Centre for Innovation in Health Management

National Inquiry into Management and Medicine
This report is for both managers and doctors who are trying to find better ways of working together, and for leaders wanting to promote the conditions that enable productive working relationships between managers and doctors. It will help those of you leading complex organisations find effective ways of managing and organising.

The report covers acute hospital and primary care trusts.

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Executive Summary

“If the managerial agenda isn’t a clinical agenda, then what is it?”

Chief Executive

PURPOSE
The purpose of this Inquiry was to explore the changing nature of relations between management and medicine, and the possibilities for more effective ways of organising and managing health systems. Despite the widespread cynicism often felt about the NHS and its ability to change, amongst practitioners and policy makers it is known that some parts of the system do perform well and are delivering excellent services. These outcomes, in turn, have much to do with the way managers and clinicians work together at different levels and the relationships they have forged. The prevailing story however is that management and medicine represent two opposing, possibly irreconcilable interests where never the twain shall meet.

This Inquiry seeks to tell a quite different story. The point of departure is that we have not focused on the ‘reasons for failure’ but on those parts of the system where both policy makers and practitioners believe things are working well, where a more ‘productive’ relationship between management and medicine has emerged. Our mission is to draw attention to this fact and in so doing question the idea that the NHS is ‘beyond management’. Specifically we seek to uncover what productive relations look like, how are they generated, sustained, and what difference they make in terms of better outcomes for patients. All this then leads to a broader question. If some parts of the health system can operate productively, then what needs to happen for this to be prevalent across the NHS as a whole?

This report covers the First Stage of the Inquiry, summarising the testimony of key witnesses from the field, including senior managers, clinicians, policy makers and academics. Drawing on this information we outline key features of more productive relations between management and medicine and consider examples of how these have emerged in different parts of the NHS and more generally (for example, in the US and parts of continental Europe). The report also considers what conditions support these ‘relations’ and possible threats to their sustainability. It offers a perspective on ‘what is’ in order to generate curiosity about ‘what could be’. Stage two of the Inquiry will seek to explore more fully their implications for policy and the design of health systems.

OVERVIEW
The differences in perspectives of managers and doctors have been well documented in the lifetime of the NHS. A number of attempts have been made to fix the problem of getting doctors interested and engaged in the management of health services. These have increasingly focused on structural and contractual solutions.

The NHS reform agenda has been costly. There are questions about the return on the public’s investment in the NHS. Whilst the service is improving, the rate of change is viewed (particularly by politicians) as too slow. The fact that doctors are central to reform, and that improvement in services is dependent on doctors engagement in the management and delivery of health services is not disputed. However the process of sustainably engaging doctors – how to do it over the medium to long term – remains elusive. It seems that structural changes on their own, are not enough. In fact they may not be the answer at all.

As suggested above, there are places where productive relationships exist, and managers and doctors are working together, making the most of what each has to offer – where the two perspectives have been a catalyst for service development. Rather than focus on what doesn’t work, this Inquiry was designed to focus on
what does. As such the Inquiry sought out examples of teams, groups, whole organisations and systems, where doctors and managers reported a productive relationship, and looked for the underlying causal conditions using an Appreciative Inquiry approach.

WHAT CAN MORE PRODUCTIVE RELATIONSHIPS DELIVER?
The starting assumption for this Inquiry is that more productive relationships between managers and doctors will deliver better health services. Clinical-management engagement is often associated with a) improved productivity (through the redesign of clinical work)\[^1\]; b) enhanced capacity for change and innovation\[^2\]. A number of studies have found that poor performance and clinical failure were linked in part to a ‘disconnect’ between medicine and management\[^3, 4\]. Many have also identified a positive link between effective clinical leadership and improved patient care. There is then some evidence to suggest that improving the capacity of doctors and managers to co-produce services will add value in the system.

THE PROCESS
This collaborative inquiry used a number of ways to complement the traditional witness based Inquiry. The process was designed to engage the health constituency in exploring the issues; formulating the questions; exploring the possibilities for working differently; and taking these into their management practice. It did this through:

- A workshop with doctors and managers to formulate the Inquiry questions and to uncover the conditions that supported their productive relationships;
- A discussion with policy makers to explore issues for the Inquiry
- Witness interviews and written evidence elements (from the UK, Europe and the US)
- An international academic seminar with leading researchers in this field
- Case interviews in Denmark.

The process included using international examples as catalysts to exploring options for health systems design.

This report covers this first stage of the Inquiry. It and will be taken to the workshop group, and the policy group to explore what this means for policy, what it offers managers and doctors in the design of health services and how we can take this into the wider health system. An extension to this report will then be published by the end of 2007 with recommendations based on further explorations with partner health organisations.
KEY FINDINGS FROM STAGE 1

1. Productive relationships are characterised by:

a) Working for the whole:
  Shared sense of endeavour across the whole of the Trust, and collective responsibility between managers and clinicians for managing the service. Ambitions for the service are shared, as are questions about future design and delivery.

b) Working together:
  Participative and open decision-making. An inclusive approach to information; feedback processes at personal, team and organisational levels; and a culture that makes the most of ‘differences’ seeing conflict as a possibility for further options.

c) Collaborative leadership:
  A more distributed model, shifting away from traditional notions of elitist, expert, positional leadership. Where general managers are concerned this involves a shift towards partnership and facilitator roles. New clinical leadership roles are also apparent. These are associated with increased capabilities to balance corporate and clinical priorities and a more effective change agent and ‘boundary spanning’ role.

d) Shared decisions:
  Greater alignment of decisions at all levels, with a narrowing of the gap (or tension) between managerial and clinical domains of work, and greater understanding of interdependency.

e) Our business is health:
  An organisational focus on the centrality of managing the means of production – “…it’s not rocket science is it, our product is delivering healthcare”. In particular this is modelled at the top by the Chief Executive and executive team, and by the Board. It is reflected in internal performance metrics, and the internal conversations and decision-making of the organisation. The clinical business really matters, and this is evidenced in the attention given to it across the organisation. The top team really understands the clinical work and patients’ experiences.

2. Productive relationships seemed to be delivering:

a) Improved alignment (congruency) of decisions across the domains of financial control, service improvement, clinical quality, governance, operational management.

b) Greater willingness to engage with and share responsibility for service change.

c) Greater capacity for service innovation.

3. Necessary conditions for establishing and maintaining productive working:

1. The strategies and choices made by organisational leaders:
   i. What they focus on (clinical work ‘counting’) – the main focus of organisational attention being on the care and treatment of patients/users and their families/carers, evidenced by language, performance management and information, and how leaders engage with clinical work in the organisation.

   ii. Creating space for change by managing upwards and outwards, particularly the tensions between local innovation and local ownership, and national requirements. An important theme here concerned the ability of top leaders to negotiate the rules and ‘keep the madness of the system away from the organisation’, and to push for decisions being made at the right level.

   iii. Delegated control and decision-making. Taking responsibility and decision-making to the level it needs to be exercised, shared in partnership...
between clinicians and managers.

iv. Ensuring continuity over time.
Commitment of all parties to the future of the organisation – a sense of being ‘in it together’, characterised by the chief executive ‘sticking’ with the organisation and see through change (in the Inquiry interviews this was cited as the CE being in post 6-7 years). This builds shared identity and shared ambition.

v. Avoiding complacency by seeking external ideas, generating energy for change, and constantly questioning the here and now.

2. Management approaches for getting productive relations started and sustaining change:

i. Aligning interests through the presentation of information and through the generation of incentives. Creating ‘pulls’ into new ways of working, through reward structures, and the use of information.

ii. Exploiting opportunities in the context to gain support for change. Persistently and repeatedly spending time on making sense of the external conditions and drivers for change together, to determine a collective response

iii. Frequent dialogue to build a shared vision and support new ways of working. Doctors and managers are persistent in ‘stepping into each other’s shoes’, trying to understand each other perspectives, in all areas of their work together. This further supports the process of handling conflict and difference – seeking to understand differences and use these to come up with better solutions.

iv. Importance of listening, taking an interest, getting involved – this comes from a belief that the clinical work matters, and the need to work with and understand clinical issues. It also reinforced the point that constructive relationships take time.

3. Investments in the organisation to support productive working:

i. Organisational Development – supporting organisational change through designed organisational development activities across the whole organisation.

ii. Investments in Human Resource Management. These are characterised by investment in learning together (managers and doctors) through in-house development/leadership programmes and organisational change programmes, alongside specific programmes for doctors. More systematic approaches to recruitment and selection of clinical leaders were also important.

iii. Internal Performance Management Systems. Open information to support change. Performance metrics that make sense to all those involved (designed at the level at which they will be used to help the team/unit/Trust make sense of their impact), and which are shared across the organisation (open comparators).

There are other conditions that are helpful, but not critical, and these are expanded in the main report.

4. Conditions hostile to productive working

Whilst the Inquiry focused on productive working, a number of issues kept emerging as threatening to the sustainability of these relationships:

a) Frequency of turnover of general managers and particularly of Chief Executives arising partly from
b) Periodic, system-wide, re-organisations.
c) External performance management regimes
and compliance demands that are not mindful of the internal culture or performance management systems in place, and not flexible for different organisations. Some of these external compliance demands serve to reinforce management power, rather than support productive partnerships between managers and clinicians.

d) The system of professional education and socialisation.

e) Perverse incentives – it may not be in the clinicians best interest (financially – merits and private practice, and in terms of career) to devote time to managing in the NHS.

In our discussions of these findings with doctors and managers, it is notable that too many leaders at the top of NHS organisations see time spent on relationships (checking assumptions, working differences, understanding mindsets, exploring impact) and understanding (interpreting issues in the environment, making sense of the business, learning about what works) as risky. In people’s lived experience these activities, both in mainstream working practices and in organisational development work, are the only safe intervention.
Introduction

The genesis of this National Inquiry was exploratory work undertaken by the Centre for Innovation in Heath Management to identify the factors that most affect the performance of the NHS today. The creation of a productive relationship between ‘management and medicine’ came out as one of the key issues for further exploration. Whilst there has been much discussion of the problems of clinical engagement (just look at the Health Services Journal and the British Medical Journal over recent years), there is a perception that the ‘problem’ remains. However, there are instances, whole organisations, or teams, where management and medicine are working well together. We focused our Inquiry on exploring ‘what works’, to see what lessons could be learnt in the wider NHS.

This report covers the first stage of the Inquiry – the evidence gathering and analysis, and presents the conditions that support productive relationships between management and medicine; a subsequent report will cover the impact of supporting these findings in practice, in particular the implications for policy and the design of health systems.

FINDING YOUR WAY AROUND THE REPORT

We understand that our audience will be diverse, as was our Inquiry evidence-gathering. Some of you just want to know the outcomes, some will be interested in the process, some will want to follow the debate, and we hope some of you will want to join in the next stage of the Inquiry work. This report is split into the following sections:

1. Executive Summary – for those that want the essentials.
2. Why this relationship matters – what difference does it make? Why does it matter for patients?
3. The Process – How we went about it and why we chose this Inquiry approach. Getting Involved – if you want to be involved in learning more about the work, or in the next stage of the Inquiry
4. The Inquiry Process – what we did.
5. The Results – in detail.
7. International Comparisons

SOME BACKGROUND

The well documented difference of perspectives of managers and doctors, and the difficulty of engaging doctors productively in health management, has not been overcome by structural or contractual solutions (in fact we believe that these have at times exacerbated the differences). Both managers and doctors have a history that makes mutual engagement problematic. The difficulties remain, however there are some places where productive relationships have been forged, and managers and doctors are working together – where the two perspectives have been a catalyst for service development. In addition there are currently many opportunities for rethinking organisational form arising from an outward facing, community/user focused service, and possibilities of plurality. We therefore chose to focus this inquiry around ‘what works’ and ‘what’s possible’.

Taking a step back, the quest for greater effectiveness and efficiency has been with us since the inception of the NHS in 1948. The growing importance of this quest can be observed in the number of government reports and reorganisations commissioned to look for
improvements. (e.g. Porritt[5], Salmon[6] and Cogwheel[7] Reports in the 1960s, the Royal Commission following the 1974 reorganisation[8], Griffiths[9] and Working for Patients[10] in the 1980s, followed by further market reforms in the 1990s and then Wanless[11] in 2002.) Effectiveness and efficiency are an essential focus of management in every public sector organisation and these have justified the ongoing pace of reform. At the same time, there is a widespread perception that these ongoing reforms have been costly and of only limited efficacy. Management remains a vital component for the service improvement we all seek and we should acknowledge that progress has been made over the years. Equally, engaging clinicians with management is crucial for unlocking future potential. As Gerry Robinson highlighted in his programme for the BBC[12], doctors are central to the ‘means of production’ in the NHS and their relationship with managers is crucial to improving performance.

OUR APPROACH

Our approach is distinctive in that we do not focus on another version of ‘what’s wrong.’ The NHS has a long history of crisis reports (e.g. Shipman[13], Bristol[14]) that ring the bell about problems. Rather, we have explored how health organisations and systems have found ways of making the most of the potential offered by both doctors and managers in managing health services. This has led us to highlight some international, as well as United Kingdom, examples. We draw attention to existing competencies around managing in the system and aim to promote learning/dissemination within it. Our contention is that in places the system is working well and there is an urgent need to highlight this and learn from it.

A further assumption of the National Inquiry is that there is scope for ‘legitimate diversity’ within the system. Contrary to the views of some academic observers (e.g. Hoque[15]) local practice is not wholly shaped by national targets and regulatory mechanisms. The notion of a ‘legitimate diversity’ is important because unconstrained autonomy leads to outcomes like a ‘postcode lottery.’ Our evidence is that there are important outliers within the system that show how appropriate room for manoeuvre still exists and can breed the innovations necessary to improve the system as a whole, across the nation. We also seek to remind the policy community that policy is never neutral for innovation. Policy can encourage or discourage the conditions in which ‘productive working’ occurs and this needs to be taken into account when policy choices are made.

After an investigation of the existing literature on the NHS, the Inquiry used a method in the tradition of Appreciative Inquiry[16]. Semi-structured interviews were conducted beginning with a request for a story of where the relationship between medicine and management had worked particularly well. This method reflected one of the major aims of the Inquiry: to highlight successful work already existing in the system. UK witnesses were invited from cases perceived by practitioners to be “successful.” This selection method was used (rather than existing league tables or other similar metrics) as part of an attempt to discover ‘productive working’ which many observers had already given up on. The international comparisons (from Denmark, Holland and the USA) were selected to cover a range of alternative systems, but with a view to retaining some useful comparability. (More detail in the following section on Process).

THE FOCUS

The primary focus of our interest is the relationship between medicine and management in the context of the NHS. This is an inquiry into how a statutory, multidisciplinary organisation manages a key part of its means of production – medicine. As such, there is less focus on how medicine manages itself, for example in the context of private practice firms or professional
bodies. Such organisations may be working examples of a high degree of practitioner autonomy, based on collegial regulation, trust and mutual obligations. However, this broader topic of medical self-organisation will only be addressed here in so far as it relates to management within the NHS.

That ‘doctors and managers don’t get on’ is a commonplace view inside the NHS, which periodically attracts attention (e.g. *BMJ* 2003[17]). Media events like “Can Gerry Robinson Fix the NHS?”[12] have also brought attention to the issue from a wider audience. A detailed scoping of the phenomenon may be found in Appendix 5, but it is useful to consider some broad issues at this point.

Medicine is not the only component of the health-care system, but we have chosen to focus on it as the doctors are highly influential in the delivery of care. Alongside the respect they command from the general public, they take key decisions about how and when treatment is supplied and are often responsible for directing other members of the service. This adds up to a large influence on the operation of the system. At the same time, it is important to realise that the profession is not a monolith, it is split most obviously between primary and secondary care (who often have different priorities) but even the Royal Colleges do not always have a unified view on administration matters.

Management has a number of different facets within the NHS. Some observers[18] have noted that NHS managers do not have the power that managers have in the private sector. Nevertheless, it is primarily through the activities of management that the wide-scale improvement of the system occurs. Whilst managers (like doctors) are often seen as a unitary (and potentially hostile) tribe, it should be recognised that most members of the health service, including doctors, nurses and allied health professionals engage in some managing during their working day. Thus the question of management cannot be ignored at any level.

The present state of the crucial relationship between medicine and management is rooted in the history of the founding of the NHS and subsequent attempts at reform, detailed in Appendix 5. However, these ongoing reforms have not proved wholly successful. There are significant variations in practice, where some have turned reform into better practice, but most agree that the overall results of reform have been limited if not disappointing. The problem and significant challenge of how to achieve more productive relationships still remains.

We would emphasise however, that this is not about finding a “magic bullet.” We have found general conditions that support productive working relationships to be common across all sorts of health organisations. However, the context of each organisation (particularly between primary and secondary sectors) is different. Thus, the means of creating these conditions are sometimes so as well. Whilst the report contains practical suggestions for improving relationships at this time on the ground, the key element is in continually fertilising the conditions that will create relationships that stretch and respond well to the unpredictable challenges the future will bring.
Why does it matter?
Why is the relationship between management and medicine important?
Why does it matter for patients?

A common and important reaction from witnesses and workshop attendees was simply 'why are we spending time in this issue? What impact is it likely to have on the wider goal of improving patient outcomes?'

A number of measures (e.g. general waiting times, improving survival rates) suggest there are indications that the system is improving. There have been significant resource increases and capital investment which have enabled advances in the quality and in the range and standard of treatment. There are signs of enhanced networking capabilities amongst clinicians/specialities resulting in improved outcomes. There have also been changes in the self-regulation of medicine and a shift towards greater transparency and accountability, in part propelled by the reactions to the Bristol\[14\] and Shipman\[13\] Inquiries. At the same time, targets and performance management frameworks established in the system (largely post-1997) are having an impact in raising standards and reducing regional and local inequalities and variations in provision.

So, given the above, why focus on ‘management and medicine?’ Why are organisational issues important? Should we not just leave the system to continue to improve in the manner it has so far?

We would say NO, for the following reasons:

a) Productivity improvement in the system has not matched increases in resources. This can partly be explained by the need to replace ageing technology, facilities, etc. However, these factors do not explain the complete lack of improvement. This report suggests that the relative failure to develop productive relationships between management and medicine is a key issue.

b) Continued examples of failure and malpractice in the system. There have been high profile problems of accountability (e.g. Health Commission investigations into Northwick Park\[19\], Stoke Mandeville\[20\], Cornwall Learning Disability\[21\]) where a breakdown of trust between doctors and managers has been cited as a large problem. However, of even greater concern should be the rising dissatisfaction with the day-to-day patient experience. From things as simple as scruffy ward toilets to an inability to find medical staff in an emergency, these issues point to organisational, rather than medical difficulties.

c) Future challenges. Changes in policy are generating new demands in the system for enhanced strategic management capabilities amongst provider organisations. We would highlight particularly the ability to produce and adapt services more flexibly to respond to changes in need. For example, new commissioning frameworks (practice based commissioning, new criteria for commissioning and payment by results) and Foundation trust status (a range of changes required at local level to take on new ‘freedoms’). At the same time, just like every other service organisation, the NHS must face up to the ongoing growth of public expectations.

d) Lost opportunities. The research/existing knowledge on health systems more generally suggests that systems based on co-producing the organisation are more effective in terms of promoting learning, productivity innovations and capabilities for change\[2, 22\]. These outcomes will have implications for end users and are likely to result in improved services/outcomes. We will produce examples of this in the remainder of the report. In short, improvements in the capacity of doctors and managers to co-produce services will add value in the system. This value and potential is frequently lost under current arrangements.
The Process

This collaborative inquiry uses a number of ways to complement the traditional witness based Inquiry. The process has been designed to engage the health constituency in

- exploring the issues;
- formulating the questions;
- exploring the possibilities for working differently;
- and taking these into their management practice.

The witness-based, and written evidence elements seek to pursue approaches that overcome the difficulties between the two disciplines. This includes using international examples as catalysts to exploring options for health systems design.

The process is not focusing on another version of ‘what’s wrong’, but on exploring how health organisations and systems have found ways of making the most of the potential offered by both doctors and managers in managing health services.

The Inquiry sought examples of a productive relationship between management and medicine; for examples where people have moved beyond the fraught history, and found ways of working together that makes sense for patients and the organisation. The inquiry was looking for the conditions that support that productive relationship.

The outputs are therefore a discussion of the conditions that can be created in the here and now to potentiate the capability of management and medicine together; and exploration of effective models for organising. This report contains the results of the first stage of work – gathering evidence.

The process started with a ‘high-level’ dinner conversation to gain some buy-in from senior leaders; to scope the work; and to take views on key strategic questions (please see Appendix 1 for participants in the Inquiry). This was complemented by a workshop with a number of managers, doctors and stakeholders to scope the work again; think deeply about the questions; network stories that could be used as evidence; access possible witnesses; develop a constituent group committed to trying to work on this issue with the Inquiry (See Appendix 2 for an outline of the results of the workshop.)

The next stage was a witness and evidence gathering inquiry supported by the research team, that took place in London and Leeds (for the witness panel briefing please see Appendix 3). The interviews used Appreciative Inquiry to uncover where and how the relationship between management and medicine is working; focus energy and attention on understanding why and how it works; and uncover the conditions that are enabling it to work well.

The results of this have been taken back to the workshop group (February 2007) and to the ‘high-level’ dinner group (March 2007), to explore what this means for their organizations and how we can take this into the wider health system.

Alongside this we explored the research evidence base for organising professional public services fit for purpose for the future, through a literature review and an International academic seminar. (See Appendix 4 for a summary of the Seminar.)

GETTING INVOLVED – STAGE 2

The Centre for Innovation in Health Management does not restrict itself to commenting on the state of the NHS, or on making recommendations for the NHS. Our approach is to work with the NHS to support productive change efforts. This Inquiry report is a catalyst for organisations and leaders wanting to improve their own internal relationships and ways of working. Stage 2 is about deepening our knowledge of these productive relations and the conditions that support them. It is also about supporting NHS organisations that want to use the work here on conditions that support productive relationships to craft their own organisational development. In conversation, and by experimenting with these conditions in NHS Trusts; and by conversing with policy makers, we aim to uncover ways that the NHS can make the most of management and medicine in service to patients and communities. This will be the subject of Stage 2, and subsequent extension to this report.
The Results

This section begins with a general examination of ‘productive relationships’ and the benefits that flow from these in terms of the different kinds of outcomes. This is followed by a typology of the forms of ‘productive relationship’ found by the Inquiry. Finally we explore in detail the conditions that support these relationships and help to sustain them.

1. What Do ‘Productive Relationships’ Look Like?

The Inquiry encountered some examples of the poor or ‘non-productive’ working relationships that have formed the common perception of the problem of ‘medicine and management.’ For example, in secondary care settings: a kind of cold war between management and clinicians, where management ignores clinical innovations and clinicians ignore management attempts to improve the organisation. Clinicians are seen as too concerned with work in “my firm” where “I am the ruler, I am going to command my forces.” At the same time, managers are seen as obsessed with their own interests and careers. All this adds up to a sense of the hospital as just “a place where a number of tribes interact.”

In primary care, there were scenes of almost complete atomisation within Primary Care Trusts, with Professional Executive Committees that “withered on the vine” and little more than contractual contacts between doctors and managers. GPs were viewed as narrow-minded individualists and in turn they viewed the PCT as “distant and mechanical”. In some accounts the impression was given of managers and clinicians operating almost in entirely different parallel worlds or universes. As one witness (the Chief Executive of a PCT) put it: “there was a big point of realisation for me, that where I saw the collective of 21 practices, they [the GPs] didn’t see that collective, they just saw the practice. They didn’t see the PCT and they didn’t see the NHS, they just saw the practice…”

However, our witnesses also unanimously suggested that in many parts of the system management and medicine were positively engaged and working together productively. Witnesses described this in various ways: “a shared corporate mentality,” “a happy organisation,” a move to “a broader perspective” which recognised “mutual dependency” and a need to “engage with the system in its entirety.” In these instances, it was claimed, clinicians were generally more willing to work with managers and more centrally involved in the process of managing care itself.

From these descriptions of ‘what works well’ one might argue that within the existing system particular capabilities have emerged, capabilities that facilitate, alternative ways of working to the norm and which yield certain beneficial results. Because of the exploratory nature of this inquiry it is hard to assess just how widespread or deeply rooted these competencies are. Some witnesses gave examples of isolated pockets of productive working found within specific geographical locations, GP practices or clinical directorates. Others described entire organisations, such as Hospital Trusts or PCTs, where productive relations were more generalised and embedded.

Later on, specific examples will be given of organisations that do seem to be working differently. We will also explore the links between this and outcomes, such as improved quality, innovation, efficiency and responsiveness to change. However, before that it is necessary to describe in more detail what we mean by ‘productive relations’. Specifically we focus on how our witnesses themselves described these work arrangements and what features they saw as being important.

In doing so it is useful to differentiate between FIVE main features of ‘productive working’ that were common across all accounts:
• A negotiated sense of shared identity and collective responsibility for the ‘management of outcomes.’
• Open, participative and inclusive modes of communication
• Collaborative leadership styles, both of clinicians and managers.
• Greater clinical input into management decision-making at all levels.
• A shared focus on the centrality of managing the means of production

1.1 Working with the whole:
A negotiated sense of shared organisational identity and collective responsibility for the ‘management of outcomes.’

Earlier we noted that health organisations in the NHS and more widely are characterised by high levels of service fragmentation and a limited overall consensus on goals and priorities. Indeed, as one witness put it, hospitals and primary care agencies may best be viewed not as ‘organisations’ but as “places where a number of tribes interact”. This situation has generated perennial difficulties for managers seeking to formulate common strategies and negotiate change. Yet, what the evidence of this inquiry suggests is that while such negotiation is undeniably hard it is not impossible. In some parts of the system the interests of clinicians and managers are more closely aligned and there does appear to be an emergent sense of collective ownership of the management of services. To be sure, this does not mean pre-existing divisions have been fully overcome or that they ever will be. As Bate [9] suggests, professional allegiances and tribalism may be too strong to develop a harmonious, overarching culture in hospitals or PCTs. Rather the trick is to contain these divisions through a kind of “regulated pluralism” based on shared understandings and from this develop some sense of shared responsibility.

This theme was apparent in all examples of productive working given by our witnesses. These emphasised the importance of trust and building a shared agenda. More than one suggested that the first sign of success was when clinicians and managers stopped thinking in terms of ‘them and us’ and there was a sense of moving on from the old tribal conflicts found in many parts of the system. Sometimes this amounted only to a mutual (and perhaps temporary) recognition of shared interests and a willingness to work together on that basis. Elsewhere a deeper sense of common responsibility for management seems to have emerged. An example of the latter was given by the CE of a Hospital Trust, describing the reaction to a new consultant who was complaining in a clinician meeting: “it’s bloody management and if they would do this and if they would do that.’ And a Chief [Doctor in charge of a division] would stand up and he’d say ‘who do you mean, they?’ And the guy would say ‘well management’ and the Chief says ‘well we’re management, what you are talking about, we manage the service’”.

Where a collective sense of responsibility for management had emerged it was clear that this did not emerge wholly by chance. Rather it was the result of ongoing and incremental negotiation. Two managers of a Hospital Trust gave us a sense of an evolution, from a set of clinical fiefdoms, run by “Barons” who largely opposed engagement with management to a situation where a “poacher turned gamekeeper” and moved from a sole focus on their particular tasks and departments to participating in a stronger collective endeavour. This evolution was prompted by concerted efforts to negotiate around difficult issues and create a new culture of co-operation. The new emerging collective spirit allowed difficult actions to be taken to address (for example) staff shortages in a less prominent specialism like Paediatrics. As the CE put it: “now we are singing from the same hymn sheet”.

This sense of a ‘shared ambition’ and a desire to change things can be seen in another development path in the story of a large-scale
service re-engineering project, also in a Hospital Trust. Here, it was the initial ‘give and take’ of creating a new plan to address changing circumstances and improve service provision, followed by the bonding experience of persuading those outside the Trust of the merits of the plan that created a strong feeling of community. As one clinical director involved in the process remarked: “that’s important to me, that we’d done it together … we’d done it and that ‘we’d done it’ feeling was very, very, very important.” This amplified the issue that it’s not what’s talked about that matters it’s how this relates to action.

Examples of how a shared sense of ownership for services had developed were also given from primary care. Here, if anything, the obstacles to such change are more pronounced given the highly fragmented, loosely coupled and geographically dispersed nature of organisations. A number of witnesses however talked about how in their PCTs these difficulties had been partially overcome as a result of negotiations between managers and other relevant stakeholders. One PEC chair talked about the transition from “those very sort of GP dominated, very what happens in my practice, discussions, to a broader perspective”. A manager at another PCT in the north of England also described how an initiative aimed at developing a spin off company involving local GP practices had led to a “step change” in thinking. Whereas before most GPs saw the world only through the narrow lens of their own practice, increasingly they had come to appreciate their “mutual dependency” and “collective strengths”. All this is indicative of some shift from individuality to collegiality amongst GPs, or as another witness put it, towards a kind of “corporate primary care” where practices worked together as opposed to in competition.

An important characteristic of ‘productive working’ is therefore some emergent sense of common endeavour and responsibility for the management of services. None of this suggests a complete consensus or alignment of values. Rather the point is that in many areas traditional conflicts between managers and clinicians, arising from service fragmentation and inter-professional rivalry, have been partially overcome or at least contained. In their place one sees a more productive or creative tension between collective needs and individual interests.

1.2 Working Together: Open, participative and inclusive modes of communication

The divergence of goals and interests noted above has also generated severe problems of communication between clinicians and managers in the NHS. Where managers are concerned there may be a tendency to become overly secretive, defensive and increasingly unwilling to share information or engage clinicians in strategic discussions about organisational goals and priorities. Clinicians, by contrast, may respond by engaging in “difficult”, “disruptive”, “un-co-operative” or “non-organisational behaviour”. The result all too often is that communication is either limited, outwardly confrontational or simply non-existent, as both sides engage in various strategies to avoid conflict. The latter is often manifest in situations where managers and clinicians pursue their own agendas independently, seeking to define problems in ways that avoid encroaching on each other’s expertise or responsibility.

The testimony of our witnesses provided numerous examples of this kind of near ‘communication breakdown’. However, most were also keen to draw attention to alternative patterns of more inclusive, open and productive communication between managers and clinicians. One witness laid out the theme of “open conversations” particularly between people from different levels or departments in the organisation. Another described how in his Hospital Trust inclusiveness extended to clinical directors refusing to hold consultant meetings without managers present. Those who excluded managers
were seen as “potentially putting subversive cultures within their departments.” A number of witnesses noted it was important to be frank, whilst others pointed to the necessity of frequent dialogue. This was seen to have a number of benefits. It could serve as “a measure of community, a shared frame of reference”. Regular exchange of information could also help prevent people feeling disenfranchised and allow people to express any frustrations. As one manager put it: “everyone can have an issue, you just have to raise it.”

These examples should not be taken to imply that all barriers to communication had been overcome or that relationships were suddenly harmonious. As one CE explained, “cosy would be entirely the wrong word… there’s a lot of fairly straight talking” and “we’ve had some real stomping discussions.” Another commented on how, while positive, his interactions with clinicians were far from smooth, admitting to getting into “a bit of a scrap every now and then”. In this context it was seen as important to create an atmosphere of transparency, “not having secrets I think and explaining why things are difficult when you’re doing them” and also being willing to admit mistakes. One witness highlighted the benefits of this approach with an example where the atmosphere of trust and transparency allowed the effects of some perverse incentives to come to light:

…so there was actually an amazing moment in that meeting, where one of the GPs admitted that … he had a huge number of ghost patients, so he had to do the sums about reconciling targets and money against these ghost patients. And actually that was an important discussion because if the managers need to achieve their target, they need to understand why that’s not happening. And if you can be open about that you know, you get a better understanding.

Others emphasised the importance of creating “safe vessels” or mutually agreed zones of tolerance that helped both parties to work with difference without allowing this to undermine relationships.

A further caveat placed on these descriptions of open, inclusive communication was the view that in many instances some disagreement was actually useful. In order to have discussions that include “some fairly straight talking” witnesses suggested that it was important to focus on channelling conflict in a positive way. As one manager put it: “I think it’s about you know, sitting down with them [the consultants], taking the grief, quite a lot of taking the grief … [then] work with them, to get them to where they needed to be.” A critical part of this process is an attitude that difference and conflict are both necessary and useful for the organisation. According to one manager, a key challenge is, “how do I harness this passion that exists?” while another remarked that “If you haven’t got any enemies, you’d better invent some”.

**Box 1.1 Harnessing conflict**

“…My experience has been very positive but the world isn’t perfect. In the Trusts I’ve worked with, they’d say that the managers and clinicians worked together very closely. When I joined them at first I was trying to build something good and that included transparency, having vision, sharing values and being clear about what you’re trying to do, then having an organisational structure that replicates that. I’ve always had clinical directors and general managers who recognised the importance of transparency about their role, being clear that the clinical role is not representational, it’s managerial. I also think it’s important not to shy away from conflict. A lot of management and clinicians pretend the world’s alright but whinge behind the scenes, but I do conflict. In my current position everyone thought they were marvellous, my predecessor was marvellous, but it wasn’t a
management structure and I wanted to change that. What I inherited was a traditional two sessions a week with the medics meeting the executive team and all they’d ever say for the first 2 months was ‘Can I have?’ ‘Can I have?’ I’d ask: ‘Is there a business case? Is it in the plan? Do you have the money?’ And they kept going: ‘no’, ‘no’, ‘no’. So I’d have to say ‘No, but if you do those, we can look at it’. This was novel to them because they were used to going to the pub, having a beer and getting what they wanted. It wasn’t quite the sort of accountability I was used to!’

(General Manager)

Many witnesses coupled the productive use of conflict to a general atmosphere of respectful interaction or understanding the limits. Examples of disrespectful behaviour included shouting at nurses and other lower-ranked colleagues, agreeing to collective goals and then undermining them through inaction or bad-mouthing colleagues in group emails. In one Trust, some clear statements have been made that “we pay attention to behaviour” because effective working requires “mutual and professional respect between people.” Another witness remarked that it had been necessary to say explicitly that some behaviours were “totally unacceptable, this is not non-negotiable. You may not like people here, you may not like your colleagues but no matter, you’ve got to work with them as a team and there’s no future here for you unless you’re prepared to work as a sort of team”.

Box 1.2
Re-defining ‘acceptable behaviour’

“I remember a consultant who told me that and some of the behaviours of some of her consultant colleagues was completely sort of un-collegiate in the way that they interacted. Very much working with a strong sense of an independent clinician rather than as a team. In fact we’ve had a recent case in Specially X of where we took someone to task for their lack of effective team-working…. a whistle blowing complaint was raised, the Medical Director and I worked very closely together on anything like that and we set up an investigation and the job was reduced. And what the investigation identified was that the basis of the complaint - that this consultant would be killing people or of an unacceptable mode of practice - that wasn’t supported by the investigation. What was supported was the history and the evidence of people behaving as individuals, not part of a team. And that has given us the opportunity to say “totally unacceptable, this is not non-negotiable. You may not like people here, you may not like your colleagues but no matter, you’ve got to work with them as a team and there’s no future here for you unless you’re prepared to work as a sort of team”. And you know, even in Speciality X, that message is accepted. Probably five years ago, seven years ago, it would be much more questionable as to whether it had been accepted.”

(Clinical Director)

A final point to note here concerns how expectations regarding ‘appropriate’ communication were disseminated and reinforced. Peer feedback was mentioned several times as a key leverage point in changing behaviour. One witness bravely admitted that he had “behaved badly” at one point, but it had
been immediately addressed by a colleague who saw what happened and challenged him to think about his actions. Others stressed the symbolic role played by top managers in this respect. The CE of a teaching hospital noted the “enormous personal respect” that existed between him and his medical director and how this “respect and authority transmits itself down the organisation”. Finally, a number of witnesses referred to more formal policies and structures designed to ensure feedback. According to one Chief Executive it was necessary to “have an organisational structure that replicates what you are trying to do”. In another Hospital Trust, significant investments were been made in “OD activities that run across the organisation” and are all about “reinforcing behaviours and cultures”. Our witnesses therefore described various systems and tactics for encouraging more inclusive modes of communication and, more generally, some capacity for collective learning within their organisations.

1.3 Collaborative leadership styles, both of clinicians and managers.

The objective of enhancing leadership capabilities within the NHS continues to occupy a great deal of time and attention in today’s policy community[23]. All too often, the argument goes, clinicians lack leadership or management skills and remain indifferent or disengaged from this activity. General managers, both at senior and middle levels, may also lack the necessary leadership qualities. Indeed, managers may feel they have little choice but to rely on their formal authority to impose change in a dictatorial fashion. Poor leadership therefore is seen as endemic and for some lies at the heart of many of the problems now facing the NHS.

Our witnesses reiterated many of these concerns. However at that same time many also noted how in many parts of the system alternative styles of leadership had emerged. In essence these newer forms represent a departure from traditional notions of leadership based on élitism, patronage and position-based authority. This, in turn, implied quite different roles for both general managers and senior clinicians and in some respects a convergence between them around a notion of ‘collaborative’ leadership.

Starting with general managers, a majority of witnesses talked about how the most successful managers were those who adopted a “partnership” role, facilitating and supporting clinical self-management as opposed to directing or telling people what to do. Numerous accounts were given of how in those services where relations were most productive managers acted as “facilitators and enablers”, “professional civil servants working for a politician” or, in the words of one clinician “our right-hand men”. Effective leadership, all agreed, was “not about control, it’s about influence and then how do you get influence”.

In some respects this ‘new’ role runs counter to the expectations of many managers in the NHS, “edging them down a peg or two”. Most witnesses however were at pains to stress that being a partner did not imply a return to the old pre-Griffiths culture of passive, consensus administration[24]. Nor did it mean that managers would take a “back seat” or shirk their “co-responsibility” for ensuring the performance of services. Rather the message was that managers needed to use alternative ways of bringing about change, through negotiation rather than imposition, and that their focus should be on using their skills to assist and add value to clinical work. As one manager explained, “patients and professionals are best placed to advise on how services should be organised, to ensure a kind of optimal outcome and optimal patient experience”. By contrast, “Managers are best placed to make things happen by implementing things in the most efficient way.” Others referred to the role of general managers in “squaring the circle”, helping to reconcile professional aspirations with
resources. Finally, managers were seen to have an important role in “challenging” clinicians, helping them make more effective decisions with a wider use of information and avoid the tendency of some doctors to make over-hasty decisions.

Running parallel with this 'support' role of managers were changes in clinical leadership, especially for senior positions such as PEC chairs, medical and clinical directors. Research on this topic has already noted certain shifts in the behaviour of doctors or nurses who enter into these 'hybrid' or 'part time manager' roles [91]. Ferlie et al.[25] for example note how some clinical managers have begun to address “thorny” issues such as “differential levels of performance amongst colleagues” and the “inequitable distribution of workloads”. Similarly Flynn[26] looks at a study which shows that some clinicians simultaneously display a commitment to clinical freedom (a familiar part of the old élitist notions) whilst accepting there needs to be a limit on variation between the clinical practice of doctors. It is also noted that doctors who take on management responsibilities may end up playing a key ‘boundary spanning role’, spending their time mediating and translating between their fellow clinicians and other managers [2].

Turning to our own investigation, witnesses highlighted a number of examples where doctors displayed leadership on issues that traditionally were considered taboo or outside the medical domain. These doctors, it was argued, adopted less of a ‘custodial role’, as first amongst equals seeking only to protect or minimise disruption to clinical practice[27]. Instead their focus was on creating greater alignment in the organisation by “making sense of the managerial agenda for clinicians and making sense of the clinician’s agenda for managers.”

A consistent example of this ‘new’ leadership is the action of certain clinicians in leading change, particularly in engaging other clinicians as “ambassadors to stimulate support”. One witness explained that she had a particular credibility in being able to ‘sell’ change to colleagues:

The fact that I’m a practising GP half the week and I really understand the hassles of seeing a huge number of patients in a limited amount of time. And the hassles of the doctor/patient relationship and the beauties of the doctor/patient relationship. I understand the hassles of running the business because I do it myself.

Another witness told a similar story but went further in explaining the role (referring first to the skills of the Chief Executive who they co-operated with): “Whereas he’s really good at managing the politics and calming things down … I deliver the clinicians across the health community.”

Some witnesses expressed important qualities and conditions for selecting clinicians to formally take on these leadership roles (a theme we shall also return to below in section 3). It was judged that careful selection was necessary, taking a step away from the traditional “elected representative” status of many senior clinicians. An interest and capability in management issues was also required and candidates needed a clear job description, real incentives and adequate resourcing. At the same time, clinician leaders need to have the respect of their colleagues, they cannot be doctors who seem to be professionally sub-standard. Referring to his medical director the CE of one Trust observed that Dr X has: “got the passion…the presence, he’s got the clinical ability and it’s how you redirect that and how you use that to benefit not him on an individual basis but across the whole organisation”. Others were in agreement that “those that are most clinically competent and are clinically respected” are likely to be the most effective clinical leaders.

These examples of clinical leadership are of course nothing new. For some time researchers focusing on the NHS have observed the
emergence of hybrid professional manager roles and the tensions and stresses this creates for those who enter into them. But what this Inquiry suggests is that these roles may be developing in ways previously unforeseen in the literature. There is a sense that some clinical managers are becoming increasingly adept at reconciling different priorities and that their modus operandi is no longer just to act as custodians of medical interests (as is often suggested [92]). Added to this are subtle changes in the contexts in which these clinical leaders operate. In some parts of the system these contexts appear to be supporting, valuing and reinforcing particular forms of clinical leadership behaviour rather than, as is so often documented in the literature, working to undermine them.

1.4 Shared decisions: Greater clinical input into management decision-making at all levels.

Since the early 1980s an important theme running through attempts to reform healthcare provision in the UK is the objective of shifting roles, to draw clinicians into the management decision process. This has been most pronounced with the delegation of budgets and HR responsibilities to clinical directorates and individual GP practices. However, the indications are that such change has been variable in its outcomes. One recent survey of 1,092 chief executives and lower level managers in 192 Hospital Trusts noted considerable dissatisfaction amongst Clinical Directors with limited resources, declining autonomy and the growing emphasis on financial (over clinical) goals[28]. This and other research suggests that the engagement of many doctors with management work is often pragmatic or half-hearted.

In contrast to this picture our witnesses were more upbeat about the prospects for breaking down traditional clinical-manager role demarcations. Some organisations, it seems, have already progressed quite far in this respect. In one Trust there are plans to supplement existing clinical involvement by giving clinical teams profit and loss accounts, along with “activity based budgets”. Clinicians there have responded by increasingly “taking ownership of costs” as linked to their own practice and being prepared to make cuts (see section 2 for more examples). Others talked about escalating involvement of clinicians in the strategic management and planning of services. The CE of one Hospital Trust described how “the whole middle level of clinicians” were so “engaged in the strategic direction” of the service that as soon as any new plan was circulated: “they wanted to speak to the Board, one by one the Clinical Directors … ‘why isn’t our service mentioned…why am I not mentioned specifically; does that mean you are not supporting me?'”. He went on to explain how to consolidate this process, Board meetings were held more frequently with separate “strategy days” in between. This change: “ ….really got an engagement that I’ve never heard of before. And the non-exec were completely taken aback”.

A number of witnesses talked about formal structures that helped to facilitate greater involvement of clinicians in management at different levels. Several Hospital Trusts, for example, have focused on increasing medical representation in senior management discussions. One has weekly meetings of all Clinical Directors with the Executive Management Team, whilst another has sought to enhance clinical involvement at the top level by creating additional Medical Director posts. In the latter the decision had been taken to appoint three Medical Directors to the main board, each representing different groupings within the hospital, but also with responsibilities for “corporate areas”. In one case this included “education and training, job plans and consultant appraisal”, in another, “responsibility for all the external relationships with Primary Care”, while the third had a specific role of developing a new “Clinical Services Strategy”.

In contrast to this picture our witnesses were more upbeat about the prospects for breaking down traditional clinical-manager role demarcations. Some organisations, it seems, have already
Even more radical were the moves by two Hospital Trusts (both in the north of England) to develop re-integrated Divisional management structures, where managers report to clinicians who then report directly to the Chief Executive. At one Trust 55 clinical directorates had been clustered into “family groupings” of nine divisions. Each division was headed by a Chief of Service, “fully accountable for what goes on within their divisions, both in terms of governance and quality, but also targets, resource management, leadership, etc”. In this case, the chiefs of service sat alongside the CE and other functional managers on the main board and were thought to have a significant input into strategic as well as operational decisions. At another Trust a similar structure of four “clinically led” divisions had been established, each directly accountable to the CE and largely responsible for “operational decisions”. According to the CE: “These guys hold the budget, I don’t have any money, I am the only person in the Trust that doesn’t have a budget…So if I want to spend anything, I have to go begging”.

New structures for involving clinicians in strategic and operational management were also evident in primary care. Here it was noted that many Professional Executive Committees (PECs) had “withered on the vine” and “failed to deliver clinical engagement”. This however was not always the case. Witnesses gave examples of how some PCTs had developed strong links between the PEC and the main executive board with beneficial consequences. As one PEC chair explained: “I can tell the managers [colleagues on the PCT board] what patients are actually saying.” In this case medical input into the setting of vaccination targets created a greater sense of “buy-in” from clinicians to achieving these goals. A variety of different organisational forms had been created to facilitate this process. At one PCT PEC members were formally part of the main board acting both as advisers and executive leads in areas such as the clinical governance strategy and the implementation of GP performance appraisals. At another, a “matrix of involvement for the Professional Executive Committee” had been established, defining different levels of involvement for clinicians and their associated roles, including: “clinical sponsor, clinical representative, clinical champion or clinical lead”.

However, some witnesses cited the risks involved in these approaches. One concern was that formal structures could actually represent little more than “paying lip service” to integrated working, unless real responsibility was delegated to clinicians. Complementary to this were the risks of delegation. As one CE explained “When we went live with management, the clinicians in management, handed them the chequebooks out, we went to about £1.5million overspend in the first five months.”

According to our witnesses, reinforcing many of these initiatives were deeper changes in the values of both general managers and doctors. The former increasingly saw clinical engagement as integral to management (see below) and were therefore more willing to let go and take risks with delegation. The latter, in turn, were more prone to value management activity and no longer regard it as irrelevant or peripheral to delivering care. As one clinician witness put it “I’m not a manager and I wouldn’t begin to think I could have done a Chief Executive job in the way that some of the people I’ve worked with could do it. Because they’ve trained all their lives to do that.” But this witness had still volunteered to undertake management activities and take on a management role because he saw it as another opportunity to make a positive impact on patient care. In another case “there was a GP came across from the research project in Plymouth, he suddenly realised he could do more for patients…to actually use his words, ‘I can do more than see people every day by going to see other doctors and talking to them about systems…”.
These kinds of positive statements about the value of management to clinical work have of course been noted elsewhere in the literature\[29\]. Llewellyn\[76\], for example, notes how some clinical directors have actively sought to engage with and ‘capture’ management and how this, in turn, has helped to ‘enable cost consciousness, performance review, standardisation and evidence based practice’. But what our evidence suggests is that in some parts of the system, this engagement has moved beyond the pragmatic responses of small numbers of isolated clinicians and is linked to wider, more deeply rooted changes in cultures and working practices. In the, albeit small number of, cases we have considered there is a sense that more clinicians than ever are engaging with management and that increasingly this is viewed more as an opportunity than a threat. As one academic witness put it, “to protect clinical autonomy you need transparent accountability”.

1.5. Our business is health: A shared focus on the centrality of managing the means of production

The final characteristic of what we understand by ‘productive relations’ concerns beliefs and overarching philosophy. Specifically it relates to what senior and middle managers think they should be paying attention to. As noted earlier, there is sense that even after 20 years of reform, new structures of governance and cost control in the NHS remain ‘out of sync’ with clinical practice\[31\]. In many parts of the system management work continues to be viewed as separate or even irrelevant to the day-to-day concerns of doctors and nurses. The sense of disconnect is further exaggerated by the current system of performance targets and external regulation. This system, many argue, has driven clinicians and managers even further apart by forcing the latter to focus all of their efforts “looking upward” as opposed to focusing on clinical production itself\[15\]\[18\].

In stark contrast all our witnesses were of the opinion that productive relations were only possible if management itself was centrally focused on the means of production, or as one put it: “Manage the service, don’t manage the buildings”. This philosophy begins with a recognition of what is the core business of the organisation. In the words of one witness: “… it’s not rocket science is it, our product is delivering healthcare”, so “If the managerial agenda isn’t a clinical agenda, then what is it?”. From this follows a sense that the key act of management is to engage with the delivery of care. Management exists in the organisation not merely to ‘balance the books’ or ‘keep things neat’ but to continually improve the provision of care. Indeed, for most of our witnesses, doing anything different from this was simply a “no brainer”.

One manifestation of this philosophy of action was the very real attention paid by many senior executives to understanding the needs and priorities of clinicians (a theme we shall return to later, in section 3). As one witness said of his CE: “clinical work does not come out of the mouths of the (other) Chief Executives like the way it comes out of the mouth of David.” A key element here was also interpreting external demands in terms of clinical and service provision standards that had relevance to the working lives of staff.

A slightly different manifestation of the belief in focusing management on the means of production were devolved structures established by two of the Hospital Trusts (already mentioned above, in section d)). In both cases new divisional structures had been established delegating significant executive powers to clinicians. The objective behind these arrangements was to ensure that operational management was “led by clinicians” and that clinicians also had a key role in strategy formation. According to the CE of one of these trusts: “Where managers had been running the service through the title of Divisional Managers or Directorate Managers, those managers really
should be clinicians”. This, he went on to explain: “was the only way where clinicians would join the real world of understanding what…limited resources meant and start making judgments based on delivering the best healthcare and the most healthcare for the limited amount of money we had”.

2. What can productive relations deliver?
So far we have described at some length what the witnesses to this inquiry defined and understood by productive relations between medicine and management. Less however has been said about the outcomes of these ways of working, whether or not they actually make a difference. Turning to the wider literature on healthcare management this remains a neglected area. In the US there have been a number of studies focusing on the relative impact of different health delivery systems[93]. In the UK there has also been a growing interest in seeking to explore the outcomes of clinical management roles[2], clinical networks[94] and corporate cultures within hospitals[4]. But notwithstanding this work, even after two decades of management reform in the NHS, we still know very little about the impact or consequences of such change. One reason for this of course is the complexity of such evaluations. Trying to establish firm cause and effect relationships between given management practices and performance outcomes is a hazardous affair. Various factors will mediate the impact of management, not least particular historical conditions the design of health systems and the characteristics of staff and patient groups. Added to this are also questions about what we mean by outcomes. An obvious route is to evaluate the success of local management in terms of the achievement of national performance targets (see Mannion et al.[4]; also see recent reports by the Healthcare Commission[19-21]). This however, may focus too much on organisational outcomes, ignoring the effects of working practices that are nested within organisations, for example, within particular teams or directorates. Too much emphasis on targets may also fail to capture innovations in the system at lower levels which, all too often, are ‘hidden from view’ of senior managers and not reflected in broader performance evaluations.

These problems spell the need for caution when trying to draw conclusions about the relative effectiveness of different practices and ways of working. That said it would also be a mistake to ignore other sources of anecdotal evidence and opinion. What stood out from this inquiry was the very strong conviction of policy makers and practitioners alike that a greater alignment between medicine and management can deliver results. To many these connections seemed obvious, almost beyond question. Indeed the very term ‘productive’ suggests that alternative ways of working were somehow beneficial. Of course given the limited nature of our evidence we would not of course wish to make too much of this claim. Future research will be needed to assess the proposition that the kinds of practices described in section 1 do in fact lead to improvements. It is however, useful at this stage to at least look at what our witnesses themselves saw as the main value of productive relations. In particular we might focus on three kinds of outcomes.

2.1 Aligning clinical and resource based decisions
The point most frequently made by our witnesses with regard to ‘outcomes’ was the possibility for a more effective alignment of clinical and management decision making. This was especially the case with regard to resources. According to one witness, drawing managers and clinicians together could help to align two “discursive domains” of “clinical purism” and “financial realism”. Others offered more concrete examples of how this might work in practice. In circumstances of financial constraint there was a greater likelihood that decisions about cuts would be better focused around clinical priorities. As the CE of one Hospital Trust explained:
I remember calling a crunch meeting in the September and saying ‘well this is a big moment for us guys because clinicians in management will fail if you don’t manage the difficult things as well as the nice things’. And you wouldn’t believe it; I remember there was one Chief of Service in Surgery, it was a fellow of the Royal College of Surgeons and he was you know, a bigwig down in London, he came to me and said ‘I’m closing 60 surgery beds’. Well I nearly dropped off the chair because he was an eminent surgeon who ‘you take half a bed away from me and I’ll sort of have you’, was coming in and saying, ‘I can survive for the next six months, doing the same output, delivering the same amount of quality and better quality and I’m going to close two wards’.

Another witness suggested that having “managers and doctors in a sense inhabiting the same space” also led to improved allocation of resources in positive situations when funding was available. This was reflected in the story of another trust where a group of consultants specialising in chronic lung disease had been hugely frustrated about the failure to progress planned service changes. In this case it was suggested, against the normal practice, that General Managers should attend a clinical audit meeting. At the meeting it was revealed that attempts to implement a care pathway had been only 60% successful because the clinicians were lacking a particular “bit of kit’. At this point, however: “one of the managers asked ‘well how much does it cost?’ And you know, ‘it’s £5,000’ and they said ‘right well you know, come and talk to me at the end of the meeting and we’ll get it’ you know, ‘it seems a no-brainer’”.

**Box 2.1  Aligning clinical and resource decisions**

… one of our PCTs had quite a significant reduction in commissioned emergency activity in Medicine. So what they were saying was ‘we’re going to reduce the number of patients that we’re going to send to you as emergencies by 13%, so you won’t need as many beds and you won’t need as many nurses, so we expect you to shut some beds’. Now what we actually have been doing … is tracking non-elective admissions through this physical process control methodology. And in a sense even before they said it, we’d recognised … actually on one of the patches there’d been quite a step change in our emergency admissions and we’d started to share this with our clinicians. Now the initial response from the clinicians was ‘we don’t believe the data’ but actually we kept on sharing it, we said ‘well look, this isn’t going away, this is real’. And you might be not experiencing lots and lots of empty beds for some other reason but, the numbers coming through the doors are genuinely going down. And because that’s going to have an impact on our income, the current service is not sustainable’. So rather than just saying ‘oh and we’re going to close this ward’, within the division, we had a meeting with our Clinical Directors and the Clinical Directors then went to the clinicians. And as a team of consultants and senior nurses, we sat down and we looked at ‘well what do you think as a body we ought to do?’ In a sense, ‘we have to do nothing is not an option, we have to do something; it’s a hard decision that we have to make and you need to help us make it’. And together we identified the wards that would close. We then went through a process of talking to all the staff to say ‘we’ve got vacancies, we
can find you another job you know, we do not want to make you redundant. It may not be where you were working before, so it may be a process of change and we’re going to help you through that transition’. And that whole process took six weeks from deciding to do something to actually having those wards closed….And, it was an unpleasant thing to do, but because we were open and honest with all the staff concerned and engaged them from the very outset and brought them with us and we listened to people’s objections and we listened to ‘well we can’t do this’ and we just said ‘but doing nothing is not an option’. And we took the time to bring them with us.

(General Manager)

2.2 Greater willingness to engage with and share responsibility for change

A second, related, outcome, according to our witnesses, was a greater likelihood that clinicians and managers would jointly support and take ownership of change. From the literature we know that change in health settings is invariably a complex and often contested affair. Indeed it is often noted that top down, or programmed change initiatives have only limited chances of success [35] [(McNulty and Ferlie, 2002; Locock, 2001). By contrast where there is a greater investment in what Denis and colleagues describe as ‘collective leadership’, involving a multiplicity of stakeholders planned changes are more likely to be successful [22].

This point was strongly made by all our witnesses. In some instances, productive relations were seen to emerge as a direct consequence of change initiatives. Numerous examples were given both from primary and secondary care settings of projects where specific groups of stakeholders came together (sometimes for the first time) and had been able to negotiate shared goals. It was also felt that, when more established, productive relations generated highly ‘receptive contexts for change’. Indeed, they might enhance the ‘change capabilities’ of whole divisions or even organisations. Under these circumstances gaining acceptance of the need for change and support for implementation was perceived to be far easier than might otherwise have been the case.

This change capability, according to our witnesses, had positive implications for attempts to innovate and re-design services (see below). It also made it more likely that key groups of clinicians would engage with and participate in ‘hard’ decision making such as with regard to resources (see Box 2.2). A number of examples were given of this. The CE of one Hospital Trust noted how in the past, senior clinicians had been semi detached from the annual planning process. This had amounted to a kind of “make-believe sort of salami slicing” exercise with “no real enthusiasm or sense of ownership of it”. More recently, however, attempts to build a different compact between clinicians and management had led to a step change in attitudes. The clinicians, in particular are “really taking ownership of their destiny. Taking ownership of their costs but also taking ownership in a much greater way of their income and really looking at what they’re doing”. Another witness described how in his organisation the job of taking “£11 million out of the Trust this year” had been “jointly owned” and “jointly delivered” (see Box 2.1 for more details).

Box 2.2 Enhancing capabilities for change

“I think it’s always easier for the relationship to go well with clinicians and managers when they’re working on something together which unites them. In general, consultants are not as wedded to their profession as they were. They’re very wedded to their service and its development, but not, frankly, to the corporate good in most cases. What clinicians want is to
No one wants to keep it the same or to downsize it. It’s always easier to think of examples where the development of a service has happened because the managers and the consultants have come together to develop a case and it’s worked. One example of that for me was when we put a business case forward for doing Cochlear implants. The manager worked closely with the clinician who was passionate about its importance and we started to do the operations. That was great because there was a common purpose. It’s harder to come together to downsize something or take large amounts of savings out, pressing for efficiencies and still come through with a good working relationship. I’ve recently been involved with a financial recovery project. By and large the consultants have been on board with it. They weren’t necessarily happy at first and had a great deal of anxiety about how the new service would work, but we did get through it.

(Service Manager)

### 2.3 Greater capacity for service innovation.

A final observation to make here concerns the link between productive working at local levels and innovations in the design and provision of services. This topic has attracted a great deal of attention in recent years. Across the NHS there have been moves to re-engineer services, break down inter-professional boundaries and develop more systematic ways of organising provision around so-called care pathways. Linked to this have been moves to harness the creative powers of clinical networks, for example in areas such as cancer treatment. All these changes connect with a broader agenda of ‘modernising’ the NHS to raise standards and unlock, what are believed to be important efficiency gains, trapped within the system.

The testimony of our witnesses revealed many examples of this kind of innovation. In particular it seemed that a great deal of work had gone into the development of care pathways and attempts to re-configure services (see Box 2.3). Typical of this were the comments of one witness who described how, in his (hospital) trust there had been a concerted effort to define particular “business areas” around “either a disease or a patient grouping” and then “segmenting our business, cutting it up into pieces”. Others were keen to stress the benefits of this kind of change. One academic witness described how a care pathways approach represented a useful vehicle to achieve greater integration between different activities and improve standards:

… instead of there being a series of silos in which you’ve got one silo looking at evidence … the evidence base of clinical practice, and the other side are looking at clinical or quality issues, another one looking at adverse events, risks, etc, etc. What you would have is for instance, the orthopaedics unit saying ‘we’ve identified our high volume case types, we’ve pathways for those high volume case types and here’s how we’re performing in respect of cost, quality, outcomes, risks, etc, etc’.

Related to this was the view that re-configuring services might improve standards of care while, at the same time, unlocking significant gains in efficiency. This was apparent in a story, from a HT which had introduced Nurse Colposcopists into the Women and Children’s Division. This change “streamlined the service such that ladies weren’t waiting a quarter of the time to be told is that cancer or isn’t that cancer”. It also meant that the consultant involved could “go off and do other interesting things”, therefore producing a saving on staff costs of over £60,000.
In some cases it was recognised that service innovation of this sort could emerge ‘bottom up’ and in the absence of full support from senior managers. Most witnesses however were keen to stress how such change was more likely when there had also been a more general change in the culture to foster productive relations. According to one CE, a high degree of trust, shared purpose and a willingness of managers to delegate was almost a necessary condition for innovations to occur:

...you’ve got to have confidence that actually ultimately people will deliver. And all I know is all the evidence I’ve ever seen is that solutions delivered by the clinical teams tend to be more radical, more lasting, have a higher impact and in terms of the quality of services are just more sustainable than anything I can do by stamping my foot.
Others reiterated this theme, noting how productive relations were more likely to facilitate the “release of ambition” or at least the release of curiosity”. Indeed, there seemed to be a strongly held view that when managers and clinicians were in dialogue and where ‘clinical production’ formed the primary focus of attention, this in turn, led to more change and experimentation. From the data available we are unable to assess the value and effectiveness of such change. What does seem clear however is that important links exist between the kind of relations we described in section one and the willingness and ability to re-configure services. Following Mueller (1996: 77) one might at least say that ‘productive working’ “results in a more extensive process of tapping the organisation’s ‘hidden reservoir’”.

3. The conditions for productive relationships

So far we have defined what we mean by ‘productive relations’, and talked about some of the benefits that might accrue from them. In this section we now turn to a broader discussion of the conditions that seem to support this kind of development in the NHS. Specifically we focus on a range of management philosophies, practices, resources and structures that were directly favourable to the emergence of alternative ways of working. In doing so however we differentiate between two types of conditions:

1. Necessary conditions for establishing and maintaining productive relations
2. Other conditions that helped in supporting change in some cases, but not present in others. We record these conditions as possible catalysts that may inspire other organisations that have similar opportunities waiting to be exploited.

In developing these categories we have sought to generalise as far as possible across a range of different health organisations: primary care trusts, district general hospitals and university hospitals.

In places however it is noted that some conditions have greater salience to certain parts of the service than others.

3.1. Necessary conditions for establishing and maintaining productive relations

From the testimony and stories of our witnesses it seemed that while productive relations can be present in any part of the system their long-term sustainability depended very much on the role played by leaders and on a particular mix of management policies and practices. Specifically, we would emphasise three broad factors that were important:

1. The strategies and choices made by organisational leaders.
2. Management approaches for getting productive relations started and sustaining change.
3. Investments in the organisation to support productive working.

3.1.1. The strategies and choices made by organisational leaders

Our analysis suggests that productive working can develop spontaneously at any level or location within the system. However, what it also suggests is that for these relations to become more entrenched and sustainable in the longer term, top-level management support and encouragement is essential. One aspect of this, already noted in section 1 of The Results, concerns the philosophy of top leaders and what they pay attention to. Also clear is that the kind of transformations described above require the help of gatekeepers to create and maintain space for new ways of working to emerge and then make an impact across the organisation. Hence choices and strategies of top leaders are of crucial importance. In what follows we focus on four characteristics of these strategies and their implications for productive working:
• Creating space for local change by managing upwards and outwards.
• Being prepared to take early risks through delegation internally.
• Ensuring continuity.
• Avoiding complacency.


i) Creating space for local change by managing upwards and outwards

The first and perhaps crucial point to note here is the role played by gatekeepers in managing and negotiating the boundaries between their organisations and the rest of the system. A key choice is about how far to try to generate space to pursue local goals, to do things differently, or to settle into reacting to outside pressures. In the literature, the prevailing view is that the latter course is most frequently taken. As Edwards suggests “it sometimes feels, [the] raison d’être of general management is not to manage local services, but to make detailed ministerial accountability a constitutional reality.”

By contrast, our witnesses brought a much more positive tone to proceedings. One noted strongly that “it wasn’t a case of you know, this organisation just has to achieve targets because if you take that approach, I think you hit the targets but you miss the point … we actually spent a lot of time talking about how we would achieve targets at the same time as doing what was required locally.” Tied to this was the notion that it was better to be a “perpetrator” (who seeks to shape the environment by action) than a “happen-ee” (blown by the wind). It was important, many argued, to realise that blindly following rules from above could seriously damage local initiatives. As one GP explained: “The thing is that the DOH gives us a series of policy initiatives, most of them not very joined up at the moment unfortunately, and it is the job of the management team to implement them out of primary care. My view is that you can either sit on the outside, moaning about how awful it all is or you can get on the inside and influence the way it is implemented.”

Crucial here is the role played by senior managers and other boundary spanners (such as non-executive board members) in interpreting the environment and seeking to protect and preserve space for local innovation by filtering out or mediating external demands. As one witness explained: “I have to keep the centre happy and as long as I keep the centre happy, I can get on with what I really want to do.” Another was even more frank about the need to manage external relationships, stating: “you have to keep the madness of the system away from the organisation” (see Box 3.1 for other examples).

Seeking to do things differently and ‘manage boundaries’ of course was not without its risks both for managers and organisations. As one witness noted, her management team felt able to innovate because “we’ve delivered”, although “The day we stop delivering, they’ll descend on me like flies around a honey pot…”. This message came across forcefully in the testimony of our witnesses, with another manager (also a CE) explaining: “getting the performance agenda done, working towards financial balance was going to give us air cover to do the things that we wanted to do”. The generation of ‘air cover’ to purse local priorities was seen as vital. Indeed, the “real trick” according to this witness “is to make sure our eyes are scanning well enough” but, at the same time, not to allow people to believe that you could fail to meet external targets “or else you’re absolutely sunk.”
Box 3.1
Keeping the ‘madness of the system’ away from the organisation

“…up and down the country what was happening was Chief Executives, Medical Directors, very senior people were down in A&E you know, practically threatening SHOs to make sure that there weren’t any waiting times over the target. … What I said to the clinicians was, we sat down and said ‘well how are we going to sort this out?’ And over time we put in a radically different model of … putting consultants in the frontline of treating patients as they attend rather than seeing people on a consultancy basis … a model the people involved had ownership of …we had to let that settle in for the first quarter, at which time I was taking brickbats from the Centre and heat from the SHA and all sorts of things. But that’s now settled in and we’re consistently in the top ten Trusts in the country for our A&E score.”

(Hospital Trust Chief Executive)

ii) Being prepared to take risks through delegation internally

Following on from the above, our witnesses talked about the importance of senior managers being willing to “let go” and delegate power and responsibility. As one witness explained, “you are not going to achieve radical change dictating from the CE’s office….” Indeed, a common theme running through many accounts was that positive change is more likely when senior decision makers are prepared to “give freedom” for people to take initiative on the clinical side. One CE went so far as to say “I view my role as managing the culture, as opposed to managing the business… clinical change must be led by clinicians”. She also went on to suggest that: “the top team, whoever they are in an organisation, have to give the influence and the power away in order to get it back”. 
However, as we noted earlier (see section 1 of The Results), letting go is not without its risks and, as one witness put it can be “very uncomfortable for a traditional manager.” These risks were perceived to be especially high in a context of growing demands on managers to ensure compliance with relevant targets and policy requirements. In this connection the theme of playing by the rules to gain ‘air cover’, mentioned above, was especially important. So too was the need to negotiate some kind of understanding or accountability framework with lower level managers and clinicians. As the CE of an Acute Trust explained: “I don’t think you can manage a devolved ‘clinicians in management system’ without absolute clarity about what people are accountable for”. Another reiterated this point, describing how, in her organisation many decisions were “totally devolved” but within a “framework” which is “non-negotiable”.

iii) Ensuring continuity over time

Just about every organisation has outbreaks of productivity improvement at some point, but it is clear that ‘productive relations’ survive and prosper only if there is a longer-term vision and some continuity over time. Our witnesses considered it important to be open about goals and constraints on those goals, but at the same time necessary to bring clarity, “peel back the complexity” and concentrate on the heart of things: “striving for the best in health care” and defining goals by “working back from the patient.”

Clarity about goals, many argued, also needed to be coupled with a willingness of senior decision-makers to see through change in the long term, what Mueller[33] describes as “persistent intent”. As one witness explained:

Clearly some things require swift action and sometimes you have to cut these processes and just kind of do it. But you’d always find that if you did that, you’d get a wash back you know. There’s no real substitution … if you want to succeed in the long-term for… a kind of philosophy of the Chief Executive, ‘some of the goals we’re trying to get are long-term goals’. If you want to be able to do that, you need to build relationships and that takes time. And you need to build trust and that takes time … if you’re there and you’re the Chief Executive…that is what you do”.

This theme of being in it for the longer term, was raised by almost all of our witnesses. Many talked about the need for senior managers to be willing to see change through, to be “in it for the long haul” and engage the organisation in “long term goals”. Sometimes this was linked to the tenure of CEs and their willingness (or not) to “stick around” (a theme we shall return to later). Others, however, noted that it might be possible to ensure continuity through a succession of different managers. This was apparent in a Teaching Hospital where efforts to bring about “cultural change” had been ongoing for a decade, even though some managers (including the CEO) had left and returned during that period. As one witness put it: “the number of executive years associated with addressing the problem of the existence of XXX…remains quite considerable”.

iv) Avoiding complacency

The final point to make with regard to ‘strategy’ is best captured by the term ‘avoiding complacency’. A number of witnesses talked about the vulnerability of productive relations (also see below under Sustainability) and the need for “constant vigilance” to maintain and renew them. The CE of an Acute Trust in the north of England described how a series of events, including a major PFI deal, had taken the “Senior Team’s eye off what was really happening” and that, as a consequence of this “we lost the clinicians in terms of where they were”. He also noted that professionals and managers had become “slightly arrogant about themselves”. A related danger highlighted was the possibility of becoming
“introspective.” Members of another Trust, for example, felt that one potential criticism of what they were doing was that it was “too clinically led” and may not do enough to engage the public and get public support.

The task of avoiding complacency, many felt was a crucial part of leadership in this context. One CE described how he had turned things around by re-focusing the trust on meeting financial targets, introducing “new blood” in clinical leadership roles and “re-engaging them (the doctors) on a story”. Productive relations, he added, need “constant attention” and it was crucial to keep clinicians “aligned with what’s going on.” Another CEO, when asked about ‘conditions for success in your organisation,’ explicitly said, “Let’s not declare success,” citing a need for “prudent paranoia.” In practice, this meant constantly searching for ways in which to renew and re-invigorate change as well as constantly reminding his, sometimes over-confident staff, that while the institution may be a success “world domination doesn’t tend to last terribly long”.

3.1.2. Management approaches to getting productive relations started and sustained

So far we have focused on the crucial role of senior decision makers in helping to set direction and create space for alternative ways of working to develop and flourish. An equally important theme however concerned the way these managers, and others (including middle managers and clinicians), went about initiating and supporting change.

It is often assumed that in the NHS the power of inertia and a desire to maintain the status quo effectively rules out radical change. Both professionals and managers might be indifferent or perceive they have little or no incentive to cooperate with calls to develop new ways of working. By contrast our witnesses provided a much more upbeat account. Most were keen to emphasise the possibilities for change, how managers and clinicians could overcome a sense of inertia, engage support and build what Greenwood and Hinings describe as a “reformative commitment” [30]. A great deal was said about the tactics and approaches that seemed to work and which most felt were crucial for getting productive relations started. Specifically witnesses drew attention to four broad themes:

- Aligning interests through the presentation of information and through the generation of incentives.
- Creating context and exploiting opportunities in the context to gain support for change.
- Frequent communication to develop shared vision and support new ways of working.
- Importance of listening, taking an interest, getting involved.

i) Aligning interests through the presentation of information and through the generation of incentives

The overarching point here, according to our witnesses, is that managers need to link change agendas to things that professionals care about because, otherwise, there is little chance of success. This, it seems, can be achieved in two broad ways. First, is by generating hard incentives for clinicians to engage with and support change. Secondly are more subtle processes of selling or “packaging” change proposals to enhance their perceived worth and legitimacy.

With regard to incentives a number of witnesses spoke about how it might be possible to offer “pay backs” for clinicians willing to engage in alternative ways of working. According to one manager: “there is a recognition that rewards for efficiency and success should in part come back to the care group where that’s been made, almost recognition that if successful we’ll make a contribution elsewhere”. Another manager
explained how, at his Trust:

… we had rules of saying ‘you keep half the savings that you make and you put half into the pot for redistribution’. You could bid out of that pot, so you could get two bites of the cherry. You know … you might save £20,000, you would keep £10,000 and you could do what you like with it, as a Chief of Service. And the other £10,000 would go into the pot along with anything else that was going into the pot and then you would bid for what the savings had been.

The wider literature on management reform in the NHS often suggests that clinicians have little interest or enthusiasm for managing budgets or engaging with financial priorities. These examples, however, suggest that one way of overcoming this opposition to generate direct incentives for such change, in effect linking co-operation to something positive: increased resources. While this might be easier in primary care settings, it was not necessarily limited to them.

Turning to the second theme of selling or presenting change proposals a number of witnesses mentioned the need to focus “on the clinical case for change.” For example, it was considered that discussions around “long term quality” were much more engaging than “activity rates or efficiency targets.” One witness explained that his challenge was to get people to:

…understand that the pursuit of efficiency either generates financial balance or if we can, actually generate some benefit which we can then plough back into the organisation. And that therefore you know, the pursuit of efficiency isn’t some sort of managerial problem, it should be a collective task for us all, so we can move the organisation forward.

Others noted that presentation is not just about ‘spin’ but rather honest communication, aligning interests or “harnessing change to other ambition”. As a CEO explained:

…if we’d have gone to them [the clinicians] and said ‘we need you to be more efficient’, they’d have said ‘yeah, great, yeah, right’, as my kids would say to me, which means ‘get lost’. But if we said to them ‘look you know, we’ve got a problem here’, if we could find ways of getting length of stay and use this as the single denominator, we put length of stay down from X to X minus Y, you would be in a much more comfortable place when it comes to the rest of the Trust and yourself. And so we can organise our futures together a lot more easily.

A related, but distinct ‘strategy’ was that of generating support for change by appealing to professional pride. One witness, for example, described how he had inspired a community of doctors to reach agreement on new performance targets by de-anonymising the data for the previous year. Faced with their own results, they felt an immediate ambition to improve. Another witness described how his PEC appealed to “curiosity” and fear of “competition” amongst GPs in “constructive ways” to engender feelings of “we can do better” and build support for change.

This necessity to ‘package’ change in certain ways placed new demands on managers and clinical leaders. Of crucial importance was an understanding of the language and priorities of clinicians and how to present information effectively in this context. According to one witness: “the manager needs to be able to put themselves in the eyes, ears and mind and heard of the clinicians, in order to understand where they’re coming from, and vice versa”. Another explained that building commitment to change meant “taking all the gobbledygook that comes out of the Department of Health and translating it into a certain … language that GPs understand”.

As we shall see, this kind of understanding may require that those leading change have a medical background themselves or that they have acquired sufficient knowledge and experience.
to appear credible. That said it was felt that any manager could improve the likelihood of success by learning how to present information in more systematic ways. In a context where clinicians are being required to focus their practice on so called ‘evidence-based medicine’, one may find a heightened sensitivity to the evidence claims of management itself[34]. To gain support for change initiatives therefore, it was felt that management also needed to become “more ‘evidence informed’”. As one witness put it “Management needs to match the rigour and scepticism of clinicians to get its message across”.

ii) **Exploiting opportunities in the context to gain support for change.**

Following on from the above, witnesses talked about how managers and others might generate support for change by manipulating context, seeking to turn external threats into potential opportunities. One witness used the phrase “context creation” as indicative of this whole exercise of engaging with, parsing and formulating action with awareness of the environment. Another spoke about how successful change involved not just “finding”, but actually “creating” a “common interest” amongst clinicians by making appeals to “their perceived future sustainability and threats”.

This manipulation of context took on a variety of forms. A number of witnesses made explicit reference to so called “burning platforms” or “burning decks”, how a “gradually deteriorating environment” could be used to kick start internal changes. Examples of this were given of hospital trusts threatened with closure or takeover but had responded by raising their game and improving management. A CE for example, described how a merger between two local trusts that he had been involved in managing had resulted in considerable “blood on the wall” threatening disaster for all concerned. This threat however was turned into an opportunity, using the merger to “go back to first principles” and radically design the new organisation around clinical divisions. Other witnesses described more recent policy shifts such as the restructuring or primary care and moves to implement clinical governance as equally important potential ‘threats’ that might be skilfully turned into opportunities. As one manager put it: “there are times when people need to realise the status quo isn’t an option”.

Another strand was the way those seeking change might exploit historical legacy. This point was emphasised by a number of witnesses. Some talked about how previous events might foster a sense of anxiety or anger that could be turned to positive effect. A Hospital Trust CE for example noted how his organisation was characterised by “a permanent fear of its neighbours, that it might be eaten or the best bits taken away, and remains paranoid”. While such paranoia had its downside, it also represented an important resource that could be used to legitimate change. Another witness (also a CE) described how in her organisation, it was, paradoxically, the past failure of clinical leadership that generated opportunities to do things differently for change. Powerful groups of clinicians, she explained, “were so angry with their previous Medical Director, that any change would have been welcome”.

iii) **Frequent dialogue to build a shared vision and support new ways of working**

According to our witnesses a marked feature of those organisations most successful in developing alternative ways of working was the large amount of time spent talking and negotiating shared objectives. Numerous examples were given of this kind of ‘bottom up’ change both in primary and secondary care. At one trust, the CE described how: “We took away 40 medical consultants as well as nurses and physios and managers for a few away days, really just to say ‘what the hell is delivering healthcare here all about?’ you know, first principle stuff.” In another Trust major
change was preceded by a training course for everyone near the top of the organisation to promote: “joint learning and joint … sharing of experiences and expectations, right at the beginning”. According to a witness who had been involved: “the subtle kind of ploy behind that was to buy in this group together towards a common goal”, because “unless there is a common goal… then you won’t get the right outcome.”

Another important approach utilised by one witness in a primary care setting was the action of forming a sub-group who acted as “ambassadors to stimulate support.” In this case, there was a strong sense that it was necessary to “engage significant system stakeholders,” particularly influential clinicians who could explain and promote change to their peers. The CE of a large acute Trust also explained how in her organisations clinicians had played a leading role in defining and leading change. Central to this had been “lots and lots of meetings” and a “really strong clinical debate”. The current structure (of Divisions) “emerged” as a result of this large-scale consultation and, in her view, was successful because of the high amount of “buy in” from clinicians.

Major consultation exercises such as these were seen as important for developing a mutual understanding between professional staff, building ownership of change and seeing the “bigger picture”. Others saw such meetings, or “conversations”, as useful “in themselves…in terms of forms of ceremony that get all the elements linked together”. Frequent meetings, according to one CE, were also important as a means of understanding and keeping abreast of the political climate, “finding out where, if you like, where does the … what seems to be the dominant group that is very much for that, where the people are, the sort of one or two standard deviations either side of that”.

iv) Importance of listening, taking an interest, getting involved

Finally, and closely following on from the above, witnesses drew attention to the need for those leading change to practise various kinds of outreach, such as: listening, talking to clinicians, being visible and available to talk. These activities, many argued, not only enhanced the credibility of senior managers (see below), but also made it easier to engage people and to agree common agendas for change.

Effective communication came in a number of different styles. One witness (a CE of a teaching hospital) focused particularly on being available to listen, suggesting that clinicians would say that if they wanted to get something across to her “They’d say take her a cappuccino at 8 o’clock in the morning … to have a conversation about what they might want to do.” Along similar lines, it was noted that being “a sounding board … genuinely interested in their perspective” was crucial. Another witness used technology to work past the reserved nature of some relationships: “the consultants are very good at emailing, I get emails the minute they’re upset.”

Others had a more proactive style, seeking regular conversations with different stakeholders and “planned gratuitous wandering round, freely turning up here and there, ‘how are you, what’s going on, what’s happening?’”. A similar style took in the importance of “being pushy” or just “difficult to ignore”.

A number of witnesses took up the theme of ‘being out and about in clinical areas’. One CEO described how he went to great lengths to educate himself in clinical work and to understand how others in his organisation feel and see the world:

“I’ve worked so far as a Healthcare Assistant in one ward, a Receptionist in a clinic and my next job is a Healthcare Assistant in a neurosciences
ward because I’m particularly interested in a number of issues there, in terms of… how the clinical constituencies get an understanding and connection to the top end of the organisation and ways that they feel…rather than through the governance process.

Another CE also explained how making a deliberate effort to visit different departments. For him “to be around a bit” was useful in terms of having “a bit of a barometer for what’s going on in the place” and for understanding both likely obstacles to change and opportunities.

Box 3.2
Listening, taking an interest and being visible

“Unplanned Care Design is a good example. Early on we had the idea that we needed to do a major system re-design. There were pockets of resistance to this. The biggest being GPs working in the out of hours service because the integrated approach to unplanned care puts GPs into a new model. There were people who thought they would lose some of their earnings and thought what they were doing was already good. It helped that I was a respected clinician with 25 years experience and I’d done a lot of this management stuff. I got out there, walking the patch, you don’t think this out by email, don’t do it by letter, not by sending out messages. You’ve got to visit all the localities and ask everyone involved. “What are your issues? What do you need? What can we do differently? What would you like to see? You go out and sell it.”

(GP)

“For example, a good clinician will be able to come up with a deferential diagnosis from having taken a history. Then come up with a plan and execute it. If necessary they need to demonstrate why they did what they did and review it. I try to get managers to go about their decision making in a similar, transparent way. If in clinical circumstances you do things in a hurry, you need to be clear about it, you need to be able to change and say you’re not right. I know when I’m in the wrong and I’m prepared to say ‘Ok I got that wrong’, even as a Chief Executive. It’s empowering for people to realise that you’re not perfect.”

(Chief Executive)

3.1.3 Investments in the organisation to support productive working

A final condition we have judged to be ‘necessary’ for sustainable productive working was various kinds of investments in systems and policies to support change. Typical of this were investments in organisation development, human resource management systems (especially those concerned with training and recruitment) and, to a lesser extent, the use of external consultants and change agents. Spending money in this way was viewed as important to build internal capabilities for change and also to reinforce productive relations once they had become established. Specifically, three main kinds of investment can be identified:

- Organisation development activities and capabilities
- Investments in human resource management
- Internal performance management systems

i) Organisation development activities and capabilities

Running through many accounts of productive working was the importance of devoting time and resources to supporting change through organisational development (OD). Indeed we were given numerous examples of this across both primary and secondary care settings. One manifestation was frequent organisation-wide
staff meetings (involving managers and senior clinicians) and “one off events” such as away days. A small number of trusts, it seems, are also using OD style interventions in a more targeted fashion. The CE of a Hospital Trust, for example, described at length how OD teams would be sent into “trouble spots” to support desired ways of working:

_Not in a blaze of glory…but in a sense very quietly saying to the Chief ‘we’ll give you some help,…you’d put the OD Team in and they would work with the division for a number of months. And then when the division was back on the rails again, they would just quietly pull out.”_

Others were even more enthusiastic about the contribution of OD. Witnesses from another Trust described how “OD activities that run across the organisation” are not just important in terms of training and skill development, but were “about reinforcing the behaviours and the cultures”.

To acquire this OD expertise many of the organisations described in this Inquiry were employing external consultants. One of the best examples of this was where an HR manager noted how his (hospital) Trust had initially employed a large consultancy to do “transformational work” and then, when this initiative “ran out of steam”, another consultancy to develop internal change management capabilities. A Clinical Director at another Trust also talked about how his organisation had employed a consultant to work as “project manager” to oversee the development of a new quality control system. In his view, change would have been “impossible” without this consultant and her “constant challenging” of clinicians.

In addition to this a smaller number of (hospital) Trusts had developed their own internal OD capabilities. One London teaching hospital had established a “Change Leaders Team” made up of managers and clinicians with a roving brief to develop new working practices and management systems. According to the HR manager this team represented a “significant investment” for the Trust. At another Trust in the north of England things had been taken even further with the appointment of an OD Director sitting on the main board and the development of an “OD network”. The aim of this network, according to one witness, was to draw together managers and clinicians from across the organisation to encourage learning and “getting people to think outside their professional boxes”.

**ii) Investments in human resource management**

A different kind of ‘investment’ that featured prominently in the testimony of witnesses concerned human resources management policies and practices. The importance of management development for clinical leaders has long been highlighted in the policy and academic literature. Fitzgerald _et al._, for example note that the level of management skill and experience of clinicians may be crucial in determining how far it is possible to delegate budgetary and HR responsibilities. This connection also came out strongly from our own investigation. One PEC Chair, for example, talked about the how clinical leaders often “struggle” in their roles when “people who’ve been appointed to those posts haven’t been given any training in…how to put new changes in place or how to influence their colleagues”.

By contrast, it seemed that where significant investments in training were being made, the opposite was true. Some talked about how focused management development programmes might have an almost ‘transformational’ impact on professional practice (see Box 3.3). Others noted how such training could help clinicians, even those most disinterested in change, to understand the ‘big picture’. One GP described how her organisation had commissioned a “development programme” for the PEC members...
over a course of six half-day sessions and that this had been “really, really well received and was really valuable in terms of making the PEC work better as a team, getting them to understand each other’s perspectives.” Training and development programmes were also thought to be useful ways of getting doctors and managers to sit down together. This activity, in itself, many suggested, could promote joint learning and help to bridge some of the differences in language and attitude.

**Box 3.3**

**On some positive consequences of management development**

“….we have a young consultant who wanted to be a Service Leader in his speciality. His colleagues didn’t want him but he did the Health Foundation Development Programme… So doing it with managers and learning as managers. And it’s one of those schemes where they have mentors and coaches and he asked me in advance what he was going to get out of it and I thought, ‘…he’s a lost cause’. And I don’t often give up on people but I thought he was actually a lost cause. I have to say he is now a Service Lead, he completed the course and when I said you know, ‘what is different for you now?’ What’s different for him now is he understands that you don’t snap your fingers to make things happen and it doesn’t happen around you, you have to do things in the background, you have to work through people. So he’s got a much broader portfolio of skill to empower him to do it, whereas he was a bit of a one-horse race.”

*(General Manager)*

This faith in the value of management training was also being backed up by major investments in this area in some parts of the system. The CE of a Trust hospital in the north of England described how over 1000 staff at all levels had undertaken “leadership development training” in the past 18 months. Others described more “targeted” initiatives. At a PCT in London an “extensive induction programme” had been introduced for clinicians on the PEC, “some of who, had no understanding of the structure and working of the NHS, beyond their own department and yet were expected to contribute to the management of the £330million organisation”. Another CE also described how she had set up a ten day “special leadership programme” for the “Under 5s Group” (made up of consultants with five or less years work experience at the trust).

As well as formal training, many were also keen to emphasise the role of senior managers as mentors promoting informal learning amongst clinicians. A number of our witnesses talked in very positive terms about this process. One PEC chair in London, for example described the “inspirational relationship” he had experienced with a previous Chief Executive:

*I learnt a huge amount from him, in terms of managerial workings, the governance of NHS bodies, but also the way to influence people, the way to influence managers, the way that managers could possibly influence clinicians.*

Another witness, also a GP, told us how his CE had similarly been “very supportive in personal development, which was very helpful for me, to challenge my thinking and ways of working”.

A further investment in human resources concerned processes of recruitment and selection for clinical managers. Many acknowledged that in the NHS as a whole very little attention is paid to these issues and that often even high level appointments (say Clinical director) are made on the basis of clinical expertise, seniority or through ‘elections’. Against this, a small number of witnesses talked about the need to invest more time and resources in “picking the right people”, “picking the Chiefs”, in effect “choosing leaders who have some management experience”. According to one CE, this means moving away from a system of elections to the use of formal interviews and a greater role for both the Medical Director and Chief Executive in seeking to identify “a cohort of emerging leaders” and “putting
themselves about to make sure they get the right people for the job”. At another Trust, formal “assessment centres” had been introduced for the selection of all new consultants with a focus not just on clinical abilities, but also future potential as managers. As the CE explained: “we don’t constrict ourselves with consultant recruitment to just asking the ordinary things. We tend to ask what their vision is for the service, what they know about performance. And actually you know…how are we going to make sure that we recruit people who can be in management?”.  

iii) Internal performance management systems

A final point to make here regards investments in performance management and control systems. In recent years NHS organisations have faced growing pressure to develop these systems, pressure that is likely to intensify with the advent of foundation trusts and the further reorganisation of primary care. Not surprisingly our witnesses also drew attention to these developments. A senior manager at one London Teaching hospital, for example, described the introduction of “a very much more robust performance framework than has existed previously”, based on “key performance indicators” agreed between managers and clinicians and “information systems…to populate the metrics”. Others also noted the growing emphasis on setting performance targets for clinicians and the moves to develop strong systems to ensure financial accountability.  

Recent studies have found strong correlations between these kinds of investments in performance management systems and the effectiveness of hospitals (see for example, Mannion et al. [4]). Our own inquiry is less conclusive, although does point to the role that such systems might play as a kind of ‘back up’ for wider changes in working practices. Having more accurate “information” about the performance of services might help in terms of planning, setting realistic priorities and developing incentives. Accountability systems were also important for supporting delegation to clinical directorates or divisions, a way of allowing “lots of room for manoeuvre but within certain parameters”. Last but not least, these systems were needed to ensure compliance with external demands and targets. As noted earlier, only by taking this task seriously would it be possible for senior decision makers to generate sufficient space or “air cover” for productive relations to emerge in the first place.

3.2. Other conditions helpful in supporting change but which were not necessary

The factors outlined above we suggest represented necessary conditions for productive working. Without these leadership strategies, management practices and investments it is hard to envisage how alternative ways of working could survive and prosper over time. Beyond this however, our witnesses suggested a number of more general conditions relating to the surrounding context of the organisation and the characteristics and resources of managers and clinicians that were favourable to productive working. These factors it should be noted were not essential for change to occur. Rather they must be viewed as background conditions that made the negotiation of alternative compacts between management and medicine easier than might otherwise be the case.

Four broad factors fall under this category:

- The financial or resource position of the organisation
- The strength of local commitments to local institutions and communities
- The characteristics and ‘resources’ of those in leadership or management positions
- Professional orientations and interests

3.2.1. The financial or resource position of the organisation

First and perhaps most obviously the resource position of the organisation was important in either helping or hindering change. A number of witnesses noted that it was far easier for managers to innovate or pursue new ways of working in Trusts or PCTs that were financially viable or undergoing expansion. The CE of one Trust, for example pointed out that changing the culture had been less difficult in the 1990s because it
coincided with a period of “huge growth” and major new capital investment. He went on to suggest that: “it’s easier to get people engaged in change when their paths are strewn with gold”. A PEC chair of a large PCT in the north of England, also talked at length about how GPs in her case were willing to participate in wider networks because of the “deficit in capacity” in the PCT and a “climate” that promoted co-operation as opposed to competition. There is therefore some evidence to suggest that a positive resource position, while not essential, is extremely useful in supporting change.

3.2.2. The strength of local commitments to local institutions and communities

A quite different aspect of context that was thought to support new ways of working was a shared commitment of managers and clinicians to local services and communities. This was apparent in some, if not all, the examples of productive working we were given. One CE, for example, noted how good working relations were underpinned by “a sort of parochial endemic culture” with many staff (her included) spending large chunks, if not all, of their careers working for the same institution. Similarly the CE of a teaching hospital compared his organisation to “a virus for which there hasn’t been any treatment, but a virus of which the benefits are largely positive”. In this case, and others it was argued such orientations helped to deepen relationships between clinicians and managers fostering trust and willingness to cooperate. It was also felt that they might reinforce a commitment to serving local patients and local communities. As another witness from a HT in the northeast explained, clinicians “felt like champions of a group of people in a geographic area”.

In a small number of cases, it was noted that, largely by historical accident a particular organisation might be fortunate in having a critical mass of senior managers and clinicians with a shared interest in service improvement. An example of this was a Hospital Trust where a charismatic CE, ex-communist party member, had attracted a large number of like-minded “left wing” individuals to come and work there. According to one witness, this “ideological baggage” meant that the Trust “ended up with a body of clinicians that weren’t very interested in private practice but were interested in service improvement”. It also meant that professionals were more “receptive” to innovation and changes in working practices. As the same witness went on to explain: “there were a number of clinicians who appeared to be very engaged personally with issues of service modernisation and service redesign and who kind of owned it”.

There are of course risks as well as benefits of strong local orientations and commitments. As one witness explained, this situation could just as easily foster a culture that is “dangerous, inward looking and conservative”. That said, most also recognised the usefulness of having long standing relationships between managers and clinicians and how this kind of historical legacy might be exploited to good effect by those seeking to initiate change.

3.2.3. The characteristics and ‘resources’ of those in leadership or management positions

Managers and clinical leaders are individuals and all of them will generate the conditions for ‘productive relationships’ outlined above in ways that play to their own strengths. However, our evidence indicates that leaders who have certain ‘resources’ broadly defined in terms of cultural, political and intellectual capital find it potentially less difficult to set such a virtuous chain of events in motion.

One theme that surfaced from a number of witnesses was the intellectual resources of senior managers. As one said when asked about important qualities for managers who work with clinicians: “They have to be bright. If they are not bright… They’re dead”. This blunt assessment was elucidated a little more to show that a lot of managers in the service had an “anxiety about perceived differences in standards of intellectual ability.”. This in turn was made worse by the deep-rooted cynicism shared by many doctors regarding the knowledge claims of management and its perceived lower status as a profession.
In the absence of intellectual resources it was noted how a reputation for toughness and self-confidence might enhance the credibility of managers. A demonstrable track record for getting things done and solving problems was also a key resource. As one witness explained: “The manager commands respect” because of in “part track record I would say of delivering and being an… enabler rather than somebody that would block things.”

A further valuable resource of managers that was helpful in negotiating change was their ability to “understand the business.” For some of the witnesses, this sprang naturally from a previous clinical background that allowed them access to “the medical mindset”. As one put it: “They see me as a doctor and they see me dealing with patients”. A clinical background however was not always seen as essential. One witness felt insight had come from his engineering background, which had shown him that specialist could be involved in general management. Another emphasised the “practical understanding of clinical matters” picked up from spending time out ‘on the wards’ with doctors and taking on the roles of other staff. Another earned respect simply by “learning the language,” being prepared to listen and “see the world from their shoes.”

A final major theme was a connection with the organisation. One noted that he had worked in the Trust before and said “the DNA is already in me.” This kind of familiarity bred a sense of continuity, of “one of our own” which gave the decision maker latitude to push at more boundaries.

3.2.4 Professional orientations and interests

Finally we should note that productive relations are naturally more likely to arise in situations where doctors themselves are more willing to get involved. Across the system as a whole the prospects for this still seem rather bleak. As one witness remarked, there is an “enormous amount of apathy” in many clinical settings towards management issues. Another noted that so far not many clinicians have “aspired or wanted to be Chief Executives,” and that perhaps fewer than 10% of doctors would actively volunteer for such roles. Many witnesses however were keen to point out that management work could and often did appeal to clinicians. A senior consultant at one trust for example, described how his “main passion is governance…I like to frame things that are clinically efficient”. Others talked about management as a way of influencing broader decisions (see Box 3.4) or even as “exciting”, presenting a new challenge after clinical work.

Perhaps not surprisingly many of our witnesses took the view that where professionals were sympathetic to management, this in turn helped to foster more productive relations. By chance some institutions or parts of the system had attracted more doctors of this calibre, willing to take on management roles, than had others. However, it was also noted that the existence of productive working might itself have a positive impact on the orientations of doctors. These contexts, as we have seen seek to discourage ‘non-corporate behaviour’ and provide various kinds of incentives for clinicians to engage with management. It is also possible, although we found no direct evidence, that productive relations may act as a magnet for other like-minded people to self-select to work in particular organisations.

Box 3.4 Clinicians in management

…it was apparent to me, that certainly with investments in Primary Care, there were huge variations. And what really upset me was actually a practice in the Trust next door, when they were this size, half of ours, was getting a lot of investment put in compared to ours. And I thought why is that and that started me on the road of starting to explore how the then Health Authority worked. How to get into the way decisions are made, principally because I thought that there was an iniquitous distribution of resources, certainly within general practice … my own personal remit, or my own personal drive, to make sure there was an open and transparent distribution of resources within general practice … that’s how I got involved.”

(GP)
Possible threats to the sustainability of productive relationships

So far we have demonstrated that ‘productive relations’ between medicine and management do exist and that these relations, in turn, can yield many benefits. In the previous section we also outlined a number of supporting conditions for these relations, factors that bolster productive ways of working and high trust. However, while all of this may be cause for celebration, it is necessary to sound a note of caution. Running through the accounts of our witnesses and indeed many other studies is an appreciation of the difficulties costs and risks associated with building and maintaining productive relations. More worryingly are concerns about whether – given the nature of the UK NHS and the demands placed upon it – these, often localised, practices can be sustained in the longer term. To what extent are the emergent ways of organising identified in this study a sign of the future, something that will spread to other parts of the system? Alternatively are they just a flash in the pan? Is it the case, as one of our witnesses put it that: “in the NHS nothing lasts forever”?

While this inquiry has been limited in scope, the evidence from it suggests that the kinds of relations between medicine and management we have described are more the exception than the rule. This, in turn raises questions about why these patterns have not spread more widely? The witnesses to this inquiry were strongly of the opinion that productive relations can deliver improved outcomes, a conclusion also borne out by other studies (Mannion et al. [4]; also see recent reports by the Healthcare Commission [19-21]). But if this is the case then why has change been so limited in scope? If forging trust between managers and clinicians is so “blindingly obvious”, to use the words of one witness, then why have others not followed this line?

These of course are weighty questions, and it is beyond the scope of this report to address them in full. That said it is useful to note a number of factors that our witnesses identified as potential obstacles to the wider development of productive relations. Specifically we can point to seven aspects of the current system that get in the way of a more ‘productive’ compact between medicine and management or, where this already exists, threaten its survival and long term sustainability.

- High set up costs and the risk of decay
- Failure of the system to learn, general convergent tendencies
- Constant or periodic reorganisations, shifting goal-posts
- Turnover of senior managers
- Performance management frameworks
- System of professional education and socialisation
- Perverse incentives working to limit doctor involvement in management

1. High set up costs and the risk of decay

The first and perhaps most obvious point is that developing the kinds of working practices and cultures we have described is a complex, time consuming and potentially very risky affair both for managers and clinicians. This observation is well made in the literature on health organisations and professional services more generally (see for example, Fitzgerald et al [21]). A majority of our witnesses, even those most optimistic about the future, also noted how prevailing cultures and modes of organisation in the NHS were strongly stacked against change. As one manager put it: “clinicians don’t trust managers because they think they’re agents of Government and managers don’t trust clinicians because they think they’re kind of mavericks who are going to go and spend all the resources and are only concerned with the patient in front of them and not the millions of others sitting outside the door”.

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Achieving change in this context was thought not only to be difficult, but also very costly. As we have argued (above) substantial investments are required, in terms of training and development as well as particular capabilities in leadership and the management of resources. Furthermore, if the task of building relationships is not hard enough, managers are required to deal with a whole host of other, potentially competing, demands and requirements such as assurance of healthcare standards, financial performance and patient involvement. As one ex-manager put it: “there’s mixed messages that are coming all the way through the system”.

Added to this were some indirect costs associated with trying to change ways of working. Witnesses noted risks of raising expectations and then failing to follow through and the damaging consequences this might have for the morale. One manager, for example, described how, as a new CE responsible for turning around a large hospital trust she had been confronted by “a huge schism between senior doctors and senior managers”. This problem in turn was largely attributable to the fact that senior doctors “felt let down”. The previous management team had made promises of new funding to develop new “Centres of Excellence”, but then the “money hadn’t come”. This failure to consult in the past resulted in a lack of trust in management, such that “if you told them the real financial situation, it wasn’t trusted”. Doctors felt betrayed, angry, disengaged and disenfranchised, making it harder for the current management team to re-build trust and initiate further change.

These difficulties of managing and sustaining productive relations were even present in those cases, where they were strongest and most developed. A number of witnesses talked, for example, about the tenuous nature of these relations and the constant possibility that older, more established cultures and ways of working would reassert themselves. As one ex-general manager put it:

…”deep down there’s always a ‘them and us’ and I think there are limits to the loyalty that goes across that divide. And I think the medical profession has a lot of power and knows what it wants and will more than tolerate management. It is prepared to go along with management if it seems that the management is doing the best it can to facilitate the things it cares about…But you know, if things had gone wrong, they would have thrown us to the dogs with no hesitation whatsoever”.

While generally less pessimistic, others were also keen to stress that patterns of productive working, once established, could not be taken for granted and might easily be undermined. As the CE of a London teaching hospital explained:

…”what happens in complex systems…is that, you know…the overall system self-reassembles. So you know, the vigilance needed to guarantee this for all time …. not because people are just wanting to get cosy again but, because these things have a habit of degrading. ….So we’re pretty pleased with it but next year we might say ‘how do we kick on again because it looks like it’s falling off its perch’.

It was partly for this reason, as we saw earlier, that so much emphasis was placed on the need for senior decision makers to avoid complacency, even when things appeared to be working well.

2. Failure of the system to learn, general convergent tendencies

A second explanation given for the limited coverage of productive relations was obstacles to dissemination and learning, not just within organisations but the system as a whole. A tendency for change to be ‘convergent’ – reinforcing the status quo – is well understood in the literature on health organisations[35, 36]. More recently Ferlie et al. [97] note how cognitive and social boundaries within and between professions can impede the diffusion of change, while Currie and Suhomlinova [98] identify a series of obstacles to inter-organisational learning.
These themes were also writ large in our own inquiry. A classic example was the story of a major innovation in managing pre-admissions to Cardiac Surgery within a large hospital trust. This initiative had been led locally by a consultant and nursing staff and had achieved significant savings in resources and improvements in patient satisfaction. Despite this, it had not been publicised more widely across the trust and was virtually ignored by senior management and other groups of consultants, wedded to their own particular ways of working.

This weakness in terms of learning from new innovations in the management of services was also felt to be a characteristic of the NHS more generally. One academic witness, reflecting on over 1 year of research, commented on how the NHS had produced numerous “positive outliers” or “experiments” where medicine and management had worked together. Yet the dominant pattern was for these outliers to ultimately fail or to revert back to the status quo without other parts of the system learning from them:

…we have quite a literature, quite a lot of empirical material on the positive outliers. But it’s not kind of picked up, ‘what can we learn from these places, how can we encourage other places to look at this to try and become more like you’. We don’t do that. There’s a big absence of I think organisational reflection within the Health Service.

Others also commented on this problem raising questions about the lack of coherent policies or institutions that might allow for the spread of good practice in management across the NHS. One witness described this succinctly as a “failure in the architecture”. Another made similar observations about the “un-joined up” nature of decision making with regard to management, the “lack of synergy” and how “at the national level it is hugely confusing around kind of who’s responsible for what and how does the system fit together”.

Hence, a key theme emerging from this Inquiry concerns the problem of learning and reflection about management both within and between health organisations and the apparent inability of the system as a whole to benefit from innovations that occur within it.

3. Constant or periodic reorganisations, shifting goal-posts

Following on from the previous point, it was noted that constant reorganisations and policy changes within the system might also have a damaging effect on local efforts to build productive relations. Over the past decade primary care has undergone significant restructuring, with the formation of PCGs, then PCTs and now a radically different set of relationships. Similar change has occurred in secondary care following the abolition of the internal market and subsequently a host of new governance arrangements linked to foundation trust status. In the wider policy and academic literature it is reported that constant changes to the broad structure of the service may be having a disruptive effect, leading to cynicism, initiative fatigue and instability at local levels[18, 37]. Such views were also expressed strongly by witnesses participating in our own Inquiry.

A common perception was that restructuring was often undertaken with minimal “evidence” and without much thought given to problems of implementation at local/operational levels. Some commented on the “great uncertainty” about the future and the problems this created in terms of planning and the design of services, for example, in the context of primary care. There was also a feeling that a climate of constant restructuring only served to reinforce the cynicism of practitioners and a tendency to view policies as “yet another new initiative” destined to be badly run and likely to be forgotten within a year. Such emotions, our witnesses argued, were especially pronounced when the “objectives of policy” appeared to shift as well. As one manager put it, while the “underlying process” of applying for Foundation
Trust status had been “helpful”: “what's been frustrating has been that the goal-posts appear to be sort of moving just as we appear to be sort of crossing the line and breaking through the tape, sort of something moves”.

Periodic restructuring of the system also tended to exaggerate many of the problems of management turnover described below. Our witnesses described how such change led to entire management teams being “blown apart” or “chucked up in the air”. This in turn, often meant the loss of accumulated knowledge, goodwill and the destruction of relationships between managers and other stakeholders that, sometimes, had taken years to develop. According to one senior manager of a PCT, over time, “in any organisation, you can negotiate a set of shared outcomes where everybody knows what they're doing” and where managers “learn how to relate to their clinicians and the clinicians can then learn how to relate to them”. Major reorganisations however tend to “throw all that up in the air”, producing a situation in which managers are no longer interested in the “bigger picture” but are instead “busy scrapping round for jobs...”. Such problems it is noted are frequently exaggerated by the lack of succession planning or indeed any kind of HR strategy whatsoever for handling appointments in the wake of major re-organisations. Little thought it seems is given to ensuring continuity of successful management teams or even of preserving local networks. Rather, policy makers tend to appoint “the leaders they want, rather than the leaders they need”.

4. Turnover of senior managers
Related to the above many felt that a further obstacle to lasting change was the high turnover of general managers in the system. Exact figures on this turnover are hard to come by, although a number of observers now estimate the average length of stay of a CE in the NHS as being in the region of 2.5 years\(^{18}\) or 700 days\(^{38}\). Such turnover is in part a consequence of frequent re-organisations of the service (see above). However it can also be linked to the nature of management careers in the NHS and the (most likely very accurate) perception that moving jobs and changing institutions will advance one’s position much more than will staying in the same place.

Most witnesses agreed that current levels of Chief Executive turnover were having a detrimental effect on local efforts to foster more productive relations. According to one academic witness “you need to recruit teams and keep them together, I would say for five to eight years if you've got a strategic change exercise going”. However where the management itself is constantly being disrupted such change is obviously hard to sustain. Frequent turnover not only implies a loss of skills and direction, but may undermine the morale of clinicians and their willingness to take management seriously. As another witness put it: “Every time these organisations change their Chief Executive that trust will have to be rebuilt from the ground upwards”. Others noted how clinicians might view with suspicion managers who they believed would only stay in the organisation for a limited time – “what's the point in building a relationship with this guy, he's not going to be around much longer?”. It was also noted that management turnover could generate considerable cynicism and anxiety for staff, especially in a context of pending financial crisis when it might be viewed as “a sign of worse things to come”.

The evidence of this Inquiry therefore points to some potentially damaging effects of high and frequent turnover. To be sure this does not mean that all turnover is bad. Internal management mobility can serve a useful purpose of disseminating knowledge and expertise through the system and clearly, in some instances, it is possible for managers to out-stay their welcome. That said most witnesses were of the opinion that current levels of ‘churn’ were possibly unsustainable. Indeed, it was felt that current incentive structures were skewed too far in favour...
of rewarding mobility as opposed to stability and long term institution building. As one witness remarked, the dominant view seems to be that “staying in one place for too long is bad.”

5. Performance management frameworks

The fifth and, for many, one of the more serious obstacles to building productive relations in the long term are national systems of regulation and performance targets. In recent years there has been a marked increase in the range and detail of such targets, financial and otherwise, set by central government, linked to processes of audit and inspection and feeding into national statistics. Examples that have been prominent in the media over recent times include the A&E 4 hour waiting target, National Cancer Plan waiting times target and many others. In General Practice, the Quality and Outcomes Framework has linked a portion of GP pay directly to achievements on over 140 indicators.

Only a minority of participants in this Inquiry took the view that it was wrong for central government to set performance targets or that the whole process is necessarily a waste of time. That said, concerns were raised about the nature of targets and the way in which they were formulated and implemented. Correctly or not it was widely believed that central government had not consulted local practitioners on the nature and relevance of targets and that they had simply been imposed from above. As one PEC Chair remarked: “GP practices have very little ownership of targets, they’re not our targets”.

In addition to this were more specific concerns about implementation. Many talked about how the current focus on performance targets had helped to foster an increasingly “dictatorial”, “command and control”, or “we need to do it yesterday” style of management. This applied at all levels of the system, from SHAs down to individual managers within a hospital or primary care trust. According to one PEC Chair a “stamping culture” had emerged in which local managers get:

…kind of trampled on and stamped on and you just have this kind of political directive ‘oh no, we don’t want to hear any problems, we just want to hear you can do it and what the solution is’…. not listening to any other considerations than their own, which are just targets and money and not seeing things outside that.

Others remarked on the pressures placed on general managers to deliver on targets, or at least be seen to deliver, in ridiculously short time-scales. One witness, for example, described how the Chief Executive of his PCT:

…but has a terrible job in that she is getting all sorts of pressures from … Strategic Health Authorities to do things now you know, to achieve this target now, to achieve whatever, to get full coverage of practice based commissioning.

In some cases, it was claimed, the pressure to comply with targets was so great that local managers were being asked to impose change regardless of the consequences for their own organisations. An example of this is given by the CE of a large hospital trust in the north of England. This witness explained that she had been asked by her SHA to announce staff redundancies in large part because of a national target for headcount reductions that the SHA was working towards. In her view such policies were inappropriate given local conditions (in her trust) and amounted to “massive scare-mongering”. They also seemed to represent a “very simplistic approach to what people think they should see in organisations in order to demonstrate control or good governance…”.

A theme running through much of the recent academic and policy literature is that an overbearing emphasis on performance targets has greatly limited the scope for autonomy of local managers. Dewar[39] for example, suggests that
NHS managers are now “highly constrained” and have “little room to determine priorities”, while Hoque et al\textsuperscript{[1]} suggest that local managers only have freedom “to do what they are told”. Many of our witnesses shared this perspective. One ex-general manager remarked that while “in theory, there should be lots of … scope for innovation and doing management better at the local level”, in practice:

\begin{quote}
...the volume of compliance type activities and activities which are required to keep up with the stream of policy ... the pace of policy change at the Centre is such that it... it leaves very little autonomy for people. So you end up just running around doing what the Centre wants done all the time really. So there's not really any kind of space to do things from a different sort of philosophical basis really. So you know, you have to decide whether you'll contend to be a sort of commissar type figure or whether you want to do something a bit more independent.
\end{quote}

Others talked about how targets often meant that general managers were overwhelmed by target compliance and were “looking up” for most of the time as opposed to seeking to manage change at local levels.

Of course, not all our witnesses agreed that the current focus on performance targets had completely driven out all management autonomy. As we saw in the previous section there remains considerable scope for managers to innovate at local levels and to interpret or filter top down demands in ways that minimise disruption. As one PCT manager explained:

\begin{quote}
...you can either sit on the outside moaning and whinging about how awful it all is or you can get on the inside and you can influence the way it's implemented because we get a broad strategic document. How we operationalise it out on the ground is sometimes flexible.
\end{quote}

It was also suggested that less capable managers might use pressures to comply with targets – “they told me to do it” – as an excuse for inactivity. However, at the same time, it was felt that current performance demands did make it more likely (if not inevitable) that managers would be “risk averse” and prefer to ‘play it safe’. As one ex-manager explained, taking initiatives at local levels may be “career limiting” because “the Centre doesn’t want people to promote themselves locally” and is more interested in “organisational compliance”. Doing things differently therefore, by seeking to foster productive relationships in the longer term may be extremely risky for the managers concerned. This may be especially true if the results of such change fail to match up straight away with the targets and expectations of higher-level managers or policy makers (also see section 3 of The Results).

It is possible therefore that current performance demands are reinforcing what one of our witnesses described as a “culture of mediocrity” in which managers are concerned increasingly with delivering compliance for its own sake. To be sure this does not rule out the possibility that productive relationships will emerge at local levels. Nor does it necessarily mean that focusing attention on the development of these relationships is incompatible with being in compliance. As one policy witness explained, the key to success is not just an ability to “hit targets” but also an “understanding of what the local priorities are and being able to respond to those and getting clinicians to work with you”. That said, it is clear that achieving this combination is far from easy or risk free in the current context. Indeed it may be that doing things differently or against the norm is becoming an increasingly high risk strategy not simply for individual managers in terms of careers, but for entire organisations as well.
6. System of professional education and socialisation

A quite different potential obstacle to the formation of productive relations, many witnesses argued, was the wider system of clinical education and socialisation. As we have seen, there are numerous examples of doctors (and other clinicians) becoming more engaged in management work. One can also find broader survey evidence to suggest that professional attitudes, especially with regard to ‘clinical resource issues’ are slowly changing\(^{(40)}\). That said, most of the witnesses to this inquiry felt that older values and orientations remain deeply embedded and that these continue to work against the development of alternative, more productive ways of doing things.

In seeking to describe these ‘values and orientations’ many witnesses talked about what they saw as the pervasive culture of consultant individualism that is still pervasive in many parts of the NHS. According to one clinical director:

\[\ldots \text{I think autonomy in Medicine has been a bit disruptive and I think it's that belief of autonomy and individual practice that I think has caused a lot of problems within Medicine. I would like to see less autonomy and less individual practice. I would like to see people work in teams rather than work in ‘my firm’}\]

Another witness suggested that junior doctors are “conditioned” to believe that they “are going to be these all-empowering consultants who have this, if you want, autonomy to work in singular silos rather than in teams”. Such attitudes, many felt, could be extremely “disruptive”, often resulting in “difficult”, “uncooperative” or “non-organisational behaviour”. At best the dominant tendency may be to tolerate or grudgingly accept management. At worst management may be viewed as “the dark side”, viewed as irrelevant and potentially threatening to professional practice.

It was noted that quite often these negative views could be linked to the perception that management represented an ‘inferior profession’ to medicine both in terms of status and knowledge claims. Management is also negatively associated with the top down financial targets and attempts to cut back or ration service provision. Beyond this however, it was felt that a continued disengagement of many doctors with management had much to do with wider processes of medical education and socialisation both inside and outside employing organisations. One academic witness spoke about how Royal Collages had in the past been ambivalent about management training (although this is now changing) and that, even when specific modules are available, only a minority (perhaps 10%) of students opt for them because “it's not seen as institutionally important”. Others suggested that this lack of training, not only reinforced certain negative stereotypes about management work (see above) but also – by failing to develop particular kinds of skills – made it harder for doctors to actually do their own jobs. As one clinical director explained:

\[\ldots \text{we don’t develop systems… in the training, either as undergraduates or at postgraduate level. So I will see a patient in a clinic but it won’t occur to me that that patient has had to have transport to be brought from their home to the clinic; that Records have had to get the case notes, that Pathology have had to do the blood tests and Radiology have had to X-ray them; and that the nurse outside has had to weigh them and take their blood pressure and actually calm them down because they couldn’t find the clinic and they spent 15/20 minutes and they’re really fuming… Now I’m not aware of any of that, all I see is the patient in front of me. And they’re not aware of Pharmacy who make sure that the drug I prescribe is actually in the pharmacy and the patient then gets the information leaflet to take the drug properly…So if I’m thinking systems for me, it’s really important that the nurse outside, actually nobody’s upset her, that the ambulance service works, so that I’m not doing anything which is going to have an adverse effect on the whole system.}\]

A general feeling therefore was that in many respects new medical graduates entering the system were ill prepared or as one witness put it: “unfit for purpose”.
Given the evidence presented elsewhere in this report one cannot say that professional values and orientations represent an insurmountable obstacle to change. There are, as we have seen, many ways in which clinicians can be engaged in the system and effectively “rendered fit for purpose”. Broader changes are also afoot in the system of professional education, as reflected in the initiative of the Royal College of Physicians\textsuperscript{[30]} to mainstream management concerns in the training of doctors. But what does seem clear is that the prevailing culture of medicine is still broadly hostile to the kind of change described here. This culture makes the task of engaging clinicians – achieving some kind of “reverse socialisation” – harder than might otherwise be the case. It also increases the likelihood that over time, even in the most successful ‘outliers’, older values and patterns of behaviour will simply re-assert themselves.

**Box 6.1. Non-organisational behaviour**

“…there was one character who was famous in the hospital for being of a very unforgiving temperament if I can put it that way, a bit old-fashioned you know… Sir Lancelot Spratt sort of comes to mind, as a role model. But you know, man and action, totally impatient with all aspects of management, very hard working. Typical surgeon, only happy when he’s in the operating theatre. And I had to work with him to start with before he became a Clinical Director, around some of the aspects of his business case and he was very, very difficult to work with because you know, all he was interested in was what they wanted as surgeons. And he wasn’t interested in having a broader perspective, he was very difficult, he had about three secretaries, all of whom defended his diary. It took me a whole year to work out that the only way actually to get him to a meeting was to just organise the meeting, tell him it was happening and if he was interested he’d turn up. There was no point in trying to arrange a meeting with him because it would never happen. Oh he liked to create drama, he liked to say he had to leave a meeting because … or threatened to leave because it wasn’t going the way he wanted, all these sorts of behaviours.”

*(General manager)*

“I arrived in this directorate and everybody sidled up to me and said ‘we’ve got to do something about Mr Smith’…. So I have a look at Mr Smith and I find out that he is practising in a private hospital on Monday and Tuesday. He plays golf on a Wednesday, goes sailing on a Thursday and he does his eight hours in the public hospital system with us on a Friday. And inevitably that means he’d cut them up and the patients need high intensity nursing and they need physio and they need this and that and it always happens at the weekend and it’s hard to get the staff and it’s expensive. It’s definitely not favourable as far as cost’s concerned. So everybody’s saying ‘we’ve got to do something about Smith’. So I find out all of these things and etc, etc and eventually have a chat with Smith, saying that ‘we’re thinking about moving your operating hours to a Wednesday’. And later on in a meeting with my general manager, he said ‘you may have noticed as you came in, the door was off its hinges’; that was Smith leaving.”

*(General manager)*

7. Perverse incentives working to limit doctor involvement in management

In a previous section (part 3 of The Results) we noted that under some conditions clinicians might look upon management work favourably and actively volunteer to do it. However, what the accounts of our witnesses also suggest is that there exist a series of perverse incentives for doctors in the current system not to become more involved with management. As with values
and orientations discussed above these are not insurmountable. They do nevertheless represent a further potential obstacle to the development and sustainability of productive working. In describing these ‘perverse’ incentives our witnesses focused on three main issues. The first concerned financial remuneration and social status. A key problem here is that for a majority of clinicians entering management roles, both in primary and secondary care, is most likely to involve additional work for limited or no improved financial reward (also see Fitzgerald and Ferlie[41]; Hoque, Davies and Humphreys[1]). As one PEC Chair explained, while medical leadership roles in hospitals are under-developed:

…in Primary Care, it’s much more difficult because GPs are self-employed and actually PEC remuneration’s not all that brilliant, particularly with the new contract payments as well.

In some contexts, entering management could imply reduced pay for clinicians, especially if this meant reduced time for more lucrative private work and the loss of “clinical excellence” (or merit) awards that tended to reward mainly academic achievements. Added to this is a potential loss of status for those clinicians who become managers. As we saw above, the dominant professional culture of medicine has tended to down-grade the importance of management and place more value instead on academic prowess and ‘cutting edge’ clinical prowess. In the past, as one witness put it, “there’s been no culture of valuing” management input from doctors. Indeed it is possible that for some doctors entering management may imply a loss of cultural capital and social status, not to mention the risk of becoming isolated or even ostracised in the workplace[89].

Second, and following on from this is the absence of any definable career structure for doctors in management. While there are now, especially in secondary care, designated clinical leadership roles, some (for example at medical director level) being quite senior, more often than not these are taken on in addition to other clinical tasks and are not linked to any kind of distinctive career pathway[4]. As one witness explained:

…there isn’t a door that’s open at the moment. You kind of stumble into it (management) by circuitous routes. And I think there’s something about going back to basic training around an acknowledgement of the value of these things, right the way through the training…So you do need something both in the training and working up through with people that allows people to discover those things earlier on and think ‘this is what I’d really be interested in doing’. But also for people to acknowledge that these are key and important roles.

By contrast, as we will see in the next section, our international examples (e.g. Kaiser Permanente in the US) show how organisations that really wish to bring clinicians into management, structure a career path to encourage and develop potential candidates.

A final point to note here are the views expressed by some witnesses that high levels of clinical involvement in private work might also work against the development of productive relations. Pollock[42] notes that in 1998 roughly 16,000 of the 23,000 consultants in the NHS undertook some private practice. One result of this are possible financial disincentives to take on management roles. More generally it was felt that high involvement in private work, if taken to extremes, could help to reinforce a kind of anti-corporate, anti-corporate similar to what we described in the previous section (see Box 6.1 for an illustration). According to one witness, the task of managing change becomes all the more difficult when large numbers of doctors are engaged in private work.

It would of course be a mistake to overstate the extent of private practice or assume that it necessarily works against clinical involvement in management. That said, where significant opportunities do exist for clinicians to increase their earnings by focusing outwards, this can serve as an additional obstacle to change. At worst it may offer a hard economic rationale for some clinicians to disengage from employing institutions and adopt a ‘fee for service’ mentality towards them.
International comparisons

The spirit of this inquiry, focusing on how health organisations are making the most of the management-medicine relationship, naturally leads to some examination of ‘productive working’ from outside the UK. With this in mind we have chosen to look at three alternative health systems, those of: Denmark, Holland and Kaiser Permanente in the US. As we shall see, these systems all represent examples of innovation in the forging of alternative contracts between medicine and management. However, before exploring this in detail, it is useful to reflect briefly on the value of making international comparisons and the approach we have adopted.

OUR APPROACH

It is evident that health systems across the world are now undergoing significant reforms in their organisation and management. It is also apparent that very similar challenges have been faced. As in the UK, one finds a reluctance of doctors to fully embrace the new management or to depart from older, more established collegial ways of working. However it is also clear that this change has occurred at different rates and with markedly different consequences. For example, while in the UK, the task of reforming the system has been handed over to a new cadre of general managers, elsewhere doctors and nurses themselves have assumed this responsibility. The latter is apparent in a country like Finland where there has been a willing adoption of management accounting techniques by medical professionals, who have sought to make this a legitimate domain of medical expertise. More generally, reactions to the new management in health have. Recent cross-cultural survey data on clinical attitudes reveals a markedly more positive reaction to management in China than is the case in England, Australia and New Zealand. Our view is that these differences matter and that much can be gained from learning more about them. At a most basic level this is to open our minds to the possibility for change. According to Noble one of the chief benefits of international comparison is: “to see ourselves differently by understanding the things that we find strange and that others take for granted. It may not be applicable this morning, but it opens our minds to new ways of approaching…issues”. Of course comparison for its own sake should be avoided. We must also be mindful of the limitations and risks of comparison. Examples of ‘what works’ in one national context may not be easily transferable to another, where different institutions and cultures shape practice. That said, the exercise of investigating differences in national systems of healthcare management still remains useful. At very least it draws our attention to different ways in which productive working might emerge. At best it could yield a new and potent source of information to feed into policy and develop practice in our own national context.

Given the limits of time and resources, for the purposes of this Inquiry we have chosen to focus only on a small number of health systems: Denmark, Holland and the Kaiser Permanente (KP) organisation. We have also needed to rely primarily on published secondary sources. However, in each case, interviews were conducted with leading practitioners, academics and representatives of relevant professional bodies.

Prior to looking at these findings in more detail, it is useful to add a brief note on why we selected these three cases. Specifically, our rationale for focusing on Denmark, Holland and KP was twofold. First, all three health systems are notable for having made significant advances in terms of developing new forms of clinical engagement with management. KP has already been subject of discussion as a comparison to the UK NHS and represents one of the more efficient and successful ‘managed care organisations’ in the
US. The Danish system also has a long history of experimenting with new modes of governance and, as we shall see, (in the hospital sector at least) has made great strides towards the development of clinical leadership roles.

Notwithstanding these common tendencies, these three health systems are also sufficiently different to make comparison interesting. While in all three, there has been a drive to reform management, this has occurred in markedly different ways and from quite different starting points. Denmark, Holland and KP, one might say, have followed different pathways of change and represent alternative ways in which essentially the same result of more productive working can be achieved.

To illustrate this latter point it is useful to compare our three cases along two key dimensions (see diagram 1). First a distinction needs to be made between health systems that are largely publicly owned and managed and those in private hands. Moran\textsuperscript{[43]} describes the former as ‘Command and Control’ systems and the latter as ‘Supply’ or ‘Corporatist’ health systems. The Command and Control variant is characterised by public ownership and the use of state power (local or national) to raise funds through taxation. The UK NHS traditionally fits into this category, as do the health systems of Scandinavia (including Denmark) and Mediterranean Europe. By contrast, in Supply (such as the US) or Corporatist health systems (including Holland or Germany), control of the organisations that deliver health care is largely (if not exclusively) in the hands of private firms or voluntary, not-for-profit organisations such as sickness funds and other public law bodies.

A second dimension concerns the degree to which clinical professions (especially medicine) are involved and committed to the organisations of healthcare delivery. In any context, hospitals are likely to resemble ‘professional bureaucracies’ characterised by some tension between the priorities of managers and professionals. That said it is likely that the nature and force of this conflict of interest will vary a great deal. Much will depend on the nature of employment relationships and on how far doctors are involved in private practice. At one extreme it is possible that doctors engage with hospitals as independent contractors, on a fee for service basis. At another, doctors may be direct employees of the state, even tenured civil servants. Levels of commitment may also be determined by the relative strength of occupational cultures in relation to those of corporate cultures. Whereas the latter may facilitate some common sense of purpose around the organisational goals of, say a hospital, the former may result in a stronger sense of disconnect between professional and organisational interests. This in turn may result in a more transactional contract between doctors and the organisations where they work. Here employers may “not expect (and do not obtain) organisational commitment”. Instead the focus turns to “securing compliance with the terms and conditions of the contract versus executing broader responsibilities and assuming organisational roles…”\textsuperscript{[102]} Hence, a second key dimension relates to the degree of professional incorporation within and commitment to health organisations.

\textit{Diagram 1: Comparing health organisations}

<table>
<thead>
<tr>
<th>Ownership structure</th>
<th>Denmark</th>
<th>Kaiser Permanente</th>
<th>NHS</th>
<th>Holland</th>
</tr>
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<tbody>
<tr>
<td>High Degree of professional incorporation in health organisations</td>
<td></td>
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<td></td>
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<tr>
<td>Weak Public</td>
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\textit{Ownership structure}
Using this framework one might argue that the NHS is best placed in the lower left-hand corner, a system that is mainly state owned but where professionals continue to have strong private interests and weak attachments of employing organisations. Denmark, as noted earlier is very similar to the UK in its basic structure, although here professional groups are much more deeply involved in their employing organisations and have few if any outside private interests. Holland, by contrast, does look quite different to the UK. As we shall see, most healthcare provision is organised by private and voluntary bodies, while doctors have traditionally been fiercely independent, preferring the status of independent contractors. A similar pattern also applies to much of the US health system. However, KP, the focus of our attention here, is somewhat different in that it has historically been characterised by a strong corporate culture in which doctors have tended to self-select to join the group and strongly identify with it.

The usefulness of this framework is in drawing our attention to the different conditions that have shaped the relationship between management and medicine. Implied are radically different starting points and different kinds of threats and opportunities to the development of productive working. As we shall see, these factors have been important in influencing practice in Denmark, Holland and KP. But before addressing these broad questions it is first of all necessary to describe our cases in detail. The following sections provide such an account, looking first at the general background and then at the specific features of productive working and how they are sustained.

1. Denmark

Denmark has often been seen, along with its Scandinavian neighbours, as the archetype of a successful ‘Command and Control’ system of healthcare. It has a record of providing good quality health services that meet the expectations of the population to a greater extent than has historically been the case in the UK. Our focus however is not on comparing performance or levels of funding (which are significantly higher than the UK). Rather attention will be given to describing the unique management arrangements of the Danish system and how these have resulted in significant benefits in terms of productive working and clinical involvement.

BACKGROUND

The Danish health system, covering just under 5.5 million people, has always been decentralised and democratically administered within 14 regions. In contrast to the NHS, it is the counties and municipalities (equivalent to UK local government) that directly control the health services, their funding and management structures. Most recently, the counties’ control has been somewhat reduced with the introduction of the free choice of hospital scheme in 1993[49]. There are also clear signs that the autonomy of the counties is being further undercut with the imposition of greater direction from the Ministry of Health who can now directly regulate medical education, treatments, quality standards and hospital specialisation[48]. But notwithstanding these trends, the Danish system remains markedly more decentralised than the UK.

SIGNIFICANT FEATURES OF ‘PRODUCTIVE WORKING’ IN THE DANISH SYSTEM

A notable feature of hospital organisation in Denmark is the high degree of medical involvement in hospital management. The Danish system boasts a particular model that incorporates doctors and nurses into senior management within a ‘troika’ model (a troika being a sled drawn by three horses working together). This ‘model’ was first introduced in 1984, around the same time as the Griffiths Report in the UK. A Danish hospital commission produced a white paper, which recommended that management and budgets should be decentralised to the clinic level and the model of hospital management should
be changed[50]. The reform of clinic management paralleled that of clinical directorates introduced in the UK later on that decade[101]. As for the hospital management itself, while the commission did not recommend a particular model all the counties introduced the same troika structure.

On the surface, this arrangement would appear to automatically address the problem of medicine and managers working together, as well as ensuring nursing has an equivalent role. In most hospitals the medical director is seen as a senior executive, who along with the nursing director and chief executive ‘run the hospital’. As one witness explained:

“the model is that you can be a doctor or you could be administrative educated on any of these posts. You could have four doctors, you could have four nurses, you could have four administrators, except that it says in the leadership of the hospital you should have the competence to govern the hospital, the medical and the nursing and the administrative competence you should have in the leadership. And in practice, you will always have some administrative and some medical experience.”

Within this approach finance, HRM and administration generally are subordinate functions to the top team whose first focus is to ‘manage medical work.’

Historically, the troika model reflects some erosion of medical dominance within the Danish system, for doctors, since the 1980s have had to accept that non-medical chief executives ultimately head the organisation. But while some in the medical profession remain committed to their traditional specialist and clinical structures, most have been pragmatic in their collective response to external pressures and need for change. Also, despite a recent history of professional conflict, at the executive level nurses and doctors have had to work ‘side by side’. Indeed, our witnesses were keen to stress that in the more advanced hospitals there had been a clear move away from ‘physician managers’ (simply representing different tribes or departments on the main board) to senior doctors and nurses adopting a shared corporate orientation. The practice in many hospitals is also for management roles at this level to be interchangeable.

A related feature of the Danish system, possibly linked to the above is extensive delegation to clinical managers in clinics or departments. Successful leaders in the Danish system have to be comfortable with delegation and are expected to exercise rather a lot of managerial autonomy with regard to financial and human resource issues. As one witness put it:

“They [clinical directors] are not so used to it, so they still ask a lot. But as a principle, when we have made a contract from the beginning of the year, here’s the money, here’s what you should perform. We do not put barriers up for them. They can move around with their salary, money and money for production and so on, as they like. And they can hire another senior doctor if they want.”

It would appear that a chief outcome of these arrangements is that hospital management tends to be much more focused on clinical work (the means of production) than would be normal in the UK. The chief executive has to lead their medical and nursing directors within the troika team. To do this effectively they must have legitimacy and credibility in executive management. Their intellectual capital may come from law, economics, business or social sciences, but they have to be able to prove their capacity to understand clinical issues as well. It is also the case that clinical directors are more content in accepting hard decisions coming from a medical director who is an integral part of the executive. As one manager explained:
"I go into a professional dialogue with them on medical terms as well as general managerial terms. So I see that as a role. I try to integrate the general managerial language and put it into a language that gives meaning for healthcare professionals in the organisation."

Reflecting the focus on the ‘means of production’ managers tend to emphasise innovation and clinician involvement, rather than pure financial engineering or cutbacks in patient care. Again, this approach ties in with the fact that management teams contain clinical expertise, which gives them the knowledge and legitimacy to stimulate ‘productive working’ by challenging the professional pride of clinicians. One witness explained how in his organisation it was normal to have “a very tight dialogue with the departments of keeping budgets on one hand but, on the other hand, pushing… professional development … And do it all the time; ‘why are patients in this department, why are they inpatients for ten days when I can see that best practice from Leeds for example is four days for a hip replacement?’ ‘Why can’t you do it better?’”.

What is perhaps most significant about the Danish system, at least those parts of it we observed, was that there seems to be no hard and fast ‘geological’ barrier between executive and departments. Doctors would appear to accept that they have to be receptive to alternative ways of working in order to maintain their autonomy. Unlike the UK variant, Danish doctors seem to believe that the executive integrally includes medics and that they play a central role not only in operations but also determining the strategic direction of the service.

GENERAL CONDITIONS AND PRACTICES THAT SUPPORT PRODUCTIVE WORKING

A key factor helping to explain this collaborative working in the Danish case is the historical attachment of doctors to their organisations.

Hospital consultants have had far fewer opportunities for private practice than their UK counterparts and therefore are much more reliant on their hospital salary. As a consequence, a career in hospital management would appear to have more appeal. As one witness outlined:

“we like every one of the consultants to be here. But probably … consultants in Denmark are more employed by the hospitals… they don’t work that much in private practice. … I have about 80 consultants at this hospital and 75 of them only work here, they don’t any other work outside, so they are here every day. So those consultants are mine, they work for me and they are not coming from their private practices, going into the hospitals and then going back again every day or so as you’re used to in the UK.”

Added to this is a willingness in the Danish system to offer incentives for doctors to take on management work (higher salaries) and engage in substantive investments in management training. As one witness [a medical director] explained, he not only provided funding for his doctors to attend Masters or MBAs in public management, he expected to find the time and resources for nearly all of them to attend a new, nationally accredited course in clinical leadership. Another witness involved in the running of this course outlined the success so far: “for the last two years I think the numbers are around 700 who have been through the basic course. And that’s 700 out of about 4,000 Danish consultants.”.

CONCLUDING REMARKS: DENMARK

While obviously hard to draw strict comparisons between the Danish system and the NHS (given the small size of the former), a great deal can be learnt from its emerging approach to management. The evidence of our witnesses indicated that the introduction of the troika model some 20 or more years ago paved the way for a effective integration between management and medicine. This has been achieved not by
challenging the doctors’ right to be in control, but by creating space for management to enter and make a contribution. In turn, this has been backed up with investments in management training for doctors at national and hospital levels. These arrangements, it seems, have laid the groundwork for leadership within hospitals to respond to challenging financial and service requirements by an emphasis on innovation and improvements to patient care.

2. KAISER PERMANENTE
Kaiser Permanente is a familiar name for those involved with the NHS over recent years. The organisation has been utilised as a comparison point, highlighting potential improvements in NHS practice and governance. Whilst these comparisons have made some reference to the unique organisational history and attributes of Kaiser Permanente the majority of attention has been put on specific aspects of innovative practice (e.g. Bed Utilisation) and the ‘internal schism’ between primary and secondary care in the NHS which is absent from the differently structured Kaiser system. In our work we have concentrated on the organisation of doctors and managers within Kaiser Permanente. Rather than looking at particular innovations of medical practice, this is an attempt to understand the conditions that generate such innovations (which benefit patients through reduced cost and improved outcomes). It seems more valuable for the NHS to develop a similar capacity for innovation to Kaiser Permanente than only imitate the innovations produced by the US group.

BACKGROUND
Kaiser Permanente is the largest non-profit health plan in the USA, with 8 million members across 9 states. The group is composed of the Kaiser Foundation Health Plans (non-profit, public-benefit corporations), Kaiser Foundation Hospitals (a non-profit, public-benefit corporation), and the Permanente Medical Groups (for-profit professional organisations).

The Kaiser Plans part of the group is one of a number of HMOs (Health Maintenance Organisations). In contrast to many of the indemnity insurance schemes operating in the US, the HMO chooses the doctor on behalf of the patient (in the case of Kaiser they contract exclusively with the Permanente group).

The structure of the group comes out of a long history. The beginnings can be found in the group practice set up to provide prepaid, preventive healthcare to workers at the Kaiser Shipyards in the early 40s. This prepaid, fixed budget approach was very unpopular with the US medical profession generally and the organisation was barred from many general medical facilities and thus forced to develop its own complete (vertically integrated) system of nurses, doctors and hospitals. Later, after the war, the Permanente Health Plan was opened up to the general public. The history of the group pushed it towards a “whole systems” approach and brought in doctors who were interested in broader aspects of healthcare. This allowed the organisation to put an emphasis on giving responsibility for financial and clinical governance to the clinicians.

In comparison to the NHS, two points should be acknowledged. As a group responsible for all “levels” of care, Kaiser Permanente never developed a primary/secondary structure like the NHS. At the same time, as large as it is, it is one choice amongst many. As such, it is possible that the pressures from patients and employees are subtly different to those in the NHS.

SIGNIFICANT FEATURES OF ‘PRODUCTIVE RELATIONSHIPS’ AT KAISER PERMANENTE.
The level of clinical input into management decision-making at all levels in Kaiser Permanente was stated to be high. The formal structure involves a ‘physician leader’ and ‘hospital manager’ with equal and partially overlapping responsibilities for the functioning of a treatment
centre. Management tasks are viewed as important to medical work, with physicians encouraged to participate in these roles through the financial incentive of the Permanente Group's partnership arrangement. Management has also gained a status of being integral to financial success and thus given status alongside clinical issues particularly because of a recent history where the group had encountered severe financial difficulties. The company structure ensured that managers and doctors were “tied together in a three legged race” through interrelated budget structures as well as clinician involvement in management.

Underpinning these arrangements was a strong corporate culture unique to KP. Witnesses described a particular mindset for working with difference, especially working with conflict and seeing it as a useful force for change. To quote one witness: “So you know, it’s a situation in which there are clear expectations and an established practice for resolving conflict. And I would say it is an agreement that non-resolution of the conflict is not an option.” This ties in with a notion of ‘organisational citizenship’ which emphasises ‘appropriate’ behaviours. Here it translates to: an expectation (carried through to selection interviews) that even doctors who do not practise management will have an understanding of the team working and systems issues involved in their work; a commitment to non-adversarial conflict-resolution training for all staff, with a special emphasis on doctors (as powerful members of the organisation) behaving with appropriate respect for other members of staff.

This ‘citizenship’ model can be seen to encompass a shift away from forms of leadership often considered traditional in the NHS. The ‘physician-managers’ in Kaiser Permanente (who may be considered analogous to ‘Clinical Directors’ in some NHS settings) still need to have the respect of their colleagues, but they are selected by central management and are primarily responsible to them. Thus leadership involved both ‘collegial’ and ‘executive’ dimensions, which represents a full engagement with management (as opposed to just clinical) concerns. One witness noted a sense of “changed worldview” as the post of physician-manager evolved and that part of Kaiser’s success in developing good clinician leaders might be the avoidance of purely “academic doctors.” At the same time, managers have a role that places more emphasis on partnership, based on “shared respect and understanding” and a sense that doctors and managers were “both bringing needed skills to the table.”

The overall performance of the Kaiser organisation cannot easily be separated from the significantly different context and history of the organisation. For example, the greater success with ambulatory care likely has roots in the lack of a split between primary/secondary care. However, our witnesses confirmed the focus of various studies on innovations in the organisation of clinical practice. The consensus was that the close working relationship between doctors and managers within Kaiser Permanente had created a culture of continual improvement. One witness who had also worked in the NHS compared “the Kaiser four-day length of stay for a total hip replacement protocol” to “a 14-day length of stay” in the NHS. This difference (and others) in outcomes, she argued, was directly attributable to the greater involvement of clinicians in the management of Kaiser Permanente.

GENERAL CONDITIONS AND PRACTICES THAT SUPPORT PRODUCTIVE WORKING

Like the Danish case, certain historical conditions have favoured productive working in Kaiser Permanente. As noted earlier, this history involved an early struggle to promote the pre-paid model in the face of opposition from the rest of the US medical profession. The main customers
in the early days were working-class families and the structure of the Permanente group has always meant that it was not the most financially rewarding career option for newly qualified US doctors. It is fair to say then that the history of Kaiser Permanente (combined with its position as one provider amongst many) may have positioned it as a natural home for doctors committed to doing things in a different way to the norm in the US and maybe more open to greater engagement with management issues.

Beyond this, it is evident that productive working at KP is also backed up by particular management practices and investments. Developing the organisation and the people within it overall was considered to be crucial. One group of managers within the Permanente organisation functioned largely as an internal consulting group who worked to develop the capabilities of the organisation.

Investments in human resource management, especially in selection and training were also seen as vital. According to one witness Kaiser Permanente has established:

for probably 15 years, an intentional strategy of building leadership into a sub-speciality of medicine. Training for it, hiring and recruiting for leadership, creating many leadership roles to develop a deep bench from which to select physicians for these senior roles. So in our medical group of 5,500 doctors, we probably have 1,500 physicians who hold some kind of title, administrative title.

Thus it can be seen that they select physicians with an interest in management issues, if not an active desire to participate in management.

Those who are drawn to management posts receive extensive leadership training to prepare them for the task. These training programs and the amount spent on selecting the correct candidates (internally and externally) represent a large investment. The prevailing belief however is that such investments are vital and are possibly the single most important reason for the success of the organisation.

A different kind of management practice that seemed to support success was linked to incentives. One point given emphasis by witnesses was that the contractual arrangements of doctors tied them to the performance of the organisation as a whole. As a senior manager put it:

I believe that that contractual structure, which means that the managers and the doctors rise and fall together in a very direct financial way, is … has been material to Kaiser being able to, you know, get a grip and get doctors involved and be jointly motivated towards the outcomes.

Whilst this is an incentive to engage with management issues, there are more incentives designed around actually bringing clinicians into management roles. It is a clear decision within the organisation to attach a tangible level of extra income to physician-manager roles. At the same time the 15 year program (mentioned earlier in connection with training and development) included a conscious effort to change the status of the physician-manager. Where previously it was the case of “manage when you’re fed up of clinical and ready to defect” the role now has a respect and status inside the organisation. As one witness explained:

“we have a very intentional process of choosing younger, clinically inspired, to take on these roles, rewarding it, recognising it. We’ve really over the last 15 years made it something that looks attractive to physicians, it creates variety in their work, they’re not thrown cold into situations where they don’t have the support or the skills.”

An extra incentive, both to join Kaiser Permanente and to engage with the physician-manager roles
on offer is the prospect of a long (30 year) career in the organisation. Competing organisations may offer more money, but few offer the same potential for a structured career path. The structures of physician-manager careers are also the main outlet for extra-curricular work in the organisation, which is not involved in academic medicine to the degree seen in many NHS hospitals. These factors contribute to a measure of ‘self-selection’ in doctors who apply to join Kaiser Permanente, especially when combined with the historical roots of the organisation (see Background section). Thus, if a clinician is not interested in management at all, she is more likely to join a competitor. This ‘self-selection’ likely facilitates easier success in training doctors for, and engaging them with the world of managers and managing.

CONCLUDING REMARKS: KAISER PERMANENTE

Like the Danish system, Kaiser Permanente serves a smaller constituency than the NHS. It also benefits from some self-selection in patients and employees who have a number of choices. At the same time, the history of the organisation, with no primary-secondary split likely contributes to its success.

However, ‘productive working’ at Kaiser Permanente is also clearly the result of conscious decisions to put clinician managers at the centre of the organisation. A serious investment in training and development of clinicians allows them to step up into influential management roles. The incentives of doctors and managers are aligned inside the organisation through the contracts of employment. The day-to-day relationship is further bolstered by a sense of ‘citizenship’ and respect in both sides of the medicine-management relationship.

3. The Netherlands

The Netherlands is a country historically characterised by distinct Catholic, Protestant and secularist interests and traditions. This has given rise to a unique set of institutional arrangements, which mean that all governments are coalitions with the remit to maintain consensus, while corporate and professional bodies represent citizens’ interests. All this is especially relevant to health policy and management, for the health system is comprised of voluntary, charitable, religious, trade union and professional interests. The relationship between the health service and the state is very different to the UK (including England) and Denmark, with some similarity to the US. Crucially one also finds in The Netherlands a strong, independently minded medical profession with very weak attachments to the organisations of healthcare delivery.

BACKGROUND/CONTEXT

In some respects The Netherlands is more like the NHS than their corporatist neighbours Germany and France, while in others it is quite different. The hospitals are typically autonomous, charitable organisations of religious origin and ‘not-for-profit’ (although this is beginning to change). Hospital doctors are a little similar to British GPs in that most are contracted exclusively to one hospital, and historically paid through fee for service 1. This has meant that they too have typically exhibited a ‘small business’ mentality and attempts to reform secondary care and encourage doctors to engage in management has been met with vigorous opposition from within the profession. Dutch patients, however, have remained generally well satisfied with their health services with 73.2% of them reporting they were ‘very satisfied’ or ‘fairly satisfied’ in 1999. This is less than that for Denmark but still fairly high when compared to other European countries where it ranks sixth 56.

As in the UK and Denmark, from the early 1980s a primary focus of policy turned to the control of expenditure. The traditional medical remuneration system (FFS) was crippingly expensive, while the sickness funds (including the health insurance

1 Currently, about 60 per cent of hospital specialists are paid fee for service and 40 per cent are salaried (all medical staff within University Hospitals are salaried) 56.
companies) lacked the initiative or means of controlling the escalation of costs. Added to this the medical profession itself enjoyed the advantage of being so structurally dominant within the health system that they could even be divided internally and still exert considerable power to undermine reforms. This is in part because the doctors could ensure they could maintain claim to be independent providers to the hospital services in much the same way as GPs in the NHS. While many Dutch medical specialists only work for one hospital their allegiance to the missions and goals of that enterprise are weakened by their strong commitment to being part of a company of doctors (*a matschaap mentality*). However, there is now evidence that the introduction of ‘clusters’ and a Diagnosis Related Groups (DRG) system of accounting, is leading to a more collaborative, ‘network’ approach to working between managers and clinicians. In what follows we describe this emerging model and some of the main consequences of it.

**SIGNIFICANT FEATURES OF ‘PRODUCTIVE RELATIONSHIPS’ IN THE NETHERLANDS.**

The basic organisation of medicine within Dutch hospitals would be recognisable to those familiar with the NHS. Doctors are organised into specialist ‘firms’ (*Maatschappen*), and are collectively represented by a hospital medical executive committee. This committee has been (and often continues to be) viewed as the ‘sparring partner’ of the hospital management. More recently there has been a move towards increasing clinical involvement within the executive board. Typically this consists of the General Director who is the chairperson and who is expected to have a business background, a Medical Director and an Administrative Director – the Dutch equivalent of the ‘troika’ (see above on Denmark). One consequence is that medical specialists have become more involved in strategic management and there are signs of greater collaboration. However, as an academic witness explained:

“There are … many situations where [the new arrangements are] problematic and … in our hospital system, usually at the end of the day, the doctors win, and the Director of a hospital has to go”.

Similar to England and Denmark, The Netherlands has also followed a strategy of seeking to engaging doctors in management at lower levels with the introduction of ‘clusters’. These clusters represent cognate groups of specialties and clinical activities and effectively trade with the hospital board, agreeing budgets and activity. This system is intended to be a more effective means of harnessing the work of the doctors and controlling costs than was possible under the previous fee for service (FFS) payment system.

Culturally speaking the new cluster model is the child of the medical-management history in The Netherlands. Dutch hospital doctors have tended to see their clinics as small businesses and the hospital as their domain. ‘Clusters’ appear to be the strategy for ‘squaring the circle’ of engaging the doctors in reorganising hospital services more effectively by harnessing their entrepreneurial spirit in a way that complements and can, possibly, be controlled by the hospital executive board. Accounting is now in terms of Diagnosis Related Groups (DRGs) rather than FFS. While it is possible that costs may still rise under a DRG system one would anticipate lower cost inflation than was found within FFS systems. Clusters are, therefore, different from English clinical directorates in their dynamic, although they will be, similarly, headed by a clinician as the official manager supported by an administrator and possibly a nurse.

Overall, this reorganisation has been viewed as a success story. While specialists continue to exercise great influence over processing the patient they are now far more dependent upon executive leadership than would ever have previously been the case\(^{[56]}\).
This is based on the hospital management recognition of the organisational autonomy of the ‘clusters’ and the doctors controlling and running them. In return the medical specialists now accept that they have to operate these ‘clusters’ effectively within the new reality of DRG accounting systems (and not FFS) and within the overall hospital strategy. The successful introduction of clusters – say for example at the Academic Medical Centre, Amsterdam (University Hospital) – has also led to medical specialists and nurses learning the management skills for organising and taking responsibility for their working processes. In this case and elsewhere there has been more focus on setting up good systems, work-flows, records and processing patients effectively.

**GENERAL CONDITIONS AND PRACTICES THAT SUPPORT PRODUCTIVE WORKING**

In some key respects the task of achieving a closer alignment between medicine and management has been harder in The Netherlands than elsewhere. The relationship between the board and clusters would appear to be less a matter of management and more one of trading within an internal market for clinical services. Compared with other countries the senior decision makers within Dutch hospitals have also traditionally had a legitimacy problem with the medical specialists who remain dominant in the system. Because of this considerable emphasis has been placed on linking reform to the interests, concerns and priorities of doctors. It is not uncommon for the medical director to be recruited from the MEC and continue to carry with them the view that their role is to represent the doctors on the board rather than the strategic interest of the hospital as a whole. To limit this risk, the focus has been on recruiting medical directors from within successful ‘clusters’ where one might suppose the new reality of contract trading and strategic game plans are well understood. Certainly, it is the need for intelligence and acumen of the medical director that would appear to be the crucial link for the future success of any hospital, alongside that of the hospital director and just possibly more so.

A further point to note about the Dutch system is that the establishment of ‘productive working’ is dependent upon robust negotiations. Medical specialists want to influence hospital policies in ways that protect and advance their interests while the hospital boards want to incorporate the specialists as partners in the decision-making process. The outcome, where it has been successful, has been for the doctors to take responsibility for the organisation and delivery of clinical services in a collective contractual relationship with the board. By all accounts, such change has been slow and contested with some doctors still harping back to the old order. The indications are however that the most conservative elements within the profession are now realising that the status quo ante is no longer an option. Increasingly they are willing to negotiate around a new agenda, which has for the last decade been the ‘cluster’ model.

A final point to make here is with regard to investments needed to support and sustain the changes in culture and working practice mentioned above. New efforts are under way to increase the management training supplied to clinicians. The aim is to improve relationships with management by giving doctors an understanding of operational management and the financial implications of day-to-day decisions.

**CONCLUDING REMARKS: THE NETHERLANDS**

The Netherlands’ health system is the most complex of these international comparisons. Doctors have truly enjoyed medical dominance of the hospitals and enjoyed the fee income that it has generated too. Consequently the challenge to their supremacy has not been aimed at subordinating them to management as has been attempted in the UK. Instead the effort is on incorporating them within a restructured hospital
management structure. This is one that has, like both Denmark and Kaiser Permanente, recognised the importance of putting doctors in charge (and holding them accountable for) clinical services. It is evident that there remains a substantial element within the profession who regret the passing of the old order. At the same time however there is also a growing realisation that medical-management integration in the form of ‘clusters’ provides a realistic way forward.

**INTERNATIONAL COMPARISONS: CONCLUSIONS**

None of the three cases discussed here provide a neat, instant alternative model for the NHS. As we suggested in the introduction (see diagram 1) all three systems initiated change from radically different starting points and have followed different *pathways* of reform. The Danish case offers an example of how a much greater strategic alignment between doctors and managers can be achieved within the context of a decentralised, largely state run and funded public health system. Kaiser Permanente, by contrast, shows how a similar alignment is possible within the private sector. Indeed, this model – with its focus of strengthening corporate culture – displays many similarities with new forms of management that are emerging within large professional service firms, such as in law and accounting. Finally, the Dutch system is illustrative of a more negotiated, contractual pattern of alignment between management and medicine. This form emerges in a context of powerful, independent professions and historically weak administration within hospitals.

These alternative pathways reflect the particular institutional histories of healthcare and medical professions in each case. For example, negotiated relations are clearly what many Dutch doctors thrive on, something that would be an anathema to the Danish doctors (and managers) and alien to the corporate spirit of Kaiser Permanente. It is in this context that the role of the medical director can be seen as particularly case specific. Their title might be the same but the way they engage with their corporate and strategic roles, and interpret any leadership role in relation to their professional colleagues does vary substantially.

On the other hand, what all three cases have in common and which is not yet widely shared within the NHS is the acceptance that to make doctors properly accountable they need to be responsible for organising and designing clinical services. Their role needs to be revamped and incorporated centrally within the management processes. This is not in any ad hoc individualistic way, but systematically, according to agreed care pathways, guidelines and protocols that connect the work of the specialisms and crosses the divide between primary and secondary care as well.

These lessons are especially apparent in the Danish system and Kaiser Permanente. By contrast The Netherlands ‘cluster’ model still feels like ‘work in progress’. There might also be concerns that this more contractual route to achieving productive working will fail to engender the same levels of trust and commitment towards the hospital as is the case in our other two examples. However, none of this is inevitable. Long-standing contractual relations, like any repeated transactions can engender trust relations, especially if they satisfy the interests of different parties involved. The Dutch system therefore highlights both the risks and possibilities of a more market driven mode of co-ordination with doctors locating themselves (both contractually and psychologically) outside the formal structures of health delivery organisations.

To reiterate, there is no ‘off the shelf’ solution for sorting out medicine-management relations. But at the same time, some common conditions and practices have been found to contribute to ‘productive working.’ The common threads of alignment in goals and incentives for managers and clinicians, investments in the organisation and its individuals and a focus on the management of clinical work in these international cases echo the findings in the rest of this Inquiry. Above all these cases point to the possibilities for such change and how productive working can be taken to levels yet unseen in the UK.
Conclusions and Recommendations

This Inquiry has sought to challenge the dominant view that doctors and managers struggle to work together. Indeed, our aim has been to tell a quite different story. What we found is that in some parts of the system managers and doctors have forged productive relationships and that these are to the benefit of services. A primary contribution of this Inquiry is to draw attention to this fact. It is important to recognise and value what has been achieved, to understand how ‘productive’ ways of working come about, and to learn from this.

In this short concluding chapter our aim is to consider in more detail what kind of learning is required. A number of recommendations will be made, some relevant to the service as a whole, others to particular stakeholders such as managers, policy makers, and professional bodies. Before that however, it is useful to reflect on some of the core messages of this report and on the broad changes implied by it.

A great deal of space has been devoted in this report to outlining what we mean by ‘productive relations’ and their consequences. Attention has also focused on the conditions that support these ways of working. Specifically we found that a more productive partnership between medicine and management is most likely to emerge when the following conditions are evident in the organisation:

- a clear focus on the clinical business
- space is created for local innovation by managing upwards
- decisions are devolved to the right level
- there is continuity over time
- complacency is avoided by seeking internal and external challenge
- there is congruency by aligning interests through rewards, information, performance management.

- doctors and managers make sense of the external environment together
- there is frequent dialogue to build share purpose
- differences are seen as an asset – conflict is used positively
- managers and doctors understand each other
- there is investment in organisational change, learning together, and developing locally relevant performance management systems.

It is important to note that these conditions are not unique to any specific part of the NHS. Rather they are all aspects that managers and clinicians in any context can do something about. As such, we are suggesting that in all parts of the NHS there is considerable scope to develop partnership and to learn from these experiences. But what are also implied are some broader changes in attitudes and in the demands of the system as a whole.

Where productive relations have become most established it is clear that important shifts have occurred in the way doctors and managers view the world. Managers pay more attention to the core business of the service (clinical treatment and care, and patients, experiences), while doctors take more responsibility for managing that business. This does not mean some kind of compromise or fudge. Rather what we found was a new partnership making the most of what both sides have to offer. Management is not seen as something to be tolerated as a necessary evil, a set of boxes to be ticked, it is seen as integral and vital to delivering clinical services. This means managers being closer to the clinical work – asking questions, understanding patients’ experiences, being aware of clinical developments. Where doctors are concerned it means being closer to the managerial work – the impact of clinical decisions on how the service is organised, developing the strategy of the whole organisation to make the most of the parts, and looking at viability, including the financial position.
This new partnership is one in which both parties understand the macro and micro issues – the context in which the organisation is developing services, as well as the day-to-day issues.

Looked at in this way productive working requires not just deep changes in values and culture, but also in roles. For doctors this could mean taking on a much more substantial responsibility for the management of health than has previously been the case. Indeed, one might envisage a similar trend towards doctors becoming the primary ‘managers of the service’ to what has been observed in other health systems, notably in Scandinavia and Kaiser Permanente. Such a shift will have implications for medical education and what is included on the curriculum. It might also be seen as downgrading the role and status of general managers. This however should not be exaggerated. It is clear that general management expertise remains an important feature of productive working (including in those situations where doctors themselves have taken on strategic roles). As we have seen, the most effective managers are those able to provide leadership to facilitate change, in supporting productive working and adding value to clinical work.

This Inquiry further suggests that for productive working to develop changes in the policy and regulatory context will also be needed. What struck us was that while the conditions needed to foster and sustain new relationships are simple, the task of building and keeping them alive was neither easy nor risk free. This is especially in the current climate in the NHS, which at times militates against productive working between managers and doctors. Some witnesses spoke of an attitude across the NHS that investing resources in trying to build partnership is not the way the real business should be managed. This kind of work is often not seen as a core function of managers, but rather something they do if they can spare the time. Even more damaging were accounts that suggested that too much attention to local institution building might be counter-productive for managers, distracting them from the task of responding to external demands and targets.

It seemed to be the case that aspects of the way the NHS is managed are making the task of building partnership much harder than it needs to be. Many of the innovations in management described in this report are occurring in spite of the system rather than because of it. Individuals and groups persistently talked about such change as ‘risky, or outside the norm. But for us it seems far more ‘risky' to carry on with this ‘norm’. Developing productive relationships is the only safe way to ensure improved care for patients and users, and organisational viability. Hence a further big change implied by this Inquiry is in the demands and expectations of the system as a whole. Our message is that these demands need to be framed in ways that encourage local partnership rather, as is so often the case, discourage it. If developing productive relations is risky, then, arguably, not taking the risk is the most risky thing you can do.
Recommendations

The conditions for productive relationships listed above imply changes in focus, attitude, and process. The recommendations therefore reflect this. The Inquiry shows that doctors and managers have to create the conditions themselves.

In essence the only recommendation is a process – create the necessary conditions for productive relationships at different levels of the NHS. This means thinking about changes that are a joint responsibility of managers and policy makers, those that are a matter primarily for policy makers or for contracting agencies and finally longer term changes that involve a broader range of stakeholders, including universities and professional associations. In what follows we now outline some recommendations pertinent at each of these levels.

AT EVERY MANAGEMENT LEVEL IN THE NHS

1. Take the conditions that establish and maintain productive relationships described in this report and foster them.

Review your own working practices against these conditions. This is not another box to be ticked. This is a medium term objective and commitment to patients and your organisation. The starting place is not to assume you are already doing it – but assume you could be doing it better. We suggest that you peer review the way you work for instance ask another part of the NHS to help you ‘diagnose’ how well you are fostering these conditions then take action. For instance if you are unsure whether you are focusing on the clinical business as an organisation, you could take your Board agenda and look at the balance of time spent on the clinical work in relation to other issues.

An example of one simple action you can take would be to plan investments to develop the doctor manager relationship. Invest in bespoke development programmes where doctors, managers and other health professionals learn together.

2. Have conversations in your organisation about the conditions described in the report.

Work with people in your organisation, starting with their real stories of their experiences of working together. Are these lived examples congruent with the conditions in this report?

If these conditions are to be evident across the NHS, then this has to be modelled at every level. This is work that is as relevant for the NHS Management Board as it is for an individual NHS Trust.

AT POLICY LEVEL

Change the parameters to make it easier for these conditions to be fostered in NHS Trusts.

1. Set direction and expectations, but leave NHS Trusts to develop metrics that demonstrate performance against these expectations.

2. Stop reorganising and shifting Chief Executives around. Pay more attention to the hidden costs of reorganising – these may be substantial and outweigh the benefits. If reorganisation simply cannot be avoided then at minimum have succession plans that recognise local capabilities and build around them rather than destroy them.

3. Set the parameters and act as leaders not managers. This means setting direction, having clear vision, clear expectations of outcomes and requiring the service to find its own way of managing. Let the system take decisions at the right level and hold it to account for those decisions. Fitness for purpose must include this partnership between managers and doctors, and taking the right decisions at the right level. This does not always have to be at the top of the organisation.
4. Look for ways of ensuring local accountability for commissioners and providers within policies.

**AT COMMISSIONING LEVEL**

1. Require your providers to be investing in development practices that foster productive relationships between doctors and managers. As we have seen, this is a necessary condition for improving patients’ experiences.

2. Require performance data that demonstrates delivery against your contract; that have been developed with full clinician and management involvement; and that are relevant to the organisation as a whole and to individual teams. Ask for examples of how these metrics have changed behaviour.

**FOR INDIVIDUALS**

1. Doctors – there is one thing you can do tomorrow, you can use your 10 hours a week for supporting professional activity for working with your local managers to achieve local improvements.

2. Educators – take the stories in this report and use them as cases in the classroom.

3. Managers – shift the balance of your attention tomorrow onto the clinical business of your organisation.

**FOR EDUCATORS AND PROFESSIONAL BODIES**

**Longer term changes**

Changes at this level are needed simply to reinforce changes that are already beginning to happen:

1. Expose medical students to management earlier on. Design education around the notion that management is core business for doctors.

2. Ensure incentive structures are aligned with the conditions described in this report. Can more be done for example, to encourage doctors to enter management? What kind of incentives and changes to career structures might help?

**WHAT WE ARE GOING TO DO**

As a result of the workshops and seminars sharing the results of the Inquiry we are going to:

1. Establish a Learning community of NHS organisations who will be learning together and peer reviewing their work on developing productive working (May 2007).

2. Designing a set of questions for Trusts/ Boards as a diagnostic to support local learning (July 2007)

3. Putting stories of how managers and doctors are developing productive relationships on our website, with a discussion board (July 2007)

If you would like to take part in any of this activity please contact us on busle@leeds.ac.uk or 01133438036.
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APPENDIX 1: EMERGING ORGANISATIONAL MODELS OF PRODUCTIVE WORKING

Elements of the productive relations we have described could exist in pockets at all parts of the system (for example within specific clinical directorates). However our analysis suggested that in some places productive relations had become generalised to the whole organisation, taking different forms in different places. We found three forms/approaches:

a) Negotiated
b) Aligned
c) Network

a) Negotiated Model

In this model both managers and doctors are aware of their interdependence, but power is not fully delegated to clinical leads. The organisation negotiates clinical leadership of areas of work or functions, and there is partnership in running services. There is still an ‘opt-out’ clause for both managers and doctors. This feels like both disciplines recognise the need for each other, but don’t want to get into bed together. It is a model where managers engage clinicians rather than one where managers and clinicians lead the Trust together. It is heavily reliant on negotiations and conversations. The hierarchy still feels very powerful.

Focus: The clinical work is the core work of the Trust.

Governance: Participation is negotiated. Strategy at Unit/Directorate level is a joint management, clinician activity, and they take shared and mutual responsibility for their service. The Clinical and Managerial lead of a unit can be interchangeable. There is some devolved decision-making, but the top team is definitely ‘in charge’.

Rules of engagement at Top Team level: All Executive Team members equal and take equal shared responsibility for the whole. The Executive Team is management dominated. The CE and the Medical Director have a robust partnership.

Change: Clinical change led by change champions, and instigated as a result of open information systems. It can come from anywhere. There is a heavy reliance on doing deals, making compacts, negotiating decisions.

Decision-making: Clinicians and managers partner in decision-making. The Executive team set the parameters for decisions and there is still a reliance on central control and decisions.

Risks: It is not always clear where the ‘buck stops’ so it relies on constant negotiation, with different services having different levels of autonomy. It may not draw the doctors into taking enough responsibility for the organisation’s business.

Finances: Budgets devolved. Some central control of budget areas.

b) Aligned Model

The Chief Executives that have led the organisation into an aligned model talk about it as the only way that ‘makes sense’ if you truly want to focus on clinical innovation; clinical quality; the clinical work as central to the organisation. At the early stages of establishing clinical professionals in charge of clinical directorates, they tend towards pushing the boundaries of their own autonomy – testing how much they can do alone. Over time the clinical directors (clinical professionals) learn the interdependencies of the directorates and the part the directorate plays in the whole organisation. The clinical directorates may be organised as large directorates, or smaller ones may have a divisional structure overlayed, with the clinical head of the larger unit being on the Executive Team. The clinical professionals are dominant in terms of numbers on this team. Whilst the NHS as a whole seems to view this form as ‘risky’, for the CEs leading it, it’s the only model
that makes sense. It supports a self-organising, fully engaged organisation, that can lead innovation, quality clinical care and meet national targets.

**Focus:** The clinical work is the real work of the organisation – a focus on the ‘product’ which is healthcare. The fundamental organising principle here is that those that have control over the means of production (clinical staff, primarily doctors) should be at the heart of organisational decision-making. The management and clinical agendas are symbiotic.

**Governance:** Clinicians taking full responsibility for governance at every level in the organisation. Clinical governance integrated into day-to-day decision making, not separate from – clinical governance is seen as core business for the directorates. The directorates may be small or large – and are led & managed by a clinical professional. Where they are small they are managed in divisions. The heads of the divisions/large directorates are clinical professionals, and are also part of the Trust Executive Team and have control over the service budgets. They outnumber the non-clinical managers in the Executive Team. The managers facilitate and enable the directorates to work effectively.

“If you went to an engineering firm, you would find usually a chartered engineer as the Managing Director or the Chief Executive….If you go to a chemical company, you’d find a chemist.”

**Rules of engagement at Top Team level:** All Executive Team members equal and take equal shared responsibility for the whole. Mature effective relationships including being able to make the most of difference, give each other feedback.

**Change:** Clinical change led by clinicians. As there is great connectivity in the organisation and learning across the organisation, change spreads quickly.

**Decision-making:** Grounded in a full knowledge of what is happening at every level – so clinical directorates have specific performance data related to their area, that is part of the Trust’s performance management system, from which they can interpret their performance and choose action. The directorates take full responsibility for their service, within clear organisational parameters and ways of behaving.

Managerial and clinical processes are aligned. They are interdependent and feed off each other.

**Risks:** Requires absolute clarity about accountability, direction and boundaries. There is a risk of being too inward-looking, and not challenging the dominant clinical ideology, particularly in developing patient-focused services/community lead services, engaging the public. It requires congruent systems across the Trust.

**Budgets:** Fully devolved to service areas for all financial issues.

**Hurdles:**

- Delegation can be a bit uncomfortable for traditional managers.
- The managers may feel that they are being ‘downgraded’.
- Requires constant attention to keep the directorates and the whole aligned – as it can get too autonomous at directorate level.

“When I came here we had Clinical Directors who were supported by business or general managers who reported in through them. And that was not working at all, it was hopeless, nothing ever got done because the Clinical Directors didn’t have enough time to do the managerial task that the role demanded. Neither did they have the interest in it either. So a decision was taken to switch that around and have a General Manager with a Clinical Director. That caused a bro-ha-ha amongst the clinicians
who saw this as hugely demeaning and a reduction of their status. There was a lot of debate over a long period of time and in the end there was an acceptance that the new roles would be a partnership between the Clinical and General Manager. We felt it was a fudge at the time but in fact it’s worked very well.

The clinical directors of specialties would have a direct line through to the Operations Director but they would have to report into the General Manager. This issue was very important to the clinicians. Now, in practice, the General Managers and the Clinical Directors see themselves as having co-responsibility for delivering the Care Group’s objectives. There’s a strong sense of shared agenda which percolates down through the rest of the medical workforce. That’s been a huge change because when I first came there was a very strong sense of ‘us and them’.

Director

c) Network Model

This form is a model of collaboration and mutuality between independent organisations, and is dominant in Primary Care. The chief executive of the PCT works hard at fostering understanding across the network, and persistently focuses on shared purpose. General Practice as a small enterprise, sees itself as a self-contained and managed business that is largely reactive. In order for it to become proactive, to reap the economies of scale of shared functions, and to impact health care, it needs to build relationships with the PCT and other Practices. The form that suits autonomy and shared decision-making is a network. Here members ‘join’ based on what they can contribute and what they need. They use the scale of the network to influence and shape services and to collaborate over functions. The network is dependent on mutual understanding and respect between practices; between practices and the PCT; and between managers and GPs. GPs working at the collective level are marshals of language – interpreting the environment to practices; interpreting managerial work; helping practices make sense of the whole network activity.

Focus: What can be better done together. Clarity about what works at a network level, and what is best left at a membership level. Focus on learning as a mode of change.

Governance: Clear about what rests at local level and what the members hold the whole accountable for.

Rules of engagement at Top Team level (in this case PEC): Persistence in understanding what each party brings to the team; their perspectives, skills and expertise.

Change: Can come from anywhere in the network – shared across the network.

Decision-making: Emerges from engagement. Decision-making vested in a few leaders, but those leaders required to fully engage the membership.

Risks: It’s very easy for members to opt-out of responsibility for their part in the network, and the network is dependent on all members being active.

Hurdles:

- Generating impetus around the time needed for members to collectively understand each other’s perspective and make sense of the context in which they are operating.

The tendency to bureaucratise managerial activity across the network.
APPENDIX 2: PARTICIPANTS IN THE INQUIRY POLICY DINNER

Professor Michael Arthur, Vice-Chancellor, University of Leeds
Dame Carol Black, President, Royal College of Physicians
Dr David Colin-Thome, Clinical Director of Primary Care, The Department of Health
Bernard Crump, Chief Executive, The NHS Institute for Innovation and Improvement
Stephen Davies, Director SDO Programme, London School of Hygiene and Tropical Medicine
Nigel Edwards, Director of Policy, NHS Confederation
Martin Else, Royal College of Physicians
Jonathan Fielden, Deputy Chairman Central Consultants & Specialists Committee, BMA
Professor Ed Hillhouse, Dean, Faculty of Medicine and Health, University of Leeds
Heather Lawrence, Chief Executive, Chelsea and Westminster Healthcare NHS Trust
Professor Andrew Locke, Dean, Leeds University Business School
Barry McCormick, Chief Economist, The Department of Health
Helen Moffat, Chief Executive, Royal College of Obstetricians and Gynaecologists
Dr Peter Reader, NHS Alliance
Graham Rich, Chief Operating Officer, United Bristol Healthcare NHS Trust

8. Martin Fischer, Associate CIHM
9. Jan Freer, Director of Organisational Development, Calderdale & Huddersfield NHS Trust
10. Lesley Hill – North Bradford PCT
11. Sebastian Hendricks – Barnet and Chase Farm Hospitals NHS Trust
12. Andy Horne, Chief Executive, Medway NHS Trust
13. Jayne Hoskins, Medical Director, Leicestershire Partnership NHS Trust
14. John Morgan, Consultant, Yorkshire Eating Disorders Service
15. Mark Morgan – Nations Healthcare
16. Topsy Murray, Associate Director, South West Peninsula Strategic Health Authority
17. David O’Regan, Consultant, Leeds Teaching Hospitals NHS Trust
18. Linda Pollard, non-executive director
19. John Sandars – Medical Education Unit
20. Miles Scott – Bradford Teaching Hospital NHS Foundation
21. Paul Shannon, Dr, National Clinical Lead
22. Martin Shelley, GP, Leeds North West PCT
23. Thea Stein, Chief Executive, North East Leeds PCT

The Witnesses

Thursday 28th September 2006 RIBA London
Malcolm Lowe-Lourie, Chief Executive, Kings College Foundation Hospital NHS Trust
Dr Dennis Abadi, PEC Chair, Westminster PCT
Professor Niek Klasinga, University of Amsterdam - telephone conference
Naaz Coker, Chair, St George’s Hospital Trust + a manager
Nigel Edwards, Director of Policy, NHS Confederation
Dr Peter Reader, GP, NHS Alliance

Friday 29th September 2006 RIBA London
Sebastian Hendricks, Consultant, Barnet & Chase Farm Hospitals NHS Trust
Gary Needle, Head of Improvement Programme, Healthcare Commission
Stephen Davies, Director SDO
Professor Ewan Ferlie, Director, Centre for PSO, University of London
Heather Lawrence, Chief Executive, Chelsea and Westminster Healthcare NHS Foundation Trust
Sharon Levine, Kaiser Permanente – telephone conference

Monday 2nd October – Leeds University Business School
Pieter Degeling, Professor of Healthcare Management, Wolfson Research Institute
Lesley Smith, Chief Executive Leeds North West PCT
Dr Martin Shelly, GP and National Clinical Governance Support Unit
Ian Hall, Gentrium consulting – telephone conference

Tuesday 3rd October 2006 – Leeds University Business School
Dr Helen Alpin East Leeds PCT and Tony Heywood, Practice Manager
Diane Whittingham (CE) Jan Freer (Head of OD) Jo Bibby (project director) John Naylor (Consultant) Martin Debono (Consultant), Calderdale and Huddersfield NHS Trust
Lindsey Ingoldby (Sister Cardiac Outpatients) & Sarah Hartley (Medical Secretary), Leeds Teaching Hospitals Trust (for David O Reagan)
Dr Lis Rodgers, PEC Chair, Doncaster West PCT

Supplementary telephone interviews
Michael Griffin, Director of Human Resources, King’s College Hospital Trust
Bill Murray, Chairman of NHS Estates; Former Chief Executive, South Tees Hospitals NHS Trust
Simon Pleydell, Current Chief Executive, South Tees Hospitals NHS Trust
Joanne Wallace, Chief Executive, Aptium Cancer Care Ltd.
Mats Brommels, Professor and Director, Medical Management Centre, Karolinska Institutet and Professor of Health Services Management, University of Helsinki.

International Site Visits
Henning Daugaard, Chief Executive, Gentofte Hospital, Copenhagen, Denmark
Erik Jylling, Hospital Medical Director, Gentofte Hospital, Copenhagen, Denmark
Erling Birk Madsen, Chief Medical Director, Frederiksberg Hospital, Copenhagen, Denmark

The Academic Seminar
Paula Hyde, Senior Lecturer in Leadership and Experiential Learning, Manchester Business School
Steve Harrison, Professor of Social Policy, University of Manchester
Graeme Currie, Professor of Public Services Management, Nottingham University Business School
Mark Learmonth, Lecturer in Organizational Behaviour, Nottingham University Business School
Theresa A Domagalski, Associate Professor, College of Business, Florida Institute of Technology
Colin Haslam, Professor of Finance and Accounting, University of Hertfordshire
Ian Greener, Senior Lecturer in Public Policy and Management, Manchester Business School
Jonathan Shapiro, Senior Fellow, Health Services Management Centre, University of Birmingham
Charlotta Levay, Researcher, Department of Business Studies, Uppsala University
Gerry McGivern, Research Fellow in Organisational Behaviour, Health and Public Services Management, Royal Holloway, University of London
Peter Kragh Jespersen, Associate Professor of Economics, Politics and Public Administration, Aalborg University
Mark Exworthy, Reader in Public Management and Policy, Royal Holloway, University of London
Stephen Ackroyd, Professor of Organisational Analysis, Lancaster University Management School
Stephen Bach, Reader in Employment Relations and Management, King’s College, University of London
APPENDIX 3: ISSUES FOR THE INQUIRY FROM THE NATIONAL WORKSHOP

Questions that would make the inquiry valuable:

- Under the right circumstance, do national targets help?
- Is the top down structure of commands causing issues between managers and clinicians?
- There is a need to search for truly locally embedded organisations, how do they organise for real local connection?
- Why do clinicians feel disengaged from national targets?
- Has the move from earlier forms of “consensus management” to current ways of management produced improved patient outcomes?
- How do successful teams of managers and clinicians meet national policy imperatives whilst also delivering locally appropriate high quality services?
- How do you get agreement on locally important areas of concentration as well as national targets?
- Is it different values or different roles and scales and perspectives at work in disagreements between management and medicine? The generally held perception (c.f. the briefing) is that the values of medicine and management are different, but is this true? Can we find evidence of it?
- How do you link the incentives of consultants (including remuneration) to patient based outcomes. (It is noted that there is a Quality and Outcome framework linking GP pay to target achievement, but no such system exists for hospital consultants.)
- Do you need incentives for doctors to improve patient outcomes? If what you measure is what you get, are links between targets and rewards appropriate or distorting?
- How do we engage GPs in the move of services out of the hospital and into the community and primary care arena?
- Describe what good relationships between managers and doctors really looks like on the ground? And what benefits for patients result from this? (The discussion of relations between management and medicine has always been present in the NHS, we need to clarify what a good relationship would look like in the present day.)
- A National Inquiry should try to understand where there is variation in the management and medicine relationships. The briefing and other sources have often painted a picture of crisis that is not recognised everywhere. This is not only from locality to locality, but from institution type to institution type. It was noted that the previously mentioned issue of “rapid manager turnover” varies considerably in intensity from place to place.
- It is important not too focus too strongly on “top level” management, middle managers are an important factor too.
- What enables good practice to spread, because it often doesn’t seem to spread well. Indeed, does it spread at all?
- What are the characteristics managers value in clinicians and vice versa. What does each group value in the other?
- Do managers need to have a clinical background to be effective?
- Are clinical management teams and clinical directors the appropriate way of organising for a patient focused service? Do practical descriptions of successful teams fit into a “top-down” model or more of a “partnership” model? How effective are the systems for eliciting feedback from patients to hospitals who may never see that patient again?

The group were then asked for their thoughts on the process of the inquiry, things that should be done, things proposed that could be done differently:

- The attendees of the inquiry day can be perceived as “the enthusiasts.” There was a desire expressed to engage with and challenge
the “laggards.” It was also considered important to get their views, as they might be living with these problems on a more regular basis than some. Are we missing something by not getting the non-enthusiast perception, especially in the witnesses? At the same time, there was support for the notion that concentrating on what works well is a valuable exercise.

- Valuable insights might be gathered from in depth interviews of managers and clinicians who don’t think working together is a problem, to see why they have no problem in cooperating.
- There are avenues to explore the attitudes of trainees and medical students, to see when attitudes about the groups harden and how values are formed. Why does a new business graduate decide to work in the NHS? Equally, this could be a basis for action, bringing medical and business students together at this early career point might be beneficial in the long run.
- Find examples of existing “must dos” of Chief Executives that are supported by investing in training and skills (particularly skills of cooperation?).
- Look for witnesses from places where doctors and managers are well integrated.
- Students of both medicine and business might prove to be valuable witnesses, particularly in highlighting the values of the medicine and management groups.
- More research on whether the medicine-management relationship affects performance. Evidence of this, appropriately presented and publicised, is critical to making the case for choosing this issue to focus on in the inquiry.
APPENDIX 4: THE BRIEFING FOR THE WITNESS INTERVIEWS

Firstly, we are interviewing witnesses as part of the Inquiry, and here is a reminder about the purpose of the Inquiry. The interviews need to relate to the purpose:

“This Inquiry seeks to explore the changing nature of relationships between management and medicine, and the possibilities for more effective ways of organising and managing health systems.”

FOCUS OF THE INTERVIEWS

We are looking for examples of a productive relationship between management and medicine. We know that the relationship is fraught with history and difficulty, but we are looking for examples where people have moved beyond this, and found ways of working together that makes sense for patients and the organisation. The inquiry is looking for the conditions that support that productive relationship.

INTERVIEW PROCESS

1. Hugo as Chair, welcomes the interviewee, gives an overview of the interview, and asks them a little about who they are to get it going. He then hands over to the Lead Interviewer for this witness. Where Hugo is Lead Interviewer, Becky will Chair.

2. For each witness we have a Lead Interviewer. They ask the interviewee(s) to tell their story of a productive relationship between management and medicine in their own workplace, that they have been part of. They ask the interviewee to take their time, telling the story as richly as possible. They then prompt the interviewee in order for us to get to the underlying conditions in the story. The process of this interview is described more fully below.

3. During this first part of the interview, the Panel have the invaluable job of listening. We will all hear the story slightly differently, and it is this difference that will help us debrief all the information. Each interviewer needs to keep notes during the interview. The panel is listening for the underlying conditions, and to make sure that we have covered as many of our categories (see below) as we can with the interviewee.

4. At the end of the Lead Interviewer’s session, the rest of the panel can ask questions relating to our categories. The Lead Interviewer will hand over when (a) they have gone as far as they can or (b) we are 45 mins into the interview – whichever comes earlier!

5. The Chair thanks the interviewee, and reminds them of ‘what next’ – they will get to see the report in December, for comments before it is released; and invited to a workshop in February.

CATEGORIES

Over the course of the interviews we want to shed some light on the following:

(a) Means of Production – What circumstances make the means of production as effective as possible? Does the leader understand the business? Does it matter? What relationship do medicine and management have to the service?

(b) What is Legitimate Diversity? – Diversity for what….fit for purpose. What is it legitimate to have autonomy over?

(c) Working with difference – conflict. Can they disagree for the sake of the task and do this usefully? Is this a feature of productive relationships? Can the productive ones work with conflict constructively?

(d) The NHS as a whole versus the Trust/Organisation/Practice – what incentivises doctors/managers to work on behalf of the whole and/or the parts? Is it different (By group? For scale?).

(e) Scale – is the process for productive relationship different at different scales? Small organisations to big ones? Cities/regions/rural/teaching/DGH…..
(f) Who’s in charge? What difference does it make? Should it be those that understand the means of production?

(g) What’s improved? If there is a productive relationship – what difference has it made – to who/what? What counts as success? What do you measure? Why?

(h) Is ownership sustained over time? Does this productive relationship last? Is it fragile? Does it stick?

THE INTERVIEW PROCESS

Appreciative Interviewing

Appreciative Interviewing is described as part of a wider process called Appreciative Inquiry. Essentially AI is based on the premise that all systems work to some degree. Our approach is to uncover where and how the relationship between management and medicine is working; focus energy and attention on understanding why and how it works; and uncover the conditions that are enabling it to work well.

We use the term Appreciate here in the affective. It does not mean ‘like’ or focusing on positive scenarios – it literally means appreciating the conditions that support things working round here (which could be how conflict is handled for instance).

THE INTERVIEWS

So, to start the interviews the Lead Interviewer needs to introduce the process of the Interview, saying that the interview will focus on the times in the interviewees work when the relationship between management and medicine has been at its best. Explain that this is to help learn about what it takes to make this relationship work well.

The Lead Interviewer will be listening and looking during the interview for the instances when the person being interviewed ‘comes alive’ to gain a better understanding between you of what gives the interviewee vitality and success.

In interviewing the participants, ask for their story and then when you have given them time to tell the story out, probe deeply and intently to get to what they did and thought and felt.

Use open ended questions such as:

- ‘Why do you think that?’
- ‘Who else is involved?’
- ‘What do you think he/she would say, if they were here?’
- ‘What is the most important thing?’
- ‘Have you been in this sort of situation before?’
- ‘What did you do then?’
- ‘How were the outcomes different?’

Then ask about the conditions that supported the times when the interviewee felt like this. Use questions like:

- ‘How do you know that?’
- ‘How is this different? (from other work and the ways things are done round here).’
- ‘What about the relationships (in the team, across the organisation, with partners, with the community).’
- ‘What about information did you use?’
- ‘What are your hypotheses/ ideas about what was going on?’

Some of the interviews may move into analysis/hypothesising. The Interviewer needs to keep them on the evidence rather than their interpretations/assumptions/ opinions, for as long as they can to get the full story, then let the interviewee move onto their views as to ‘why’. Guide them back to the work of the interview.

THE PANEL

The role of the Panel is to listen for the conditions for a productive relationship, that underpin the interviewee’s stories and make notes of these. The conditions need to be specific (saying good communication is not enough – what made it good, who was involved?).
APPENDIX 5: 
NOTES FROM THE ACADEMIC SEMINAR

The academic seminar was a day divided into a number of parts. Discussion of any issue obviously bled across the whole day, but they remain useful categories to explain how the Seminar influenced this report:

MEDICINE AND MANAGEMENT IN THE NHS

BACKGROUND

The presentations in the morning all contained a volume of insight and factual information about the history of the NHS and how it has influenced the state of the medicine-management relationship in the present day. This all added greatly to the grounding of the report.

• One issue that ran through the day’s discussions was that there has been a distinctive shift in the NHS since the Griffiths report which has seen the arrival of many more managers, with increased remits. It has taken 20 years for those managers to gain some of the informal (and arguably real) power that their job descriptions implied, but this represents a very real shift that could not help but add tension to the medicine-management relationship.

CURRENT TRENDS

• Evidence was produced of an increasing managerialisation and commodification of care in the Health Service. This was seen to be part of a drive to improve efficiency and effectiveness using models derived from private industry giants like Tesco and Toyota. The process is advancing largely through the emphasis on Evidence Based Medicine and the institutions most connected with this development were the Healthcare Commission and NICE.
  • One effect of this was to stress relationships between doctors who value their ‘clinical autonomy’ for both professional and pragmatic reasons and managers who were keen to take advantage of new ways of working to improve outcomes.
  • It was noted that this was not the only pressure on autonomy. The increasing knowledge and understanding of patients was requiring doctors to justify their actions and treatments much more than ever before. This was considered to heighten the psychological impact of the situation.
  • Another effect was a confusion in the Service about the conflict between this drive and the drive to patient choice. Choosing between different practitioners using the same protocols was not seen to be ‘real choice.’
  • One contributor highlighted work that suggested doctors (particularly GPs) were adjusting their notions of ‘quality care’ to fit in with governmental targets and the standards like the Quality and Outcomes Framework. This would not seem beneficial to patient choice and also suggests a profession moving towards less independence.
  • It was also suggested that this drive to “standards commodification” was significant in that protocols had been a mechanism by which nurses and other health professionals took on work previously held by doctors. This had at times increased tensions between the professions and between medicine and management.
  • One of the mechanisms of Evidence Based Medicine, where doctors at the top of the profession write protocols for the whole service, some doctors move into management roles where they essentially police the application of protocols by rank and file doctors was examined. One clear lesson was that ‘medicine’ cannot be considered to be a monolith that interacts with management in a
single way. There are different attitudes up and down the hierarchy and also between different specialties (both within hospitals and between secondary and primary care).

- There was a strong sense that many in the medical profession had seen a lot of changes in the health service and the rise in size and influence of a group of managers, but that the rank and file were quite confused about how things had gotten to their present state. There was a sense of lost opportunity to influence the development of the service and a feeling that maybe the bodies in charge of the profession (Royal Colleges) had not exercised as much leadership as necessary.

- This was connected to the observation (by those involved with management education) that many doctors were seeking management courses like the MBA. One conclusion was that the grassroots of the medical profession seemed to have more desire and pro-activity in engaging with management than some of the Royal Colleges.

- One doctor and one manager present at the debate reacted in very different ways to the tone in the room. The doctor felt that the room was “quite anti-doctor” whilst the manager felt “that management was not seen as having a part of the ‘doing good’ that doctors did.” This brought home to the Inquiry that the way questions were asked of witnesses and the language used to write up results is key to the reception of our ideas. (And indeed the ideas of any who attempt to address the management-medicine relationship, be they outsiders, managers or doctors.)

- A question was raised, “Who in the current contexts ‘owns’ (takes responsibility for) the money, the patient, the treatment and the institution in today’s NHS?” The pattern of changes referred to so far was seen to have blurred old certainties about these issues, leaving management and medicine in constant negotiation and potential conflict. It was noted that some of these problems, especially the relationship between clinicians and the institution they work in might be partly an issue of scale. The Seminar thought it important to ask if the rise of Foundation Trusts had helped solve any of the ‘ownership’ questions.

- Almost as a summation about these points of potential conflict, it was thought important to emphasise that conflict is not inherently bad!

- One contributor noted that it was good that doctors could “kick back” at managers who might be too keen to put the welfare of the population of the whole over that of the patient in treatment at the time.

- At the same time, it’s healthy for managers to ask questions about the balance between individual treatment and the spreading of resources across patients as a whole.

- Channelling conflict, making it useful for improvement, rather than “removing conflict” was emphasised.

- An important extra strand was that the commodification debate missed an important reality of medical work. Complex knowledge based activities are not easy to commodify and by excluding people with knowledge, experience and direct observation of the patient from deciding how treatment should be undertaken there was a great danger of failing to generate improvement. The people who do the work, the means of production need to be considered as vital to improving the system.

INTERNATIONAL EXAMPLES

Presentations from Denmark, Sweden and the United States were given at the Seminar. They provided important information and clues to where good comparison evidence might be found for our inquiry. At the same time a key reminder was that in places with different histories, things have organised in a different manner. There are still (and always will be) tensions between medicine and management, but other countries have found some ways to begin to channel the conflict productively.
• The first insightful reminder was that despite different histories, every system was under similar pressures to the NHS.
• Cost containment is a concern everywhere.
• Relations can be strained between clinicians, managers and other health professionals as work is moved from the realm of only doctors to include nurses and others.
• Commodification and standardisation are part of the challenge everywhere, along with notions of choice and quality.
• Despite this, other countries showed a greater growth of collaboration between medicine and management.
• This was highlighted by the increasing number of hybrid “clinician-manager” roles in all the presented countries.
• It was noted that these roles attracted more status and rewards than equivalent (Clinical Director) roles in the UK.
• Importantly, it was emphasised again that the experiments in the United States show that commodification is no answer to questions of cost containment. Rather, engaging with the ‘means of production’ in the shape of the doctors providing the service is critical to improvement.

CONCLUDING THOUGHTS
The seminar concluded with an attempt to coalesce some thoughts about key issues around the relationship between medicine and management which could inform the creation of the Inquiry report:

• One hopeful vision of the future was that observation of the management-medicine relationship in other countries provided some example to us in the UK. Under similar pressures, there was a sense that other systems had found some routes to involving clinicians in medicine and slowly improving the quality of the relationship.
• However, the profession of medicine, particularly as represented by the Royal Colleges needs to make a choice of how it will approach these issues.
• Will doctors see themselves as members of the public sector, or private hands for hire?
• If they desire a public sector role, they need to take an active part in shaping the way forward. For now they seem to have been involved in a “sleepwalk into commodification and possible preparation for privatisation.”
• What are the interests of the profession as a whole? Older, more senior doctors may be doing well writing protocols as part of Evidence Based Medicine, but are younger, more junior colleagues losing autonomy and involvement in care?
• The attitude of the profession was seen as critical because they are at the centre of providing patient care. If they give up the potential to shape the care, it is hard to see outcomes improving by any measure, be it efficiency targets or patient satisfaction. Historically over the last 20 years, the Seminar felt there had been a lack of leadership from clinicians on these issues.
• However, it was recognised that merely discussing the medicine-management relationship was not looking at the whole problem. The problem cannot be solved by persuading doctors and managers alone. The context of a drift into commoditised care propelled by government politics was seen to be crucial to the problem.
• Only by addressing policymakers and asking them to consider the extra impacts of their actions (notably in the sustainability section of this report) could the Inquiry make a significant difference to the medicine-management relationship.
APPENDIX 6:
HISTORY AND BACKGROUND TO THE ISSUE

As noted in the main report, the primary focus of our interest is the relationship between medicine and management in the context of the NHS. This is an inquiry into how a statutory, multidisciplinary organisation manages a key part of its means of production – medicine. As such, there is less focus on how medicine manages itself, for example in the context of private practice firms or professional bodies. Such organisations may be working examples of a high degree of practitioner autonomy, based on collegial regulation, trust and mutual obligations. However, this broader topic of medical self-organisation will only be addressed here insofar as it relates to management within the NHS.

In the first instance, ‘everybody knows’ that ‘doctors and managers don’t get on’ and why. However, if recent discussion of this topic in the media is anything to go by, there is also considerable scope for misunderstanding.

2.1 Defining the terms of the problem

Medicine?

Medicine is the dominant profession in the NHS. Bach\(^6\) (p3) summarises the features of a profession as the control of specialist expertise (abstract knowledge), a monopoly on the use of that knowledge and on the process of acquiring it (what Larson\(^6\) famously termed, ‘the production of producers’). Elston\(^6\) (p58) notes that medicine ‘was the paradigmatic profession, a publicly mandated and state-backed monopolistic supplier of a valued service, exercising autonomy in the workplace and collegiate control over recruitment, training and the regulation of members’ conduct’.

In the UK, this collegiate control is split over a number of professional associations, including the General Medical Council (GMC), British Medical Association (BMA) and the Royal Colleges of various specialties.

When we say that medicine is the dominant profession in the NHS this is not of course in numerical terms. The NHS as we all know is a complex system of professions (Doctors, AHPs, Nurses and others). It is estimated that there are 679,157 professionally qualified clinical staff in the NHS, including 122,345 doctors, 404,161 qualified nursing, midwifery & health visiting staff (including practice nurses), 134,534 qualified scientific, therapeutic & technical (ST&T) staff and 18,117 qualified ambulance staff. http://www.ic.nhs.uk/pubs/nhsstaff/nhsleaflets/file

So what makes medicine the dominant profession in the hierarchy?

They take the responsibility for key decisions about patient care, defining the work of those who provide such care, diagnosing patients and providing treatment themselves. These operational decisions clearly have significant influence upon budgets. The status of doctors is further augmented by the high esteem an ageing society gives to them and (particularly for General Practitioners) the gate-keeping role where they control patient access to healthcare.

It is important, however, to note some nuances to this picture of a powerful profession. Rather than a unified body, the profession can fracture along various lines, depending on the issue at hand. The historical split within the NHS between primary and secondary care affects the professions as well. General Practitioners operate in a rather different world to hospital consultants and this often shows in conflicts of opinion between the two groups. General Practice has been the locus of management reforms that placed them in an adversarial role with hospital consultants. Likewise, within consultants, the Royal Colleges (professional bodies) of various specialties only rarely speak with a single voice.

Management?

When the word ‘management’ is used in the context of the NHS, many people think...
immediately of a discreet group of people called ‘managers.’ Composed of executives, board members and other senior managers, it is common to see this group as a tribe, competing with the tribes of professionals for power and influence within the organisation. Managers, it would seem are also in the ascendancy. Recent labour force statistics for NHS as a whole indicate that the number of senior managers employed in England has risen from 20,842 in 1995 to 39,391 in 2005. More resources are clearly now devoted to the active management of the service (according to one estimate, from 5% of total expenditure in 1981 to 12% in 1996). However, management must also be understood as an activity or process. It is a mode of coordination, control and planning that is not necessarily attached to specific people. As Grey (p562) notes ‘activities classically thought of as ‘managerial’ are in fact performed by all sorts of people in all sorts of contexts.’ Indeed this concept is familiar from the early history of the NHS where resource allocation was largely directed by professionals, rather than managers, a situation described by Klein as a ‘producers’ cooperative.’ The NHS in this era of ‘custodial management’ was certainly still managed, but in a different manner, with different outcomes. Today’s management, one might argue, is more explicit, with a more transparent focus on efficiency and key objectives and is less dominated by the priorities of doctors.

Medicine and Management?

Medicine and management is about the crucial meeting ground, the link or possibly even the integration between these two groups and respective activities. This occurs most clearly within organisational settings, such as Primary Care Trusts (PCTs), Acute Hospital Trusts, GP Personal Medical Services (PMS) practices, etc. All of these organisations share some very particular characteristics, which would suggest, according to the classification of Mintzberg, they are ‘professional bureaucracies.’ Such organisations are noted for standardising the professional skills required to undertake work, rather than output of work done, and a work environment where the professionals enjoy a high degree of autonomy and are more focused on individual work than organisational goals. Employees in these settings more often invest in skill acquisition to raise their professional status than as part of an institutional plan.

These features are not unique to the NHS but are also found in many ‘Professional Service Firms’ in the private sector, notably in areas such as law and accounting. A key feature in this kind of organisation is a live tension between the values of managers and professionals and the groups formed around those values.

In the history of the NHS (see section 2.2 or wherever it ends up for more detail) we can elicit two major themes of reform. One is a focus on the management of medicine and the other, management in medicine.

THE MANAGEMENT OF MEDICINE

Goals

As we noted in Section 2.2, at the inception of the health service, hospitals were not ‘directly managed’ by an executive with a management team, but organised around consensus decision making between professional groups on the hospital administration committee. The competing interests and desires of the various groups (and the budget implications) were mediated by the administrators. The government, as the paymaster, controlled the overall level of the budget, but exercised only a little direct influence over how it was spent. This arrangement represented a large degree of operational autonomy throughout the system.
In the 1970s, the increasing pressure to contain costs and at the same time maintain the quality of the service resulted in a trend to add new tiers of the organisation focused on more explicit management, including new personnel departments and planning regimes. Tighter spending limits were introduced as the decade went on and as the overall economic climate of the country declined.

The 1980s then saw the critical intervention of the Griffiths report. A cadre of managers was introduced into the operational levels for the first time. The following years saw the creation of executive boards which drew power and strategic decision making away from the profession dominated hospital committees. The new structure of authority in hospitals was based on position, rather than expertise and was heavily oriented towards the control of resources. This trend has been the dominant one up to the present time, with managers as ‘representatives of the government’ positioned as agents of change.

A key assumption in the Griffiths report and much of what has followed is that the NHS lacked management competency. Famously disparaging of the consensus style of management it said ‘In short, if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.’ The implication was that the desired cost control and service could only come if dedicated managers are in post. Structures have therefore been created to give managers responsibility for controlling costs, human resources, planning and strategy. In addition to general personnel responsibilities there was a focus on creating new competencies in discrete management functions, such as planning and strategy, and building a system of corporate governance. Most recently this has been extended to include systems of quality assurance that would change the relationship with the profession and further tighten managerial control of clinicians.

The problem
Turning to the question of how much has actually changed; the evidence is mixed. Managers are now an accepted part of the NHS landscape and, as we noted earlier, more time and resources are now devoted to ‘management’. Yet 20 years of ongoing reform certainly suggests that we are still short of all the benefits envisaged at each stage. Questions have also been raised about the extent to which general managers have been able to assert their authority and drive change (for a review, see Ackroyd et al. [74]). Indeed much of this research points to a number of obstacles facing managers in this context, three of which stand out:

a) Organisational characteristics
As noted earlier, the situation of the NHS is not essentially unique. There are numerous organisations with similar characteristics, classified by Mintzberg [71] as ‘professional bureaucracies.’ In such organisations some degree of conflict between professionals and managers is largely unavoidable. The existence of competing objectives and power bases is hard to manage, almost by definition and has proved challenging across the public and private sectors. However, at the same time, these problems are writ large in the NHS, amplified by the political and personal sensitivity of the health issue.

b) Culture clash with doctors
The rhetoric with which managers were first introduced to the NHS was dominated by a neo-liberal discourse around cost cutting, competition and rationing. This naturally led to clinician suspicion about management goals. Freidson [75] highlighted how the professional identity of clinicians puts them in conflict with a rhetoric of cost-cutting: ‘professionals claim the moral as well as the technical content of their disciplines, so they must resist economic and political restrictions that arbitrarily limit its benefits to others’.
At the same time, the replacement of hospital committees with managerial boards represented a serious reduction in the influence of clinicians over the management of the institution. In the view of some clinicians, the managerial class is composed too often of outsiders who do not understand the special nature of health care. This concern is amplified by the cultural gap between the essentially academic and formalised knowledge of medicine and the tacit knowledge base of managers, based on experience. It has been hard for clinicians to accept a managerial edict about 'evidence based medicine' whilst 'evidence based management' is not on the agenda. The worries about loss of control are heightened by the potential for various models of clinical governance to reduce clinician autonomy in treatment decisions.

Managers themselves, of course, might see the problem from a different viewpoint. They have keenly felt a lack of respect from doctors who place a greater weight on formal qualifications than the management world. Managers come from a culture of loyalty to an institution and can find it hard to understand the clinician loyalty to their vocation which has often implied a disinterest in strengthening the organisation as a whole, particularly when it comes to engaging with financial constraints. This feeling is amplified by the split loyalties that private practice can generate. A doctor who operates a private practice may have no incentive to reduce the long NHS waiting lists that encourage patients to ‘go private.’ In a small number of cases this appears to have become the de facto policy of some consultants. These cases have helped raise suspicion of doctors’ self-interested attitudes not only regarding private practice, but also reforms of reporting and measurement.

c) Power
The dominant logic about change in the NHS has been about structural and contractual models for change. However, the cultural factors mentioned above lead to a lack of social and political capital with which to negotiate such reform. The asymmetry of knowledge between doctors and managers has meant that managers have often not had the understanding or credibility to refashion work practices to improve efficiency. Even more damaging to managers is their fundamental lack of negotiating power. The majority of targets and regulations are created by central government. Managers have little freedom to set goals for the organisation or determine terms and conditions and thus lack the negotiating leeway to develop a dialogue with clinicians. This illustrates the inherent tension between two of the government’s aims: devolving power and ensuring uniformity of service. Attempts to delegate the power to effect change in the service have often been stymied by the desire to avoid local variations in service.

MANAGEMENT IN MEDICINE

Goals
We have already noted that management is an ongoing activity performed by many people within the organisation all the time. In the light of this, the pre-Griffiths era of ‘consensus management’ suggests that medicine has previously contained some element of administration through participation in hospital committees. After Griffiths – when these arrangements were abolished – it became clear that the new structure needed to draw doctors back into the decision making process. Doing so held out the prospect of resolving problems around knowledge asymmetry, credibility and social legitimacy mentioned in the discussion of power above.

As noted the 1989 “Working for Patients” white paper led to a purchaser/provider split in the NHS and Fundholding General Practices who were given a budget with which to be purchasers of treatment. Fundholding GPs were directly involved in resource management, balancing their budget whilst optimising the quality and access...
of care received by their patients. The situation also pitched GPs as purchasers against hospital consultants as providers, providing (through contracts, at least) management of doctors by other doctors.

A number of models were explored for bringing clinicians into hospital management, but one that gained ascendancy was the Clinical Directorate model that was instituted in the 1990 NHS Act. Senior consultants were given budgets along with explicit HR and supervisory responsibilities. They usually reported to a Medical Director who had a seat on the Trust Executive Board.

Another approach was to bring management concerns and priorities into the existing structures of peer group control. Examples include the development of clinical audit as a peer group controlled assessment of competence and the development of clinical guidelines. Clinical guidelines for treatment and prescribing choices are laid down by the National Institute for Clinical Excellence (NICE) which takes advice not only from health economists, but has drawn in top tiers of the medical profession itself to write guidelines and procedures. Either way, the goal is to build upon notions of collegiality and harness the capacity of medicine to regulate itself. This, it was hoped, would improve both efficiency and accountability, overcoming what Friedson[0] describes as “the conspiracy of silence as well as the conspiracy of tolerance”. Structures of peer group control might also have wider benefits of promoting learning, innovation and new knowledge creation[1].

The problem
As with moves to extend the management of medicine, the jury is out regarding the effectiveness of these changes. Klein[2](p197-199) enumerates a number of positive benefits to GP Fundholding which, despite being somewhat reorganised under Labour (the current version will be ‘practice-based commissioning’), have filtered through to the present day. However, at the same time, the burden upon smaller practices of extra administration and the question of the monopsony power of hospitals in some regions remained problematic. It is also clear that take up of Fundholding status occurred for many different reasons. Some doctors were enthused by the entrepreneurial possibilities; some took it up so as not to be disadvantaged and others were only induced by extra payments. It remains to be seen whether or not the new version of the model (practice-based commissioning) can resolve these problems of engagement and capacity.

Within hospitals, one recent survey of 1,092 chief executives and lower level managers in 192 trusts suggests that at more senior levels doctors are increasingly upbeat about their role in management[2]. However, the same survey also reported dissatisfaction amongst Clinical directors over limited resources, declining autonomy and the growing emphasis on financial (over clinical) goals. Other research gives a similar impression that most doctors continue to be ambivalent about management and have engaged with it only for pragmatic reasons.

This mixed success in drawing the professional community into the management of the NHS might be explained in five main ways:

a) Incentives
First is with regard to incentives and what doctors might gain from becoming more involved in management. In 1997, GP Fundholding practices covered around 50% of the population. Despite grants put in place to aid with management and IT, generous starting budgets and the potential to improve patient treatment, many doctors did not take up the option. Robinson and Hayter[3] suggest that the key reasons included unhappiness about GPs greater responsibility for rationing care and the extra workload and time commitment. Whilst the workload issue may have a number of solutions, we should note
that ‘rationing’ is a key dilemma for the medical profession, which (as noted earlier) draws its legitimacy in part from doing everything it can for the welfare of the patient.

The role of clinical director can leave little time for clinical work, which damages clinical career prospects. At the same time, the career opportunities in management seem to be limited to moving up to the role of Medical Director and a possible leap to the Executive, but this is a highly competitive field. Also, Clinical Directors who appear to be too obviously managerial in outlook (particularly those who seek to implement resource restraint) risk isolation from clinical colleagues with both social and political implications[76].

b) Orientations
Another key strand is the relationship between the professions and the organisation. The historical independence of consultants (particularly related to national bargaining and region-level contracts) has meant that many do not see themselves as stakeholders of a particular trust and thus lack the motivation to take on the hard work of improving performance of a team beyond their individual contribution[77]. A similar kind of issue had the potential to cause problems where GP Fundholders attempted to band together to increase their purchasing power in the internal market. As soon as a number of practices are involved in the negotiation, tensions could arise between competing priorities of location, efficiency, timeliness and quality in purchasing decisions. The independent practices rarely had the incentive to develop a common managerial structure to resolve such problems.

c) Capabilities
Even those doctors who decide they are willing to take on the job, despite the factors listed above encounter some difficulties. General Practitioners have always had the status of independent contractors, which implies the managerial capacities of small businessmen, but at the same time, they have expressed reservations about the management capacity within their practices to undertake Fundholding[83]. Likewise, although senior consultants have some day-to-day experience of people management, they are often unprepared for the complexities of a large department and budget. Too often they have not been given appropriate support or training to help them out.

d) Power
Whilst clinician managers may have more clinical credibility with their peers than general managers, they find themselves similarly lacking in methods of control. The formal mechanisms of HR management, from pay to assessment and discipline are still out of the direct sphere of management and the goals and funding of the department are largely set out in Whitehall, leaving clinician managers and managers with little room for manoeuvre[15].

For GP Fundholders, the potential power problem resided in the dynamics of the market. As a small purchaser from a large provider, they may not have had the clout to negotiate changes inside the provider. At the same time, attempts to solve this by banding together invoked further problems of management capacity and orientation.

e) Historical legacy
Finally, if we posit that hospital clinicians had power to influence hospital administration in the ‘consensus era,’ it is important to realise that the new managerial roles for doctors are more specialised and fragmented, with less strategic input. There may be some lingering resentment within the professional community regarding this loss of control. This in turn could mean that some doctors are unwilling to engage in roles that are perceived to give them far less influence than in the past.
Regulatory context

A significant factor in any discussion of the NHS has to be the policies of central government, which form the backdrop for the actions of both medicine and management. The rhetoric of reform, from Griffiths onwards has emphasised the power and influence of local management to raise efficiency and create innovations in service and quality. However, the political reality of the NHS is that the media are always on the lookout for examples of ‘the post code lottery’ and it is perhaps this kind of pressure that has propelled a government desire to standardise and control from the centre[1]. Indeed, one might argue that the principle of ‘earned autonomy’ for managers runs against the reality of numerous central targets with onerous reporting requirements[18]. The rhetoric of ‘spreading best practice’ theoretically rewards and takes advantage of local innovation, but the reality of Government funding ring-fenced to specific projects with numerous conditions often leaves little room for local autonomy.

2.2 Brief history of management reform in the NHS

From recent discussions one might get the impression that conflicts between management and medicine are a fairly recent phenomenon. This however, is misleading. In some respects, the history of the NHS since founding is a history of repeated attempts to confront the challenge of how to co-ordinate and control this large (indeed the largest public sector) organisation. Given this it is useful to briefly consider this history. Any discussion of the relationship between management and medicine today must surely be couched in a wider understanding of the context and of the institutions that have framed (and often continue to frame) practice.

Foundation

The most famous principle to come out of the creation of the NHS was ‘free at the point of use.’ However, the political compromises (Klein[82], p15-19; Pollock[42] p15-16) involved in the foundation of the organisation left a number of other legacies. One result was a historical division between primary and acute/secondary care. The reality of drawing independent GPs into the new service alongside existing hospitals precluded a rethink of this organising principle, which survives to this day. Likewise, drawing in hospital consultants involved compromises over private practice and doctor independence. The continuance of private practice ensured that some doctors would always have an income from, and a personal investment in work outside the NHS, with the possibility for conflicts of interest[78]. At the same time, this independence seems to have created a mindset which, in some respects holds today of separating professional and hospital concerns. The profession was trusted to ‘look after the health of the nation,’ supported by administrators and financed by block funding from the government. Hospitals were to be managed by committees and not by a specific group of people called ‘managers’.

1960’s: ‘consensus management’

The 1960s saw the high point of what came to be known as the consensus model. In this period, according to Klein[84] ‘the medical profession permeated the decision making machinery of the NHS at every level and achieved an effective right of veto over the policy agenda.’ This situation also gave rise to what Ackroyd et al[70] term ‘custodial management’ where policy and practice is focused on incremental improvements and a general defence of the status quo. The position of the administrators in the service (who were the closest thing to a managerial body) was characterised by Harrison[73] as ‘Management as Diplomacy,’ balancing the competing interests of the various professionals represented on the hospital administration committees, whilst undertaking the matching of demands to the block finance provided.

The fundamental weaknesses of the ‘custodial’
style of management were in controlling costs and fixing regional imbalances in quality and access to care. The tendency of the professions to defend the status quo also suppressed innovation and attempts to focus on patients. This prompted ongoing concern from the governments of the day and triggered a number of attempts to strengthen management and planning in the service[85].

1970s: Bureaucracy and planning
The drive to enhance management capabilities in the service accelerated in the 1970s as costs grew. Change was propelled in part by the oil shocks and resulting downturn in Western economies and in part by impressive but costly advances in medical technology and practice. The 1974 reorganisation saw the creation of new tiers of planning and control, conceived to promote the doctrine of managerial efficiency (Klein, 2001, p73). However, the complexity of the new system seemed to prevent these goals being realised and the governments that followed imposed ever tighter spending limits.

1980s: General Management
It is in this period we see evidence of what Harrison[73] classes as the use of the ‘Manager as Scapegoat’. The administrators of the NHS, positioned in the organisational structure of the 1970s were blamed for the failure to control rising costs and failures of service. The Normansfield Inquiry into a 1976 strike (Edwards[32] p) was an example of a growing sentiment that a lack of management leadership, rather than a lack of finance, was corroding the quality of patient care.

The Griffiths report of 1983 was the key moment of reform, resulting in the insertion of general managers at the head of hospitals who were given a devolved budget. The growth in management capacity can be seen in the increase in senior managers from around 1,000 in 1986 to 20,842 in 1995 (Pollock[42] p39). The aims of the process were to create a management cadre who would pursue further reforms, a role which Harrison[73] christens as ‘Manager as the representative of a 3rd party.’

One focus was to be on efficiency and further attempts to cost clinical activities with the ‘promise of tighter measurement and control of clinicians’ work by business managers’ (Pollock[42] p107). The other was on devolving power to lower levels, and “delivering services at a local level by seeking out the experience and perceptions of patients and the community.” (Edwards[32] p83).

1990s Quasi-market
The political climate of the 1990s saw an increasing focus on a neo-liberal critique of the public services. This propelled an experiment with the use of market forces, both as a means of controlling spending and empowering patients as consumers of health care[86]. The introduction of the quasi-market strengthened the position of managers, expanding their influence to the negotiation and administration of contracts in the market.

The 1989 white paper “Working for Patients” also introduced an important attempt to bring power closer to the patient. Central to it was the objective splitting the NHS into purchasers and providers. Trusts were to be formed out of hospital provider units and District Health Authorities would become purchasers of service. GP Fundholding was piloted, allowing practices with large lists to become independent purchasers, with their own budget for buying treatment. This represented a major attempt to draw medicine into the management of care.

At the same time, the 1990 NHS Act saw the formalisation of the Clinical Directorate structure as the approved method of drawing clinicians into hospital management structures. The structure was inspired by the organisation at Johns Hopkins Hospital in Baltimore, USA and promoted with the aim of devolving budgets down towards the departments headed by senior clinicians. These
units were to be the building blocks of the new internal market system.

2000s New Managerialism?
The arrival of the new Labour government in 1997 resulted in a partial retreat from marketisation. GP Fundholding was officially put on hold, although a similar system of ‘practice-based commissioning’ is now being implemented. Instead, improvements in efficiency and quality were to be attained through increased regulation and a regime of performance management including numerous targets. Clinical governance and evidence-based medicine are the latest elements to potentially strengthen the role of management and lessen clinician autonomy. This greater level of scrutiny also came out of the reduced trust (from both public and government) of the profession resulting from the 1997 revelations at Bristol Infirmary and the 2000 Shipman scandal.

All of these elements also derive from a government desire to reduce the variability of service access and quality. In a 2003 press release about NICE (National Institute for Clinical Excellence), the Health Secretary commented, “The government is committed to ensuring that patients, wherever they live, have equal access to treatments that are clinically and cost effective.”

Although somewhat restricted this historical account draws our attention to the way current structures and problems are to a large extent framed by past decisions. It also suggests that attempts to build a larger management capacity within the NHS have been ongoing for some time. Indeed, since the 1960s, the aim has been to build capacity both in terms of dedicated management functions and management within medicine itself.