What have NHS managers ever done for us?

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Abstract:
The image of the UK National Health Service manager has not always been positive. Like others in the public sector, NHS managers are sometimes associated in the media with waste and inefficiency, in contrast to those in ‘front line roles’. Thus healthcare professionals and members of the public might ask, in the tradition of Monty Python’s Life of Brian, what NHS managers have ever done for us. In this short article, we outline some of the evidence from the literature on attitudes to, and role of, healthcare managers, before drawing on our own interview and observation based fieldwork with managers themselves. We argue that the role of the healthcare manager is not always well understood, and that in a sector facing ever more intense and large scale organisational challenges, managers should be seen as important partners in a health service focused on clinical outcomes.

Key Words: Managers, NHS, efficiency, organisations, policy

Key Message(s): NHS Managers are often a target for criticism, yet our research shows that they play a necessary role under difficult organisational circumstances. Managers are motivated by a desire to improve patient care.

Why this Matters to Me: It is important to us as social researchers that the realities of organisational life in the NHS are presented in a way, which is evidence based, avoiding hackneyed stereotypes. It matters to us that the voices of NHS managers are heard alongside those of other healthcare professionals.

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In 1993, when McCartney et al. conducted their survey of doctors’ views of managers, they noted efforts by the Conservative government to change, to professionalise the role of hospital administrator. The aim was to elevate NHS administrators to a management role in line with those in other large organisations, leaving medical professionals free to get on with the business of patient care. NHS resources being finite, another aim for the government of the day was to more closely control resources. While this approach may have achieved efficiency savings and greater organisational accountability, the cost was a growing sense among medical professionals that managers were: ‘more interested in money, flow charts, etc., than with treating people’.

Many doctors surveyed by McCartney et al. thought that managers spent too much of their time in meetings – presumably going through those flow charts and budgets. More recently, and even more pejoratively, Smith (himself a defender of healthcare managers) recalls a doctor colleague stating that managers were about as useful as chocolate teapots.

In this journal, Lasserson bemoaned the encroachment of ‘managerese’ after changes associated with the Contract of 1991, and complained of ‘tedious arguments with administrators rather than doctors’. Perhaps this is what Davies and Harrison meant when they wrote that many of these difficulties resulted from problems in the ‘doctor-management interface’. Returning to the Life of Brian theme, many doctors, it seems, consider themselves rather like the ‘People’s Front of Judea’ – ‘conquered peoples of a once-great civilization, suffering the indignities and authoritarian brutalities of a barbarian, occupying power’.

Some of these responses can certainly be viewed as the product of incompatible professional cultures; doctors traditionally seen as autonomous and loyal only to the patient, and managers to the bottom line. Crucially however, writers such as Lasserson, Davies and Harrison, are aware that many issues in the doctor/manager relationship can be traced back to changes in government policy. More widely, the apparent rise of the NHS manager since the 1980’s, which continued under the New Labour project 1997-2010, can be seen an attempt to manage resources more effectively, as already noted, and further, to do so in a global context of public sector rationalisation.

Let us examine some of the issues highlighted above in the light of responses in the literature, and our own ethnographic research. (see Box 1)

**Box 1. Roles and behaviours of middle and junior managers: managing organizational forms of health care**

This three year study is funded by the NHS National Institute of Health Research (NIHR), Service Delivery and Organisation (SDO) programme between 2009 and 2012. It is an ethnographic study seeking to contribute to understanding the realities of working life for middle and junior managers across four types of health care organization: a PCT, a Mental Health Trust, an Ambulance Trust and an Acute Trust. The study investigates how managers’ roles, behaviours and interactions with frontline staff contribute to wider organizational performance.

To begin, we might note the sheer scale and complexity of the National Health Service as an organisation. Most managers will work within a unit of that organisation - a hospital, GP surgery and so on - but many of these sub units are themselves large in scale; whatever their size, they must be managed in relation to sometimes complex governance regimes. Further, managers must be able to negotiate relationships with partner organisations across the wider health service.

Although we know that large organisations in today’s ultra competitive global marketplace seek to reduce management costs as much as possible, rarely are managers denigrated in the corporate world as they are in the NHS. And if managers in the private sector are expected to do more with less, those working in the NHS are no different. Many of the healthcare managers in our study stated that they felt under pressure to ‘balance the books’. Middle managers were asked by their own managers, “have you looked across your budget statements? Can you save any money?” (Lacey, Nurse Manager at an acute Trust). Certainly, the meetings that NHS managers are obliged to attend - and yes, many do attend a large number of meetings - often have a budgetary element, which means that skills in, and experience of financial management are very useful. These are skills that even managers from a non financial back-
ground will at least have had time to master ‘on the job’.

Our observations of management meetings found managers focused on operational management, as well as actively improving services for patients. Rather than talking shops, management meetings were a necessary space for co-ordinating and improving the running of a large organisation. They were, so to speak ‘all business’. As for ‘flow charts etc.’, it is true that a large proportion of healthcare managers’ time is spent on what we could call information management, but it is difficult to see this as anything other than a response to pressures from above, at the level of national policy. While successive governments come to power on claims that they will cut wasteful bureaucracy, pointless targets, and so on, this is yet to materialise. It is yet to be seen how a move to a supposedly more ‘outcomes based’ system of performance management will distinguish itself from the tyranny of targets that generates so much work for managers at the moment.

Managers are also tasked with implementing the almost constant organisational change that characterises NHS organisations. While middle managers in particular are often seen as a brake upon change, Huy has noted their entrepreneurial instincts for finding new ways of working, as well as their ability to translate strategy into practice on the front line. Certainly in our own research, many middle managers found that almost constant reorganisation “decreases the potential satisfaction for people. It does impact upon patient care because you can’t have your eye on both at the same time” (Tamara, Nurse Manager, Acute Trust). But, in line with Huy’s observations, many of the managers we spoke to responded to organisational change in a positive fashion, by taking the opportunity to drive forward initiatives that improve patient care directly.

Not all Doctors enjoy administrative and managerial roles and responsibilities. We wouldn’t go as far as Degeling et al., who suggested that some doctors were ‘equivocal about financial realism’. However, it is hard to imagine the sheer amount of change management, information management, strategic management, and financial management that is necessary for the running of the NHS, being able to succeed without professional managers having a central role.

The ultimate aim for both managers and clinicians, perhaps, is effective joint leadership. Crosson calls not only for shared leadership between managers and doctors, but for improved management training for the latter. This is echoed by Atun, who suggests that ‘early investment in such training is needed to help overcome the doctor-manager divide and improve NHS management’. Sitting in on the meetings of NHS managers, it is clear that their view of doctors is not always entirely positive either, and some doctors are sometimes seen as obstructive of management initiatives, or simply refusing to toe the line and work to a prescribed routine. Doctors may respond that this is because commitment to patient care leaves limited time to attend to changing organisational demands.

In many management meetings, the issue of patient care might appear to be buried beneath a mountain of statistics and flowcharts, but managers we spoke to all pointed to patient care as their absolute priority, with management initiatives within their organisation both a way to improve services for patients, but also to cope with ever greater top-down demands for efficiency – with minimal impact on the patient. Many managers, it is true, speak of the tension between efficiency (more usually cost cutting, in practice) and patient care, and in a climate of public sector austerity, it is hard to see this tension decreasing. Doctors are already aware of this tension also, and any wholesale rise in management responsibility for them will surely highlight it even more.

It is worth noting that in fact, many in the sometimes rather undifferentiated category of ‘NHS manager’, have a clinical background. From executive board level down, we encountered very many nurses, for instance, who had moved into management. These are individuals who have entered the health service in order to care for patients. In apparent contrast, over the last few years, increasing numbers of managers have been brought into PCTs, Mental Health Trusts, Ambulance Trusts and Acute Trusts, from the private sector. Private sector managers are seen as coming equipped with the business savvy and private sector mindset that is increasingly valued by the NHS. It is worth considering the reasons that managers have for moving from the private sector into socialised healthcare. While it is true that for some, family friendly
working arrangements were a factor, all of the former private sector managers we spoke to were proud of the contribution they were making to patients using their services – and ultimately, in many cases, to society as a whole. One business manager in a Primary Care Trust who we spoke to had moved from the banking sector, hoping to apply his skills in change management in a more socially worthwhile setting. It seems then, that doctors and managers do indeed share common goals, something that can only make partnership working easier.

With Doctors being asked to take on increasing managerial roles and responsibilities, it is the case that management training for doctors is expanding. A recent example is Wythenshawe Hospital in Manchester, which has entered into a partnership with Manchester Business School for this purpose. The situation, in the wake of the Department of Health white paper of July 2010, is unclear however. PCTs are to be abolished, but it seems likely that even with increased involvement of primary care doctors in the management of patient pathways, there will be a role for managers. While there is talk of local authorities and ‘third sector’ organisations taking over the role of PCTs, there is also a strong possibility that private sector providers will be seeking to participate.

It remains to be seen whether the role of healthcare manager will be different once it is devolved beyond the traditional NHS organisational family. Interestingly, independent healthcare providers such as Kaiser Permanente have pioneered ways of working which emphasise a leadership role for both managers and doctors. Kaiser, according to Crosson7, has created an organisation where ‘physician leaders now understand both the bedside and the boardroom and make competent partners for similarly well trained managers’. Perhaps this is the model for the NHS, in primary care and beyond.

Returning, in conclusion, to the theme of change in the UK National Health Service, it is tempting to wonder if the best way to cut management and bureaucracy costs would be to introduce a period of stability, rather than constant change, into the NHS. Governments, almost since the establishment of the NHS, have sought ways to cut costs and increase efficiency. In recent years, it is possible to argue that the management and administration involved in implementing profound organisational changes emanating from government has suffered from the law of diminishing returns. Could it be that managers are important, if unappreciated, mediators between NHS policy and medical practice?

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