NHS MANAGEMENT: 60 YEARS OF TRANSITION

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Key points:

1. Managers have become an established part of the NHS in the 25 years since their formal introduction. The story of NHS managers matches many of the transitions that the NHS has undergone in its recent history.
2. Managers now occupy crucial positions in implementing government health policy and bringing about local organisational change
3. Managers come from a variety of backgrounds. Traditionally, entrants from the private sector have not fared well in the NHS culture. Whatever their background, the value of good local working relationships and experience cannot be under-estimated. In particular it is essential for all managers, regardless of their background, fully to understand the prevailing culture.
4. The transition from administrator to general manager to market manager has involved a change of role and status. This has provided opportunities and challenges for the development and support needed by this key group of staff. In many cases managers have successfully developed their careers without formal talent management support.
5. Many clinicians now occupy many managerial positions, which connect clinical and managerial agendas. However, general managers will still continue to play key roles throughout the NHS.
6. Managers need to sustain networks, which support them during their career and provide vital intelligence across organisations. Networks also assist managers when they face career problems and exit from the NHS.
7. Managers need to adapt and evolve in order to meet changing public expectations and to reflect on-going national policy developments. However, there is a danger that frequent structural reforms are eroding the organisational memory of the NHS. If so, the NHS is in danger of failing to learn from its own history.

1. Background

NHS managers are a crucial part of the NHS `story' and embody its organisational and institutional memory. Although it is now over 25 years since the Griffiths Inquiry, which introduced `formal' management into the NHS, some managers pre-date this significant change/transition. The NHS needs to pay heed to the insights and experience of these and other managers; otherwise this vital memory will be lost. This is especially critical in the recent past of NHS when organisational change has been so rapid and far-reaching. Such reforms signify, theoretically, a shift from the bureaucratic organisations (with layers of hierarchy and clearly-defined procedures) to one which is called `post-bureaucratic', comprising networks of public and private organisations, bound by contracts within market-style relations[1]. One way to overcome such possible amnesia (`organisational forgetting'[1]) associated with the post-bureaucratic era is to interpret the past with the benefit of managers' hindsight and so offers a new perspective on current and future direction of health policy. This was the remit of this study.

2. The project

The project undertook a review of evidence (in academic and grey literature) and in 2007 and 2008, conducted 20 in-depth interviews with NHS managers who had at least 25 years experience in the NHS. The unit of analysis was the individual manager and their career. We used a process called narrative based interviewing which involved exploring participants' own stories and focused on the issues in their career that they felt to be important. The assumption was that transitions in the institutional and policy environment would be transmitted into significant transitions in managers' own careers.

3. Understanding NHS management: lessons from the literature

The published literature was widespread and detailed. We found 445 relevant articles on NHS management which included the 1983 Griffiths Inquiry. In our analysis, we identified five separate themes relating to `career transitions': changing times for management, managers' identity, managerial character, background of managers, and impact made by management. Each is explored in turn.

Changing times for management

Management forms part of the wider socio-political transition within employment generally. For example, the "*psychological employment contract*" between employers and employees has changed from the exchange of "*loyalty for job security*" to "*performance [in exchange for] continuous learning and marketability*"[2] which has lead to "*decreased job security, decreased employee loyalty and increased worker cynicism*"[3]. These changes are significant for the NHS because they indicate a more diverse and contingent managerial workforce. The mix of public and private sectors (in terms of workforce, practices and ethos) is challenging traditional NHS ways of dealing with managers (including recruitment, retention and handling career `failures').

Managers' identity

Authors have developed typologies to describe the identities of managers (e.g. as "*hero*" and "*villain*"[4]). A rational model sees managers as engineers controlling the organization as a machine[5] but that it is also possible to see them in an emotional framework, where the manager is a parent with: "*feelings of protectiveness and personal responsibility … [with] subordinate staff as in a sense children*" who need to be controlled (p.1007). The change in name, from calling people 'administrators' to 'managers' symbolises the shift in perceived status[6]. Administrators were associated with a relatively prestigious position and mostly male role but many were re-labelled

by the 1983 Griffiths report as 'manager.' Also, as a result, the label of 'administrator' was to become associated with lower status, lower-paid and generally female roles.

Managerial character

Some suggest that the managers' personality was important in the implementation of reforms[7,8]. This may imply that some people are ill suited and incapable of adapting to NHS reforms although willingness to adopt new roles may be shaped by external factors. The managerial reforms of the 1980s brought "*a new sense that change is actually possible, a readiness to challenge professionals and a willingness to take risks*" which was "*liberating*" for managers[9]. This reflects wider literature on careers where adaptability, (readiness to cope with changing work and working conditions) is found to be important in career transitions.

Importance of previous background

The background of NHS managers has been discussed widely, perhaps unsurprisingly because the Griffiths Inquiry intended a change in the types of people recruited as managers. The numbers of clinician managers, women managers and minority ethic managers have been significant focus of attention. Despite its rhetoric, the Griffiths reforms were not successful in attracting and (crucially) retaining managers from outside the NHS for example, from business and other public services including the military.

Impact of management (since the 1983 Griffiths reforms)

Although Griffiths had *"immediate effect on individual roles, powers and relationships"* at senior level, many everyday processes carried on as usual[10]. The power of NHS managers, compared to other groups, has derived from their ability to shape local organizational structures but the influence of this power on service delivery is doubtful[11]. As clinicians have taken on more managerial roles, *"simple dichotomies of either professional autonomy or bureaucratic managerial control… are inadequate"* to describe the complexity of the relationship between managers and clinicians[12]. Stephen Harrison suggests that NHS managers' role has evolved from being a "*diplomat*" working in a pluralist environment (the era of consensus teams), to a "*scapegoat*" for the failings of this system, to an "*agent of government*" from the mid-1980s onwards[11,13]. This suggests that the role of administrators and managers in the NHS has always been defined by the tension between who has decision-making power in the NHS, either the government or doctors. Clearly, these roles entail different lines of accountability and responsibilities.

4. The manager's voice: findings from interviews

Five broad areas can be identified that respondents considered as important: joining the NHS, career development, dealing with problems, dealing with reorganization, and leaving the NHS.

Joining: what does the NHS have to offer?

Our sample of managers joined the NHS between the 1960s and 1980s, the NHS was seen by most as a good choice of career as it carried a sense of job security, moderate pay and a sense of vocation. However, several spoke of their family influences, with parents/family members either working in the NHS or other public services, or shaping their values and beliefs. They also talked about the opportunities for development and learning during an NHS career. Several participants had joined as (trainee) clinicians and then after a period of practicing their profession, chose to move into management. For them, this was a strategic decision as a way of furthering their careers by providing a new pathway, which was not previously available to them.

Many respondents had entered the NHS through the Management Training Scheme (MTS), which they regarded highly. Early experiences inculcated managers into the NHS culture, which proved valuable. Respondents identified one of the critical qualities to be instilled during induction into the NHS was an awareness of the organisational culture of the NHS including the barriers to reforms which one respondent referred to as 'concrete slabs'. In particular, respondents spoke of the need to understand and identify the 'concrete slabs', which could terminate or limit one's career. Some contrasted this cultural knowledge with apparent lack of success of 'outside' managers; some spoke of knowing how to avoid 'these concrete slabs unlike their `outside' colleagues. Gaining experience in a range of health care settings (through the MTS or local schemes) was seen as a way of developing this knowledge and hence aiding future career prospects in the NHS.

Career development and moving through roles: what help is available?

The type of job (from and to which managers moved) seemed not as important, as the personal competence and interest. Moves across organisation type (e.g. from purchaser to provider) did seem to be significant. It seemed as if many jobs `changed' over time – in terms of titles, responsibilities etc – so transition was often as much within organisations as between organisations. Respondents talked about the different competencies that helped determine job choice. For example, one talked about his need to work in jobs managing groups and teams of people. It was the opportunity to do this that informed his choice of organisation. So, for example, when he was given the opportunity to move away from a planning role to managing the closure of a hospital, he willing took on the new role. Others, however, said that they preferred roles, which were less dependent on people management. Many moves were planned (both by the service and/or the individual manager) and were often overseen by mentor / 'guide'. (Mentors also played a role in acting as a "role model" for our sample of managers). Respondents spoke of being contacted by their mentor/guide/senior colleague who advised of the forthcoming position and encouraged them to apply. There was a fear of losing these networks in the increasingly diverse NHS.

Dealing with career problems: who is there to turn to?

Most managers interviewed had times in their career which they described as a `failure' or `challenging'. It was notable that informal networks and structures (which had been nurtured over time) were vital to their management of these testing transitions. Such support rarely came from within the organisation within which they worked. This is unsurprising given the sensitivity associated with raising issues of `poor' performance. More commonly, advice and support came from the wider NHS family, often from former colleagues. This may be under strain in a less cohesive NHS.

Dealing with reorganization: how can I cope with all these changes?

While some decried the apparent `constant' re-organisation, most recognised it as `part and parcel' of a publicly funded organisation. Perhaps, given the rapidity of change, our respondents have been accustomed to dealing with major structural and organisational change. For example, major re-organisation took place every few years (1974, 1982, 1983/5, 1991, 1997, 2000/2001). Even this litany of reforms overlooks the changes that took place during, for example, the 1990s internal market (in terms of the evolution of GP fund-holding or the expansion of Trust status). Most recognised the need for change and accepted their role in that process. Indeed, some saw managers as being a dynamic agent of change, either as being part of the hierarchical structure of the NHS (with ultimate line authority to ministers) or as significant actors locally.

Some managers had joined the NHS in the 1960s and reflected on the lack of change then since the inception of the NHS in 1948. There were mixed responses about the number and rapidity of organisational changes. Some respondents were untroubled by these stating that organisational values and their role tended to remain static despite reorganisation. It was felt that it was often 'business as usual' and many reorganisations offered opportunities for them to develop their career and take on extra challenges. This would reflect a sense in which managerial career changes and policy transitions were separate. Other respondents stated that changes made huge differences to their role and the style of management and leadership that was required for success.

Leaving the NHS: where do I go next?

Many spoke of exits as `natural' (e.g. `done all I could'; `time to go'). It was hard to corroborate whether these were their decisions or whether they were encouraged to move on (or retire). Opportunities for consultancy might also have aided their transition. Such consultancy positions employ their accumulated knowledge of the NHS and their managerial skills in ways, which continued to bind them into the NHS – its ethos and values. There were many examples of people being assisted with life after NHS employment in consultancy and academia, often related to their former careers. Indeed, the majority of our sample no longer works in the NHS though several still have links through education, research and/or consultancy. They all valued the opportunity to remain involved in NHS management though in an advisory or consultative role.

5. Implications for NHS management in practice

The sample of 20 current and former NHS managers was not designed to be a representative sample across the NHS. Although we offer no corroborative evidence to the interviews, the literature review does help confirm the identified themes. Nonetheless, the findings do indicate a strong sense in which the managers, as individuals, have had to navigate the course of their career through the shifting `waters' of organisational change and policy reform. The career transitions, which each manager under-went did not always coincide with wider policy reforms. On occasion, the link between the individual and the environment was clear (especially in terms of the reforms associated with the 1983 Griffiths reforms).

However, it is also evident that some changes appeared much less significant that might have been first thought. The 1991 introduction of the internal market was, according to our sample, much less significant that had been hypothesised, for example. The reforms associated with the 1997 Labour government were perhaps even less traumatic for managers. Such interpretations may reflect the sense in which some changes were anticipated or expected (and hence, managers were, in some sense, prepared). This conclusion suggests that NHS managers have become increasingly sensitised to, and aware, of the shifting policy environment and adapting their roles and expectations accordingly. For our group of managers, it is questionable whether formal talent management programmes would have been of significant benefit.

The findings associated with transitions since the Griffiths reforms highlight an interesting omission in the stories told by NHS managers; the public and patients were notably absent. Given the emphasis placed by the Griffiths' reforms (and subsequent reforms) on responsiveness, it is surprising that patients hardly registered in managers' narratives. This may be interpreted in two ways. First, managers may have been pre-occupied with implementing organisational change and policy reforms. The rapidity of such reform may have left them little time to focus

their attentions elsewhere. Second, managers may have become inculcated into the NHS `culture' to the extent that they overlooked the communities whom they were serving. Both seem to be valid.

Due to the overarching culture of the NHS, managers appeared to have strongly associated themselves with the values, ethos and culture of the NHS. Clearly, tensions arose with other stakeholders inside the NHS (especially clinicians). However, managers strongly defended the ends and means of the NHS. For them, the NHS ethos helped to explain the (relative) lack of success by `external' managers, the ways in which job and career transitions were handled and the collaborative spirit of (competing) organisations. As such, managers had truly become paid-up members of the NHS `tribe.' However, in an era when the boundaries of the NHS have become more fluid (with the introduction of more private sector providers, for example), it is more important than ever to ensure that the experience and knowledge of existing managers are brought to bear in the design and implementation of health policy reforms.

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