BriefingPaper

Making change happen in the NHS: clinical and management tasks

This briefing paper is for people with managerial responsibilities in primary care teams, primary care trusts and hospital trusts, as well as practitioners and service users who are interested in the management of change in the drive for service improvement within the NHS. It is based on a research study commissioned by the NHS Service Delivery and Organisation (SDO) Research and Development Programme and led by Professor Louise Fitzgerald, De Montfort University. The study examined the ways in which managers from clinical and non-clinical backgrounds interpret and carry out their roles in the process of implementing service improvements, as well as the other factors that influence the effectiveness of such a process. It focused on the management of change in cancer, maternity and diabetes care.

Key messages

- In recent years UK health care policy has placed considerable emphasis on meeting targets for service improvement. But while these targets may appear simple, they are in many cases dependent on health care services achieving far-reaching organisational change.
- Organisational change arises from a complex interplay of factors to do with the local context (in particular the historical development of local health services and structures), people's roles, the way they carry out their jobs and their interactions with each other. It is the combination of these factors which is crucial to progress in improving services. There are specific combinations of core factors which support or limit clinical service improvements.
- In health care services, power is not derived solely from position or hierarchy, but from professional knowledge. Such 'professionalisation' has particular implications in relation to the way that roles are carried out and change is managed. The emergence of roles which span clinical and managerial tasks (so-called 'hybrid' roles) is a good example of a move away from traditional roles and structures which can facilitate service improvement, but which also brings challenges.
- There is an important role for human resource (HR) departments in facilitating the development of new ways of working, mapping out whether roles are manageable and supporting professional development for 'hybrid' managers. However, at the moment this HR function is not being carried out consistently.

DH Department of Health

sdo NHS Service Delivery and Organisation R&D Programme

Background

The policy context

Since 1997, the Government has introduced a range of strategies aimed at achieving service improvements in health care. The Department of Health's Modernisation Agency was formed in 2001 to facilitate this process (superceded in July 2005 by the NHS Institute for Innovation and Improvement). As well as structural changes leading, for example, to the creation of primary care trusts (PCTs), strategic health authorities (SHAs) and, more recently, foundation trusts, there has been a greater focus on targets for service improvement. This has been illustrated by the introduction of the NHS Plan (Department of Health, 2000) and the National Service Frameworks (NSFs) for defined service or care groups, which set national standards and identify key interventions.

In cancer, maternity and diabetes care, the overarching NHS Plan – and the accompanying NSFs – have set targets which create particular pressures for change in the way that roles are defined, resources allocated and structures organised. As such, an analysis of what is happening in these three areas helps to illuminate the challenges facing those responsible for implementing service improvement across health care services today.

Aims of the study

The aim of the study was to address two questions for the SDO Programme:

1. How do clinical directors and service managers from non-clinical backgrounds interpret and enact their roles and use them to implement service change?
2. What additional factors account for individual or organisational differences in the effectiveness of change implementation?

The research focused on improving the understanding of the roles of clinical managers and their counterparts from non-clinical backgrounds, within different parts of the health services, looking at how management roles are defined and what works well and why.

Practical *findings*

1) The local context, including historical and forthcoming strategic developments, is central to an understanding of how service improvements will progress

The local context is critical in gaining an understanding of why and under what conditions clinical service improvements may or may not progress. The study showed that clusters of factors, for example past mergers, local networks and senior management commitment, have a strong negative or positive impact on the progress of clinical service improvements. The core factors that assist service improvement appear to be:

- attention of executive team focused on that particular service and senior management not distracted by other agendas
- capacity for change leadership at both senior, executive and clinical service management levels, ensuring that leadership is dispersed across the organisation
- a positive history of prior change which has generated trust and created a co-operative culture
- strong external pressures for change and some factors which will encourage change, such as incentives
- good inter-professional relationships, creating a strong foundation for change
- no vacancies among key service improvement roles.

2) Competing policy agendas can distract from service improvements

Where the attention of senior management is concentrated on an externally-imposed target or structural change (as was the case in a number of the research sites), they are likely to be distracted from clinical service improvement. This suggests that externally-imposed changes can hamper the development of clinical services.

3) New and changing roles are emerging

The number and range of clinical staff performing management roles in addition to their clinical duties appears to be on the increase. 'Portfolio' roles where people have to work across a number of different areas (typically three to seven) are also much in evidence. These roles are most commonly held by senior executives and also by managers working within or between networks and trust organisations. Among those carrying out the new hybrid roles (roles which span clinical and managerial tasks), most clinical managers appear to focus on operational rather than strategic management, with little attention paid to service improvement or change management. This conclusion is more pessimistic than much of the earlier literature which had assumed that the role of clinical managers was defined in relatively broad terms. Currently there is a lack of HR resource and attention looking at whether the targets for these managers are achievable and their workload manageable.

4) 'Bridging' roles can help to drive forward change

A number of staff play 'bridging' roles. These are largely, but not exclusively, hybrid roles which, by their nature, cause people to move between managerial and clinical areas. As such, they are critical in driving forward change. Other staff who play useful 'bridging' roles may be those who hold a position with oversight across a PCT, such as a pharmacy advisor; or those who hold a management or facilitative role in a network.

5) There is a need for solid inter-professional relationships

The study shows that in order to implement service changes in a multi-professional service organisation such as health care, you need to establish and maintain a foundation of good intra- and inter-professional relationships.

The quality of relationships between clinicians and general managers was generally sound, if slightly distanced. However, relationships between clinical managers and other clinicians were more variable and on occasion proved very disruptive to providing good care. In many cases, senior management did not take action to resolve the situation. This was due to various factors, including a reluctance to be seen as 'interfering' and a lack of time, particularly if they were focused on strategic developments elsewhere.

Good communication networks across primary and acute care can achieve better outcomes for service users in the areas of cancer, maternity and diabetes care. However, existing networks are predominantly either managerial or clinical. This means that decisions about service improvement processes may be one-sided.

6) New patterns of leadership are emerging in effective sites

Those research sites which appeared most receptive and proactive in improving services demonstrated a 'dispersed' leadership of change. This involves the active engagement of staff both at different levels in the organisation and from a range of professional and managerial backgrounds. Effective sites had small groups (duos and trios) of senior managers who worked effectively together, consulted with each other and had respect for each others' viewpoints; as well as leaders at clinical service management levels and individual managers and clinicians in a variety of professions.

7) The HR management function can make an important contribution in supporting change

The HR function within many of the trusts was distanced from clinical activities and the clinical workforce. With one or two exceptions, individual HR specialists were rarely seen playing an active part in facilitating change within their organisations. This was a significant finding given the centrality of new roles and new ways of working in achieving service improvements and the need for HR support in developing such roles.

8) There are differences in change capacity between primary and acute care

There are some key differences between primary and acute care – particularly in relation to their structures and resource capacity – which appears to be affecting the ability of PCTs to deliver clinical service improvements. PCTs are in a state of transition, with new tasks, new relationships and new systems still to be put in place. There was clear evidence of management and clinical staff being stretched thinly over too many issues. This appears to be partially an issue of scale, raising the question of whether PCTs can legitimately, within their budgets, expect to employ high quality support staff. Consequently the leadership of clinical service improvements in primary care appears fragile and based on the willingness, motivation and dedication of a few people.

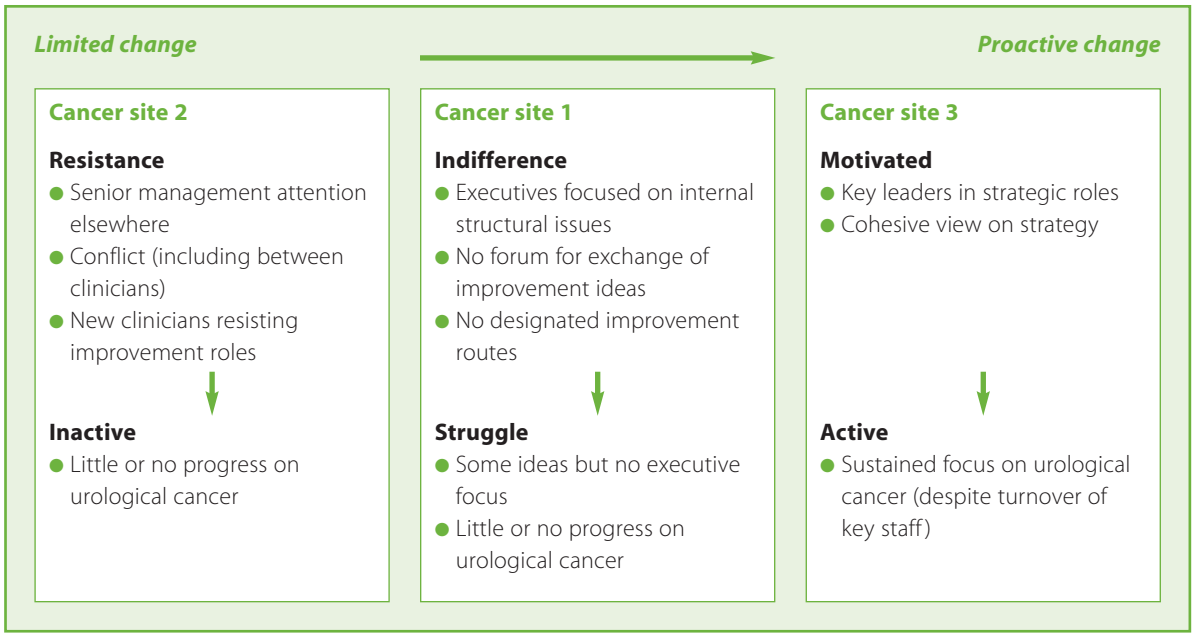
9) The combination of contextual factors and individual behaviours are crucial to progress

Driving forward service improvements depends on a complex interaction between all of the factors mentioned in the themes above. Some of these combinations lead to positive progress in clinical service improvements; others have a negative impact. A brief typology of some of these factors is outlined in Box 1. It takes as examples the three sites delivering cancer services, which are studied in the main report, showing the clusters of organisational characteristics which are significant to the change capacity of these organisations.

Cancer services in sites 1 and 2 experienced significant barriers to enacting service improvement, while cancer site 3 was sustaining meaningful service improvement. For example, the clinical lead for cancer services at site 3 was focused on service improvement, while the clinical managers from the two other sites were HR management-oriented, leaving both surgical directorates without any genuine strategic leadership.

There is no single factor that explains why these two organisations had not been able to develop or sustain significant change management in cancer services. Instead it was the lack of clinical leadership and preoccupation with high-level strategic development that represented key obstacles to implementation. This table is a much shorter version of the complete typology of eleven sites which appears in the final report (see *Appendix 5*, Fitzgerald *et al.*, 2006).

Box 1. The impact of different organisational contexts and individual behaviours on service improvement capacity in three sites providing cancer services



Implications of the findings

1) Avoid further significant policy changes

Multiple, changing policy targets and directives can be distracting. While strategic changes rightly claim the attention of senior management, it limits their capacity to monitor ongoing clinical service change, where improvements to health care systems are actually delivered.

2) Professional development opportunities to build capacity for change at a local level

While many staff members are doing astounding work in difficult circumstances, there are also frequent examples of staff struggling, and few opportunities for support and development. Rather than focusing on training and development around specific techniques, it would be more valuable to shift the focus towards building longer-term change capacity in the organisation. This would entail better training and development opportunities for those in clinical management posts, and offering them support, either to work with experienced change facilitators or to attend regular, local forums to debate their problems and plan actions.

3) Better recognition for clinical managers and a process of role review

There needs to be an acknowledgement from government and professional bodies that the development of hybrid roles is a growing area and that hybrid managers have the potential to aid service improvement.

Hybrid managers do not yet have a coherent work identity, an adequate knowledge base or many development opportunities. Other medical professionals do not consider clinical management to represent a medical specialty – rather clinical managers uncomfortably span the managerial/clinical divide and are not full or influential members of either occupational group. This area needs to be recognised by the broader profession and professional bodies as an issue of importance to the health care system, with attendant support systems and training and development opportunities.

4) Give HR departments the remit to support change and intervene when necessary

The findings raise issues about the intended role of the HR function in health care. Traditionally seen as an administrative function, it can play an important role as a business partner in supporting change and developing the leaders of change. Senior management and HR specialists need to pay more attention to the appointment of staff to hybrid and new roles, both in relation to how the role is defined and whether the aims of the role are achievable and manageable. The HR function could also facilitate relationship building and the resolution of disputes.

Given their capacity issues, PCTs may need to consider other means of developing these resources, such as through shared services or contract outsourcing.

Recommendations

For policy makers in government and SHAs

Reflect on the necessity of and risks posed by multiple changes and directives, before new policies are introduced.

Set realistic timescales for change, to avoid undue pressure and dysfunctional outcomes such as high staff turnover.

Consider how to support capacity building within health services, as a counterpoint to top-down measures such as targets.

SHAs and workforce confederations to review and redirect the HR function to support change facilitation.

Consider offering greater incentives to SHAs and trusts to work collaboratively with local advocacy and service user groups.

For management

Ensure that service improvements have senior management attention and dedicated project management resource.

Develop dispersed leadership structures and ensure clinical involvement in the change process.

Develop hybrid roles to span boundaries between clinical and managerial groups, and primary and secondary care.

Ensure new hybrid managers have an adequate understanding of their role and a review at six months and a year.

Review the delivery of the HR function; in particular consider how the facilitation of change and leadership development could be better supported by HR.

Further *research*

- **Capacity in primary care services to undertake further change:** For example looking at the rate of senior staff turnover; management training and views on progress towards targets.
- **The career paths of clinical directors:** To find out why some wish to stay in management while others wish to return to full-time clinical careers.
- **The nature of portfolio roles:** For example the strengths and weaknesses of defining roles in this way and their implications for organisational structures.
- **The HR function in health care:** To explore differing models of HR as they currently exist and their impact on clinical service improvement activity.
- **Clinical management as a profession:** To explore why this has been so slow to develop, using theory derived from the sociology of the professions and also international comparisons of the development of the profession of clinical management.

About the *study*

The study commenced with a review of research publications and commentary pertaining to the roles and relationships of clinicians, clinical managers and general managers, within the broader contexts of role theory and national policy developments. The major part of the study was a comparative case study analysis. This qualitative approach enabled the researchers to explore concepts around change management, role enactment and service improvement in great depth.

The researchers looked at 11 sites across the UK and in acute and primary sectors – three cancer sites, three maternity sites and five diabetes sites. The sites were selected via a two-stage process. The first stage assessed organisational complexity by considering two criteria.

1. The Jarman index and predicted workforce shortages for primary care organisations.
2. The scale, the number of sites and whether it was a tertiary referral centre for secondary care organisations.

The second stage was a more qualitative consideration of a number of other potential drivers, for example senior management team changes, merger activity, financial situation and performance rating. Having selected the sites, the three methods used to gather data addressed a wide range of issues, providing a more convincing and accurate contextual account. These methods included:

- semi-structured interviews
- document analysis
- observation at meetings.

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Further *information*

References and further reading

Department of Health. 2000. *The NHS Plan: A plan for investment, a plan for reform*. London: The Stationery Office.

Fitzgerald L, Lilley C, Ferlie E, Addicott R, McGivern G, Buchanan D. 2006. *Managing change and role enactment in the professionalised organisation*. London: NCCSDO.

The full report, this briefing paper and details of current SDO research in the field can be downloaded at www.sdo.lshtm.ac.uk

Feedback

The SDO Programme welcomes your feedback on this briefing paper. To tell us your views, please complete our online survey, available at: www.sdo.lshtm.ac.uk/briefingpapers.html

About the SDO Programme

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For further information about the NCCSDO or the SDO Programme visit our website at www.sdo.lshtm.ac.uk or contact:

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Disclaimer

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Addendum

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The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk