term conditions and provide rehabilitation, end-of-life care, rapid response services (community crisis support), and orthopaedic choice.

An ambitious programme of management restructuring and service redesign had begun in Greenshire, aimed at reducing managerial posts, improving service quality and reducing costs. The area was divided into geographical localities, each with a service manager, and community care teams to deliver core services directly and to act as the gateway to more specialised care. The whole workforce was affected by these changes, but the legacy of the foregoing PCTs, which differed in organisational culture, service provision and delivery of care, meant that implementing the desired model of 'integrated community services' envisaged in the Department of Health's agenda for transforming community services (TCS), required more profound shifts in practice and attitudes for some groups of staff than others.

There had already been a 'cull' of professional lead posts for physiotherapy and OT; in clinical teams, predominantly managerial jobs held by nurses and AHPs had been deleted; and other clinician manager roles had been redesigned. Most significantly, the community matron, originally an expert clinical nursing role, now had responsibility for clinical leadership and line management of staff in community care teams. Some localities already had well-established multidisciplinary teams of nurses and therapists, working flexibly and to some degree interchangeably, with interdisciplinary management by a single leader, and these were lauded as beacons of good practice by Greenshire's senior managers. Other areas had a more

chequered history of integrating nursing and therapies or had not attempted it; here OTs and physiotherapists were working in therapy teams, alongside community nursing teams, with separate management arrangements. The teams that were not fully 'integrated' were expecting further changes in the way they worked.

Greenshire CHC's nursing and AHP workforce had already experienced at least three years of rapid organisational change and there were clear signals that service modernisation would continue. However, senior managers were concerned that AHPs (in this context mainly OTs and physiotherapists) remained "disenfranchised" and did not wholeheartedly support the strategy that was being pursued; indeed, some were perceived to be resisting aspects of change they found unpalatable or threatening. Managers made no secret of their disapproval of those they identified as attached to the "old ways" of separatism and uni-professional management. There were high hopes that the newly-appointed AHP Lead would be able to rebuild relationships and establish better communication between AHPs and senior managers. His remit included engaging AHPs with plans for the strategy of "moving forward together", and carrying out a review of AHP services for the Board, addressing questions about the appropriate skill mix for the AHP workforce.

As fieldwork got underway the pressure for change at the clinical front line seemed to ease as senior management attention was diverted to other issues; not least how GPs would coalesce into commissioning groups and whether Greenshire CHC's internal management boundaries would need to be realigned to match them. And further top level change was happening: a merger with the county's community mental health foundation trust. By the time the fieldwork ended in 2011, community health services had become part of a much larger and re-branded foundation trust.

This chapter explores how AHP clinician managers were responding to these developments and the identity work they engaged in to make sense of changing organisational structures, occupational roles and relationships. Identity work is a complex social process, 'the dynamic interplay between internal strivings and external prescriptions, between self-presentation and labelling by others, between achievement and ascription and between regulation and resistance' (20) (p.301). Identity is always a transient accomplishment; narratives are constantly under construction, continuously revised, modified in presentation to different audiences and for particular purposes. Self-other comparisons are central to how we define who we are and who we are not, establishing relationships of similarity and difference (63). Claims to identity inevitably have moral and political implications: in Greenshire CHC AHPs positioned themselves in opposition to nurses, which influenced inter-professional relationships and perceptions of organisational order. It also enabled some AHPs to interpret change initiatives as threats to their professional status.

We show how the emergent organisational discourse of service transformation in Greenshire CHC wove together narratives about

clinical/professional work, management and leadership and created new expectations of clinician managers (16,17). We present three case studies of AHPs working in different locations and a variety of roles to show the different ways in which Band 7 AHPs were responding to these prescriptions. They illustrate how narratives of leadership, professionalism and managerialism were employed by clinician managers to define themselves; to make sense of their work; and to embrace or oppose change. The chapter concludes with a commentary.

5.1 AHPs and the politics of professional identities

'AHP' was an established and accepted term used widely by Greenshire managers and clinical staff, who generally thought that aggregating the "smaller professions" was advantageous at organisational level in terms of gaining management attention and exerting influence, even though together AHPs were a much smaller group than nurses, the most numerous profession in the community health workforce. Greenshire AHPs were known to be sensitive about their minority status and perceived themselves as marginalised in the organisation. It was common to hear them expressing doubts about whether those in the higher echelons of the organisation fully understood or appreciated the AHP contribution to community services. They took every opportunity to assert their professional distinctiveness and accentuate their differences from the nursing majority. They were acutely alert to any indication that they had not been considered in policies, plans and official statements, or, even worse, that they had been categorised with nurses and not differentiated as a group with specific skills and requirements. There was suspicion that "overlooking" AHPs was convenient for managers, who found it easier to deal with the uniformity of nursing as a single profession rather than the diversity of AHPs.

In an attempt to avoid being written out of the organisational script, AHPs had adopted the tactic of objecting or correcting managers if they spoke or wrote only about nurses rather than "nurses and AHPs". Although this tactic showed signs of becoming tedious and was parodied, even by some AHPs, in references to AHPs having "a chip on both shoulders", it seemed to have worked, at least in establishing an organisational discourse that acknowledged AHPs and differentiated them from nurses. For example, a strategy document for clinical staff published in September 2010 referred throughout to "nurses and AHPs"; and senior managers were observed in meetings that included AHPs taking care over their phrasing when discussing the workforce and correcting themselves if they omitted to mention AHPs.

Adopting the tactics of identity politics may have raised the profile of AHPs, but it also brought risks. Identity politics is based on shared experience of minority oppression and (re)articulating a self-determined, more authentic identity in opposition to the dominant majority. In Greenshire, AHPs positioned nurses overtly as 'other'. While professional rivalries are ever-present, repudiating nursing clearly risks exacerbating inter-professional

tensions. Indeed, positions had become entrenched and some therapists had come to view this as a struggle not only for recognition in the trust but also for survival as distinct professions in an organisation "controlled by nurses". There were risks too in using AHP as a collective identity, since it might gloss over the diversity and distinctiveness of the constituent professions. Physiotherapists and OTs - the most numerous allied health professionals in Greenshire CHC - were typically referred to as 'AHPs', even when it would have been easy to use profession-specific titles. This convention held the potential to further misunderstandings that therapists found they frequently had to challenge: a tendency to conflate the two professions; and the assumption that they had the same skills and thus were interchangeable.

5.2 The AHP Lead

Unlike some other trusts, Greenshire had retained an AHP Lead post in the organisation's governance structure; although by all accounts there had been difficulties clarifying what was required from the post and finding the right person for the job. Neil, an OT who had worked in various management jobs in Greenshire for more than 10 years, had recently been seconded to the role, his "ideal job". He took the insecurity of secondment in his stride, "I've had to reapply for my job three times in five years", and thought he had been chosen for his positive attitude and analytical skills, which singled him out from the majority of AHPs. There were tensions inherent in his new role, representing AHP views and contributing to continuing modernisation of services, but Neil did not see them as irreconcilable. Nevertheless, he described himself as "on trial" and needing to prove himself to the Board, whilst simultaneously retaining the confidence and respect of the AHP workforce.

Among AHPs there was support for the appointment of an AHP Lead, who was seen as a champion and "voice to the Board for AHPs". Some had high expectations of what Neil would achieve for them but others, while they had no doubt about his commitment to raising the profile of AHPs and his political nous, remained sceptical because of the constraints of the role. A physio described him as "incredibly tough and streetwise, he can duck and dive with the best of them", but thought he would be "battered from both sides" and could not risk "rocking the boat too hard."

Neil became the project's sponsor in Greenshire. He played a key role in gaining approval for the research; facilitating access to AHP colleagues; and providing background information about the organisation and its AHP workforce. Serendipitously he was organising a workshop for Greenshire AHP managers to discuss the organisation's strategy and their part in it, which offered an opportunity to introduce the research to them and invite their collaboration.

5.3 Clinicians, managers, leaders

The strategy for continuing organisational transformation put forward by Greenshire's senior managers was a discourse that drew on divergent narratives, not always fully or clearly articulated, about the nature of management, leadership and clinical work, their inter-relationship and where they should be located in the organisation. The discourse delineated different ways of acting and interacting, created possibilities for new roles and required reworking of occupational identities.

A dominant theme in the strategy was developing leadership, based on the belief that this was the key to organisational success. This echoes the 'call to leadership' that has sounded in NHS policy rhetoric for more than a decade, and reflects the incorporation of notions of leadership into NHS discourse more generally (16,17). Indeed, Greenshire had already made a substantial investment in leadership development for all staff at Band 7 level and above, commissioning from external consultants an innovative programme that included coaching for the executive team and a development initiative that took groups of clinician managers out of the workplace for several days at a time. Most of those encountered during fieldwork had participated in residential sessions and recalled their experiences with a smile and positive comments. Senior managers characterised this initiative as an attempt to unlock leadership potential as an organisational resource in pursuit of cultural change. However, since it had been directed at those in managerial grades, it was generally perceived as affirming the organisation's commitment to management and realising individual potential.

While managers talked of seeking out and enhancing leadership qualities throughout the organisation, management was seen as needing to be dissociated further from clinical work, compressed, contained and centralised. Administration and some routine managerial work were to be pushed further down the hierarchy; line management in clinical teams had been rebranded as clinical leadership; and 'management' per se was equated with the technocratic, business-focused and strategic activities of non-clinical service managers. Delivery of clinical care, equitably and to a high standard, was the declared central purpose of the organisation. Everyone with a clinical remit was urged to maximise the time they spent on clinical work; and meeting the needs of patients was presented as the common goal that united the workforce across professional, service and geographical boundaries. The narratives also conveyed a particular understanding of professionalism, in which accountability, compliance with externally-set standards, teamworking, a customer focus and performance measurement were privileged over its more traditional associations with expertise, autonomy, self-regulation and specialisation.

The emerging discourse appeared to diverge significantly from managerialist ideas that have dominated the public sector in recent times, in which leadership is strongly associated with management, and managers

are expected to perform and embody 'leadership' in the organisation (17). In Greenshire leadership was constructed as a set of generic personal qualities, dispersed throughout the organisation, inherent potential waiting to be released and enabling anyone to assert agency and authority. It was implicitly contrasted with the specialised and technocratic skills and competencies that define managers, an elite group, whose authority is derived from their position in the organisation. Consequently, the discourse played down clinician managers' managerial activities and made new connections between clinical/professional work and leadership in a bureaucratic context, requiring every clinician to demonstrate 'clinical leadership' in pursuit of providing excellent care for patients. The strategy document directed at AHPs and nurses declared that 'all members of the team will assume leadership roles in some elements of care', but made no mention of managers or management, or the responsibilities of different grades of staff. Nevertheless, every vision of transformed clinical activity was accompanied by 'measures of success', familiar targets, audits and performance and outcome measures, indicating a strong managerial presence with an undiminished appetite for control and accountability.

Greenshire's vision of the relationship between clinical work, management and leadership had implications for AHP clinician managers, particularly those in roles with significant line management responsibilities, such as Band 7 posts. There were substantial variations within Greenshire in the job descriptions and expectations of Band 7s, including in the extent and scope of their managerial responsibilities, clinical expertise and specialisation. Some posts had been redesigned to accommodate the TCS model, strategic aspirations and local needs, but others remained unaltered, with fairly traditional job descriptions and expectations. However, the numbers and skill mix of the AHP workforce, and its distribution in relation to population and need across the county, were under review, further fuelling fears in some areas that AHP posts, particularly the higher clinical grades, would be the target for further cuts. A consultation was held on introducing named 'Lead AHPs' for community care teams, to 'provide an AHP 'voice' with the same level of clinical authority as a community matron … and be key to maintaining high standards of therapy for patients.' These designated Band 7s would link with the 'clinical governance matrix supporting patient safety mechanisms across teams, localities, and the organisation as a whole'.

5.4 Three case studies

The following case studies have been constructed from fieldwork material from three sites in Greenshire to illustrate clinician managers' experiences in different roles and contexts, focusing on Band 7 posts. At two of the sites, Flagship and Alderhill, the new model of inter-professional working in integrated teams had been adopted. At the third site, Longbourn, there were uni-disciplinary teams of OTs and physios, managed by a therapy services manager, and a separately-managed community nursing team. The case studies explore how narratives of leadership, professionalism and

managerialism were employed by clinician managers to define themselves; to make sense of their work; and to embrace or oppose change.

5.4.1 Flagship Community Hospital: being a clinical leader

When planning the fieldwork in Greenshire, I was encouraged to make contact with managers based at Flagship Community Hospital, and visit this recently purpose-built, PFI-funded facility, described as a 'state of the art' local hospital of 'award-winning design'. The hospital provided outpatient clinics, medical and surgical wards, rehabilitation, day case surgery, operating theatres and an imaging department, as well as being a focus for the locality's integrated and innovative community teams. Flagship had pride of place in Greenshire's fleet of community hospitals, larger than most and offering a wider range of services in a light, spacious building, whose sleek lines, open public spaces and uninterrupted flow spoke of efficient, modern services without feeling institutional or impersonal. Flagship and its local services were an emblem of Greenshire's aspirations for community services, symbolising a unified and harmonious future.

AHPs were well represented in the management hierarchy in this part of Greenshire, and the AHP managers I met there were experienced, confident and outspoken. Observing meetings, I twice encountered Barbara, Band 7 therapy team leader, before asking her for an interview. The meetings included a mix of professions and managers from different levels in the Greenshire hierarchy; the proceedings were formally structured, but there was encouragement to air opinions in informal discussion of issues. On both occasions Barbara was a frequent contributor to debate, putting forward her views with conviction and challenging approaches she disagreed with. An account of Barbara's experience of working as a team leader, constructed from interview material, is presented in the vignette below (Box 6).

Box 6. Flagship: Inpatient Therapy Team Leader

Barbara is an OT and Inpatient Therapy Team Leader at Flagship, a large community hospital in the Heathlands, a rural area of Greenshire. She was appointed just over a year ago, after briefly holding a community matron post, and previously leading a multidisciplinary community team. Barbara has spent most of her 20 year career in the area and is a strong advocate of the inter-professional working that she helped establish, which has become a way of life here: "the tribal instinct" has long gone. She sees inter-professionalism as "the only way forward" for the survival of allied health professions and for improving service quality. Barbara's line manager is an AHP, as is the manager in the tier above that. Barbara's commitment to the area is absolute: "I sold my soul to the Heathlands, I want to grow old here myself.So I want services to be in place for me to benefit".

Barbara begins the interview by saying "I'm not really a manager" and explains that she sees herself as a clinical leader, although she has management responsibilities: "management and leadership come together,

but you can be a leader without managing people". In her view, those who provide patient care directly are not managers, this label is should be reserved for those with responsibility for business management of a service. "I wear a clinical uniform and the team sees me as part of the clinical team." Barbara estimates that she works clinically for between 60 and 80 per cent of the time, which includes leadership, with the remainder spent on management. Her clinical responsibilities require her "to know what's happening to every patient on the medical and rehab wards … I couldn't maintain that level of influence over the bed management if I didn't know the patients." She leads her team clinically and supports the development of the junior staff and students. Barbara highlights the need for one-to-one clinical supervision "that's a difference between nurses and AHPs," which she provides for Band 6 OTs and physios she manages, at least until the physios need clinical support from another physio, then she finds someone with appropriate skills.

Managing and developing a service "to meet the needs of a changing financial environment" is how Barbara describes the managerial aspect of her role. She takes responsibility for the budget; "covering services when we haven't got enough staff; and all the human resource management that comes into play, managing sickness absence, poor performance." Her team includes occupational therapists and physiotherapists, as well as speech and language therapists and a dietician whom she does not manage, "because I don't influence the contracts anymore." Staff development is important to Barbara, encouraging people to look to the future and making sure "everyone works to the highest level they can whatever their grade." She finds performance management of staff "uncomfortable." "I don't like having to address people who are late all the time … because I like to be part of the team, but I don't have a problem with confidence to do it."

While she's in the hospital, Barbara concentrates on clinical work, spending additional time at home on management work and "thinking about things." She emphasises that this is her choice, it isn't expected by the organisation, although there is the problem of not having her own office, being "constantly interrupted" in the team room. "I do it because I love the job, I love coming to work, I'm quite bossy, but I do like being a leader and out in front."

Barbara also represents AHPs in the locality at a trust-wide strategy meeting, and says her opinion is sought and respected: "I perhaps had to earn that respect and it's about the role you play." She thinks that AHPs are keen to influence the future of the organisation, but won't be successful until more are appointed to higher level posts. "Nurses are a very strong band of professionals because they're huge in number," but she pins her hopes on AHPs' training making them adaptable and able to survive.

Barbara emphasises her personal convictions and professional commitment to the Heathlands locality and her long experience of working in the area

with like-minded colleagues. Her biography conveys a settled self and strong sense of authenticity: interpreting her role and making choices about how she does her job consistent with her beliefs and personality. Barbara's representation of the interplay between clinical work, leadership and management is consistent with views at the top of the organisation, reflecting Flagship's favoured position in Greenshire as an exemplar of good practice. Barbara's account weaves together and privileges clinical work and leadership, separating and marginalising the managerial aspects of her job, although she lists a broad range of activities that are traditionally considered part of management. She avoids the label 'manager', seeing this as more appropriate for those with a strategic role and no clinical responsibilities.

Leadership is characterised as active and visible, a performance: being on the wards in uniform with the clinical team and "out in front." A senior manager used similar language to Barbara, describing "a clinical leader, out there, leading from the front." In contrast, managerial work is represented as reactive and back room: carried out alone or generally without face-to-face interaction; sitting at a desk in private space such as an office or at home; largely unobserved and sometimes unobservable ("thinking about things").It is removed from the sphere of clinical action in time and place, pushed to the edges. These contrasts are encapsulated in a phrase that was heard used pejoratively several times during fieldwork, "sitting in an office managing", which served to undermine the worth of the activity and the person.

Barbara refers to "survival" of the allied health professions, linking this obliquely to the dominance of nurses in Greenshire CHC. Despite the assertion that professional tribalism has disappeared, she notes differences between AHPs and nurses, in particular the way clinical practice is supervised, highlighting therapists' "need" for higher levels of supervision and support than nurses. This perception of AHP 'difference' resonated with other Greenshire clinician managers. Heather, a physiotherapist by profession and Band 8 service manager, commented that in her experience therapists expected a high level of support from their managers, particularly in the form of "one-to-ones"; indeed, that was her own expectation:

> "If I didn't have my one-to-one and I didn't get my support … then I'd ask for it, as a therapist. I wouldn't wait for someone to say, "I haven't seen you in my office for [a while]" … and nurses don't expect it at all."

She thought therapists in community services looked to managers for support because they worked mainly in multi-professional settings, often as a "lone practitioner," without the same ready access to colleagues that is available in nursing teams. Heather emphasised being approachable to her staff, making time to talk with them, and establishing good personal relationships, so she could find out "what makes someone tick." She said she had not thought about why therapist managers placed such high importance on knowing and "looking after" their staff, but agreed that they

could be "looking for the same therapeutic relationship that they have had with their patients."

A nurse director took a more critical view of the "the supervision thing," describing her "shock" when she first discovered the time therapists spent on supervision. She gave examples of what she perceived to be excessive and indulgent supervision, amounting to unacceptable "hand holding," and expressed concern about the process becoming too much like counselling. She conceded that "discussing patients in a constructive way" was a valuable way of learning from experience, and in supervisory relationships it could be difficult to make a distinction between clinical and managerial issues. However, she thought AHPs generally needed "a lot of stroking", a view also voiced by the AHP Lead.

5.4.2 Alderhill Community Care Team: trouble with 'matron'

It was well known in Greenshire that there was only one AHP among the 30 or so 'new' community matrons, despite AHPs having been encouraged to apply for these posts. I encountered Tom while observing a meeting at trust headquarters; it was the first time Tom had attended. Towards the end of the lengthy but fairly informal proceedings, the chair (Erin) asked for views on the committee's terms of reference and membership, which aimed to represent all professions, localities and levels of management. In the middle of discussions about who should be included, one of the nurse managers turned to Tom and asked abruptly, "Are you here as an AHP or a community matron?" If Tom was surprised at his credentials being questioned, he concealed it well. Calmly, he replied, "I'm here because Erin said I should come, but this may be the first and last time." Erin's attempt to defuse the palpable tension was lost in a hubbub of mainly jocular comments on the incongruity of Tom's job title. When she quietened the group, Tom concluded the exchange by saying firmly, "I'm a team leader, physio, member of a community care team, if I'm dealing with the hospital I do use matron occasionally…"

A subsequent visit to Alderhill Health Centre, where Tom and his team were based, provided an opportunity to find out more about his experiences as a community matron. The vignette below (Box 7) presents an account that was constructed from interview material.

Box 7. Alderhill: AHP community matron

Alderhill Community Care Team is linked with five GP practices providing services to a population of 42,000 in a mixed industrial, suburban and semi-rural area between Norton and Crestbury. Most of the team members are based on the upper floor of a small modern health centre, and there are plans to bring in those who are currently located in outlying GP practices, for reasons of coordination and efficiency. The team is not linked to a community hospital or ward. Tom, the community matron and only Band 7 in the team, is a physiotherapist. He was 'team leader' (alongside a clinical community matron) managing a mixed team of nurses and therapists in the same area, until his post was deleted in the workforce reorganisation a year ago, and he chose to apply for the new-style community matron post, "responsible for all community services in this area as the senior clinician." He has nine Band 6 nurses and therapists who report to him.

The challenges Tom faces include managing the balance between clinical and managerial workloads, "not easy, really not easy at all," and how, as a physio, he should interpret expectations of 'expert clinical input' in a role designed with community nurses in mind. Furthermore, he has to deal with misunderstandings about the new role, not helped by the gendered job title, which suggests a clinical nursing focus, rather than conveying what he sees as the distinctive aspect of the role: responsibility for operational management of the community care team. When staff criticise managers he says to them, "well, that's me," although he knows they mean "the suits that sit at [trust headquarters]," because he feels perceptions need to change. "Band 7s and Band 6s are the clinical managers and responsible for service development locally. Senior managers are now being less prescriptive and encourage innovation from us."

The clinical side of the community matron role "was envisaged to be around managing long term conditions, putting patients on a virtual ward, with regular review and expert clinical input." Tom's emphasis is on "getting the whole CCT focused on those patients." He estimates that he does between one and two days a week clinically – "and that's not just seeing patients, but meetings around the virtual ward, taking on the rapid response role or more of a therapy role. A bit of everything really." He worries about being expected to build a caseload of complex patients: should he develop his clinical skills towards medical management, "nursing-focused, all the drugs management…" or stay with "what I'm good at, the chronic disability stuff from a physical perspective"?

On the management side, Tom lists "all the rest of it, all the recruitment, the management of the Band 6s," who are relatively inexperienced and currently need quite a lot of support. He finds staff development particularly rewarding: while he enjoys clinical contact with patients, having people to develop is something he would be loath to lose. "Then there's DATIX, team meetings. It's a constant battle, a day-to-day struggle and frankly what doesn't need to be done today will get put off."

Summing up he says, "I feel confident in what I'm doing, it's just having enough time to do it." He could "manufacture some more time" by "letting go" of involvement with staff, but "responsibility for knowing what's going on … weighs quite heavily." "If anyone's off I quite like stepping in and covering, or if there's an urgent patient, but it has a knock on effect." To the suggestion that this is how some managers try to protect their teams, Tom admits that he sometimes takes on more than he should, "maybe it's paternalistic, but I'd like to think of it more as facilitative" … "I'll throw myself into the resource pot," rather than standing aside as the team leader. This can help to build trust with the team, especially when "everything needs to be done, we just have to get on and do it," but "the down side is they may come to rely on you and my manager's head doesn't want me to be relied on." A better way of releasing clinical time, he thinks, would be reducing the "admin burden" carried by clinicians, something his team is trying to do.

Tom's job is "hard, but I enjoy it." However, he's been on Band 7 for more than nine years, with ever growing management and leadership responsibilities, and "now I'm expected to be a clinical expert, as well as clinical lead." He can't help comparing the demands and breadth of his role with other Band 7 therapists who have a community caseload: their work is much more structured, and the managerial responsibilities significantly less. "I wouldn't want to leave here or change the responsibility of the role, I'd just like more recognition in terms of remuneration."

Tom has taken on a new role with high expectations in terms of expert clinical input, leadership and management and he is candid about his continuing efforts to accomplish it satisfactorily. He emphasises team-working and his managerial responsibilities for a large team of nurses and therapists, identifying himself primarily as a manager, although he differentiates himself from the "suits" at headquarters (top managers and mainly women).Tom recognises that he provides leadership for the team but, unlike Barbara, he does not single out leadership as a defining feature of either his job or himself.

A job title inscribed with expectations of gender, profession and a clinical orientation make Tom something of a curiosity, attracting comments from those who perceive him as anomalous in his current role. Tom deals with their comments patiently, but would prefer a different job title, preferably one that comes with less risk of being stereotyped and better conveys what he does and who he is. He suggests his previous designation 'team leader' is more suitable: it is not profession-specific and is generally understood to encompass managerial and clinical responsibilities.

Tom's estimate of how he divides his time between clinical and managerial activities (30:70) is the opposite of Barbara's (70:30). He emphasises managerial demands on the team: not becoming overwhelmed by them is a "struggle." He is trying to find ways of increasing the time the team spends

on clinical work, but acting as a clinical resource himself may not be a the most effective way of achieving this. Tom's account of carrying a substantial and unavoidable managerial workload contrasts sharply with senior managers' insistence that Band 7s should be spending the majority of their time on clinical work. A senior nurse, who thought there should be "very little management in community teams," said:

> "You should have a bit of line management responsibility; a bit of relationship management responsibility, with other key stakeholders; but you should be a clinical leader … drop the management role."

However, she knew that Band 7s were not meeting her expectations of four days a week "hands-on clinical," and described her "on-going battle" to reduce the time spent on management: "I know it can be done!"

Tom could comply with this prescription by making the necessary discursive changes, re-labelling his managerial activities as 'clinical' or 'leadership' and re-authoring himself as a 'clinical leader'. While that might be expedient, Tom has interpreted his new role in terms of certainties about his managerial and professional/clinical identities. His uncertainties focus explicitly on accomplishing its 'clinical' aspects: meeting expectations of clinical expertise that remain strongly associated with nursing knowledge and skills. As an AHP he must continue to negotiate the ambiguities and contradictions of this role, through the process of constructing and articulating identities that are 'acceptable or respectable to others and to oneself' (20) (p.306).

5.4.3 Longbourn Community Hospital: protecting professional integrity

The therapists at Longbourn Community Hospital were resisting the model of integrated, inter-professional community care teams being promoted in Greenshire and knew that senior managers disapproved of their stance. Quite openly each side made disparaging comments about the other; there was mutual suspicion and distrust. When senior managers heard that I had spent time with the team at Longbourn, I was questioned almost reprovingly about it. I knew I had been invited to Longbourn to hear the therapy managers' side of the story and possibly with a view to being recruited as an ally in a campaign to resist change; a familiar situation for an organisational researcher. Less familiar, and trickier to navigate, was feeling obliged to demonstrate to "the other side" that, having consorted with the dissenters, I remained neutral and uninfluenced by their views.

Longbourn felt remote geographically as well as disconnected ideologically from the loci of policy making and power in Greenshire CHC. It is over 30 miles and almost an hour by road from the trust's headquarters and the locality manager post was currently vacant. Longbourn staff reported little personal contact with professional colleagues in more 'progressive' centres, such as Flagship and Alderhill, so they had heard few first-hand reports of new ways of working, which fuelled speculation, rumour and

misinterpretation. The following account gives a glimpse of how management was accomplished at Longbourn and how clinician managers presented themselves and their work. It illustrates how the therapy team had developed a shared narrative that drew primarily on notions of professionalism, privileging professional autonomy over managerial control and accountability. This narrative was deployed to preserve professional boundaries and resist the rhetoric of inter-professional teamwork.

Longbourn is a small market town in a rural area of Greenshire, with an unassuming 1970s low-rise community hospital and health centre located on its periphery. The therapy team has its base in one wing of the building, with a rehabilitation ward, OT kitchen, gym and offices. Margaret, an OT, manages the service and has occupied the same office for eight years, having survived restructuring and the cull of middle-management posts. Recently she has been told her post will be deleted within the year.In conversation, she seems bruised by her experiences of change; she is ambivalent about being in a managerial post, saying she is "not really a manager" and prefers clinical work, but lists her achievements: providing professional leadership, developing staff and enabling the team to focus on clinical priorities. "I'd hate to see everything I've built up disappear…".

At Longbourn there are two physiotherapy teams and two OT teams, which treat patients either in the hospital or the community, and each is headed by a Band 7 senior therapist. These small teams of professionals are supported by therapy assistants and admin staff. A meeting for all staff takes place once a week in the half hour before lunchtime, an informal gathering of about 25 OTs, physiotherapists, rehabilitation assistants and administrative staff. Margaret, in the chair, controls the pace and tone of the meeting: she is the source of information, introduces topics for discussion and occasionally invites others to contribute their "news." She encourages staff to take up development opportunities, reminds them about rules and procedures; and interprets directives and policy from above. The tone is generally calm and reassuring. The meeting has a ritual quality: reinforcing authority and order; demonstrating harmony and unity of purpose; and shaping values and identity.

Disagreement is rarely voiced, but it is acceptable to gripe about others who make life difficult, for example Estates who lose requisitions and remote and fickle senior managers whose decisions create extra work or constrain the autonomy of clinicians. Margaret's ambivalence about her managerial role is apparent: she portrays herself variously as one of the clinical team ("we ought to be selling ourselves to GPs"); as an unwilling apparatchik ("I'm only following trust guidelines and rules") and occasionally as having a senior manager's privileged access to resources, although this comes at a cost ("It's soul destroying to go to these committees, but if you don't go on them you'd get left out…").The overall impression is that management is burdensome, and often irrelevant to clinical work, but Margaret is doing her best to shelter the team from the worst of its intrusions.

The team in turn displays a reluctance to comply with managerial demands that they perceive as having little relevance or benefit to their clinical work. Team meetings feature Margaret's appeals for staff to follow procedures and do the "paperwork" required for managerial accountability. Such an appeal triggered the one discordant episode observed during a team meeting. In this example, described below in Box 8, the clinical staff are almost defiant; no-one can see any value in the task except to "tick that box"; and Margaret eventually orders them to comply, to meet bureaucratic requirements and secure her precarious position.

Box 8. Seeing red

Extract from field notes of Longbourn therapies weekly staff meeting.

The team isn't doing well on gathering information about patient experience and Margaret reminds them that the form must be given to every patient on discharge. Gemma from admin says she knows people aren't giving out the questionnaire, because notes are coming back with the blank form still in them.

There's muttering around the table. A physio, smiling, calls out, "We'll take it out before we give the notes back!" Someone else says they don't like using the questionnaire, it's difficult to understand, and "patients are confused enough as it is." Gemma agrees it causes stress, "We've had some anxious phone calls."

Margaret says firmly: "We can't make a decision not to use it. It's a national questionnaire."

However, others continue to list further difficulties and objections. "There should be different forms for OT and physio!"

Speaking more loudly Margaret implies that she will be penalised if the team does not comply. "Make a note if the patient refuses, and you can indicate if it was given out but not returned."

A voice from the back persists: "What's the point of it?"

Margaret now sounds angry and abrupt. "It's the CQC! We can't tick that box. We'll be red. We have to demonstrate we've given out the forms. Without it I can't give any quality information at all. Blank forms in the notes mean they're not being given out. Log it! Move on!"

The four Band 7 senior therapists meet Margaret regularly. There's much business to discuss: reorganising equipment in the gym, procedure for DATIX reports, mastering the new e-rostering system, and keeping track of the team's nominated advisers and champions. One of the physios comments, "The team's not big enough to absorb all this admin!" Then Margaret says she has a document about the proposals to create AHP Leads

in community teams: there's a noticeable shift in the mood of the meeting and the interaction becomes more intense, the Band 7s lean in over the table and make eye contact. None of them has yet read the paper, but mentioning it is sufficient to start a vigorous and emotive exchange. The Band 7s speak vehemently, making short and apparently unconnected statements, reiterating fears and views familiar enough to be signalled by the briefest, allusive comments. "It's the same old stuff." "It's discrimination!" "Nurses think they can manage AHPs." "They're dumbing down our service!" "We'll become generic workers." "We need specialists." Margaret adds a story about a nurse practising dangerously and reasserts her view that it's difficult for AHPs to manage nurses. These 'collusive intimacies,' which Goffman (26) (p.206) has described as typical of backstage interaction among team members, involve the 'self-other' identity talk that serves to reaffirm identities and beliefs. This episode underscores Ybema *et al*.'s point that this 'discursive positioning' is not a benign process: it is coloured by emotion and moral judgments and puts a particular slant on relationships of power and status (20). In the context of the fieldwork, it gave clues to the threats perceived by the clinician managers and enabled them to be explored further in one-to-one interviews.

All the Band 7s said that their main orientation was towards patient care, as one put it, "my focus is my patients." Physiotherapist Crystal estimated spending 60-70% of her time on clinical activity, and admitted difficulty keeping a balance with her managerial responsibilities:

> "I'm terrible at it! I would far rather be seeing patients than sitting at a desk doing management stuff. So if there's any excuse not to be – you know, if somebody on the ward hasn't been done, then I'll go and do them rather than sitting down to do stuff. … I get my comeuppance sometimes, because I haven't done stuff or I'm not up to date. … But that's just me. I'm a physio to be a physio, not to be a management person."

OT Judith expressed a similar view: "the reason I do the job is to have the clinical contact with the patients, not to be managing people." She estimated she spent less than half her week face-to-face with patients, but was hesitant about categorising her work as clinical or managerial – "too black and white." She saw professional work at her level as a mix of both; for example, dealing with urgent referrals, delivering training, supporting junior staff and liaison with GPs. Judith preferred to talk about her work in terms of its unpredictability; the need for professional judgment; and the importance of responsibility, responsiveness and flexibility. Thus many 'managerial' activities were interpreted as integral to an experienced clinician's professional responsibilities; and these were undertaken willingly. However, a different attitude was held towards managerial demands seen to come 'from above', such as those dismissed by her colleague in the team meeting as "admin." Judith saw managerial accountability as interfering with clinical work, requiring "jumping through hoops". "So you get a little bit cynical because you just want to carry on seeing patients."

The Band 7s at Longbourn associated professionalism with clinical specialisation and they had added specialist designations to their job titles. This was a way of showing that they were 'leading' a particular clinical service, but it was also a tactic they hoped would safeguard their job gradings in the forthcoming review. Leadership in any other sense was rarely discussed explicitly, although it was implicit that all professionally qualified staff should be able to 'lead' when necessary. However, physio Crystal felt claims to specialisation were hard to justify in what was essentially a generalist community role:

> "I don't see myself as that specialised, maybe because I've never worked with a specialist team or at a specialist hospital. … my knowledge is from experience. … I always feel a bit dumbed down because I'm not working in a specialist centre, where you would be constantly building your skills and learning. … Here you have to know a bit about everything, rather than lots about one thing."

The professional distinctiveness of OTs and physiotherapists was constantly reiterated and rehearsed; reinforcing a belief in the value of the boundaries created by uni-professional line management.

> "I wouldn't speak up for physio and I don't think a physio can talk for OT. From the clinical point of view, I think you need to be managed by someone who has got the same clinical skills, to have an understanding."

It was considered a matter of principle and professional survival for the Band 7s to resist inter-professional management. If being managed by another therapy profession was considered unacceptable, the prospect of integrated teams managed by nurses was unthinkable. The OTs and physios have made common cause against the perceived threat of being "taken over" by nurses. The Band 7s portrayed their own professions as "more professional" than nursing:

> "Physios are taught principles and how to apply them. Nurses are taught procedures. As a nurse you qualify into a specialty. Physios rotate through a number of specialties."

> "I just think we're a lot more professional in the way that we've been trained as regards supervision, documentation, codes of conduct. I'm not sure I see that in how some of the nurses work …. things that you'd assume they'd do, they don't do."

The Band 7s saw themselves as struggling to put their views across in an organisation dominated by nurses. Physiotherapist Crystal told a story of volunteering to join a group developing a care pathway that included specialist nurses but no therapists. Her suggestions for physio involvement in the pathway were questioned by the nurses, and she felt "slapped down," but with support from a GP her ideas had prevailed. "… you do feel that nurses try and rule the world. And you have to make yourself unpopular sometimes. We have to voice our opinions and be prepared to be glared at…."

Most of the Band 7s thought Margaret a good manager ("she looks after us"), but they had little appetite themselves for taking on roles with more managerial responsibility, seeing this as inimical to their professionalism, and morally hazardous. One of the Band 7s summed up:

> "I'd say the higher you move up the management hierarchy, the more you lose sight of your professional values. You sell your soul, you do the grovelling and toe the party line."

5.5 Commentary

This chapter recounts the experiences of AHP clinician managers in Greenshire Community Health Care during a period of significant organisational change and continuing modernisation of services. Local, disparate services had become part of a single organisation and were being redesigned by a management team seeking coherence, consistency, improved productivity and 'a paradigm shift' towards integration and innovation in service delivery. The strategy was bold, driven by national policy and inspired by home-grown approaches to inter-professional working. It drew on the prevailing discourse of leadership in the NHS to present a 'particular way of being' to professionals (clinical leadership) and to write management, and its negative associations, out of front line services. At the time fieldwork was carried out, implementation of the operational and cultural changes implied by the strategy was still patchy and some AHP clinician managers were perceived to be disengaged from debate and 'disenfranchised' in the organisation. In a context in which the imperative was transformation - of organisational structures, service delivery, relationships, expectations, roles and jobs- it is perhaps not surprising that AHP managers' collective and individual identity work came to the fore in their narratives and in observed interactions.

While some AHPs supported senior management ideals and had developed inter-professional working, collectively AHPs feared nursing hegemony in Greenshire, and harboured suspicions that the integration strategy would diminish or erase their contribution to community services. They felt their 'survival' as professions with distinctive identities was at stake. Constituting themselves as a marginalised minority and adopting 'identity politics' to improve their position in the organisation appeared to have resulted in some gains, but also magnified and consolidated perceived 'essential' differences between AHPs and nurses. The social construction of identity is always a matter of negotiating, establishing and signifying relationships of similarity and difference, and 'discursive positioning' by professionals to make sense of their situation has been described extensively in the research literature (20). The Greenshire AHPs' stance may have enhanced AHP solidarity, but it threatened to exacerbate tensions in a multi-professional organisation. Articulating narratives of professionalism also created possibilities for resisting change and managerial attempts at identity

regulation,[2] by offering an alternative to the discourse being promoted by senior managers, which required professional differences and interests to be suppressed in pursuit of integration and emphasised shared values and the fluidity and interdependence of roles.

In investigating the three localities within Greenshire, we explored how AHP clinician managers presented themselves and explained their work, looking in particular at how notions of clinical work and professionalism, managerialism and leadership were incorporated into their narratives. Leadership was of particular interest because it is a prominent policy discourse in the NHS and Greenshire senior managers saw the shift from management to leadership as key to transforming services. The ubiquity of leadership in mainstream NHS terminology and its powerful discursive appeal have been analysed by Martin and Learmonth (16), who argue that using the term 'leadership' influences how people think and act, aligning their identities with policy intentions, to create 'self-regulating' subjects.

Both Barbara and Tom had helped develop inter-professional working and were seen by their managers as effective 'clinical leaders', however they presented contrasting accounts of their work. Barbara embodies 'clinical leader', portraying herself and her work in ways that are completely congruent with official organisational discourse, even to the extent of containing managerial activities to match senior managers' expectations. Tom identifies himself as a manager, emphasising continuities with his previous managerial job, but differentiating himself from the "suits" who sit in offices. He acknowledges the ambiguities and incongruities of being an AHP in a job designed for nurses and highlights the practical obstacles to minimising the time taken by managerial work. Tom locates his difficulty in accomplishing 'clinical leader' not in its leadership aspect, but in clinical expertise that he perceives is required of him, which he does not possess. Claiming an identity that cannot be sustained satisfactorily in narratives or performance places an individual at risk of being discredited as an imposter by others or by themselves, thus jeopardising their sense of authenticity and worth (55,67). Tom also notes that the demands of his job have increased while his grading remains unchanged, suggesting that his reluctance to rebrand himself as 'clinical leader' may be a form protest. Martin and Learmonth have suggested that simply re-labelling activities as leadership may be seen by those involved 'a fig leaf to hide the more oppressive aspects of life in healthcare provision' (16) (p.287).

At Longbourn the AHP clinician managers felt threatened and insecure; they were cynical about senior managers' plans for change and reluctant to comply with them, although they were exploring ways of improving patient care. They had been able to secure organisational space (at least temporarily), which allowed them to resist managerial domination, and

[2]Identity regulation denotes strategies aimed at influencing identity work in directions that support organizational goals(59,128).

justify their resistance, by creating an isolated counter culture[3] and constructing and enacting a collective identity as autonomous, self-regulating, highly skilled and specialised professionals. Their identity narratives privileged uni-professional clinical work; encompassed selective aspects of management and leadership; questioned the legitimacy and value of managerial systems of accountability; and enabled the AHP clinician managers to position themselves as more specialised, skilled and autonomous than nurses and thus superior professionally. The Longbourn AHP clinician managers had crafted a narrative for themselves that challenged the discourse being promoted by senior managers.

The variation in organisational culture (shared beliefs, values, norms of behaviour, routines, meanings and narratives) observed within Greenshire, is consistent with the findings of a study of NHS organisations undergoing change, all of which had identifiable subcultures, often separated along professional or occupational lines (15). A PCT responsible for health and social care services had the most complex subcultural patterns. The subcultures described by the researchers covered a spectrum of malleability, ranging from those that fervently supported change, to those that sought to protect the current order or block change. Other studies have also shown that the upheavals and challenges of modernisation may 'surface deep-seated discord and subcultural power interplay' which have the potential to stall or derail attempts at cultural transformation (2) (p.57). Greenshire's inherited local differences in practice and culture, overlaid by professional divisions, created particular challenges for senior managers trying to engage the workforce with their vision for transforming services.

Clinician managers occupy bridging roles between clinical and managerial domains; they need to maintain credibility with the clinical staff they manage; the professional peers with whom they collaborate; and the managers to whom they are accountable. They have been described as 'embedded in a web of complex and pressurised relationships' (64) (p.645). The case studies illustrate the part that clinician managers play in interpreting organisational discourse and constructing narratives that make sense of inherent ambiguities and tensions; they must also reconcile idealistic demands from above with the practicalities of delivering front-line services. The seductive narratives of leadership and empowerment as essential ingredients in transforming services required clinician managers to rework their stories and performances to accommodate leadership in their 'hybrid' roles and identities as managers and professionals. However, the variety of post-heroic, dispersed clinical leadership espoused by Greenshire senior managers (as potential in all professionals regardless of their position

[3]Mannion *et al*. describe various examples of subcultures in their study of management cultures and organisational performance in the NHS, and also identified counter cultures ('an organisational enclave that espouses values which directly challenge the dominant culture') (15) (p.198). Morgan and Ogbonna, faced with the complexities of hierarchy and profession found in large health care organisations, suggest dividing subcultures further into nano-cultures 'to incorporate the wide array of groups that may share similar values in an organizational setting'(2) (p.60).

in the organisation) was problematic for clinician managers. It devalued the managerial work that they had been doing; it called into question the quality of the leadership they had been providing; it required them to empower their staff to become leaders – all of this, while senior management retained managerial authority and intensified upward accountability. As we have seen, different responses to these apparently contradictory demands were emerging. The case studies illuminate the interplay between roles[4] and identities and the importance of not confusing the two: 'Roles influence identity, but roles are also formed (and enlarged, modified, marginalized, rejected) in identity work' (66) (p.1178). Clinician managers' identity work, the narratives they construct, and how they enact their own roles, influence not just their own responses to change, but also the functioning of teams and how front-line staff perceive the possibilities for change.

Barbara described how she accomplishes her persona as 'clinical leader' by front-stage performance, but she also raised issues about AHP professionalism and concerns about 'survival'. In particular she drew attention to the style of management AHPs expect and enact, which places high value on supervision: regular personal contact between manager/clinical leader and staff to provide practical and emotional support. Senior AHP and nursing managers in Greenshire also perceived this as a 'real' difference between AHPs and nurses. In the Whiteford case study (Chapter 4) the therapists preferred an emotionally engaged style of managing staff that replicated aspects of their approach to managing patients. This was explicitly acknowledged to be a feminine approach that was contrasted with more masculine styles associated with strategic and business management that were dominant further up the trust hierarchy. In Greenshire, with a predominantly female workforce, including the managerial elite, differences in styles of management were attributed to professional background rather than gender. We consider these findings merit further research, not least because it may have implications for achieving effective inter-professional working.

The story of Greenshire highlights the importance of recognising the nature of the collective and individual identity work that is implicated in organisational change. It may also be read, like the Cloffaugh case study (Chapter 6), as part of the continuing quest for integration in the NHS, which has often been portrayed as a struggle to overcome the divisive influences of professionalism. Exploring the Greenshire experience in the light of the literature on identity construction suggests that, paradoxically, perceived professional differences may need to be acknowledged and accommodated before they can be safely put aside.

[4] 'the point where one's presentation of self meets the perception of how others desire the self to be constructed' (129) (p.41).

6 Making Integration Transparent: The Move to Open Plan

'No one wants to be perfectly transparent: least of all to themselves'

-- Nassim Nicholas Taleb (68) (p.8)

6.1 Introduction

"Integration? That's been around as long as I have", said the Trust Occupational Therapy (OT) Lead for Social Inclusion in Mental Health. Much of the recent history of mental health service development has involved a series of efforts to break down putative barriers to integrated service delivery. For AHPs, the current formulation of this process was Transforming Community Services, with multidisciplinary teams controlling their own budgets the obvious route to improving policy outcomes (17,69).

Integration has always been elusive. "Working in the community is like working in ether", a Senior AHP Lead noted. "It's not like being on show all the time." In an attempt to pin things down, policy makers have turned their attention to 'the environment' (70,71). Burton, for example, sees health care becoming

> ' … much more inclusive of matters educational, cultural, commercial and social. I can see our buildings responding such that they become a most important network of places and spaces, paralleling the political ones' (72) (p.23).

However, buildings and politics do not sit in separate compartments. Buildings speak. Even the most literal-minded designer recognises that they carry important social meanings through which people objectify, represent and reconstruct themselves (73-75). But any analysis of the relationship between the built environment and politics has been conspicuously absent from contemporary organisational behaviour studies with clinician managers (60,76).

This chapter addresses this oversight via the move to open plan working that occurred during the research at Cloffaugh Mental Health Care for Older People (MHCOP). Together with staff housed previously in a Day Centre, multi-professional community mental health teams were to work under one roof in new, glass fronted, open plan offices, giving both tangible form to Cloffaugh's practical needs and embodying its wider political ideals. In providing much needed therapy room space for its clinicians, the move was to put the over 65s on the map, reconcile the demands of efficiency, economy and effectiveness with diversity and democracy, and rid healthcare

of contingency and disorder. Integration was to be made visible,[5] evidenced, transparent, for all to contemplate (77).

We suggest that exploring how people, buildings and the politics of integration are all tangled up puts at centre stage the values that NHS management wants its staff to live by, within which the role of AHPs was coming to life (78).

6.2 Setting the scene

Cloffaugh MHCOP is part of an NHS Trust that has University and Foundation Trust status. Hived off from Adult Mental Health Services in 2009, elder care now forms a Directorate in its own right. It is situated in one of the UK's most deprived inner city areas, with high rates of mental ill-health, under and un-employment and poor housing, currently under-going major regeneration and development. It is also a lively area, its cosmopolitan mix being vigorously supported by community and voluntary groups. This is the context for efforts to redesign services around the service-user in the community, with hospital care the last resort, consonant with the move towards a more personalised approach to providing care in mental health (79-81). Whilst personalisation was first envisaged in terms of service users handling their own budgets, more is at stake than money. Cloffaugh was seen as an important setting within which to extend people's choices about the services they received, empowering those ready to grasp the nettle (82), a dynamic that has been given additional impetus by the Royal College of Psychiatrists' recent audit (83).

These efforts were being made against a changing backdrop of major financial uncertainty and cut-backs. However, the picture was not entirely bleak. Aided by the burgeoning interest in neuroscience, money was available via the Government's Dementia Strategy Implementation Plan (84), with a boost for the 'talking therapies'. In addition, a diagnostic Memory Clinic had opened at the Trust's main Hospital to complement the Dementia Care Team being established at the Centre. Much of the work of merging a Dementia Assessment Unit for challenging Behaviour had been completed

Cloffaugh was organised into two interdisciplinary teams (North and South), made up of occupational therapists, community arts and music therapists, community psychiatric nurses, social workers, and assorted support staff. It was headed by a Clinical Director, and managed by a multi-disciplinary team of psychiatrists, clinical psychologists, a community psychiatric nurse and a social work manager, and an Intermediate Care Team Manager. Importantly for our study, there were two AHP clinician-managers (a community arts therapist and an occupational therapist).

[5] The writer Italo Calvino (130) argues that visibility is an essential 21st century value, along with lightness, quickness, exactitude, multiplicity and consistency.

Under the auspices of the Medical Director and Chief Executive, they were overseen by the Service Manager, who was also responsible for forensic and substance abuse services, currently located elsewhere in the Borough. The Centre was also home to the Alzheimer's Disease Society. In return for providing a phone-in crisis help-line and befriending services, the Primary Care Trust allowed the Society to occupy the offices rent free.

The chapter unfolds as follows. After introducing the chief characters whom I shadowed at Cloffaugh, and briefly outlining the ethnographic fieldwork in Section 6.3, Section 6.4, *The Old Place*, describes the mesh of relationships and values that were being enacted there. The story then moves on in Section 6.5 to explore the process of *Orchestrating the Move* to the new open plan office. We then describe *The New Centre* and its layout in Section 6.6, before looking at some initial responses to this in Section 6.7, *Close, but not too Close*. Two vignettes, "It's about muddling along really", and "We're the nice therapists!" highlight the specific experiences of the Arts Therapy and OT Managers. Our final commentary concludes with some tentative reflections on intertwining of managerial identity with setting: tentative, because like most things that matter to people, integration can only ever be seen through a glass darkly.

6.3 The Field

The main characters[6] encountered were:

- *Craig*: Service Manager: Head of Services for Mental Health Care of Older People, Substance Misuse Services and Forensic Services, from 2009-June 2011.
- *Sinead*: Head and Manager of Arts Therapies, appointed 2008.
- *Trudy*: Head and Manager of OT Therapies before taking up Craig's vacant post in Autumn 2011.
- *Maya*: Head and Manager of Psychology Services for Older People.
- *Corinne*: Head and Manager of Intermediate Care Services.
- *Peter*: Manager of the South Team.

Other staff included:

- *Wilfred*: Medical Director and Chairperson of the local Alzheimer's Disease Society (Psychiatrist).
- *Norman*: Consultant psychiatrist (one of three in the Team).
- *Peter*: Manager, MHCOP South (Mental health nurse and youth worker).
- *Jasmine*: Manager, MHCOP North, and subsequently Manager of Dementia Team (Social care background).
- *Naydev*: Senior Registrar (Psychiatrist).
- *Bezayou*: Clinical psychologist.
- *Tamsin*: Counselling psychologist.
- *Samantha*: Alzheimer's Disease Society Adviser (Social worker).

[6] Like Cloffaugh itself, these names are all pseudonyms.

- *Brady*: Alzheimer's Disease Society Support Manager (Social care worker).
- *Francesca*: Administrator and assistant to Head MHCOP.
- *Beth*: Community arts therapist from the wards and community centre.
- *Ayaka*: Music therapist from the wards and community centre.

Attaining a presence numerically has always been an issue for AHPs, an anxiety that as an ethnographer, I absorbed through the skin. By comparison with our other case study sites, Cloffaugh was a low density setting in terms of the complement of AHPs it represented, and the term 'AHP' was not used. They were referred to either as Middle Managers or Heads. However, as we can see above, they were not absent.

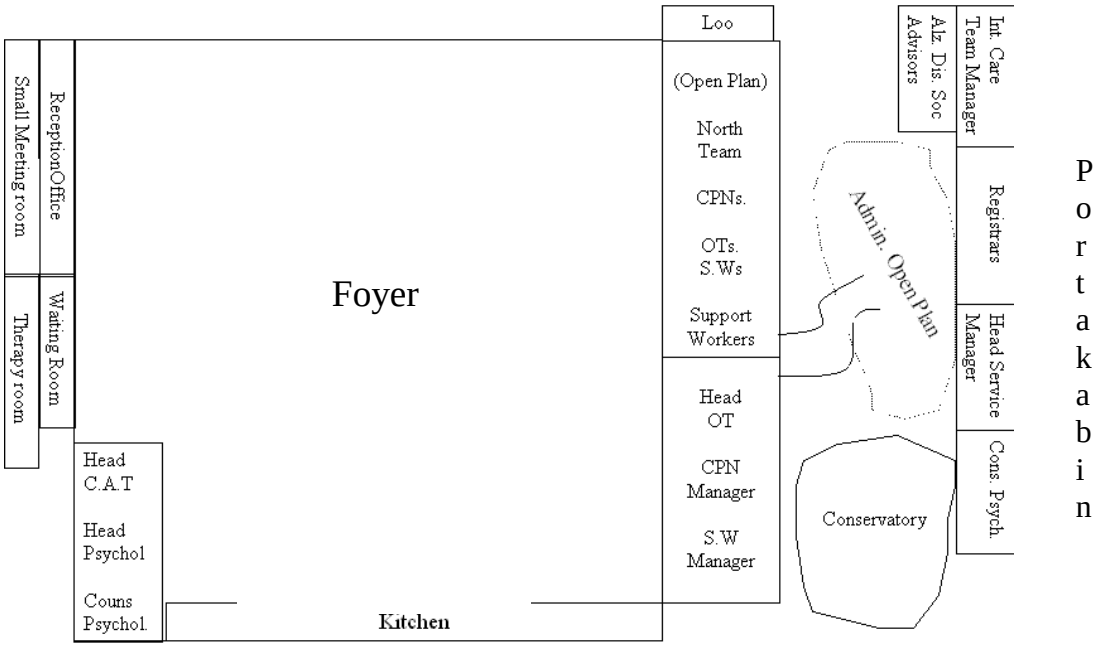
In fact it is precisely the critical mass question that makes Cloffaugh such a good case study. It foregrounds the emergence of multi-professional management teams that increasingly characterises management in community settings, such as child and adolescent psychiatry, where AHPs practise in small numbers and conditions of near professional isolation. So what initially seemed to be a disadvantage opened up possibilities that would have been missed if clinician managers are to "step up" and embrace the "positive risk-taking" that SHA Leads were advocating.

However, it meant adopting a slightly different approach from the previous case studies. As Kunda (85) (p.16) argues, many management studies focus on spokesperson's own rhetoric. Although I did conduct interviews, they were not my tool of choice. People talk about what stands out, not what they take for granted. Yet what anthropologists call 'culture', or what goes without saying, is precisely what researchers are after. Mostly it is alluded to in the acts whereby people bring the relations between them to life. So the best ethnographies come from understanding what people do, and want to talk about, rather than imposing one's own agenda right from the start (86-88).

Finding a niche for oneself is often key to sustaining fieldwork in tightly controlled settings. With both clinical and computer work out of bounds, attending the many meetings that formed a key part of managers' workload became a fruitful strategy to pursue. After the first few months, the forthcoming move to open plan offices emerged as the focus of managerial activity in which a Senior AHP Lead's advice earlier "not to treat AHPs in isolation" took on added significance. Here I was able to adopt the familiar anthropological practice of tracking an important event over time. How the move served as a touchstone for the managerial allegiances that unfolded in that process – indeed how integration is always on the move - is the subject of the next four sections.

6.4 The 'Old Place'

Figure 1. The 'Old Place' at Cloffaugh



The life behind this two-dimensional diagram (Figure 1) only slowly revealed itself.[7] Such is the stigma that still surrounds mental health, it is difficult to openly advertise the presence of mental health services. This invisibility had consequences. Asking for directions from a passer-by on my first visit, I was met by "Oh, you mean the Social Services?", only to be greeted with an NHS sign on the door. Corinne clarified the situation. It was evidently a mix. "It's a partnership, it's also a bit like a hospital, we have patients come in here, an out-patient clinic, and we also take patients outside. They work in the allotment." When words often change lives, the reference to patients raised intriguing questions about working together when less medically oriented 'psy' and social care staff preferred the term "service users." But as we will see, ambiguities went well beyond simple differences over terminology.

The centre had a comfortable shabbiness about it: it had after all been a Day Centre, and was built around a central foyer, crowned by a dome, with a kitchen to one side and offices on the other leading across to an annexe. The crocks often piled up in the kitchen sink – "a big issue", said one of the

[7] *Erratum*: The Arts Therapy Manager eventually corrected some details on this sketch drawn early on in the research. Such was my anxiety to ensure the inclusion of the AHPs that I failed to include a room of social workers. Also, the size of the adjoining offices grew, while the foyer reduced. I would draw it differently today. Despite this, it captures the essentials and the spirit of the Old Place, so we have retained it.

community psychiatric nurses (CPNs) – defying Trudy's 'Yuk' notices above the fridge, and exposing a domesticity that sat uneasily with the rational demands of an office. Books and pamphlets spilt in homely disarray from the cupboard in the adjacent conservatory, where the monthly management meetings that brought staff together were held. The foyer itself, often flooded with sunlight from the dome above, was also a busy carrefour, full of comings and goings as staff went about their business, often stopping for a chat en route, though one had to keep a watchful eye to prevent lingering from slipping into loitering. Straggles of green on the surrounding patio outside bore witness to service users' gardening efforts, and benches under the trees provided welcome shade from the sun.

The faded charms of the Old Place were deceptive. Office computers radiated proper compliance with the demands of evidence based practice - often problematic for the 'softer' therapies such as occupational, music and arts therapies (see Box 9, below). Managerial decisions, founded on well established positivist principles and procedures were not left to the caprice of individual interpretation. Less easy to spot was how the regular 'cascade downwards' of information to clinician managers at management meetings came already filtered.

The offices for middle and clinician managers allowed the intimacy of three to a room. Sinead, Maya and Tamsin occupied one side of the foyer, Peter, Jasmine and Trudy, the other, with Bezayou and other South team members occupying two adjacent offices. Intimacy was often instructional: the notice over Tamsin's desk reminding staff of their duty of care towards patients, was replicated in the reception area. Yet it was not claustrophobic. Office doors could be opened out on to the patio to let in the breeze on a summer's day, and provided unfettered physical access to the neighbourhood beyond. However, such largesse also posed a security risk in a political climate increasingly nervous about safeguarding service users and staff safety in the workplace.

There was a smaller office for Corinne and her team in the annexe that divided the Centre geographically. It also housed Norman, the psychiatry registrars, Samantha, Brady and other support staff from the Alzheimer's Disease society. Again, the divisions concealed the many comings- and-goings that took place. Craig sat astride two large computer screens that dominated his office, in anticipation of the electronic merger between health and social care. Jasmine could often be seen lunching in the North team office; Craig was a frequent visitor to Peter's office, where their mutual interest in statistics could 'capture the data' in a form that was immediately recognisable to higher echelons of management.[8] However, other relationships were more elusive. Back in the foyer, for example, the kitchen was a focal point for people to congregate. Any occasion, it seemed, was excuse for a spread of food, whose aromas often embraced reception staff,

[8] As the rules for collecting and manipulating numbers are widely shared and standardised, they are readily transferable globally across sites (131).

senior registrars and consultants alike. If talk there was often a heady mix of official business, gossip, and jokes, it also raised a question mark over the image of "people sticking in their own offices." It was my arrival on one occasion that stilled the gales of laughter that often arose there.

Box 9. "It's about muddling along really"

We'd spoken often enough for Sinead to say she was "feeling edgy" that morning. On top of last month's performance indicators, she hadn't met the 8.5 contact hours with service users quota for that month. Nothing had ever been said since she had been in post. But "it just might be", even though the current anxiety over job cuts seemed to have died down for the moment. She was free to use those hours as she thought fit, but overall, the figures had to impress. "I'm always worrying how I can translate what service users do for audit purposes", she said. "They become objects – commodities – in the process." She had shown me some examples of service users' art work produced the previous week. It was surprising how the images lingered in my mind afterwards, though I had been hard pressed to describe them. "That's the whole point", she exclaimed. If performance measures failed to do justice to her service users, then her own work could not be easily standardised either.

First and foremost she sees herself as a clinician, and is proud that her experience "prevents that ivory tower thing, where you're saying to people "why don't you do this?"" The designation 'clinician-manager' was a late arrival, as she had been 'managing' in the NHS for the past seventeen years. After completing some research in South Africa, this post working with seniors in mental health had come up. "Ideal for my situation", she thought, with scope to make a difference.

Integrating all her responsibilities required some forethought. She spends part of her working week assessing service users at home, or running groups on the ward with nurses. "It's quite daunting to go on an acute dementia ward", she told me. "You get used to refusals." Some of the interactions between nurses and patients distressed her, particularly the lack of sensitivity to cultural differences that she'd learned to appreciate in South Africa. "I know we don't have to mop up shit", she conceded, but her commitment to empowering service users sometimes got short shrift from hard pressed staff on the ward. "We haven't got time for that'', was the response on one occasion. She had wondered whether to report these incidents, but thought it would only fuel anxiety. She often worried in management meetings that the Centre was "behind" when it came to promoting user-involvement in service delivery.

She also deals with maternity, holiday and sick leave entitlements for the arts and music therapists she supervises, controlling a small budget, part pay, part equipment. With jobs in mental health often being seen as interchangeable, maintaining a recognisable presence for the softer therapies in senior managers' eyes was an on-going task.

While such activities could be distinguished from her clinical work, they couldn't always be neatly divided from it. For example, the books on her new office table spoke to her academic achievements, making her the obvious candidate to develop the Centre's on-going learning programme. With Norman and Naydev's support, she has been trying to encourage more imaginative presentations at the weekly breakfast meetings.

A captivating session given by her music therapist, Ayaka, in January 2011 was a case in point. Nicely illustrating the way that clinical and managerial work needed each other to survive, the setting allowed Sinead to work round the image of management "being about telling people what to do and what not to do."

Perched on the edge of her chair, Ayaka spoke softly at first, but gained in confidence as the story she told about her client unfolded and enfolded the group. She had not wanted to delve into the theoretical rationale of her approach, but there was no mistaking her command over it: resistance here, a puzzle there, the importance of silence as her client experimented with the instruments laid out. Then there was the vase of flowers that had been moved, the deep snow outside that had somehow "changed everything" between them over the weeks. She described that moment of recognition in the final session when they had played in unison, the shadows between them dissolved. "It was poetic", she concluded.

Sinead invited questions. There were predictable service development concerns. "What had she wanted to explore? Why had she been assigned the work?" asked one. There were other issues in a climate where jobs might become de-professionalised. Could anyone do it? The government's new Cognitive Behavioural Therapy (CBT) trainers might deliver quicker results. Ayaka was ready for the recipe knowledge-seekers. "I'm often asked that." There were techniques to any discipline, but psychodynamic therapy could not be reduced to techniques without distortion. "Was the tenth session the right cut-off point?" asked another. "It isn't something I have any choice over", Ayaka said, but she had wanted to continue working with him.

Sinead took a different tack: "Even if you can't go on, the *knowledge* of it goes on", she thought. She wondered too what happened when Ayaka was confronted with the mutiny of sounds from her instruments. "You don't reflect that chaos back to them do you?" Sometimes it appeared Ayaka did. Indeed the session here enabled her "to give other professionals deeper insight into our way of thinking." At the same time, it challenged Sinead's own ideas about the thresholds of tolerance.

Sinead now feels accepted in the Unit. "It's been gradual but I've noticed Norman has been asking my opinion lately." At the monthly management meetings, it was evident that her judgement is trusted, her comments, made sparingly, valued. It was often a matter of "slipping things in" when the time was ripe. More might be gained that way than by rubbing people up the wrong way.

She had not wished to apply for Craig's vacant post. She was only too aware of the 'politicking' that went on, but she didn't claim to understand "all the under-currents." "I don't like having to kick and fight", she said, although she remembered doing so once over the lack of therapy space, and had found it "surprisingly effective!"

Her abiding philosophy, though, was modest. It was a matter of "just muddling along really, trying to be kind to people. And trying not to get angry." More improvisatory than innovatory, this meant joining with people encountered along the way, and contributing to their on-going formation.

However, things were on the move. Although health and social care staff had occupied the same building since the earlier merger, weaving the two services more closely together "hadn't always happened" as Samantha and Brady intimated. Psychiatrists, over in the annexe, had felt out on a limb: "that's why I often work in the North team office", Norman said. Difficulties of locating the Centre geographically meant that secretarial staff often had to meet service users outside, an unproductive use of staff time. Finding additional space for an expanding therapy remit brought matters to a head. By the time fieldwork proper started in July 2010, a vacant plot had been identified in one corner of the Borough, and negotiations with local authority planners and architects were proceeding apace.

6.5 Orchestrating the Move

The move was orchestrated mainly by Craig, whose designer beard and black shirt signalled a departure from more fuddy-duddy images of ageing that the old place might have been at ease with. Initially he had allowed room for, if not shared in, some of the group's objections at the monthly management meetings. Rolling his eyes for everyone's amusement, he said "We're going to be near shops, cafes … ten minutes' walk to the nearest centre." Standard objections were raised about access for some service users, particularly the lack of parking space: cycling might be an option now that car usage in the Borough was being tightened up. The image of the over 65s wobbling around the Borough on bicycles amused Peter, but appealed to Corinne. True to the trainers she always wore, Corinne was busy implementing an 'out and about' programme of activities for service users. Sinead worried how the anarchy of noise from the music therapist could be assimilated into the new design. Maya hunched her shoulders in her chair at the prospect of losing the prized elbow room of her office, not a gesture that made its way into the minutes.

However, part of management's job is to make desirable what is obligatory. For clinician and middle managers here, "No one's going to have an office: that's the policy", Craig said. The drollery of the October meeting gave way to "I've got to present the positives…." Any reference to "battery hens" from others was replaced by, "Well it could be quite nice… It will bring us all

together." I was twice prohibited from saying anything negative about the new premises - no ambiguity there - and negativity generally was frowned on. It was a question of "appreciating how lucky we'd been to have had this", said Corinne. Yet there were many possibilities in store, not least "getting rid of the crap furniture" and "being much smarter with our archiving." Above all, the new building was evidently "a blank slate", upon which to inscribe the Directorate's fresh ethos. However, "putting our stamp upon the world" had its poignant side since Craig's job was about to be cut, a move "we were all in denial about", said one of the consultant psychiatrists.

Members of the team had been consulted on a range of technical issues, such as the flooring and soundproofing for the therapy suite, but room for manoeuvre was limited. Like the medical routine of offering patients two treatment options, there were two choices for clinician managers to decide at this stage too. The first was over the colour scheme. The Local Authority planners presented the design for clinician managers to inspect. The choice between the two shades of pale or darker blue, grey and lilac was settled quickly. "A democratic decision", Craig said, although his fondness for the light shade was apparent before he invited the group to state their preferences, and the architect's suggestion that "the dark shade wasn't all that dark" faded from view. "They were standard colours", Corinne noted later, not intended to distract clinician managers from the task at hand.

The second, more fateful, choice was between hot-desking[9] or retaining personal desks but at the cost of slightly reducing each person's desk space. Pinpointing when or how decisions about the desks were made was more elusive, but eventually sovereignty over one's IT equipment took pride of place. "Four inches wasn't much to lose", the group agreed. Whether staff had any choice as to seating was equivocal: it was a "within reason…" situation, Craig told me.

Some relief came after an early visit: after fielding his staff's ambivalence about the change, Craig had visited the site with some colleagues. One had said: ""My God it's beautiful." But there's no use looking for a nice restaurant there. Otherwise, it's all gorgeous."

However, beauty is in the eye of the beholder: an induction meeting on the new site whilst the building was still a mass of wiring and dust revealed some hesitations. "You can look out of the window here", said one, "At the trains." "The strip lighting, it's just like hospital lighting", said another. "We're all going to be in rows… No green fingers here", said a third, mindful of the proscription on embellishment and personal effects. The new building was not an empty canvas, but already contested, its newness obscuring the power relationships that had gone into its making.

The move itself was accomplished with the smoothness of a connoisseur; Craig's passing reference at interview to "moments of despair" as though it

[9] An un-lovely term for sharing one's computer with others.

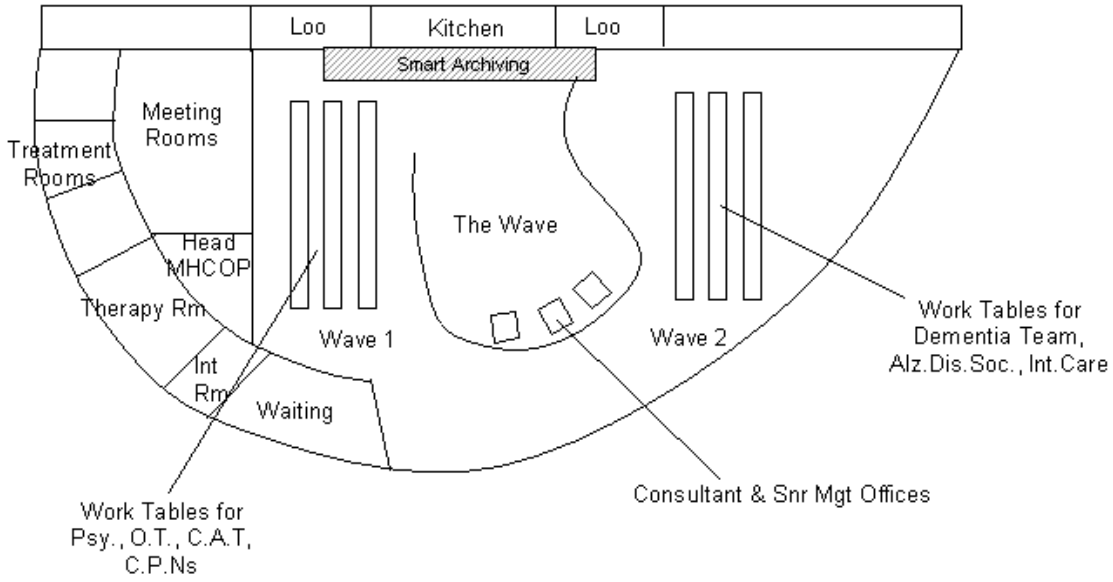
had never been. He had, after all, moved "more than 130 people from a building with 60 offices into open plan" before.

6.6 The New Centre

"We are mental health for older people, and this is what we do."

Power is often displayed through anointing rituals. It was Craig who gave the new Centre its blessing at the first management meeting in January 2011. The tone was firmly set. To smiles of encouragement all round he said: "There's been lots of anxiety about the move, but that seems to have subsided. What I'm hearing now is it's a great place. I'm hearing only positive things." And what was to come? At previous meetings, Craig had assured clinician managers that their work pathways were secure. But now North and South teams were to be harmonised, the Dementia Assessment unit consolidated, and the separate electronic system between local authority and NHS finally merged, traditional working arrangements were bound to be affected. History had been made. Indeed, the move could be deleted from the agenda. Only a forlorn echo of the old Centre remained: someone's mobile had been ringing unattended during the move. Wasn't preserving links with the past the essence of managing dementia care?

Figure 2. The New Centre at Cloffaugh



Like most institutional buildings these days, the new Centre's offices had a glass façade that provided a visible route to the community it was to serve, but at a proper distance (Figure 2). Occupants could see out, to an extent, but it was closed to view from passers-by (an arrangement that was reversed in the treatment rooms where alternate glass and opaque strips on

the door panels allowed staff to look in, but prevented patients from looking out).[10] There was a large glass enclosed reception desk where staff directed service users from a pleasant, but standard waiting area to the newly painted Therapy and treatment rooms to the left. Surgically white, their dazzle was softened by the Centre's one concession to 'green fingers': a potted plant in the waiting area.

To the right, two open plan offices for staff were built around a large Wave, a sweeping curve of desks and seating intended to symbolise management in a more flexible, collective era. Offices for the clinical director, consultants and senior registrars rode the crest of the wave, but the flat ceilings and strip lighting in Waves I and II ensured middle managers' attention was firmly grounded. Unlike the old place, there were no domes to divert one's gaze upwards. Craig's office, although self-contained, was at the back, giving a rear view of the tables where Trudy and Peter sat. There were several meeting rooms, a small kitchen, where Trudy's distinctive 'Yuk' notice had been replaced by an impersonal rota. Oddly there was no staff room. "I don't suppose anyone had thought of that", Francesca noted, and Trudy had not been invited to contribute her clinical experience in designing environments for service users to the process (see Box 10, below). The notices reminding staff of their duty of care to patients did not seem to survive the move. There was evidently no more need for compassion to wear its heart on its sleeve.

More striking were the physical boundaries separating the building from its surrounds, allowing only front door exits and entries. Outside facilities were more promising than Craig had envisaged. There were two cafés: one serving enormous platters of food was frequented by the army of local builders; the other's clientele included a mother and baby group, and was used regularly by Centre staff later on.

Box 10. "We're the nice therapists!"

I asked Trudy to tell me more about the lack of consultation noted above. There was a moment's hesitation. Then – "that would have been a massive project. There isn't the time." Like her colleagues, just completing the work she had to do was more than enough to fill a day. There were specific frustrations. "You're fairly invisible against other professions, and the larger management structure here. You don't feature unless you're there to shout." The lack of professional representation within Community Mental Health Teams had a long pedigree, one that was "felt acutely here. I think people don't understand what occupational therapy is, and how it can work within the team."

Like other OTs, she recalled being by-passed when wards were being altered, moves that ideally could draw on their professional experience in designing environments around patients' needs. "It doesn't occur to them to

[10] I discovered later that this could be manipulated and reversed - not something service users would know.

ask the OT, yet OTs have a good skills base for sorting out something like that, breaking down the task into manageable units." OTs were also well equipped to ease service users' transition from hospital to home, an increasingly important feature of integrated working in the current healthcare climate. Yet in a doctor and nurse orientated setting, it was still difficult for the social model of disability that Craig was encouraging to hold its shape.

Trudy had a strong clinical and academic background, with a degree in psychology followed by a two year post-graduate course in occupational therapy. She had spent some years doing epidemiological research at the Medical Research Council, before deciding that she really wanted to work with people again. Like her colleagues, she was "passionate" about ageing: "It's the last 'ism really." Her first Band 7 post was taxing, being split between in-patients and the community, and thankfully there was room to breathe with her next Band 8a post. "You feel you're really starting to get somewhere, rather than constantly fighting fire."

Since those early days, she had blossomed in her new post, and chaired the monthly management meetings alternately with Corrine when Craig was elsewhere – a task she performed with poise. I wondered what made OT management distinct from the other clinician managers at the Centre. The range of activities that she engaged in was certainly part of the story. These included attending mental health tribunals, supporting staff at Local Authority panel meetings, and running the regular monthly Centre meetings for support staff with Jasmine. She was also taking a University leadership course where the proclaimed transition from clinical to managerial skills exposed some of the latter's uncertainties: "You're not really sure what you should be doing. It's a different role, you have a different mind-set – things like representing yourself in large meetings."

She introduced me to the monthly meetings held at the Trust Headquarters for OT Heads from all over the Region. Despite subtle differences in emphasis between OTs Heads working with older and younger adults, the collegiality she experienced there helped come to terms with the bullying she and others had experienced earlier on in their careers. All were trying to grasp the implications of the merger that was taking place. Over the months, the lack of communication from top management had led the Senior Interim Head of Social Inclusion to bow out with early retirement. She had "done her whack." More a take-over than a merger, there evidently couldn't be *two* OT Senior managers in a new amalgamated service. "Nothing personal", I was told. Trudy was not alone in wondering later whether her decision had been too precipitate, as it closed the door on OT representation at Board level.

I wondered what integration meant at Cloffaugh. "That's a good question!", Trudy laughed. It was meant to be an "umbrella term for care", within which different specialisms could still be acknowledged. At the same time, it was "democratic … in the sense that we're working towards the same meaning of the person."

However, meanings were slippery. There were worries about stepping on other specialists' toes, with concomitant anxieties about de-skilling when the lines between nursing and social work were blurred. "Mental health's much looser than acute care … the OTs seem to be doing everything. You find them crossing boundaries more than other professionals." It meant being more flexible, adapting a busy schedule to people who missed an appointment. She was also conscious of how slow OT in mental health appeared to be compared to the acute physical sector. But, "You can't apply your 'right, let's get this done' kind of approach" here.

The difficulties in gaining recognition for her profession's performance in a payment by results system was an on-going worry for the 'nicer therapies'. It was often hard to translate what OTs were doing to support people in the community into measurable indices. "These ridiculous targets! It's not like the typical 'There's the goals and you can easily see the outcome'." But OTs had a reputation for working round obstacles without compromising their professional values, even if such creativity lay in the shadows. "We're often not as pushy as other professionals", she thought.

The leadership course had alerted her to the rising political profile of AHPs. In theory she could see the benefits of joining forces with physiotherapists. However, as autonomous professionals, she thought it would be not be in professional bodies' best interests to agree. "So you're not really allied, not in practice." But there was a problem. "The more protected you are about what you do and how you do it, the weaker actually I think others perceive you. It keeps you outside of the ball park really." She had perhaps misjudged the extent of support that existed at Cloffaugh. Norman had been irritated at the term 'AHP' at interview, seeing OTs and art therapists as fully integrated members of the team. "They're health professionals, not allied health professionals … they're often good at reaching withdrawn patients", he said. And what about psychologists? Didn't they have a place on the list?

New to her managerial post when I first talked with her, Trudy had gained in confidence since. With two OTs on a rotational basis and a couple of support workers in training, the chance came to make her mark when she successfully applied for Craig's vacant post. Whether it was a tribute to the leadership course she had just taken, her social skills, or attentiveness to her surrounds that I'd only slowly become aware of, she wasn't ready to settle for OTs being "mushrooms in the dark."

6.7 Close, but not too close

Being keyed in to Wave I, the visitor is first struck by the hush. This was not the hush of a Quaker meeting, but a scene of concentrated productivity that took on the intensity of an examination room around the end of year demand for performance targets. "I know the other offices were nice, but I

can do so much more here", Sinead thought. Sitting alongside support staff, clinician managers' faces were all directed towards their respective computing screens, and rarely seemed to glance upwards: an unfocused gaze might suggest a wandering mind. In fact, their computers acquired an added brilliance here. Any conversation was muted – a slight hum as Maya bent over her colleague's screen to check how many hours she was spending on psychology per se. Paradoxically the hush only eased when staff were out. Empty desks enabled Sinead to call across to a colleague, a move that would have been awkward otherwise. "You can even touch people!" she exclaimed.

Then there were the desks. These turned out not to be desks at all but long tables backed by a low parapet to prevent computers from having a spill, with staff staggered at carefully calculated intervals, six to each side. Who could argue with the rule of measure at this stage in the process? Whilst the tables enhanced some friendships, they also made it hard to distinguish where one person's paper work began and another's finished. The untidiness that a head OT Manager from the Trust Headquarters' meetings had confessed to was not an option for the new, compact manager here. Neither was there much room for physical movement. Any surplus energy found Corinne walking at lightning speed between service user visits outside. At the same time, the set-up was evidently an improvement on others' working conditions. Trudy noted at a monthly management meeting: "What a good deal we have here compared with X."

Open plan design revealed the push and pull of integrated working in other ways. Talking in the middle of the row was tricky. Attracting Bezayou's attention, for example, meant squatting down to avoid being over-heard by the next person along the row, but sneezing over her papers as a result. "You can't really turn round", Bezayou said. "You're tied in place." Typically conversations either occurred along the rows, the 'immediacies' Trudy referred to with her colleague, Peter; or at the row ends, where breakfast meeting speakers sometimes lingered for a chat afterward, but were careful not to over-stay their welcome. Indeed, sensing when to interrupt a co-worker was an intimacy reserved for insiders.[11] Francesca, one of the most interruptable staff members, had secured an end position alongside the smart new archiving, with her back to the pillar supporting the Wave. Other than facing her full frontal, I was reduced once to foolishly knocking on the pillar to attract attention, research being a non-urgent distraction in the scheme of things.

Negotiating interruptions was one side of the coin, respecting privacy another. "Open plan is hard to penetrate", Craig agreed, ignoring its sexual connotations, and senior managers generally respected their staff's personal space. Indeed, constant exposure makes the desire for privacy seem old-

[11] Returning a book to Sinead meant leaving it at the reception desk, whereas I would have knocked on her door and delivered it personally at the Old Centre. Being in the community evidently required a tighter grip on the division between public and private.

fashioned, even perverse. What is private and unknown might subvert organisational harmony. The only place to enjoy a moment's solitude was the toilet, or Peter's insistence on his smokes outside, a practice he carried over from the Old Place. "I feel bombarded", said one staff member – not perhaps ideal grounds on which to practise the art of "stating one's needs openly" that was being promoted at management meetings. Private conversations meant booking a meeting room, an ostentatious move given the fear of being singled out.

Managers were aware of the dangers of enforced intimacy. "Paradoxically it risks heightening paranoia, not the opposite. You see you're not going to go into that open space, you'd be stared at", said one. Moreover, now that North and South teams were unified, older loyalties that had enabled staff to support each other after a trying visit had been broken up. Bezayou's colleague now "made a beeline straight for her desk". Public scrutiny had its advantages, though. Intensifying the light helped to reduce cliquishness, making people more aware of each other. "You're much more careful of what you say and how you say it… When you're on the phone to a client, for example."

We have noted how open plan exposed staffs' computers. When screens were so visible, they posed a challenge to shared living, fuelling fears about breaches of confidentiality. Brady, otherwise nicely positioned on the end of the table in Wave II, was continually on the qui vive about untoward slips of information. Leaving her seat meant having to close down her PC in case anyone passing by glanced at its contents. Such awareness came at a price: managers seemed to be driven as much by anxiety as love. When so much was invested in expert technical systems, the transparency of additional guidelines seemed a poor substitute for trust.

What, then, of the brand new Therapy room that gave arts therapists the chance of a lifetime. Often working part-time, they have always accommodated to others' priorities. Now the tarnish of the past could be eliminated. "You mean they've got a room? I don't believe it. Tell me, where is it!", asked an outside arts psychotherapist. Not surprisingly, after all the arguments over space, the room resonated with Sinead's cherished professional values. "It's a nice clinical, professionally bounded space. People don't just drift in here. They come like any other person, for a professional service." It was a sanctuary from outside disturbance.

However, when buildings speak, they rarely do so with one voice. Ayaka and Beth, the music and arts therapists she supervised, worked more in the community, and wanted "to bring things in… It's an interesting dynamic." But doing so risked reducing the room's distinctiveness. The profession might become just like any other therapy after all. Beth, for example, contrasted the new Centre and its lack of facilities for service users to make a cup of tea, with the Community Centre she currently worked in: "I feel it's going backward, that's the way the building is really… It's more like an office." The outdoor barbecues with service users that Brady had organised at the Old Place were a thing of the past. The room's unadulterated

whiteness also struck a discordant note. Other social support staff felt it was "sterile". Familiar anxieties were surfacing. The Centre was harder for some service users to travel to after all, raising the spectre of waste that is always the shadow side of new-ness. But ideas were on the move. Beth felt differently after a service user had said "it's wonderful."

What, finally, of the power relations that helped to give integrated working at Cloffaugh its shape? As we have seen, the Wave was intended to symbolise a softer management style, to coax rather than simply extort commitment, the antithesis of the typical organisational tree. Matters did not rest there. With his eyes on refurbishing an intermediate care ward, "beige colours, oblongs and cubes", Wilfred said, were a thing of the past. Staff however, sometimes saw the Wave as "the new management wall" – seen through, not simply seen. The real power always seemed to lie elsewhere. Assembled in the new meeting room for the monthly management meeting, only clinician managers were present. Craig and the consultant psychiatrists had been summoned to a Directors' meeting. "Hierarchies!", exclaimed Maya. But the meeting provided one of the best discussions attended during the research on the now mandatory personalisation policy.[12] Like all policies its double-edged nature was troubling: whilst it might empower some, Maya's comment, "Do we want to know what service users spend their money on?" spoke to an unease about blurring the lines between privacy and intrusiveness, consent and coerciveness, always at stake in moves to bring people together. Was anyone listening?

It was no surprise, then, to find that neither buildings nor their staff were inert. "People are making their own walls", I was told. Although the policy was to get rid of everything extraneous or decorative, wiping the slate clean of human habits was a more refractory exercise. Sinead had brought in some art therapy books, stacked horizontally without protruding above the parapet. Francesca had pinned her religious maxims from the Old Place to her own parapet. Bezayou and her supervisor Peter were subtly 'turning things around' to do justice to the formal requirements of CBT and to open up imaginative ways of thinking about it.

One becomes at home in new buildings when the lustre wears off. It was not long before asking people to talk about the new building became bad form. "When you get used to it, that's what they all say", said one of the CPNs. But matters are rarely static. When Trudy took up her new post at the end of the research, she decided to alter the seating arrangements. Tantalisingly, what the alterations were lay once more beyond the research's arc of light.

[12] Of the many meetings that I attended during the research, only one occasion generated public controversy. It had a short hearing.

6.8 Commentary

Using the move as a touchstone has helped us see some of the ways in which 'proper' management at Cloffaugh was coming to life, within which AHPs and other middle managers tried to make their presence felt. No one can deny the importance of making some aspects of integrated management in health and social care more transparent. Our argument is that the over-zealous pursuit of visibility risks masking the subtler undercurrents that cut across the so-called clinician-manager interface.

At its best, the move to open plan spoke to the importance of fashioning what Wenger calls "a community of practice" (89), where professional differences or the irritations of management jargon were outwardly muted. The move certainly appeared to soften some spatial barriers that had fuelled stereotypes in the Old Place, such as 'psy' staff "sticking in their own offices", or the cliquishness that Bezayou noted. Different disciplines needed each other in order to survive if Cloffaugh was to hold its shape.

We have shown how the Wave, colours and lighting of Cloffaugh's new open plan offices gave tangible form to more accessible styles of management. Embodying a genuinely egalitarian stance, the building's softer contours also invited a wider dialogue between staff and community agencies outside. The monthly management meetings with outside presenters were pivotal in demonstrating Cloffaugh's collective vision to the outside world, encapsulated in Craig's phrase "We're mental health for older people and this is what we do." We have seen him trying to uphold democratic criteria of action that were powerful signs of collegiality there. Indeed promoting cordiality, team loyalty and interdependence in a cosmopolitan setting such as this – sensed as much as seen – was important in modelling proper managerial comportment. There was every indication that clinician managers followed suit: they were hard-working, protective of their own staff and emotionally dedicated to their jobs, an ethos that was apparent in both Old and New Place.

While making integration visible was endorsed as the outward sign of integrity, it also exacted a toll. In setting the scene for a well regulated day-lit life, without shadow, curiosity or cranny, open plan working downplayed other aspects of clinician managers' occupation of space, not least Trudy's anxieties about de-skilling, or worries about stepping on social workers' toes. In a climate of uncertainty, the well-intentioned levelling impulse of the long desks, flat ceilings and uniform strip lighting also made it hard for staff to put their heads above the parapet. The wave was less an invitation than an obstacle.

There was constant anxiety about doing or saying the right thing, a reluctance to openly critique organisational policies that sometimes risked sacrificing managerial vision for technical details of policy implementation. In contrast to the impersonality of the Centre's design, it was often personal rather than political conflicts that might threaten Cloffaugh's identity (90,91). The hesitations at the induction meeting not intended for senior

management ears, the anxiety about hurting others' feelings, or the reluctance to challenge "cultural insensitivities" on the ward, illustrate the difficulty in making known an internal democracy, the ambivalence staff had towards open forms of association. Yet without open talk of principles, political talk was hard to imagine: witness Maya's disquiet at the banking responsibilities managers were embracing that risked cheapening the moral and spiritual values they worked by, values no protocol or guideline could guarantee (92). Open plan working arrangements may not augur well for a model of leadership that requires AHPs to distinguish themselves by taking a stand on issues. Integration requires both equality and distinction (93).

Above all, in signalling a move away from overt forms of managerial control, the new integrated workplace design emphasised the elusiveness of power at Cloffaugh. It was tempting to think that power was 'not us' but 'higher up', as Maya indicated. This was not un-true. The well-documented shift from authority to manipulation, from the visible to the invisible, from the unknown to the anonymous with potentially both liberating and more coercive effects was operative here too (78,94).

The move has shown the way those see-through power relationships routinely circulated in the mix of people, practices and buildings: the glass surrounds that gave the illusion of access, but also risked denying it (95); the 'watching one's back' that was the shadow side of safeguarding; the difficulties softer therapies had in justifying their work, when audit has become a 'ritual of verification', distancing those it most wants to serve (96,97). Politics and buildings did not run in parallel tracks as Burton's earlier quotation suggested (72).

So was there no space at Cloffaugh for individual discernment, even ironic detachment? We risk over-doing the negative aspects of Brown and Crawford's masked management thesis (78). Now that more fluid opportunities for camaraderie at the Old Centre had given way to well-lit lines of communication along the New Centre's tables, staff were carving out islands of privacy around themselves in the office, unobtrusively "turning things around", as Bezayou indicated, or cementing liaisons in the local café that stood in for the Old Centre's kitchen. It was also a chance for AHPs to show what the 'softer' therapies were made of: for Sinead, the luxury of therapy room space for the first time; for Trudy, a chance to try her hand at raising OTs' profile at senior management level; for Ayaka, the opportunity to present her work with the grace, even tenderness that elevates service beyond mere efficiency.

That these were not always directly visible is precisely our point. In contrast to the demand for AHPs to 'come out of the shadows', the insistent strain for more role clarity in OB management literature - whether AHPs were more clinician-oriented here or management-oriented there - overlooks the notions of 'proper' integration that the move was bringing to life: a well-tempered activity, accomplished, at least in the mind's eye, with decorum, restraint and artistry. Like other managers on the mezzanine, half shades is where AHP clinician managers might make the best of themselves.

Finding just the right kind of illumination may be unsettling, as Taleb's aphorism at the beginning of this chapter suggests. It is not for those in a hurry.

7 Discussion

Treating our sites as independent case studies and allowing fieldwork to be shaped by the unfolding of the immanent logic of each complicates the task of summarising. Nevertheless, in this chapter we aim to pull out and draw together some of the key common threads that run – in varying combinations and to varying degrees - through the case studies, that have already been picked out in the accompanying commentaries. Six general and, we believe, generalisable themes emerge: the problematic nature of clinician-manager identity; the variability of clinician management; the variable and complex relationship between the managerial and the clinical on the front line; clinician-management as a problem to be managed; the significance of emotional labour in clinician management; the problematic transition from clinician management to clinical leadership. Although for presentational ease we treat these six themes separately, in reality they intersect and interact. We then go on to discuss the implications of our findings for current policy on leadership development in the NHS. The final section ('Envoi') includes discussion of the limitations of our research.

7.1 The problematic nature of clinician-manager identity

Our case studies reveal the identity work carried out by our clinician managers to be a complex social process, only transiently accomplished, never fully or finally realised. Neither component – the managerial and the clinical – was capable of being straightforwardly defined in any way that was sustainably meaningful. As a consequence, their narratives were constantly under construction, continuously revised, and modified for (and in) presentation to different audiences and different purposes. Like Penelope's web, perpetually embroidered, unpicked and re-embroidered, identity was a state of constant becoming, rather than of being – "morphing" as the therapists at Whiteford put it.

Given that physician executives are (almost by definition) established members of the profession that enjoys unchallenged dominance in the health care system, the professional component of their identity is highly likely to be secure and stable, unlikely to be called into question by organisational change. Certainly, this appears to be the presumption of research hitherto. Among non-executive clinician managers, however, and especially those from subordinate professions ("pond life," as the clinical service manager at Vanguard, diagnostic radiographer Nick, self-mockingly styled himself), security of professional identity cannot be taken for granted. The precariousness of professional identity is confirmed by all four case studies. Indeed, Cloffaugh and Greenshire can be read as explorations of how service transformation and integration served to render professional identity problematic and the responses that this evoked.

A key process in identity construction involved invoking similarities and differences in order to establish and assert who they (and others) were and who they (and others) were not (24). This 'discursive positioning' (27,28) served both to differentiate them and their professional colleagues from others, and to represent the others as inferior, or less worthy (29). Such positioning performed two further functions. It enabled them to establish or maintain a coherent sense of themselves as good or morally worthy people (30), and it also served to defend themselves against other professional groups. It also entailed resisting or defusing or deflecting the attempts by those other groups to define them. It thus highlighted the importance of power for identity formation, in that identity claims and ascriptions could be used to defend or challenge the status quo (31).

Because the literature on clinician managers has generally neglected identity work, we were taken by surprise by how complex and problematic was the process of defining even who they were as clinicians. Two AHP-specific factors contributed to this, we believe.

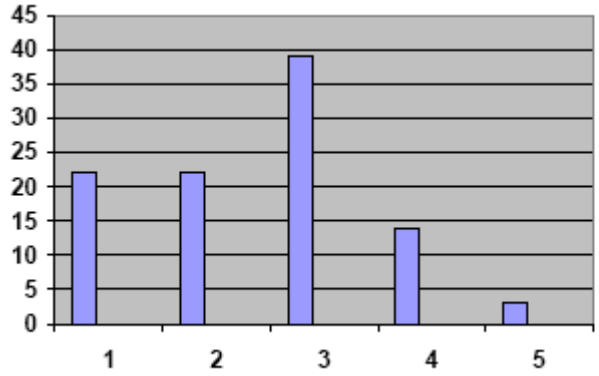
The first was the availability (in theory, at least) of an overarching collective appellation - 'Allied Health Professional' - as a potential source of identity. In reality, however, at only one site (Greenshire) was the term anything like accepted and established as a component of everyday discourse. And, even here, although it was embraced positively by some, as a tactic for raising their profile (especially of the smaller therapies) and gaining organisational presence and influence, there was a strong undercurrent of defensiveness and wariness about the potential consequences of adopting it. The collective identity of AHP was embraced not necessarily as a positive step, but as a defensive strategy, as a means of asserting their distinctiveness from the nursing majority. Elsewhere (even at Whiteford, in a nominally 'integrated' therapies department), it was simply not in use, or else was rejected (with varying degrees of vehemence) as irrelevant (as by the diagnostic radiographers at Vanguard) or (as at Greenshire) potentially dangerous, as implying interchangeability and so opening up to questioning the right (particularly of the smaller therapies) to separate existence.

This lack of a viable and acceptable professional meta-identity further complicates the already complex relationship between professional and managerial identities. We suggest that it also differentiates the situation of our AHP clinician managers from medical managers. This is not to say that we regard medicine as a monolithic profession. To the contrary, we see it as being internally deeply divided into a variety of distinctive and significant specialist sub-cultures. Be that as it may, these have received minimal attention in the literature on clinician management, which has treated medical managers as a homogeneous group and has largely omitted to explore whether and how styles of medical management might vary by specialty sub-culture. The crucial difference is that in medicine these sub-cultures are just that – internal divisions within the same profession, which have arisen out of a historic process of specialisation as branches from a common stem. In terms of their personal development also, despite

subsequent specialisation, doctors will have spent their formative years studying a common basic curriculum, being socialised into a set of core professional values and acquiring a shared 'foundational' identity.

For AHPs the situation is quite different. 'Allied Health Professions' is simply a category (essentially administrative in its origins) that comprises ten separate professions, each of which has a unique history and is independently organised. Attempts to construct a common identity for them are complicated by the fact that opportunities for joint learning, joint socialisation and joint identity formation are extremely restricted. This is a consequence of the random manner in which they are distributed across Higher Education Institutions (HEIs). As Figure 3 (below) shows, 70% of HEIs contain three or fewer Allied Health Professions. Furthermore, there is little (if any) regularity to this distribution; it is the outcome of historical chance and accident, with minimal (if any) commonality among the professions that are collocated.

Figure 3. Allied health professions by HEI (England only)



Source: (98) (p.223)

Given the widespread wariness of adopting 'AHP' as a collective designation, the clinician managers we studied had no recourse other than to embrace their individual profession as a source of identity as clinicians, but even this was problematic. The difficulty was particularly acute for members of the smaller and lower profile professions. Thus, in the drive to service integration, the arts therapists at Cloffaugh routinely found their *raison d'être* being called into question. However, even members of the larger and more prominent professions were not immune, as shown by the narratives of the physiotherapists and OTs at Longbourn in Greenshire. As we have already noted, defining who they were not was commonly as important as defining who they were. How they positioned themselves discursively revealed the inherently politicised nature of inter-professional relationships at our study sites and confirmed the importance of the role of power in identity formation. At two of the sites this was particularly evident. At Vanguard, radiologists (viewed as irresponsible and unaccountable) and general managers (characterised as remote and capricious) constituted the

other, by reference to whom diagnostic radiographers defined themselves and from whom they sought to distinguish themselves. For the physiotherapists and OTs at Greenshire it was nurses (seen as less skilled, less professional, less autonomous) who performed this function. The situation at Cloffaugh was different in some important and subtle regards. There, although psychiatry fulfilled this function to a very limited extent, the 'other' took the form of a pervasive, disembodied and internalised demand for greater transparency and accountability ('deep management' in Brown and Crawford's (78) terms), which reconstituted them as self-regulating workers.

Two recent papers offer support for our finding of the inherently politicised nature of clinician-management identity. Although concerned with professional responses to two earlier initiatives in the NHS modernisation project (networked service delivery across professional and organisational boundaries (99) and the development of General Practitioners with Specialist Interests (100)), they highlight the inescapable interconnectedness of modernisation with issues of occupational closure and professional identity. They draw attention to two particular phenomena: first, the legitimating strategies of professionals involved in and affected by workforce reconfiguration and how these interact with government policies to modernise the NHS; second, the difficulties experienced in this regard by less powerful professional groups in the face of competition from more powerful competitors. We believe that our case studies offer illustrations of the playing out at a micro-level of the dynamics of interprofessional politics.

7.2 The variability of clinician management

Another striking feature of the four case studies is their divergence and variability, not just *across*, but also *within* cases. It is hardly surprising that there were marked differences between the sub-units that comprised the two 'composite' organisations – Vanguard and Greenshire – that had come into being through organisational merger and amalgamation. Thus, the diagnostic radiographers at Hospitals A and B at Vanguard diverged substantially in terms of their perception of and response to the 'crisis.' At Greenshire, 'Flagship' and 'Longbourn' also diverged in terms of the degree to which they subscribed to the senior management agenda of clinical leadership and inter professional integrated team working. Even in the two 'unitary' organisations, however - Cloffaugh and Whiteford – we still found significant divergence and variation in the accounts of the clinician-managers we studied. This finding is consistent with that of Bate, Mendel and Robert, who identified systematically varying kinds of management, rather than a single type, in the nine hospitals they studied (37).

Such variation might appear surprising, given the importance of a common set of national policy imperatives that played a significant part in shaping the context in which all of our clinician managers were operating. All four sites had undergone at least three years of rapid and radical change in response to a series of demands from the centre, which appeared to be set

for the foreseeable future. The most important of these were: the elimination of budget deficits; the 'Nicholson challenge' to reduce management costs by 45% and to release £20bn in efficiency gains by 2015; preparation for GP commissioning; transforming and transferring community services. All four sites had also experienced a recent, marked and relatively rapid transformation in discourse and policy towards management and managers in the NHS in what O'Reilly & Reid term the transition from the dominant discourse of managerialism to the emergent discourse of 'leaderism' (17). After three decades of management and managers being promoted as the drivers of modernisation, they found themselves being redefined as the 'back office' and a bureaucratic 'drag' on front line clinicians, who as clinical leaders were now to be set free from the managerial succubus. It might have been supposed that, as potential (or even extant) bearers of the clinical leadership torch, clinician managers would have been exempted from this vilification of management, but this was not the case. Instead, their experience was of uncertainty and insecurity. Most had survived successive waves of organisational change. All had been required to reduce headcounts, particularly of managers, and to make substantial savings year on year. At Vanguard and Greenshire, there had been culls of professional lead posts for therapies and other clinician manager roles and structures had been redesigned. At Greenshire, Neil had been forced to reapply for his job three times in five years, while at Cloffaugh, despite successfully leading the move to open plan, Craig shortly afterwards found himself out of a job.

Inescapably, these demands from the centre were the focus of much of the management activity and effort we observed across all of the case studies. However, they played themselves out in a series of local site-specific challenges: the move at Cloffaugh; the financial crisis at Vanguard; the aftermath of the PCT mergers at Greenshire; consolidating integrated management of therapy services at Whiteford in anticipation of acquisition by a neighbouring foundation trust. There was however a less obvious, but in our view equally powerful, factor shaping the local context. This was the complex web of inter-professional relationships that our clinician-managers were situated in, that acted to shape their managerial work and constrain their autonomy. How they positioned themselves relative to these 'others' was a key theme of our case studies, which we return to below.

The outcome was that clinician-management, as it emerged from their narratives and enactments, proved to be not just complex and variable, but also highly situational, contextual and contingent. We found, not a single style of management, but a diverse range of styles.

7.3 The variable and complex relationship between the managerial and the clinical on the front line

The literature on clinician management is dominated by studies of medical managers. Furthermore, these medical managers have almost invariably

been in senior management positions – at clinical director level and above (what the Americans term 'physician executives'). The implications of this for our understanding of non-medical clinician managers at lower managerial levels are not generally acknowledged. Indeed, much of the literature (e.g. (101)) uses the terms 'clinical' and 'medical' as if they were entirely interchangeable. Fulop is one of the few who have addressed the implications of this narrow focus on doctors in management (12). She identifies one possible 'blind spot,' namely neglect of the potential significance for management of professional culture. She argues that media preoccupation with stories of extraordinary medical interventions and research breakthroughs that are presented as the achievements of individual doctors may have helped to create and sustain the dominance in medical culture of heroic styles of management. We would go further and suggest that it is not just the significance of medical culture that has been overlooked, but also that of specialist *sub-cultures* within medicine. For instance, although Ham and colleagues report the broad area of specialisation (rather than actual specialty) of each of the 22 medical chief executives whose careers they examined, their analysis treats them as an undifferentiated collectivity (102).

There are other blind spots that may arise from this preoccupation with senior medical management and restrict generalisation to professions other than medicine and lower levels of management. First, because women are likely to be significantly under-represented at clinical director or chief executive level, the potential importance of gender for clinical management has been disregarded. Thus, although six (27%) of the medical chief executives studied by Ham and colleagues were women, gender was not investigated as a variable (102). Indeed, it is not even reported in their 2011 publication (11). One of the very few studies that have considered the influence of gender and professional culture on leadership styles among health care middle managers concluded that

> 'gender alone is insufficient to explain the differences … The data suggested that it is the professional background that remains significant in the final analysis' (103) (p.36).

Second, preoccupation with physician executives may have important implications for the way we interpret the concept of the 'hybrid role,' which has been widely applied to clinician management. We regard the notion of hybridity as a helpful tool for capturing something of the complexity that confronts clinician managers seeking to balance or reconcile the competing and often conflicting components that make up their role set. However, we believe that, as with all metaphors, there is a risk of pushing it too far. Specifically, we see a danger of it carrying connotations of the more or less stable coupling of two fixed and distinctly bounded roles. The 'two worlds' thesis has been well expressed by Iedema and colleagues, who see physician executives as having

> '… one foot in the world of treatment and care, characterized by individualized trust and professional-expert authority, and another in the

world of organizational management, characterized by resource expenditures, budget overruns, information management, issues of treatment proceduralization, evidence-based decision-making, and appropriateness' (36) (p.16).

The 'two worlds' thesis seems to us to embody a series of assumptions which may apply only to physician executives, for whom there is likely to be a definite demarcation between their managerial and clinical roles. There is likely to be sharp differentiation not just of *focus* (organisation-wide, strategic, proactive and transformative *vs*. individual patient-focussed and routine), but also of *location* ('Mahogany Row' *vs*. ward or consulting room or theatre) and *audience* (executive team *vs*. fellow clinicians and patients). As a consequence, minimal (if any) 'bridging' is required between the two roles. For middle and front line clinician managers these assumptions are less likely to hold. As we found, instead of being separate, focus, location and audience all overlapped. As a consequence, the clinician managers we studied found the boundaries between the clinical and the managerial difficult to pin down, elusive and shifting over time and according to context. For them, management was not a 'back office' function; much of it took place on the front line. The two were inseparably intertwined. Because clinical work was invariably pressured, fast-paced and unpredictable, it could be accomplished only by virtue of a constant stream of managerial decisions. Clinical supervision of a junior could easily shade over into staff management. The teams they managed consisted of the colleagues with whom they practised as clinicians. This meant that significant bridging was required at these levels to enable them to maintain credibility with the staff they managed, the fellow professionals with whom they worked, and the managers to whom they were accountable. The stresses and strains that this could occasion was a constant theme in their narratives.

7.4 Clinician-management as a problem to be managed

Managing clinician-management was problematic in two ways and for two reasons.

For one thing, managerial work was perceived as constantly threatening to 'take over', needing to be controlled and contained, subjected to careful and continuous management, particularly in looser settings like mental health. 'Keeping a balance' and 'fitting it all in' were constant concerns and clinician managers adopted a variety of stratagems to help them in their struggle (not always successful) to achieve this. This hardly surprising, since their work displayed many of the features of the 'extreme job,' as identified by Hewlett and Luce (104) and developed by Buchanan *et al.* (105). Thus, clinician managers were confronted by: unpredictable work patterns; fast pace with rapid deadlines; broad scope of responsibility; 24/7 availability; mentoring and coaching other staff; long working hours; dealing with conflicting and changing priorities; doing more with less.

Second, given the long and contested history of management as a concept, and the rapidity with which it was evolving, it was hardly surprising that the clinician managers we studied should have struggled to make sense of what it was and what it meant to be one. As already mentioned, unlike physician executives who appear to experience little difficulty in separating out the clinical and managerial elements of their role, for our clinician managers this task was far from straightforward. Certainly, the two could be distinguished and were often presented as if they were tightly bounded. Indeed, they had to be, if only in order to meet targets for managerial posts and costs or to maintain the clinical/managerial division of time specified in job descriptions (or to protect an individual from the threat of redundancy for being 'too managerial'). As a consequence, managing clinician-management, however, was more than a matter of policing a fixed border between two distinct entities and preventing incursions across it (although this could be attempted by segregating clinical sessions from managerial ones, for instance, or signalling roles through dress). It could also be kept within bounds by downplaying managerial achievements or by redefining managerial work as non-managerial. Thus, despite having contributed to managing a £1.5m re-equipment project, Holly at Vanguard insisted that she remained a "clinical radiographer." Like Alvesson and Sveningsson's biotech managers, all of our clinician managers emphasised, not the heroic and the extraordinary, but mundane and everyday activities like

> '… administration, solving practical and technical problems … and creating a good working atmosphere' (106) (p.1436).

Instead of 'extra-ordinarizing' mundane acts (Alvesson and Sveningsson), our managers, if anything, did the precise opposite; they rendered their often extraordinary accomplishments mundane.

7.5 The significance of emotional labour in clinician management

As we have already noted, the boundary between the clinical and the managerial was permeable in both directions. As a consequence, it was not just management that spilled over into the clinical arena; the clinical could also spill over into the managerial. Greenshire and Whiteford supply the clearest evidence of this process in action, in the form of the prominence of emotional labour as a component of management. Thus, we found a dichotomy between emotionally engaged nurturing and the rational and strategic; "she's got strategic vision but she has the heart of a caring AHP." However, managing emotion was not just about providing emotional support; despite much use of terms like 'love' and 'care', it also included sanctions for 'negativity' and 'draining energy' – "she's a minx!" We found two narratives accounting for this. One saw it as an expression of the gendered nature of the professions we were studying. The alternative was to see it as an expression of professional values and clinical practice. At Whiteford, narratives prioritised gender ("that's how we work as a group of

laydees together") and the importance of managing emotion to 'keep things calm' and maximise effort. At Greenshire professional values emerged as more salient, so that regular contact with staff and the provision of emotional support were presented as expressions of the value placed on these in the clinical sphere. Given the feminised nature of the professions we were studying, it was impossible to separate out the influence of gender from that of professional culture. All we can say is that our clinician managers' approach to management was simultaneously both gendered and professionalised.

There has been extensive coverage of the topic of emotional labour in nursing work (e.g. (107)) as well as in a number of other occupations such as airline flight attendants (108) or call centre operatives (109). However, emotional labour in managerial work - as distinct from the management of emotion in the workplace (e.g. (110)) or emotion toward the organisation (111) - has received rather less attention. A recent study of (predominantly male) managers of a UK-based engineering company (46) is an exception to this rule. It found that managerial identity drew on two discourses that were organised into three sets of antagonisms: emotional detachment vs. emotional engagement; professionalism (neutral rule-enforcement) vs. un-professionalism; responsibility for the business vs. caring for people. Managers were not amoral agents. They were concerned to be good citizens and acknowledged limits on the extent of their detachment and were critical of colleagues who were uncaring to the point of 'ruthlessness.' Nevertheless, detachment, professionalism and concern for the business predominated; for instance, engagement was disparaged as 'pink and fluffy'. For our AHP clinician managers, the balance between these two discourses was reversed. In Whiteford therapists preferred an emotionally engaged style of managing staff that replicated aspects of their approach to managing patients. This was explicitly acknowledged to be a feminine approach that was contrasted with more masculine styles associated with strategic and business management that were dominant further up the trust hierarchy. In Greenshire, with a predominantly female workforce, including the managerial elite, differences in styles of management were attributed to professional background rather than gender. In both cases, while recognizing the importance of functioning effectively as a manager, they were wary of the label 'manager' and concerned to distance themselves from the politics, horsetrading and competitiveness that they saw typified it.

> "I'd say the higher you move up the management hierarchy, the more you lose sight of your professional values. You sell your soul; you do the grovelling and toe the party line."

7.6 The problematic transition from clinician management to clinical leadership

For the most part, among the AHP clinician managers we studied, leadership was 'the dog that didn't bark.' At only one site (Whiteford) did

leadership feature as an accepted and acceptable component of everyday discourse, and even here its use was confined mainly to the more senior managers. Even among them, it had not fully permeated their subjectivities; clinical and managerial narratives were far more likely to frame their discussions than were leadership ones. This was despite the presence of a charismatic leader (Fiona), clearly acclaimed as such by her colleagues. Paradoxically, they acknowledged the value of leadership, but felt that it was beyond them to carry it off as she did. More generally, the view of leadership that emerged from clinician managers' narratives was radically different from the model of shared leadership advocated by the National Leadership Council (112). First, their thinking appeared to be strongly influenced by the traditional model of leadership, exercised by exceptional, heroic individuals in formal positions of authority, rather than being distributed throughout the team. Accordingly, since they did not define themselves as exceptional, most of them denied that what they were doing could be regarded as leadership. Leadership, as they defined it, resided elsewhere in the organisation (if it existed at all, which many disputed). The continuing potency of the traditional model is hardly surprising in light of the long history (in the specialist literature, the mass media and popular culture) of associating leadership with the visionary and the heroic, charismatic, extraordinary individual. Second, their model of management differed from that of the National Leadership Council in privileging emotional labour. Their accounts emphasised the importance of emotional maturity and stability, managing emotion in oneself and in the team, enabling juniors to 'grow up' as well as gain the necessary clinical experience, and the like. These things were seen as being at the core of management, rather than being merely a subset (and a somewhat subordinate one at that) of an item in an armamentarium of leadership competencies. Thus, as we have seen, Fiona was praised as still having "the heart of a caring AHP."

The only other site at which leadership featured in clinician managers' narratives was Greenshire. Certainly we found evidence that a few clinician managers were beginning to rework their narratives and performances to accommodate leadership in their identities. However, just as at Whiteford, the type of post-heroic, distributed leadership promulgated by Greenshire senior managers had little meaning for them and was difficult to square with their experience. By characterising management as 'back office' activity, it denigrated it an optional 'add on' that contributed little to clinical work and so could readily and painlessly be separated from it. It devalued their past achievements in service development, and called into question the quality of the leadership they had been providing hitherto. It required them to empower their staff so that they could become leaders, but they themselves remained disempowered relative to senior management, who retained overall control and intensified upward accountability. Moreover, the manner of its implementation - top down and targeted at individuals in positions of formal authority, meant that it implicitly contradicted the message it was

intended to convey – that of leadership separated from formal authority and distributed throughout the organisation.

At the remaining two sites (Cloffaugh and Vanguard), leadership simply did not figure in clinician managers' narratives. This was despite the ubiquitous use of 'Lead' in job titles and departmental structures ('Team Lead,' 'Therapy Lead,' 'AHP Lead,' and the like). Here, as elsewhere, we encountered many behaviours that would qualify as leadership and might have been presented as such by the staff involved, but they simply did not construe them in those terms. At Cloffaugh, leadership with its connotations of the heroic and exceptional ran counter to the ethos of egalitarianism and teamwork. At Vanguard, although leadership was regarded as desirable, the diagnostic radiographers recognised that their subordinate status placed it beyond their reach.

The limited traction of leadership in the subjectivities of our clinician managers was something of a surprise, given its prominence in NHS policy rhetoric for more than a decade, and concerted efforts to promote it. Because roll out of the Clinical Leadership Competency Framework (CLCF) (112) was only just getting underway when our fieldwork concluded in June 2011, we had few opportunities to observe it in action directly or the responses to it. This is a limitation which we acknowledge and which means that our conclusions regarding it must remain highly provisional. Nevertheless, while in the field we were able to observe sufficient of the turn away from management and towards leadership to identify some possible limitations of the framework approach and some challenges that it may encounter in its attempt to commute the base metal of clinician management into the gold of clinical leadership.

First, although the CLCF claims to incorporate a model of shared (or distributed) leadership, it is questionable how far it has succeeded in breaking free from more traditional models of leadership that focus on the (presumed) traits of individual leaders. As a competency framework, it is open to a series of generic charges, levelled for instance by Turnbull James (113) and Ford, Harding and Learmonth (114), among others. According to this critique, the competency framework approach is liable to abstract and decontextualise leadership, to intellectualise and standardise it. By perpetuating the notion that leadership is a property of the individual rather than of the organisation it depoliticises it and implies that 'it can be effectively performed by adhering to a standard set of prescribed behaviours that remain constant regardless of context' (113) (p.18). Probert and Turnbull James go further, arguing that competency approaches are liable to be weakened by their failure to address the cultural and psychological dimensions of leadership. These comprise the set of unconscious assumptions about leadership that are embedded in organisational culture and that constitute what they refer to as the *leadership concept*. They argue that transformation of the existing leadership concept is a key challenge facing all leadership development initiatives and that failure to engage with them will reduce their prospects of

success. More specifically, they need to acknowledge the emotional components of leadership and address the emotional challenges facing would-be leaders at times of rapid and radical organisational change. In the lights of our findings, we would go beyond even this, and contend that in an organisation as large, complex and professionally differentiated as the NHS, it is likely that there will be multiple and competing leadership concepts, rather than one. Moreover, it is probable that they will be continuously evolving in response to or anticipation of changing circumstances (clinical innovation, professional and workforce development organisational change and the like). We believe that our case studies provide convincing evidence to support this contention.

Beyond these generic limitations of the competency framework approach, our findings suggest some specific challenges that the CLCF may encounter. First, as we have already noted, the circumstances under which nominally distributed leadership was being introduced – intensified performance management and a plethora of centrally determined imperatives - were hardly propitious for its prospects. Second, the fact that it derives from a framework of competencies that was originally developed for members of the apex profession and was based on self report (via interviews and focus groups) of 150 chief executives and directors (non-clinical as well as clinical) (115) leads us to question its relevance and acceptability for members of subordinate professions in lower managerial levels. The risk that it might not be meaningful will increase if, as Fulop has suggested, it unwittingly incorporates a leadership concept that is profession-specific with regard to its assumptions about the nature of professional identity, for instance, or separability of the clinical and the managerial (12). Third, Turnbull James has insisted that it is essential for organisations undertaking leadership development to recognise many collective practices and contributions as leadership (113). We found exactly the opposite occurring at both national and local levels. At the national level, there was the sustained external campaign of vilification of NHS management that formed the backdrop to the promotion of clinical leadership. At the local level, reinforcement of this message by senior managers who were responsible for promoting leadership meant that (with perhaps the partial exception of Whiteford) there was a lack of correspondence between the vision of leadership (distributed, post-heroic) they were promulgating and the more traditional model of management/leadership held by their audience.

7.7 Implications for education and training

The complex and variable nature of clinician management and the multiple challenges it posed to our clinician managers inevitably raises questions about how well and how far they were equipped to respond to them and to rise to the leadership challenges they will face in future. We have insufficient data to identify specific strategies for achieving this, but believe that our findings have implications for the design and delivery of education and training of AHPs in management/leadership at pre-and post-registration

levels. The professional bodies, HEIs and other relevant providers may wish to review their policy and practice in the light of our findings and of further, more focused and appropriate research.

7.8 Envoi

'All cases are unique and very similar to others.'

-- TS Eliot, 'The Cocktail Party'

We have discussed six intersecting and interacting themes that emerge from our case studies: the problematic nature of clinician manager identity; the variability of clinician management; the variable and complex relationship between the managerial and the clinical on the front line; clinician management as a problem to be managed; the significance of emotional labour in clinician management; the problematic transition from clinician management to clinical leadership. We have also considered the implications of our research for current approaches to clinical leadership development in the NHS, as well as for education and training.

There remains the question of the extent to which our findings may be extrapolated to clinician managers from other professions and in other settings. Although our case study settings were all unique at the micro level, they were theoretically sampled in order to cover a spread of organisational types and locations, and they also shared a common policy context with other organisations in the English NHS, which meant that the issues being grappled with by our clinician managers were not atypical. Similarly, while we focussed on a limited number of professions, selection of these was also theoretically informed in order to span the diversity of AHPs. Thus, we focused on the two most numerous professions (physiotherapy and OT), which between them account for almost 40 per cent of the AHP workforce, and two professions (radiography and arts therapies) which we regard as constituting the opposite extremes of the AHP spectrum. Nevertheless, we were unable to study the AHP professions in their entirety, so exclude professions (such as paramedics, speech and language therapists and dieticians) that are not only important in their own right, but also diverge significantly in terms of their scope of practice, public visibility, power/status, interprofessional working or intersectoral boundary spanning. Given these differences, we would fully expect them to have evolved their own distinctive approaches to clinician management. The extent to which our findings apply to these other professions is something that can be investigated only by further research.

8 Conclusions and recommendations

8.1 Conclusions

8.1.1 The problematic nature of clinician-manager identity

- Clinician managers' identity work was a complex and ongoing process, only transiently accomplished and constantly undergoing revision for different audiences and purposes.
- Both components of their identities – the clinical as well as the managerial – were problematic.
- A key process in identity construction was 'discursive positioning.' This involved differentiating themselves and their profession from others, and representing the others as less worthy. It also entailed resisting or defusing others' attempts to define them.
- Consequently, identity formation was an inherently *political* process; identity claims and ascriptions were frequently adduced in defending or challenging the status quo.
- 'Allied Health Professional' as a collective appellation was adopted by only a minority of clinician managers. While a few embraced it as a means of asserting their distinctiveness vis a vis other professions, others saw it as implying interchangeability, hence threatening their professional status.
- Insecurity of professional identity was particularly problematic for members of the smaller and lower profile professions, who, in the face of modernisation, were vulnerable to having their *raison d'être* called into question.

8.1.2 The variability of clinician-management

- Both across and within our four case studies we found multiple styles of clinician management, rather than a single style.
- Clinician management was not just complex and variable, but also highly situational, contextual and contingent.
- Although clinical managers faced a common set of national policy imperatives, these played out differently in each of the cases we studied.
- A key factor shaping the local context was the complex web of inter-professional relationships that clinician-managers were situated in. This shaped their managerial work and constrained their autonomy.

- Clinician managers had not been exempted from the denigration of management that accompanied the 'turn' in official discourse and policy towards leadership.

8.1.3 Managing on the front line

- Clinician managers found the boundary between the clinical and the managerial difficult to pin down, elusive and shifting over time and according to context.
- Management was not a 'back office' function; much of it took place on the front line. Consequently, the two were inseparably intertwined.
- The strains and stresses that this could occasion was a constant theme in their narratives.
- Significant 'bridging' was required to enable them to maintain credibility with staff, other professionals and managers.

8.1.4 Managing clinician management

- Managerial work was something that constantly threatened to 'take over', so needed to be contained and subjected to careful and continuous management. Thus, 'keeping a balance' and 'fitting it all in' were constant concerns.
- Clinician managers adopted a variety of stratagems to help them in their struggle (not always successful) to keep management in bounds.
    - One involved demarcation (e.g. by segregating clinical sessions from managerial ones, or signalling roles through dress).
    - Management could also be kept within bounds by downplaying managerial achievements.
    - Managerial work could be redefined as non-managerial.

8.1.5 Managing and caring

- The two way permeability of the boundary between management and the clinical arena meant that the clinical could spill over into the managerial.
- The clearest expression of this was the value placed on emotional labour as a component of management.
- One narrative saw this as an expression of the gendered nature of the professions concerned. Another saw it as an expression of clinical values.

8.1.6 From clinician management to clinical leadership?

- Leadership featured in clinician managers' discourse only rarely and incompletely; it was far more likely to be framed by clinical and managerial narratives.
- A traditional model of leadership predominated; leadership was associated with exceptional, heroic individuals occupying positions of formal authority.
- It thus diverged from the model of post-heroic, distributed leadership currently advocated.

8.2 Research recommendation

Our findings point to an association between clinician managers/clinical leaders' management/leadership style and their gender and professional values. Further research is needed to explore this association more systematically in a wider selection of clinician managers/clinical leaders, and to identify ways of promoting their engagement.

8.3 Implications for policy and practice

8.3.1 Clinical leadership

Four findings in particular have implications for policy and practice on leadership. These are:

- The inherently politicised nature of clinician-management and the unequal distribution of opportunities to exercise leadership
- The continuing potency of the traditional model of leadership, which associates leadership with heroic exceptional individuals in positions of formal authority.
- The existence of multiple styles of management, which appear to be associated with gender and professional values.
- The importance of emotional labour in management.

These complexities may limit the take-up of current initiatives to promote a universal model of distributed, post-heroic leadership throughout the NHS.

8.3.2 Education and training

Our findings also have implications for policy and practice regarding the education and training of AHPs at pre-and post-registration levels. They suggest that an approach to AHP leadership education and training that acknowledges the diversity of professional cultures and builds on their existing leadership/management achievements may be more likely to be productive.

References

(1) NHS Information Centre. NHS Staff 2000 - 2010. Leeds: NHS Information Centre; 2011.
(2) Morgan PI, Ogbonna E. Subcultural dynamics in transformation: A multi-perspective study of healthcare professionals. Human Relations 2008;61(1):39-65.
(3) McPherson K, Kersten P, George S, Lattimer V, Ellis B, Breton A, et al. Enhanced or Extended Roles for Allied Health Professionals in the NHS. London: NCCSDO; 2004.
(4) Department of Health. Meeting the Challenge: A Strategy for the Allied Health Professions. London: Department of Health; 2000.
(5) Allied Health Professions Federation. Working Differently: The Role of Allied Health Professionals in the Treatment and Management of Long-Term Conditions. London: AHPF; 2005.
(6) Department of Health. Transforming community services: enabling new patterns of provision. London: Department of Health; 2009.
(7) Department of Health. Framing the Contribution of Allied Health Professionals: Delivering High-Quality Healthcare. London: Department of Health; 2008.
(8) Darzi A. NHS Next Stage Review: Leading Local Change. London: Department of Health; 2008.
(9) Department of Health. Modernising Allied Health Professions (AHP) Careers: A Competence-Based Career Framework. London: Department of Health; 2008.
(10) Department of Health. AHP Bulletin, Issue 61 (November, 2007). London: Department of Health; 2007.
(11) Ham C, Clark J, Spurgeon P, Dickinson H, Armit K. Doctors who become chief executives in the NHS: from keen amateurs to skilled professionals. Journal of the Royal Society of Medicine 2011;104(3):113-119.
(12) Fulop E. Exemplary leadership, the clinician manager and a thing called 'hybridity'. Birmingham: Health Services Management Centre, University of Birmingham; 2010.
(13) Currie G, Lockett A. A critique of transformational leadership: Moral, professional and contingent dimensions of leadership within public services organizations. Human Relations 2007;60(2):341-370.
(14) Greener I, Powell M. The changing governance of the NHS: Reform in a post-Keynesian health service. Human Relations 2008;61(5):617-636.
(15) Mannion R, Davies H, Harrison S, Konteh F, Jacobs R, Fulop R, et al. Changing Management Cultures and Organisational Performance in the NHS. London: NIHR SDO; 2010.
(16) Martin GP, Learmonth M. A critical account of the rise and spread of 'leadership': The case of UK healthcare. Social Science & Medicine 2012;74(3):281-288.
(17) O'Reilly D, Reed M. The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization. Organization Studies 2011;32(8):1079-1101.

(18) Buchanan D. Names, ranks, and numbers: ...how many managers does the NHS have? ...and is that enough? Cranfield: Cranfield University School of Management; 2010.
(19) Nicholson D. The Year: NHS Chief Executive's Annual Report 2008/09. London: Department of Health; 2009.
(20) Ybema S, Keenoy T, Oswick C, Beverungen A, Ellis N, Sabelis I. Articulating identities. Human Relations 2009;62(3):299-322.
(21) Parker M. Organizational Culture and Identity: Unity and Division at Work. London: SAGE Publications; 2000.
(22) Sturdy A, Schwartz M, Spicer A. Guess who's coming to dinner? Structures and uses of liminality in strategic management consultancy. Human Relations 2006;59(7):929-960.
(23) Webb J. Organisations, Identities and The Self. Basingstoke: Palgrave Macmillan; 2006.
(24) Jenkins R. Social Identity. 2nd ed. London: Routledge; 2004.
(25) Czarniawska B. Narrating the Organization: Dramas of Institutional Identity. Chicago: University of Chicago Press; 1997.
(26) Goffman E. The Presentation of Self in Everyday Life. New York: Anchor Books; 1959.
(27) Garcia P, Hardy C. Positioning, similarity and difference: Narratives of individual and organizational identities in an Australian university. Scandinavian Journal of Management 2007;23(4):363-383.
(28) Hopkinson GC. Influence in marketing channels: A sense-making investigation. Psychology and Marketing 2001;18(5):423-444.
(29) Hall S. Representation: Cultural Representations and Signifying Practices. London: SAGE Publications; 1997.
(30) Watson TJ. Narrative, life story and manager identity: A case study in autobiographical identity work. Human Relations 2009;62(3):425-452.
(31) Ball K, Wilson DC. Power, Control and Computer-Based Performance Monitoring: Repertoires, Resistance and Subjectivities. Organization Studies 2000;21(3):539-565.
(32) Bruner J. Making stories: Law, literature, life. New York: Farrar, Straus and Giroux; 2002.
(33) Gabriel I. Storytelling in organizations: Facts, fictions, fantasies. Oxford: Oxford University Press; 2000.
(34) Boje DM. Narrative methods for organizational and communication research. London: Sage; 2001.
(35) Currie G, Brown AD. A Narratological Approach to Understanding Processes of Organizing in a UK Hospital. Human Relations 2003;56(5):563-586.
(36) Iedema R, Degeling P, Braithwaite J, White L. 'It's an Interesting Conversation I'm Hearing': The Doctor as Manager. Organ Stud 2004;25(1):15-33.
(37) Bate P, Mendel P, Robert G. Organizing for quality: the improvement journeys of leading hospitals in Europe and the United States. Oxford: Radcliffe Publishing; 2008.
(38) Beech N, Sims D. Narrative Methods for Identity Research. In: Pullen A, Beech N, Sims D, editors. Exploring Identity: concepts and methods London: Palgrave Macmillan; 2008.

(39) Sandstrom AR, Sandstrom PE. The Long and the Short of Ethnographic Research among the Nahua of Northern Veracruz, Mexico. Anthropology and Humanism 2011;36(1):25-35.
(40) Dingwall R. Accounts, interviews and observations. In: Miller G, Dingwall R, editors. Context and Method in Qualitative Research London: Sage; 1997. p. 51-65.
(41) Geertz C. Thick Description: Toward an Interpretive Theory of Culture. The Interpretation of Cultures: Selected Essays New York: Basic Books; 1973. p. 3-30.
(42) Miles MB, Huberman AM. Qualitative Data Analysis: A Sourcebook of New Methods. 2nd ed. London: Sage Publications; 1994.
(43) Spiro RJ, Vispoel WP, Schmitz JG, Samarapungavan A, Boerger AE. Knowledge acquisition for application: Cognitive flexibility and transfer in complex content domains. In: Britton BK, Glynn SM, editors. Executive Control Processes in Reading Hillsdale, NJ: Lawrence Erlbaum Associates; 1987. p. 177-199.
(44) Hammersley M, Atkinson P. Ethnography: Principles in Practice. 3rd ed. London: Routledge; 2007.
(45) Greenhalgh T, Humphrey C, Hughes J, Macfarlane F, Butler C, Pawson R. How do you modernize a health service? A realist evaluation of whole-scale transformation in London. Millbank Quarterly 2009;87(2):391-416.
(46) Clarke CA, Brown AD, Hope Hailey V. Working identities? Antagonistic discursive resources and managerial identity. Human Relations 2009;62(3):323-352.
(47) Parker M. Ethnography/ethics. Social Science & Medicine 2007;65(11):2248-2259.
(48) Murphy E, Dingwall R. Informed consent and ethnographic practice. Social Science & Medicine 2007;65(11):2223-2234.
(49) Tolich M. Internal confidentiality: when confidentiality assurances fail relational informants. Qualitative Sociology 2004;27(1):101-106.
(50) Kaiser K. Protecting respondent confidentiality in qualitative research. Qualitative Health Research 2009;19(11):1632-1641.
(51) Lewis M. New strategies of control: academic freedom and research ethics boards. Qualitative Inquiry 2008;14(5):684-699.
(52) Price R. The past is a foreign country. Radiography 2010;16(3):169-170.
(53) Propper C, Sutton M, Whitnall C, Windmeijer F. Did `Targets and Terror' Reduce Waiting Times in England for Hospital Care? The B.E. Journal of Economic Analysis & Policy 2008;8(2):Article 5.
(54) Bevan G, Hood C. What's measured is what matters: targets and gaming in the English public health care system. Public Administration 2006;84(3):517-538.
(55) Sims D. Between the Millstones: A Narrative Account of the Vulnerability of Middle Managers' Storying. Human Relations 2003;56(10):1195-1211.
(56) Finn R, Learmonth M, Reedy P. Some unintended effects of teamwork in healthcare. Social Science & Medicine 2010;70:1148-1154.
(57) Braithwaite J. An empirically-based model for clinician-managers' behavioural routines. Journal of Health Organisation and Management 2004;18(4):240-261.
(58) Down S, Reveley J. Between narration and interaction: Situating first-line supervisor identity work. Human Relations 2009;62(3):379-401.

(59) Gotsi M, Andriopoulos C, Lewis MW, Ingram AE. Managing creatives: Paradoxical approaches to identity regulation. Human Relations 2010;63(6):781-805.
(60) Kippist L, Fitzgerald A. The Paradoxical Role of the Hybrid Clinician Manager. Birmingham: Health Services Management Centre, University of Birmingham; 2010.
(61) Twigg J, Wolkowitz C, Cohen RL, Nettleton S. Conceptualising body work in health and social care. Sociology of Health and Illness 2011;33(2):171-178.
(62) Cohen RL. Time, space and touch: body work and labour process (re)organisation. Sociology of Health and Illness 2011;33(2):189-205.
(63) Lawler S. Identity: Sociological Perspectives. Cambridge: Polity Press; 2008.
(64) Kippist L, Fitzgerald A. Organisational professional conflict and hybrid clinician managers: the effects of dual role on Australian health care organisations. Journal of Health Organisation and Management 2009;23(6):642-655.
(65) Law J. Organizing Modernity: Social Order and Social Theory. Oxford: Blackwell; 1994.
(66) Sveningsson S, Alvesson M. Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle. Human Relations 2003;56(10):1163-1193.
(67) Giddens A. Modernity and self-identity: Self and society in the late modern age. Cambridge: Polity Press; 1991.
(68) Taleb N. The Bed of Procrustes: Philosophical and Practical Aphorisms. London: Penguin; 2010.
(69) Malin N editor. Professionalism, Boundaries and the Workplace. London: Routledge; 2000.
(70) Nuffield Trust editor. Health Care Building for Tomorrow: Developing a 2020 Vision. London: Nuffield Trust; 1999.
(71) Evans GW. The Built Environment and Mental Health. Journal of Urban Health 2003;80(4):536-555.
(72) Burton R. Health Care Building for Tomorrow – Architecture. In: Nuffield Trust, editor. Health Care Building for Tomorrow: Developing a 2020 Vision London: Nuffield Trust; 1999. p. 25-28.
(73) Dovey K. Framing Places: Mediating Power in Built Form. London: Routledge; 1999.
(74) De Botton A. The Architecture of Happiness: The Secret Art of Furnishing your Life. London: Hamish Hamilton; 2006.
(75) Jones P. The Sociology of Architecture. Liverpool: Liverpool University Press; 2011.
(76) Fitzgerald L, Lilley C, Ferlie E, Addicott R, McGivern G, Buchanan D. Managing change and role enactment in the professionalised organisation. London: NCCSDO; 2006.
(77) Comaroff J, Comaroff J. Transparent Fictions; or, The Conspiracies of a Liberal Imagination: An Afterword. In: West HG, Sanders T, editors. Transparency and Conspiracy: Ethnographies of Suspicion in the New World Order Durham and London: Duke University Press; 2003.
(78) Brown B, Crawford P. The clinical governance of the soul: 'deep management' and the self-regulating subject in integrated community mental health teams. Social Science & Medicine 2003;56:67-81.

(79) Department of Health. Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England. Norwich: The Stationery Office; 2005.
(80) Department of Health. Our Health, Our Care, Our Say: A New Direction for Community Services. Norwich: The Stationery Office; 2006.
(81) Department of Health. Transforming Social Care. London: HMSO; 2008.
(82) Morgan S. Personalisation Revisited. Openmind 2009;159(September/October):10-11.
(83) Royal College of Psychiatrists. Report of the National Audit of Dementia Care in General Hospitals 2011. London: Healthcare Quality Improvement Partnership; 2011.
(84) Department of Health. Living Well With Dementia: A National Dementia Strategy – Implementation Plan. London: Department of Health; 2009.
(85) Kunda G. Engineering Culture: Control and Commitment in a High-Tech Corporation. Philadelphia: Temple University Press; 1992.
(86) Gabriel Y. Organizational Nostalgia – Reflections on 'The Golden Age'. In: Fineman S, editor. Emotion in Organizations London: Sage; 1993. p. 118-141.
(87) Bate SP. Whatever happened to Organisational Anthropology? A Review of the Field of Organizational Ethnography and Anthropological Studies. Human Relations 1997;50(9):1147-1175.
(88) Moeran B. The business of ethnography: strategic exchanges, people and organisations. Oxford: Berg; 2005.
(89) Wenger E. Communities of Practice: Learning, Meaning and Identity. Cambridge: Cambridge University Press; 1998.
(90) Zeldin T. An Intimate History of Humanity. Croydon: Vintage; 1998.
(91) Darrouzet C, Wild H, Wilkinson S. Participatory ethnography at work: Practicing in the puzzle palaces of a large, complex healthcare organization. In: Cefkin M, editor. Ethnography and the Corporate Encounter: Reflections on Research in and of Corporations New York: Berghahn; 2009. p. 61-94.
(92) Boltanski L, Chiapello E. The New Spirit of Capitalism. London: Verso; 2005.
(93) Sennett R. The Craftsman. London: Allen Lane; 2008.
(94) Rose N. Powers of Freedom: Reframing Political Thought. Cambridge: Cambridge University Press; 1999.
(95) Fierro A. The Glass State: The Technology of the Spectacle, Paris, 1981–1998. Cambridge, Mass.: MIT Press; 2003.
(96) Power M. The Audit Society: Rituals of Verification. Oxford: Oxford University Press; 1997.
(97) Strathern M editor. Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy. London: Routledge; 2000.
(98) Needle JJ, Petchey RP, Benson J, Scriven A, Lawrenson J, Hilari K. The allied health professions and health promotion: a systematic literature review and narrative synthesis. Final report. Southampton: NIHR Service Delivery and Organisation programme; 2011.
(99) Currie G, Finn R, Martin G. Accounting for the 'dark side' of new organizational forms: The case of healthcare professionals. Human Relations 2008;61(4):539-564.
(100) Currie G, Finn R, Martin G. Professional competition and modernizing the clinical workforce in the NHS. Work Employment & Society 2009;23(2):267-284.

(101) MacIntosh R, Beech N, Martin G. Dialogues and dialectics: limits to clinician-manager interaction in healthcare organizations. Social Science & Medicine 2012;74(3):332-339.
(102) Ham C, Clark J, Spurgeon P, Dickinson H, Armit K. Medical Chief Executives in the NHS: Facilitators and Barriers to Their Career Progress. Coventry: NHS Institute for Innovation and Improvement; 2010.
(103) Konu A, Viitanen E. Shared leadership in Finnish health and social care. Leadership in Health Services 2008;21(1):28-40.
(104) Hewlett SA, Luce CB. Extreme jobs: the dangerous allure of the 70-hour workweek. Harvard Business Review 2006;84(12):49-59.
(105) Buchanan DA, Denyer D, Jaina J, Kelliher C, Moore C, Parry E, et al. How do they manage? The realities of middle and frontline management in healthcare. Final Report. Southampton: NIHR NETSCC Health Services and Delivery Research; 2012.
(106) Alvesson M, Sveningsson S. Managers Doing Leadership: the Extra-Ordinarization of the Mundane. Human Relations 2003;56(12):1435-1459.
(107) Aldridge M. Unlimited liability? Emotional labour in nursing and social work. Journal of Advanced Nursing 1994;20(4):722-728.
(108) Taylor S, Tyler M. Emotional labour and sexual difference in the airline industry. Work, Employment & Society 2000;14(1):77-95.
(109) Mulholland K. Gender, emotional labour and teamworking in a call centre. Personnel Review 2002;31(3):283-303.
(110) Bolton SC. Emotion Management in the Workplace. London: Palgrave; 2005.
(111) Sims D. The Velveteen Rabbit and passionate feelings for organizations. In: Gabriel Y, editor. Myths, Stories, and Organizations: Premodern Narratives for our Times Oxford: Oxford University Press; 2004. p. 209-222.
(112) National Leadership Council. Clinical Leadership Competency Framework Project: Report on findings. London: National Leadership Council; 2010.
(113) Turnbull James K. Leadership in context: Lessons from new leadership theory and current leadership development practice. London: King's Fund; 2011.
(114) Ford J, Harding N, Learmonth M. Leadership as identity: constructions and deconstructions. Basingstoke: Palgrave Macmillan; 2008.
(115) Bolden R, Wood M, Gosling J. Is the NHS Leadership Qualities Framework Missing the Wood for the Trees? In: Casebeer A, Harrison A, Mark AL, editors. Innovations in Health Care: A reality Check New York: Palgrave Macmillan; 2006. p. 17-29.
(116) Forsyth LJ, Maehle V. Consultant radiographers: profile of the first generation. Radiography 2010;16(4):279-285.
(117) Kelly J. Establishing consultant practice. Radiography 2010;16(2):93-94.
(118) Society and College of Radiographers. Medical Image Interpretation by Radiographers: Definitive Guidance. London: SCoR; 2010.
(119) Royal College of Radiologists. Medical image interpretation by radiographers: Guidance for radiologists and healthcare providers. London: Royal College of Radiologists; 2010.
(120) Price R. All change again [editorial]. Radiography 2011;17(1):1.
(121) Department of Health. Press release. Department of Health Spending Review 2010. London: Department of Health; 2010.

(122) Darton K. Arts therapies. 2009; Available at: http://www.mind.org.uk/help/medical_and_alternative_care/arts_therapies. Accessed 10 Mar, 2010.
(123) British Association of Art Therapists. What is Art Therapy? 2010; Available at: http://www.baat.org/art_therapy.html. Accessed 10 Dec, 2009.
(124) Association of Professional Music Therapists. An Introduction to Music Therapy. London: APMT; 2009.
(125) British Association of Dramatherapists. About Dramatherapy. 2010; Available at: http://www.badth.org.uk/dtherapy/. Accessed 16 Feb, 2010.
(126) Health Professions Council. Fitness to Practise Annual Report 2011. London: Health Professions Council; 2011.
(127) Department of Health. Equity and excellence: Liberating the NHS. Norwich: TSO; 2010.
(128) Alvesson M, Willmott H. Identity Regulation as Organizational Control: Producing the Appropriate Individual. Journal of Management Studies 2002;39(5):619-644.
(129) Simpson B, Carroll B. Re-viewing 'Role' in Processes of Identity Construction. Organization 2008;15(1):29-50.
(130) Calvino I. Six Memos for the Next Millenium. 2nd ed. London: Penguin; 1988.
(131) Porter TM. Trust in Numbers: The Pursuit of Objectivity in Science and Public Life. Princeton, NJ: Princeton University Press; 1995.

9 Appendix 1. Diagnostic Radiography

Diagnostic radiographers obtain images of injuries and abnormalities and monitor diseases using sophisticated equipment and techniques, such as X-rays, computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine and ultrasound. They are responsible for obtaining an accurate image safely and sometimes interpret or report on it, although traditionally this is the remit of radiologists, with whom radiographers work closely. In larger acute hospitals radiologists and radiographers also carry out interventional radiology procedures, which allow certain conditions to be treated without the need for open surgery. Radiographers are educated to degree level and trained to carry out most investigations, although they tend to specialize in a particular area.

Most diagnostic radiographers work in acute hospital imaging departments, which provide a service for other departments in the hospital (A&E, wards, operating theatres and outpatient clinics) and GPs. Smaller hospitals refer patients to larger centres for specialised examinations. Patients coming to imaging have problems across the spectrum from minor injuries to life threatening conditions, such as major trauma, stroke and cancer. Imaging services are highly regulated because of the potentially harmful effects of ionising radiation used inappropriately.

The growth of radiography as an occupation has been closely linked with the development of radiology as a branch of medicine. Radiologists remain the

dominant profession in medical imaging, claiming responsibility for the patient and control over image interpretation, with radiographers traditionally restricted to the technical production of images. This occupational division of labour is contested and changing, and radiographers have established roles in interpreting images, particularly ultrasound examinations and mammograms. Nationally, a shortage of radiologists over the last twenty years has promoted the development of extended roles for radiographers, with gradually increasing numbers of 'reporting radiographers', advanced practitioners and consultant radiographers (116-118).

Predictably perhaps, boundary disputes between the two professions continue. The Royal College of Radiologists recently issued a statement attacking the trend towards radiographer reporting; asserting radiologists' responsibility for the patient; and concluding that reporting should be 'delegated' to radiographers only in certain clearly defined circumstances (119). The Society and College of Radiographers responded with evidence that radiographer reporting is not only widespread practice but safe and 'necessary to deliver effective, timely clinical imaging services in the UK' (118) (p.4). The Department of Health also appears to support the shift towards radiographer reporting, perhaps because it has been claimed that £7.9m could be saved annually on reporting straightforward X-rays alone (120,121).

The mutual interdependence of radiographers and radiologists, coupled with inequalities in status and authority, creates 'uneasy relationships' between the two professions (52) (p.169). The unique relationship with a medical specialty differentiates radiographers from other AHPs: they do not claim to be independent practitioners or to work autonomously, as do some of the other professions, e.g. physiotherapy. The Society and College of Radiographers, radiographers' professional body, describes its members as 'individually accountable healthcare practitioners' (118) (p.1).

10 Appendix 2. Arts therapies

The arts therapies are psychological therapies which use the arts, such as music, painting, dance, or drama, to enable clients to communicate and express themselves in a therapeutic environment, and to make sense of what they have created in the context of their life experience and their state of mind (122). They are particularly helpful for people who feel disengaged from their feelings or who find it too difficult to address painful experiences in words, and would therefore have difficulty engaging with talking therapies, such as Cognitive Behavioural Therapy (CBT). Arts therapists work with clients to use their creativity in a psychotherapeutic way, within a safe environment, whilst maintaining professional boundaries. They work with both individuals and groups of all ages in a wide variety of settings, such as mental health units/teams, NHS and private hospitals, special and mainstream education, child and family centres, prisons, palliative care units and the voluntary sector. Clients include people with head injuries, mental health conditions (such as dementia, schizophrenia and depression), autism, stroke, learning and speech disabilities, emotional and behavioural difficulties, and drug and alcohol problems.

The Department of Health and the HCPC recognise three types of arts therapist: art, music and drama. *Art therapy* seeks to enable clients to effect change and growth on a personal level through the use of art materials. Clients who are referred to an art therapist need not have previous experience or skill in art, and the art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's images (123). *Music therapy* draws on the ability to listen and respond to music, which is universal and may remain unimpaired by illness, injury or disability, to help people communicate through music (124). It uses mainly improvised music and clients are encouraged to use a variety of percussion instruments to find their own personal 'voice' and to develop listening, communicating and relating. Music therapists accompany and support clients, listening and responding to them through the improvised music and building a shared understanding. *Dramatherapy* uses the performance arts to facilitate creativity, imagination, learning, insight and growth. Examples of artistic interventions the dramatherapist may employ include stories, myths, playtexts, puppetry, masks and improvisation (125).

The arts therapies are very small professions. Collectively, there are in the region of 2,900 HCPC-registered arts therapists in the UK, with around 700 employed by the NHS in England (1,126). The professional bodies are the British Association of Art Therapists, the Association of Professional Music Therapists and the British Association of Dramatherapists.

11 Appendix 3. Fieldwork details (hours)

Case study	Formal interviews	Meetings observed	Other*
Vanguard	14 (23)	11 (21)	(5)
Whiteford	9 (12)	9 (12)	(31)
Greenshire	11 (16)	8 (20)	(6)
Cloffaugh	17 (21)	27 (35)	(90)

* Includes 'shadowing,' informal observations, informal conversations.

12 Appendix 4. Management Fellow Final Report

This report has been produced in the following manner. Sections 12.1-12.5 were written jointly by the Chief Investigator (CI) and Management Fellow (MF). Sections 12.6 and 12.7 were written by the MF.

12.1 Aims and Objectives

The Management Fellow (MF) Scheme gave SDO-funded project teams the opportunity to apply for additional resources to allow them to second a health services manager to work with their team. The management fellows were, typically, practising managers working in healthcare organisations that were local to the SDO-funded research projects.

The scheme had three objectives:

- to improve the quality and relevance of the respective funded research projects through greater managerial involvement
- to develop capacity in the managerial community for accessing, appraising and using research evidence
- to encourage greater engagement, linkage and exchange between the local research producers (usually universities) and potential local research users within the NHS.

MFs effectively performed a bridging function, acting as a two-way conduit for knowledge and skills to flow from the health service to academia, and vice versa.

The aims and objectives of this Fellowship were closely modelled on those of the scheme itself. We therefore give below examples of activities under each of these three heads.

12.2 Background

Most fellowships ran for an equivalent of approximately 12 months, full time, over the total period of the research project. In this case, the duration of the Fellowship was 0.5wte, spread over 2 years. It was also envisaged as making an important contribution to building research capacity in a profession where it is currently underdeveloped. More specifically, during the peer review process, one peer reviewer had expressed regret that an AHP was not included in the Project Team:

> 'this would have offered a considerable opportunity for building research capacity amongst what is acknowledged as being research-emergent professions in great need of an enhanced evidence-base.'

Intended benefits

The appointment as MF of a high profile and experienced AHP manager, enabled us not only to add the wished-for AHP to the research team, but also conferred a number of further benefits:

1. As Project Manager of the National AHP Leadership Challenge at the Department of Health, the MF had developed an extensive network among AHP leaders, across health and social care, regionally and nationally. These were an invaluable supplement to the Project Team's existing contacts;
2. She brought a proven track record of clinician management achievement in a variety of roles and organisations, including social care and secondary care. Her breadth of experience added significantly to the Research Team's ability to make sense of clinician managers' narratives;
3. Her close involvement in the development and delivery of current policy initiatives also informed our analysis of the context of the research;
4. The MF's career trajectory to date marked her out as a professional leader of tomorrow with potential to be a future champion of research within the ranks of AHP managers. Her application had been enthusiastically endorsed by the Chief Health Professions Officer at the Department of Health.

Although the MF's employing Trust supported her application, she did not actually work there during the term of the Fellowship, because of a further secondment to DH to work on *Transforming Community Services* (TCS). This fact plus rapid and radical restructuring at the Trust (including the departure of a key sponsor) meant that they were unable to deliver on this in practice. As a consequence, the linkage and exchange that had been envisaged at local level did not materialise. Any possibility of local inter-institutional linkage and exchange was eliminated when the MF was made redundant by the Trust in May 2011. As a consequence, knowledge and skills development, linkage and exchange took place at the individual and interpersonal network levels, rather than at the inter-organisational.

12.3 Work undertaken by the MF

The MF made a significant and sustained contribution to the quality and relevance of the project at every stage, from design through to data analysis and final report writing. Although the Fellowship was awarded after the project had been approved, subsequent revisions to the protocol meant that the MF had an opportunity to advise on redesign. Despite the term of her Fellowship ending before final report submission, the MF continued her involvement with data analysis and report drafting unpaid. Activities included:

- Facilitated recruitment of key stakeholders and case study sites, using knowledge of key individuals and organisations at national, regional and local levels.
- Drafted invitation letter for key stakeholders.
- Advised on interview schedule for the stakeholders.
- Provided detailed information about numbers of AHPs at all bandings within Agenda For Change – NHS Information Centre, SHAs and DH.
- Supported research team meetings to facilitate updates and next steps and ensured action points were written up and circulated, to assure progress.
- On-going support to ethnographic researchers in their attempts to access the case study sites – offering strategies to employ and whom to target.
- Provided overview of *Liberating the NHS* White Paper (127) to project team, to assist in contextualising challenges faced by potential case study sites.
- Made full contribution to project (re)design, data analysis and report writing. This involvement continued beyond the end of the Fellowship.

12.4 Capacity in the managerial community for accessing, appraising and using research evidence

As noted above, the particular circumstances of this Fellowship meant that capacity development was restricted largely to the individual level rather than the organisational one. Nevertheless, within these limitations, we believe that capacity was significantly enhanced. The following instances provide a good overview of the kinds of research awareness and skills that the MF herself developed, and the contributions she made to both the wider professional, managerial and policy communities. The MF was treated as a full member both of the project team and of the wider academic community at City. Good working relationships were rapidly established and maintained. She underwent formal induction and the process of familiarisation was assisted by the fact that she was able to share an office with the CI. This gave her opportunities to become familiar with the routines of academic life beyond research. She was introduced to key individuals in relevant positions across the University, including the School of Social Science, and the Cass Business School.

- Attended MSc sessions on literature searching, and Qualitative Research Methods, becoming familiar with the 'new language' of ethnographic research and subsequently applying this learning to the research project.

- Working in an academic environment with academics and ethnographers, it allowed me to "learn a new language". Terms such as ethnography had not been part of my vocabulary prior to becoming a Management Fellow.
- Attended *Disability & Social Inclusion* seminar series at City University which presented research project findings and their application.
- Attended and shared learning from symposiums, e.g. *Communication in Healthcare*.
- Attended Academy of Social Science launches.
- Attended SDO Management Practice Meetings
- Attended SDO Management Fellow Network meetings to share updates on the research projects, issues and common challenges for peer support and to problem solve.
- Participated in the formative evaluation of the Management Fellow role, was interviewed, completed a questionnaire, provided content details of the CI, ethnographers and other academic project team members, and attended feedback session June 2011.

12.5 Engagement, linkage and exchange

As the following activities indicate, within the constraints noted above, the MF was active in developing two way engagement, linkage and exchange, between the NHS, DH and University. In particular, she played a prominent role in publicising the Fellowship scheme both formally and informally.

- Liaised with relevant key staff across City University London – e.g. Associate Dean and Director of Centre for Better Managed Health and Social Care.
- Links to the Chief Health Professions Officer and the Department of Health.
- Publicised MF scheme in relevant AHP publications (e.g. Occupational Therapy News), the City University bulletin and the Department of Health AHP bulletin.
- Highlighted role of the MF and research project, informally, in Strategic Health Authority TCS workshop series, delivered throughout February and March 2010.
- Highlighted role of the MF, informally, at the TCS Leadership Challenges in each region throughout February and March 2011.
- Provided information to the AHP Federation regarding the SDO Network, and the benefits of joining.

- Briefed AHPs from the Hong Kong Health Authority visiting City University on Management Fellowship.
- Appointed external advisory Board member for the Centre for Better Managed Health and Social Care (Cass Business School).
- Lead the development of a MF presentation at the *Organisational Behaviour in Health Care Conference*, April 2010 – *Co-ordination, Communication and Collaboration*.
- Presented at the SDO Network conference *Delivering Better Healthcare* in Manchester, June 2010.
- Publicised MF scheme at the national Occupational Therapy (OT) conference in Brighton 2010.
- Management Fellows' round table discussion about the role of the MF, opportunities and experiences at the *Managers in Partnership* conference, November 2010.
- Shared emerging themes of the research project at regional Dietetic Managers Meeting in London, May 2011.
- Poster presentation on MF role (*For they are Jolly Good (management) Fellows*) at OT conference, July 2011.

12.6 Lessons learnt by the Management Fellow

- That, to be a Management Fellow attached to a research project, you don't need to be an academic.
- That the knowledge, skills and experience of a practising manager within the NHS have as much value and relevance for an applied research project, as an academic's.
- That it is possible to "learn a new language" by being immersed in an academic institution, and to offer translation from a NHS, "real-life" perspective to the researchers.
- That initial support from your employing organisation is not guaranteed for the duration of the Management Fellowship.
- That, in a changing management landscape within the NHS, sustaining the role of the MF in the face of redundancy demands flexibility, resilience and resourcefulness not just on the part of the MF but also of the University and the Project Team.
- That dissemination of findings from the research project will continue beyond the end of the Fellowship. This means having a commitment (on both sides) to maintain working relationships with the project team in order to develop papers and other outputs.
- That the MF sits at the centre of a web of multiple relationships (i.e. between the HEI, NHS provider organisation(s), the MF and the

research project team) that are complex, highly dynamic and unpredictable.

- That forward planning and personal commitment are required beyond the term of the MF contract if the MF is to continue her involvement with the project beyond submission of the draft final report, by contributing to report revision and dissemination of project findings.

12.7 Future plans to use the newly acquired skills and knowledge

Evidence based practice and management are integral parts of the new Health & Social Care Act, and so it is a given that they will be part of whatever role I take in the future. However, at this stage it is difficult to anticipate more than that, or the ways that my newly acquired skills and knowledge may be applied. Certainly in the management roles I have undertaken since the fellowship, what I have learned has enabled me to access and interrogate databases in order to identify supporting evidence for a variety of initiatives at Strategic Health Authority level, such as Continuous Personal and Professional Development for AHPs, and Advanced Practice in Nursing.

In applying for a new role at the Department of Health, I was enabled to identify relevant transferable knowledge and learning from the MF scheme and apply this to the issue of survivorship in order to influence future service provision improvements.

It is not easy to pin down precisely what I have gained as a MF, but I am convinced of its value, while acknowledging that its application in future may also not be immediately apparent. We are constantly being advised that different, creative approaches will have to be applied in the future, to the challenges of health and social care provision. In the course of my Fellowship, I have had an opportunity to work in a very different kind of organisation and with colleagues from very different backgrounds, and had an opportunity to develop very different ways of thinking. The specific skills and knowledge I have acquired through this may not themselves be immediately and directly applicable, but I am convinced that the flexibility and adaptability that I have had to show will stand me in good stead in the future.