

New Evidence on Management and Leadership

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Public concern about patient care has highlighted uncertainties about the current role and nature of managers in today's NHS. This digest presents key findings from fourteen new studies on leadership and management practice.

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Five questions to ask

- 1** | Do you know your total management capacity (including hybrid clinician managers)? Are you investing in well-structured staff appraisal to identify leadership potential and support those in 'part-time' management roles?
- 2** | How many of your managers, from ward to Board, have taken part in leadership development and training programmes? This includes programmes from The Academy to strengthen frontline management capacity.
- 3** | Informal activity can also be effective - what kind of mentoring and feedback coaching, learning set and other in-house development activities happen at your organisation?
- 4** | Are you using results of annual staff surveys and other means to identify problems and success stories in staff engagement and management?
- 5** | Many managers learn by doing or seeing – have you hosted a learning event, organised an exchange of good practice or asked staff across teams and directorates to contribute to innovation events, combining evidence with live examples?

“ This is important research. It reflects the reality that ideas of heroic leadership and the 'man in a grey suit' image of management are outmoded. We now live in a world where most managers work in teams and have dual clinical and managerial roles. The big questions for me are do we understand the power and value of this model; and are we supporting managers to flourish within it. ”

Rob Webster
Chief Executive, Leeds Community
Healthcare NHS Trust

At a glance

Although official records state that 3% of staff are managers, new research suggests that around a third of hospital staff have substantial managerial roles

Most of these managers occupy dual roles as clinicians and managers, but do not always get the training and support they need for their management role

These hybrid managers may outnumber general managers by four to one – management capacity is more widely distributed than we thought

Many middle managers in healthcare are working in 'extreme jobs', characterised by long hours, fast pace and high intensity – over half of those surveyed in a new study believed their jobs to be unmanageable

Research confirms international evidence showing that organisations which achieve high levels of engagement with clinical (medical) staff are more likely to perform well – but levels of medical engagement vary considerably between healthcare organisations.

There has been substantial progress in involving medical professionals in management, through clinical directorates, divisions and service line structures although a recent literature review notes the continuing 'tribalism' of managers, doctors and nurses and suspicion of those in hybrid clinical management roles.

Other countries have been more successful in promoting medical leadership. A new survey shows that only 10-20% of medical consultants in this country are involved in leadership roles for about a fifth of their time (much less input overall than successful US initiatives like the Mayo clinic) and clinical leadership posts can be hard to fill. More attention needs to be given to career structures for senior clinical leaders, pathways back to clinical work and joint working with experienced managers.

There has been considerable research on roles such as medical directors – but new research focusing on senior managers in nursing and allied professionals (as well as clinical directors) shows that it is impossible to separate out clinical and management work and more support may be needed to carry out the managerial aspects.

Studies suggest that traditional, 'heroic' models of leadership are still dominant, although in practice responsibilities are more distributed and management styles more diverse. Research on senior therapy managers for showed that they did not see themselves as leaders even when inhabiting those roles.

Research gives us greater understanding of what managers do – less about rational tasks and more on relationship-building and negotiating complex inter-boundary activity (but more difficult to define). Observational studies show, for example, the political skills used by middle managers in difficult activities from integrating services to winter contingency ward planning.

New research from a national study of crisis resolution teams suggests that engaged leadership (leaders rating highly for engaging with others) is a good predictor of organisational performance – more so than leadership by competences or qualifications.

New studies show that managers place much greater emphasis on personal experience and good practice from other sites than on formal sources of evidence or research-based products (such as journals, guidelines or standards).

Given the importance of experiential learning, formative spaces such as action learning sets may be particularly helpful in providing reflective spaces for leaders to transform **knowledge into practice**. Exchange events involving narratives of 'what works' in other organisations are also likely to have traction with managers.

Managers need critical evaluation skills to assess the quality of evidence and what might work for their particular context.

Multiple sources of evidence are likely to be needed for complex activity like commissioning, which needs mobilising by key individuals - the right experts at the right time.

“ Very thought-provoking as to the importance of how we support ALL of our hybrid clinician-managers better - both in terms of training and preparation for the role and on a day to day basis in the workplace.”

Carole Langrick
Deputy Chief Executive
Mid Yorkshire Hospitals
NHS Trust

“ It helps to understand some of the tensions in my day job – I don’t take off one hat and put on another as a nurse and manager.”

Nigel Davies
Divisional Head of Quality,
Central London Community
Healthcare NHS Trust

Overview

Recent studies, from government inquiries into failing care at mid-Staffordshire (Francis) to high-level reviews of patient safety (Berwick) and quality of care (Keogh), underline the importance of maintaining a grip on patient care at all levels in the organisation. A review by the Kings Fund in 2011 supported the case for strengthening managerial capacity at a time of increasing demands and reduced resources (Kings Fund 2011). We know that good management can make a difference. But there is little evidence on what works and what organisations can do to support best management practice.

The NIHR Health Services & Delivery Research programme identified particular gaps in current evidence on management and leadership of healthcare. A number of calls were issued to commission new research in these areas. Many of these studies were published in 2013 and address key questions. These range from research into managerial capacity, engaging clinical staff as managers, understanding the work of frontline and middle managers, exploring the nature of leadership and the way in which managers use evidence. This digest summarises what these studies add and why they are important. They should help organisations and individuals to understand better the ways in which effective managers improve services for patients.

What do we know already and what do recent studies add?

Since the introduction of general management in the 1990s (and senior administrative functions in hospitals before then), there has been recognition of the need for managers to shape and enact a system in which clinical activity takes place. This includes making more explicit business framework and controls around the delivery and planning of health care. As noted by Hales and others, managers and managerial values have been set as “counterweights” to clinicians and clinical professional values (Hales 1986). However, in practice, NHS managers have had limited powers and authority. This was well described some time ago by Mintzberg as a ‘professional bureaucracy’, dominated by highly skilled, semi-autonomous professionals (Mintzberg 1979). There have been various initiatives to devolve accountability to clinicians and combine financial and clinical decision-making – from resource management and the introduction of clinical directorates to programme budgeting. These are important developments, worthy of detailed evaluation. But there are also wider issues around the place of ‘general’ and clinical managers in today’s complex health and care system and how these roles are defined and enacted.



Sixteen new studies have been commissioned by the NIHR HS&DR programme to address some of these gaps. They give us important new insights into who today's managers are and what they do. The popular perception of the manager as the man in the grey suit with a clipboard is outdated. In today's healthcare, the reality is more likely to be a woman (or man) in a white coat or nursing scrubs who combines clinical duties with managing staff, budgets and services. It also suggests some new fault lines – to take just one example, despite the benefits of devolving responsibilities to clinical directorates, there may be risks in creating silos and inhibiting cross-division learning.

In terms of decision-making and responsibilities, we are seeing a more distributed leadership with a range of styles among many tiers and professions throughout an organisation – but the idea of the single heroic leader still holds sway with many. Much research to date has focused on acute care and senior medical leaders – new research gives further insight into these roles, but also shines a light on leadership in nursing and allied professionals and in other overlooked settings such as mental health and commissioning organisations. A particular theme in

this portfolio of work is the tensions and realities of working life for hybrid clinical-managers. These new studies show the ways in which frontline (and more senior) managers can foster positive organisational climates and the interrelationship between leadership, staff engagement and quality of care for patients.

We also know more than we did about how managers use and access information. New studies use surveys, shadowing and case studies to understand better the realities of how managers make decision and their information needs. Evidence-based management is perhaps still elusive, but it is helpful to understand what kind of information or learning tends to stick with managers – information relating to personal experience or from a trusted member of a network or community.

There are important lessons here for all those invested in a service which faces unprecedented challenges in the years to come. If management is about making difficult choices and decisions, there is even greater need to understand what good management and leadership looks like and where it is found.

Who are the managers?

Official statistics put the proportion of managers in the NHS at around 2.9% (Health & Social Care Information Centre 2013). But new data from Buchanan shows that around 30% of staff in acute trust have some form of managerial role [Research study one]. Many of these are hybrid roles – the clinical manager, such as ward sister or clinical director, who combine patient care with supervision of staff, holding budgets and planning services. These hybrid roles outnumber dedicated service managers by four to one. But most are part-time, with little management education and support. More importantly, they often do not see themselves as managers.

Much research has focused on the behaviour and role of top leaders in organisations. Less research effort has been invested in frontline and middle managers, despite recognition that they play a crucial role in organisation performance (Wooldridge 2008). Indeed, recent research in healthcare has stressed the importance of frontline managers in profiling behaviours and generating an organisational climate conducive to safe, high quality care (Maben 2012). Middle managers are not well defined and could include any individuals with managerial responsibilities below director or Board level. In healthcare contexts, this includes service or directorate managers, matrons and clinical directors. Studies by Buchanan, Checkland [Research studies one and two] focus particularly on the middle management role.

Given blurred distinction, this elides into other research into frontline or first line management in the NHS [Research study three], including the Hales study which provides particular insight into the ward sister role [Research study four]. This study shows the role conflict in straddling the practitioner-manager divide, combining hands-on nursing, clinical leadership to ward nurses and support staff and organisational management. It also looks at the service manager tier (assisting the general manager, in parallel with the clinical director in a hospital setting) and notes the structural ambiguity in this role.

In recent years, more interest has focused on clinical leadership, with the emerging autonomy of clinical directorates in provider organisations and particular initiatives such as service line management. Although engagement of clinicians in management has been widely promoted, a recent overview (Howieson 2011) noted that clinical leaders were poorly defined and much of the literature is focused on individual traits and competences, divorced from the complex realities and context of working lives. One attempt to present a situated assessment of the clinical leader role is Storey's study [Research study five] of service-level clinical leaders in acute and primary care and their influence on service design in two health economies tackling cross-boundary services such as dementia. This study noted the complexity of these whole system projects and the potential impact of clinical leaders in engaging colleagues through lateral, informal networks across institutional and



professional boundaries. At the same time, the study noted constraints in current authorization and incentive structures which inhibited the ability of clinical leaders to shape services in some contexts.

Further insight into the medical manager role is provided by several new studies. A review by Greener [Research study six] concluded that the last twenty years had been characterised by continuity, rather than change, in the enduring dynamic of doctor, nurse and manager relationships. Evidence did not suggest that the NHS had seen a radical shift away from the model of professional bureaucracy towards a 'managed professional business'. Indeed, Greener's review suggested that the transformational nature of the hybrid doctor-manager role has not been completely realised: "Doctor-managers regard the managerial aspects of their role as part-time and temporary and having little authority over their peers who often do not regard doctor-manager roles with respect".

In this vein, the study by Ham [Research study seven] provides important new evidence of the nature of medical leadership, relationship with performance and organisational enablers for this role. Results from a national survey show variability in the level of engagement at different levels, with evidence of 'clinical-led' structures and accountability in many organisations. This study shows evidence of positive association between medical engagement and performance at a trust level. However, survey results indicate less than a fifth of medical consultants are engaged in leadership roles and this compares unfavourably to levels of engagement in US initiatives like the Mayo clinic or Kaiser Permanente. It appears that part-time management roles do not have the same status for medical leaders as those undertaking clinical, research and educational activities – indeed,

Ham's research shows that competition for these roles is often limited.

Newer research underlines the importance of clinical leaders at the microsystem level of hospital ward, mental health team or clinical directorate. The Ham study emphasises the crucial nature of personal credibility for medical-managers in engaging highly skilled and autonomous followers. Work is needed to redress historic lack of support, training, development and career structures for clinical staff adopting managerial and leadership roles. But there is some cause for optimism – the Ham study indicates a greater shift in recent years towards a transformative 'power-sharing' arrangement between clinicians and managers, rather than the dominant 'traditionalist' (or minority 'managerial') models in McKee's study of clinical directorates in Scotland fifteen years ago (McKee 1999).

There are also important new insights into the clinical-managerial role from nursing and therapy professions in studies by Hales [Research study four] and Petchey [Research study eight]. Petchey's study looks at the under-researched role of allied health professionals, from radiographer to physiotherapist, in management. It is also under-researched. He shows the problems of identity and legitimacy for therapists in leadership roles (particularly for those in smaller therapy professions) and the problematic fusion of clinical and managerial work. This is echoed by similar work on ward sisters by Hale, although with stronger professional identity in nursing roles and different kinds of tensions. These studies of non-medical leadership are also interesting for the new light they shed on issues around gender and more diverse management styles, which need further exploration.



What do managers do?

Today's healthcare managers at all levels in the organisation face increased demands, rapidly changing environments and strained resources. Traditional boundaries and silos have often been broken down, which poses new challenges for those running services. Many of the problems facing middle or frontline managers are complex or 'wicked' issues without simple, technical solutions. They require negotiation and political skills, engaging a range of stakeholders in networks and partnership forms.

In general management research, there has long been recognition of the gap between what managers are supposed to do – in Mintzberg's words, 'plan, organise, coordinate, control' – and what they actually do in their working day (Mintzberg 1975). This classic study showed that managers' work was fragmented and contingent, with considerable discretion as to what they did and how they did it. A further critical review by Hales (Hales 1986) of empirical studies charting managers and their activity shows just how difficult it is to answer the deceptively simple question of what managers do and how they behave. He asks for greater clarity in understanding the wider context of managerial tasks, responsibilities and function.

Checkland's study includes a useful, comprehensive review of the management literature on middle managers (Research study two). She notes that there was a concerted move from the 1980s to 'de-layer' and to remove the middle tier of management in many sectors. Subsequent research however suggested the importance of middle managers in shaping high-performing organisations by the broker role – influencing upwards and implementing downwards. However, there is greater risk of 'role dissonance and ambiguity' at this level.

Her study of middle managers in commissioning organisations confirmed what was already known in the literature on what managers do – the key role of cascading information (up, down and sideways) and networking within and outside the organisation. Checkland's study however identifies a particular role for commissioning managers working with general practitioners of 'animation' – influencing and shaping actively the practice of staff outside their direct control. This new research showed the way in which managers working as 'animateurs' could influence important decisions by others, such as decommissioning services. This role will be of increasing importance as Clinical Commissioning Groups assume full responsibility for commissioning.



Studies from Buchanan to Petchey emphasise the particular skills and activities for managers in negotiating 'wicked' problems like staff performance management or managing complex discharges where there are no absolute right solutions and the need for dialogue across professional and organisational boundaries. This chimes with wider evidence on the need for particular skills for leading in a network, including managing change through an alliance of agencies which may be outside the direct control of an individual – 'distributed change leadership' (Fitzgerald and Ferlie 2007).

Recent reviews on patient safety and quality of care have placed great emphasis on frontline managers – those directly supervising clinical staff. It is interesting to see how some of the tensions played out in the health service are reflected in the wider literature outside health explored by Hales in the background review for his study [Research study four]. There has been considerable evidence on 'first-line manager' role – that is, the first level of management to which general workers of whatever kind report. This has traditionally been a supervisory role – running work-groups or sub-units to 'keep the production going'. More recently, there has been a shift in many industries towards flatter organisational structures with more dynamic, 'self-managing' teams. This has led to possible erosion of supervisory tasks for first-line managers in favour of more general business unit or even entrepreneurial activity. Hales considers how these general shifts in first-line manager roles are played out in healthcare contexts by studying ward sisters and service managers in acute trusts. The study notes how



How do managers make decisions and use evidence?

There is an interesting debate around 'evidence-based management'. It is now well understood that the paradigm of evidence-based medicine cannot be imported wholesale to the management of services. As noted in a key paper by Walshe and Rundall, many managerial decisions are "constrained, contested and political" which makes it difficult to apply relevant knowledge (Walshe and Rundall 2001). Although there are ongoing debates about the difficulties in the translation of evidence into practice for clinicians, there are particular issues for managers in accessing a dispersed social science literature without clear hierarchy of evidence or easy synthesis of findings on complex problems.

There are real differences between the paradigms of clinical and managerial knowledge and no easy solutions. But there is growing recognition by many management and business schools of the limitations of a complacent, 'evidence-free' culture in which the anecdote or business case study triumphs over systematic knowledge. Proponents of evidence-based management decry the poor uptake of known effective management practices, such as goal setting and performance feedback or poor use of academic management information by general managers (Rousseau 2006).

In UK healthcare settings, uptake of management and organisation type evidence is reported to be low, despite increasing attempts to professionalise management in healthcare. At the same time, there is an increasing recognition of the importance to organisational and service performance of management and leadership behaviours in public services (Meier and O'Toole 2002) and of the potential for research evidence to improve managerial practice and decision making in healthcare (Shortell, Rundall and Hsu 2007).

Recent HS&DR studies have thrown further light on present practice in using information. In part, this research is useful in showing how evidence does not exist separately from decision-making practices and organisational contexts of healthcare. Dopson's study of managers' use of management information provides rich data on how managers make sense of information and interpret evidence according to local context [Research study nine]. It showed that managers were most highly oriented towards knowledge drawn from their own experiences

policies of devolving managerial activity down to clinical teams have given more budgetary, human resource, performance management and quality assurance responsibilities to roles like ward sisters. This has provided new tensions between their clinical and management roles.

A key finding of a number of these studies – from Hales to Alimo-Metcalf – is the importance of clinical leaders in managing the emotional climate and fostering a positive culture in the ward, team or directorate. Outside health, the role of leaders in fostering a positive 'service climate' which links staff wellbeing through good employment practice to customer (patient) outcome has been noted in the business and management literature (Hong 2013). Indeed, the call in recent healthcare reports such as the mid-Staffordshire (Francis) inquiry highlights the need for a relentless focus on the patient and patient experience. This parallels the move in areas such as retail to foreground the 'customer service profit chain' – that is, the links between customer satisfaction, staff engagement and productivity or positive outcome (Storey and Holti 2013). The need for managers and leaders to have a relentless focus on customer (or patient) care is not new in the wider organisational literature.

and from others within their own communities of practice. Managers' careers play an important (and previously neglected) role in shaping their orientation to knowledge – including their motivation and willingness to engage with and adapt management texts.

Interestingly, research-based knowledge and particularly management journals appear as the lowest source of interest and influence for most managers. Similar findings appear in the study by Edwards, which included a survey of managers and those providing information as well as case studies [Research study ten]. As well as reinforcing the importance of learning by personal experience, both studies show that the way that managers access and use evidence is complex and does not fit well with existing models for providing information in formal 'products' or services. They also highlight the importance of formal and informal networks as a primary means of exchanging information.

A third study by Swan (Research study eleven) looked in particular at commissioning organisations, using comparative case studies and surveys to understand what kind of information was most important to those making decisions about funding and shaping services. The most valued source of information for commissioners was best practice from other

organisations and local public health intelligence. A key finding was that 'evidence does not speak for itself', but needs to be mobilised by the right people at the right time to affect decisions. The study is predicated on the belief that knowledge does not exist independently as intact products, but emerges through 'co-production' by managers in their own networks and groups, who make sense of key findings and frame evidence around local context and real issues. In this way, this chimes with the notion of clinical 'mindlines' or communities of peers creating and building knowledge (Gabbay and LeMay 2004).

These studies indicate why some of the traditional methods of getting information to managers have not always worked. In 2012, the HS&DR programme funded a series of projects which should build on this kind of knowledge to test and evaluate new initiatives to strengthen evidence-based management, including the assessment by Wilson of a more dynamic problem-led information or evidence service for commissioning managers [Research study twelve]. Other insights into the particular information needs of decision-makers at the top of organisations will be provided by a new study by Nicolini shadowing chief executives in NHS bodies [Research study thirteen].



What support do managers need?

Different strategies have been used across the health service to support and develop managers and leaders. These include formal training and development programmes, including considerable investment for leaders across the NHS by The Leadership Academy, in-house coaching, learning sets or mentoring arrangements. Some initiatives have been imported from non-health industries and other countries, sometimes to address particular problems (such as difficulties in recruiting and keeping chief executives). In the last ten years, this has included formal 'talent management' programmes in the NHS. A study by Powell [Research study fourteen] assessed the impact of these and more informal activity, including studies of cohorts of managers through their career trajectory. This report concluded that the evidence base for talent management was rather unclear, particularly for healthcare in this country. However, some helpful lessons emerged, such as the importance of well-conducted appraisals in identifying and nurturing talent and the need to embrace a wide range of activities at all levels in the organisation. These included coaching, mentoring and job rotation as well as more formal leadership programmes.

Management vs leadership – an artificial divide?

The terms leaders and managers are often used interchangeably. In some contexts, management has been defined as governing in a steady state, whereas leadership is about managing change. In practice, most senior roles demand both management and leadership. But it is useful to turn to the particular evidence base on leadership to chart the shift in our understanding of these terms.

Jean Hartley's overview of literature on leadership in healthcare published in 2008 provides a thoughtful road-map for a very dispersed evidence base [Research study fifteen]. Her argument is that evidence on leadership often presumes a single model whereas, particularly in healthcare, this covers both formal and informal kinds of authority, direct and indirect leadership, clinical and non-clinical, individual and shared modes of leadership. Much literature in the past has focused on traits of leadership and personal characteristics, underplaying the importance of context (at different levels within and outside the organisation). The evidence base is largely 'descriptive and anecdotal'. Overall, there are few high quality empirical studies on different modes of leadership across and within professions

in healthcare. Those which have attempted to assess the impact of interventions on personal and organisational performance have been flawed due to inadequate understanding of the theory of leadership and its many forms, poor study design and data collection or inappropriate interpretation of findings.

One of the few studies to provide empirical evidence is the NIHR-funded study by Alimo-Metcalfe [Research study sixteen] on leadership in a particular mental health context (crisis resolution teams). Although set in a particular context, this project does suggest a strong predictive effect of engaged leadership style on organisational performance (in this case, appropriately avoided hospital admissions) compared with other kinds of leadership qualities, such as specific competences.

There has been a growing interest in distributed leadership (Gronn 2002) – replacing the focus on the individual at the top of the organisation with a study of how authority is played out across the network, system or organisation. This brings a welcome attention to the ways in which leadership is exercised at different levels and in different groupings across an organisation. Indeed, there is now an interesting school of thought on the requirements of a 'post-charismatic' leader who would need to embrace uncertainty, devolve power to teams and accept progress through experimentation and false starts (Storey and Holti 2013).



Conclusions

New studies show that today's health and care system embraces a diverse range of managers and leaders at different levels in the organisation. More are likely to combine managerial responsibilities with clinical duties than work as full-time managers. Leadership is distributed widely within organisations, with diverse management styles, although many still hold to traditional views of the heroic, lone leader. This research gives us better insight into the dispersed, sometimes conflicted nature of hybrid clinical manager roles and how they can best be supported.

Many of these research studies use a mixture of methods, including observational research, to generate evidence on how managers work in practice. This addresses gaps noted in previous evidence, which often examined leadership traits and characteristics in isolation divorced from the reality of lived experience.

This naturalistic research provides a wealth of insights into current management practice, from how evidence is used in redesigning diabetes services to nurse leadership in infection control teams. In addition, data from new national surveys provides more robust information on key questions such as the number and nature of today's managers, current levels of medical engagement and working conditions for middle managers in the health service.

These studies provide enlightenment on key problems and issues for leaders delivering and shaping health and care services. They also raise further questions and uncertainties in a rapidly changing landscape. There may be more to learn from settings outside health on how to nurture adaptive, innovative leaders who can engage with a range of staff and agencies across traditional boundaries. This research should stimulate more debate and reflection on what we need from managers and leaders of health and care services in the twenty first century.

Summaries of relevant HS&DR Projects

Following are summaries of fourteen published and two live projects cited in this digest which are directly relevant to leadership and management practice.

More details of these projects and the other work funded by the Programme are available at www.nets.nihr.ac.uk/programmes/hsdr

Research study one

Buchanan – realities of middle management in healthcare

There have been few high-quality studies to date on middle managers in healthcare organisations. The NHS has concentrated on senior leadership and less is known about the experience and attitudes of middle and front line managers, despite their importance in shaping patient care. The aim of this study was to explore the realities of management work, their role in change, and links between practice and performance by middle managers in acute care.

This study used mixed methods from in-depth organisational case studies at six acute trusts involving more than 1200 staff and a survey of over 600 staff. Bottom-up estimates at two sites suggested that around one in three staff had some kind of managerial role, rather than the official figure

of 3%. The vast majority are hybrids, combining management with clinical responsibilities. The managerial capacity of healthcare organisations include these hybrids as well as 'pure plays', although this is not always recognised. This report also identified that the work of many middle managers could be described as 'extreme jobs' with long hours and intense demands. Over half of those surveyed stated that their jobs were unmanageable. Case study research provided insight into the contribution of middle managers, noting that much of their activity was highly political, involving collaboration across professions and agencies.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808238

Contact: Professor David A. Buchanan, University of Cranfield

Research study two

Checkland – role of middle managers in commissioning organisations

Middle managers are seen as crucial in an organisation, but more research has been done on this tier of staff in provider organisations, particularly acute trusts. This study looks at middle managers in commissioning organisations.

Across four purposively sampled primary care trusts, this study used case study methods (interviews, observation and shadowing) to understand the working lives of commissioning managers. Using the theoretical lens of sense-making, the study found that the work of these managers was ill-defined. An important unique contribution was managing information downward, sideways and upward and working through and with others. This included

actively managing and working with general practitioners, without direct levers or controls that would be found in traditional hierarchies. This study explored issues of legitimacy and identity for these managers in roles which lacked clear boundaries or well-defined outputs. In three out of four of the study sites, the team identified a unique managerial role of 'animateur' – inspiring others and shaping practice of others. This was seen as particular to the role of the commissioning manager, working with those outside their direct control on complex projects such as decommissioning services.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808240

Chief Investigator: Dr Katherine Checkland, University of Manchester

Research study three

Annandale – Identity and experience of junior and middle managers

This ethnographic study explores the lived experience of junior and middle managers in the health service – an under-researched subject group. Using a social constructionist approach and sociological methods, such as observation and ‘shadowing’, the project compares those with clinical backgrounds with general managers to draw insights about identity and ways of working.

The study also aims to explore how managers use identities to shape personal, professional and organisational goals. In-depth research will take place with a purposive sample of clinical and general junior/middle managers in two acute trusts.

The report should be published in 2014



For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808239

Chief Investigator: Professor Ellen Annandale,
University of Leicester

Research study four

Hales – understanding the first-line management role

This study focuses on the important tier of those directly managing staff – both first-line managers (service managers supporting general managers of directorates) and ward sisters who combine managerial and clinical roles. In particular, this study looked at the balance between routine supervision, performance management, team leadership and wider resource responsibilities and the tensions between these activities. There was also consideration of how working identities were constructed and enacted and expectations of the managerial role.

This project consisted of comparative case studies in two acute trusts with cohorts of service managers and ward sisters and related staff. A range of research methods were used, from observation work and shadowing to interviews and documentary analysis. For ward sisters, recent developments to strengthen the role pose opportunities and threats to their own perception and experience of the

role. There were clear tensions between the clinical (senior nurse) and managerial roles. The study also identified overlap and ambiguity in aspects of the ward sister role and other key positions such as matron, specialist nurse and bed manager. For the service manager, this study showed that the role was weakly defined, being largely constructed as an adjunct to the general manager in a directorate. In this role, they have little authority over senior clinicians and others with and through whom they work. In the absence of this authority, they develop a subordinate ‘working relationship’ with consultants, going out of their way to avoid conflict and provide support through reactive, problem-solving activity. In both cases, the study identified problems in the construction of frontline management role in the health service.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808246

Chief Investigator: Dr Colin Hales, University
of Surrey

Research study five

Storey – How do service-level clinical leaders influence service redesign?

Recent policy and practice has focused on the importance of clinical leadership. But little is known about what helps and hinders effective leadership by clinicians at a service-level.

This study used mixed methods to explore the nature, scope and potential for clinical leadership by focusing on its practice in four 'cases'. The cases were cross-boundary service redesign attempts in two health economies in contrasting service areas: dementia and sexual health.

Each case contained multiple organisations including general practitioners and primary care trusts, acute hospital trusts, mental health trusts, local authorities and independent sector providers.

This study provides important new insights into the enablers and blockers for clinical service leaders to shape services. There were varying degrees of success in the cases examined, but all required navigation and collaboration with many agencies and professionals in complex areas such as dementia. The study also noted constraints, with limited authorization and incentives for the exercise



of clinical leadership beyond tight institutional boundaries in some service contexts.

A follow-on study by this investigator on clinical leadership in commissioning organisations is also being funded by NIHR HS&DR programme.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/09100122

Contact: Professor John Storey, The Open University

Research study six

Greener – evidence review on relationship between managers and clinicians

Much work was done in the 1980s to understand more about the relationship between managers and clinicians. Initiatives like clinical governance aimed to get greater engagement of doctors and nurses in the quality of services and their management.

This realist review considered evidence in the twenty years up to 2010 around the role of management and clinicians. Over a thousand items from published and grey literature were considered and analysed thematically. The authors also considered relevant national initiatives, such as performance management frameworks in primary care and new roles such as the modern matron. Overall, the review suggested that the dynamic of doctor, nurse and manager relationships remained remarkably

unchanged over twenty years, despite national initiatives to promote more 'transformative' hybrid roles. Existing evidence suggested that the model of professional bureaucracy appeared to remain dominant, where frontline staff have a large measure of control by virtue of their training and specialist knowledge. Research suggests that hybrid clinical-managers are often viewed with suspicion by their clinical colleagues. There is some evidence that senior nurses may view management roles more positively, providing opportunities for greater status and responsibility across the organisation.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808245

Chief Investigator: Professor Ian Greener, University of Durham

Research study seven

Ham and Dickinson – models of medical engagement and leadership

Policy and service priorities have reflected belief in the importance of engaging clinicians, particularly doctors, in the management of healthcare organisations. Developments such as

A mixed methods study, including a survey of provider organisations and in-depth work at nine case studies in acute and mental health trusts. This involved collection of a range of data on organisational performance related to a scale of medical engagement from 72 NHS trusts (40% of all trusts) – an instrument to measure the extent to which medical staff feel engaged in the work of their organisations. Results showed a wide variety of structures for medical leadership including divisions, directorates and service line approaches, sometimes in combination. Most of the case study sites reported themselves to be medically or clinically led with doctors holding leadership roles at three or four levels. Triumvirates of general manager, medical director and nurse director exist on paper in most sites but case study research suggested that the duality of medical leader and general manager is perceived to be more important. Case study research also indicated that there was often little or

no competition for medical leadership roles in trusts. Survey results showed that medical directors spent about half their time on leadership activities and clinical directors around a fifth of their time. This was sometimes more than the formal designated time for these activities. Only around 10-20% of consultants have taken on some kind of leadership role. This contrasts with successful US initiatives like the Mayo clinic involving a quarter of senior doctors for the majority of their time. An engagement gap between medical leaders and their colleagues is commonly reported and there are variations both between and within trusts in the extent to which doctors feel engaged in the work of their organisations. Trusts with high levels of engagement perform better on available measures of organisational performance than trusts with low levels of engagement. Challenges to effective medical engagement included lack of time and competing clinical pressures, as well as variable relationships with general managers and other staff.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808236

Chief Investigator: Professor Chris Ham,
Kings Fund

Research study eight

Petchey – management by and of allied health professionals

Little research has been done on the relatively new development of management and leadership capacity of allied health professionals. This is an under-exploited area, given that over 70,000 staff in the NHS work as allied health professionals, from speech therapists to dieticians. More individuals are now engaged in management and leadership roles. However, most of the evidence comes from medical managers (usually clinical or medical directors), which tend to differ in terms of seniority and gender from many therapist-managers.

This ethnographic study used mixed methods, including observation, at four NHS trusts. The research provided useful insights into the problematic nature of clinician-managerial identity in these professions. Individuals did not tend to define

themselves by the collective term of allied health professionals, but by their own role as paramedic or radiographer. This professional meta-identity was much more precarious than for doctors or nurses (despite existence of distinct sub-groups). The variation in management and leadership styles across and even within the study sites was striking. The report authors noted the feminised nature of these professions and how that carried over into management style and culture. This included the emotional labour of managing staff and permeability of management and clinical roles – it is impossible to separate the managerial and clinical work.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808237

Chief Investigator: Professor Roland Petchey, City
University London

Research study nine

Dopson – how healthcare managers use management research

We do not know enough about how managers in the healthcare system use management and business research in their working lives.

This study explored the access and use of management information in a range of settings, including management consultancies and knowledge brokers as well as diverse healthcare organisations. It used mixed methods, with the focus of comparative case research in six different study sites. It also looked at action learning sets as a particular kind of activity where knowledge might be formed. Results confirmed the complexity and non-linear nature of knowledge flows and the multiplicity of channels

and products in use. It underlined the notion that managers are most highly oriented towards knowledge from their own experience and those of their communities of practice. Formal research-based knowledge and management journals were the lowest source of influence. Given the importance of this experiential knowledge, the study confirmed the value of formative spaces like action learning sets. These provided a space for reflection where managers can 'transpose' knowledge into practice.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808242

Chief Investigator: Professor Sue Dopson,
University of Oxford

Research study ten

Edwards – health managers' information seeking behaviour and use

More attention has been focused on the use of evidence by clinicians and the decision support and information resources which might best support them. There has been little attention on how managers use information when making difficult decisions, but existing evidence suggests managers may rely more on intuition and past experience.

This study examined how managers look for and use information, particularly in relation to change or service transformation. The project involved five case studies across acute, mental health and primary care settings of innovative information initiatives as well as a national survey to map existing information sources and services (from libraries to information officers) available to managers as well as their information-using behaviour. The survey was the largest of its kind in this country, with responses from over 2000 managers and more than 150 intermediaries (knowledge workers). Over two thirds found it difficult to access information. Most respondents found it difficult to access information, either through lack of time, information overload or not knowing where to find it. An interesting

insight from both the qualitative and quantitative components of this study was that the way that managers access information is much more complex than the "rational" models of decision making and information use on which most information provision – such as libraries in healthcare organisations - is based. There was great variability in how and what information was used routinely by managers. A key finding though was that many managers appeared to place more value on experience and learning from others, including visits to 'see what works', than more formal or academic forms of knowledge. Management education and training can create shared understandings or meanings, a critical approach to the evaluation of "evidence", and identify sources and relevant information leading to better uptake of existing evidence. This study also showed the importance of formal and informal networks as a primary means of information exchange, which need to be nurtured in a fragile and rapidly changing service context.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808243

Chief Investigator: Professor Christine Edwards,
Kingston University

Research study eleven

Swan – knowledge use in healthcare management

We do not know enough about how evidence is used in decisions about planning and commissioning services in healthcare.

This study used a theoretical frame of co-production of evidence – an assumption that evidence is created through the interaction of groups and individuals. In this instance, the focus was on a range of professional and managerial groups including commissioning managers, public health experts, finance managers and clinicians. Mixed methods were used including in-depth interviews with senior decision-makers and then detailed cross-case comparison using naturalistic study and observation at four commissioning bodies. The team also conducted a survey of over 300 staff in eleven commissioning organisations on sources of evidence and access to information. Results

showed that the source of evidence most often used when making commissioning decision was local public health intelligence and examples of good practice from other healthcare sites. More formal products like national guidelines, benchmarking information and service standards were not used as much. Observational research showed how groups made sense of evidence and knowledge during discussion, meetings and the process of decision-making. This activity was shown to be contingent on organisational and management context and the temporal restraints of contracting. The use of evidence was highly dependent on how, when and who it was mobilised by to have impact.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808244

Chief Investigator: Professor Jacqueline Ann Swan, University of Warwick

Research study twelve

Wilson – evaluation of a new evidence service for commissioners

There are problems in how clinical and general managers use evidence to commission and decommission services. This study builds on earlier work at York University to develop a briefing and support service tailored to the needs of commissioners and other NHS managers. The service identifies, appraises and contextualises existing research evidence to inform the real world issues facing local decision makers. This is now being evaluated more widely in a quasi-experimental study of impact on use of service on knowledge and behaviour.

The study aims to evaluate whether a responsive knowledge translation service increases uptake and use of research evidence by NHS managers compared with less intensive and targeted alternatives.



For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/12500218

Chief Investigator: Mr Paul M Wilson, University of York

Research study thirteen

Nicolini – What information and knowledge do top managers use?

We know very little about how top managers in the health service derive their professional knowledge – particularly when and if different evidence conflicts with the existing rules, expectation and other aspects of the organisational context.

This study uses naturalistic qualitative techniques to provide insights into how top managers access and use a range of information and knowledge, from scientific to managerial. The project uses methods such as intensive shadowing to track the range of contexts in which decisions are made and the way in which information is used. The study is focused on chief executives in both acute and mental health provider settings. It also looks at differences between managers from clinical and non-clinical backgrounds. This in-depth study should illuminate how managers use evidence and the organisational features which help or hinder effective use, including form and channel of information.



For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/09100236

Chief Investigator: Professor Davide Nicolini,
University of Warwick

Research study fourteen

Powell – talent management in the NHS

Talent management is not well defined and includes both 'hard' (workforce planning) and 'soft' (nurturing leadership behaviours) activity. In 2004, more formal approaches were introduced in the NHS building on established practice in industry from the US and elsewhere. This included a range of practices from coaching to development centres and mentoring programmes.

This study used mixed methods to assess the impact of formal and informal talent management activities on English NHS managers. The authors studied four cohorts of managers to identify the range of activities and impact on career paths. These included a range of individuals and organisations (including some purposively sampled high-performing organisations). Results showed that the evidence

base for talent management was not clear, especially for public services and healthcare in this country. However, some findings emerged. Amongst other conclusions, the authors pointed to the need for a more inclusive approach to talent management (not just top managers) and greater clarity on approaches to encouraging diversity in management and leadership roles. Well-structured appraisal appeared to be an important foundation for good talent management, together with wider development activities including coaching, mentoring, formal/informal study programmes and job rotation.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081808247

Chief Investigator: Professor Martin Powell,
University of Birmingham

Research study fifteen

Hartley – leadership in health care

There are different views on what makes a good leader and many of these are based on false understanding of the evidence.

This review completed in 2008 was commissioned as a road map of a complex and dispersed literature on leadership within and outside healthcare. The conceptual framework grouped relevant evidence under categories of concepts, characteristics, contexts, challenges, capabilities and consequences of leadership. Iterative searching was done, using expert consensus methods to help shape the search strategy and validate results. More than ninety papers were selected for detailed review. Key messages from this comprehensive review suggested

the evidence base for leadership development strategies. These included the importance of context, the range of formal and informal development activities and leadership roles in modern healthcare organisations. Hartley's work noted the assumptions of previous studies based on particular models of leadership and the poor study design or inappropriate interpretation of findings from much previous research in this area.

For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081601148

Chief Investigator: Professor Jean Hartley,
University of Warwick

Research study sixteen

Alimo-Metcalfe – leadership and performance

Little is known about the way in which different leadership styles and behaviours affect the attitude and wellbeing of teams and their performance or productivity.

This study considered the relationship between leadership, staff attitudes and performance in mental health crisis resolution teams. Organisational performance was measured by ratio of hospital admissions to referrals to the crisis team. Detailed quantitative data were collected from 731 staff working in 46 teams across England. Mixed case study methods were used to examine six teams more closely. Regression analysis indicated that leadership behaviours that involve engagement had the greatest impact on staff attitudes to work and their wellbeing at work. Organisational performance was positively associated with engaged leadership styles. Interestingly, leadership as expressed by competencies did not predict performance in the same way.



For more information please visit:
www.nets.nihr.ac.uk/projects/hsdr/081201022

Chief Investigator: Professor Beverly Alimo-Metcalfe,
University of Bradford

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Further Reading and Resources

Useful general overview of the evidence from health and related service industries on leadership precepts and practice. This underpins the development of a new national framework for leadership which is now being promoted by the Leadership Academy – Storey J and Holti R (2013). Towards a new model of leadership for the NHS. Open University and Leadership Academy (can be downloaded from www.leadershipacademy.nhs.uk).

The Leadership Academy - recent new investment of around £50 million for a wide-ranging programme of development (www.leadershipacademy.nhs.uk). Includes resources such as 360degree tools and assessment frameworks, as well as information about courses and activities for staff.

NHS Institute for Innovation and Improvement Academy of Royal Colleges. Medical Leadership Competency Framework: Enhancing Engagement in Medical Leadership. 3rd edn. London: NI/ARC, 2010 (via NHS Improvement Quality)

Faculty of Medical Leadership and Management – a new UK-wide institute to support all doctors involved in senior manager roles
www.fmlm.ac.uk

Resources and tools on nursing leadership from the Royal College of Nursing available at www.rcn.org.uk/development/practice/clinical_governance/leadership/other_support/guidance_and_tools

Institute of Healthcare Management has identified useful resources for managers, from coaching services to e-learning to recommended management reading
www.ihm.org.uk/en/resources

Contact:

If you have any questions, please contact us using the details below, and a member of the HS&DR Programme team will be happy to help.

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