A realistic review of clinico-managerial relationships in the NHS: 1991-2010

Executive Summary

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Background

At the end of the 1980s a great deal of work was done summarising and synthesising what we knew about NHS management, and specifically clinico-managerial relationships, at that time. Research during the 1990s tended to focus on the emergent internal market, with performance management and the increasing pace of reform strongly represented during the 2000s.

Aims

This report aims to synthesise research published in the 1990s and 2000s into a form that will be useful to managers, clinicians, academics and other stakeholders, to show how clinico-managerial relationships have changed over the last twenty years, and to consider which forms of development and training programmes might best support their improvement.

Methods

The project makes use of realistic synthesis, examining the evidence in the light of the context in which it was generated to try and establish links between contexts, mechanisms (the means by which change or reform were attempted) and the outcomes that were achieved. We searched research databases and grey reports over the last twenty years to try and develop a synthesis that represents, as best as we can, the findings of published work between 1990 and 2010.

Results and Conclusions

In hospitals, research finds the educational background of staff to be a key determinant of how they view reforms, with medical clinicians still broadly characterised as generally opposing managerialist reforms, medical managers offering some support for them, nurse managers showing broad support, but nurse clinicians generally opposed to them. These differences in perception, and an associated opposition to attempts to introduce multidisciplinary team working, mean that considerable 'tribal' behaviour still seems to predominate.
Full-time managers often regard doctor-managers with suspicion, and doctor-managers regard the managerial aspects of their role as part-time, temporary, and having little authority over their peers who often do not regard doctor-manager roles with respect. Nurses have often regarded new managerial roles as offering them the opportunities to take greater responsibilities, and so consider them in a more positive light than doctors. Roles such as modern matrons, however, have been frustrated by often being located outside of hospital management structures, and by being given responsibilities for areas such as hygiene that are the result of contracts with external contractors. New nursing clinical roles have been partially successful, but nurses often find it difficult to balance the care-based model of their profession with an increased biomedical and curative focus.

In contrast to the hostility and gaming towards targets and performance management in hospitals, in GP practices there has been little opposition to Quality and Outcome Framework (QOF) reforms from either doctors or nurses. GPs regard QOF as being based on best practice, and as allowing them to pursue more specialist cases, while nurses regard it as providing them with new opportunities to extend their roles and even to run primary care entirely through nursing staff.

The extent to which the pay-for-performance element of QOF has led to its success is open to question, with GPs often using additional resources to employ more staff or purchase IT rather than raising their own salaries. QOF does appear, however, to have led to GPs taking a more biomedical view of patients and to increased standardisation of care. There is little evidence, outside of changing appointment systems to manipulate two-day targets to see patients, of QOF gaming.

Nurses express some concerns about their ability to deal with the challenges that their extended roles offer, of the lack of training available to support them, and about becoming 'absorbing groups' for jobs that GPs don't want to do, but are generally positive about QOF. In particular, where it creates an environment where greater teamworking between GPs and nurses, the changes are particularly positively regarded, although relationships with practice managers are still sometimes problematic.

**Recommendations:**

- There is much secondary care has to learn from QOF: it suggests that provided targets are linked to everyday practices that clinicians see as being evidence-led, service quality improvement can be achieve. Putting in place an outcomes-driven framework in secondary care requires central targets be
translated into everyday practices (suggesting a key role of clinical managers), and also that clinical specialities be given more autonomy in hospitals in how they meet their targets. This will require imagination and perseverance from managers of all kinds, but the achievements of QOF suggest that service quality can be driven through such a method.

In addition to attempts to reform clinico-managerial relationships, policy during the 2000s has also attempted greater patient and public involvement through patient choice and public involvement reforms that have considerable potential to change the dynamics of healthcare.

Policies to increase patient choice have struggled to achieve their goals. 'Choose and Book', the computer system upon which choice is based, has often not worked smoothly enough to allow choice to take place within a GP consultation, and GP consultations often struggle to produce patient-led decisions, with patients being offered little scope to make meaningful choices. Despite suggestions that patients will become empowered through the use of the internet, the idea of a well-informed health consumer appears to be the exception rather than the rule - and doctor-patient relationships have been remarkably stable.

Patients appear to want choice within services rather than between services - they want to be consulted about possible alternative courses where they receive on-going programmes of treatment. They would also like more choice about the date and time of treatment. Present choice policies neither empowering patients in relationships with clinicians to become better informed about their health or care, nor offer them the kinds of choices that they actually want.

Reforms to achieve greater public participation in healthcare have created considerable confusion because, in trying to put in place new structures by which the public might become more involved in healthcare decision-making, they have resulted in a raft of new organisations that have been abolished, changed role, and been reformed with remarkable rapidity.

There is a great deal of confusion as to whether public participants are meant to be representing wider communities, and whether the diverse public can even be represented through committee-led processes. There appear to be different views of what constitutes participation from policymakers and the public, with the latter wanting a far more open and dialogic form of involvement than health services have been able to provide.

There have been considerable problems in establishing boundaries between different bodies such as Local Authority Scrutiny Committees and public representative groupings such as Patient and
Public Involvement Forums, and later LINKs (Local Involvement Networks) and PALS (Patient Advice and Liaison Service), as well as difficulties with sustaining involvement as participatory mechanisms undergo considerable change.

In short, bottom-up reform has struggled to involve the public as either individual choosers of their care through patient choice policies, or to involve them in health services through public participation mechanisms. If a key reform goal of the 2000s was to drive bottom-up reform through the empowerment of patients through choice policies, and the public more generally through participatory mechanisms, current mechanisms have not achieved these goals.

Recommendations:

- Patient choice can be a mechanism for driving service improvement, but it needs to focus on the kinds of choices patients want to make (date and time of treatment), and on putting in place more dialogical means between patients and doctors of informing choices. This has the potential to change relationships between doctors and patients to a more participative framework, and to increase service quality as a result.

- Public participation also needs to be more dialogic to allow the public to engage at the deeper level they wish to, and for managers and clinicians to be trained to facilitate such an approach. The public need to be informed about what difference their participation makes to decision-making for it to work.

Training, development and education.

How can training and development best support relationships within the NHS? A number of key points have emerged.

Training needs to be contextual in providing managers and clinicians with a background of history and policy in the NHS, and to be based on inter-professional problems solving to encourage a greater appreciation of the differing perspectives differently trained staff can bring. There should be a greater use of tools such as case studies for training so that training addresses real-life problems rather than being based on competency-led approaches that does not take adequate account of the NHS context. It is also crucial that training allows critical interaction between participants and tutors to assess the robustness of the evidence and frameworks being considered.
Training should therefore follow the pattern of understanding the specific NHS context, and of active and collaborative problem-solving within it. Competencies can be taught, but in an applied setting where critical engagement and collaborative working across clinical and managerial boundaries are put at a premium.

In addition, doctors still seem to require additional training on how they can interact with patients in a more collaborative form, especially if patients are to make choices and services be commissioned through GP surgeries, with patients often still struggling to make themselves heard. As present reform proposals move commissioning to the local level it will also be crucial that GPs and those working Local Authorities to scrutinise them, are adequately trained to take on their new roles. For improved public participation, managers, clinicians and the public need to be trained and better prepared to understand the rationale and principles of their involvement, and for decision-making to be more closely linked to participative mechanisms for the public to find it meaningful.
Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.