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Management practice in primary care organisations: the roles and behaviours of middle managers and GPs

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Glossary of terms/abbreviations

AD	Assistant director
AfC	Agenda for Change, UK NHS pay and grading structure for managers
DH	Department of Health
DoC	Director of Commissioning
GP	General Practitioner
LA	Local Authority
MM	middle manager
PBC	Practice-based Commissioning
PCT	Primary Care Trust
TM	top manager
WCC	World Class Commissioning (an assurance programme instituted by the then Labour Government, designed to improve commissioning practice in PCTs)

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Contributions of authors

Dr Kath Checkland (Clinical Senior Lecturer in Primary Care) was the Principal Investigator, and performed the literature review, was involved in project design, data collection and data analysis and wrote the first draft of this report

Dr Stephanie Snow (Research Fellow) was involved in project design, data collection and data analysis, and wrote some sections of the report, as well as reviewing and editing the finished report

Dr Imelda McDermott (Research Associate) collected some of the data and was involved in data analysis. She reviewed and edited the final report.

Prof Stephen Harrison (Professor of Social Policy) was involved in project design and data analysis, as well as reviewing and commenting upon the finished report.

Dr Anna Coleman (Research Fellow) was involved in project design and data analysis, as well as reviewing and commenting upon the finished report.

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Executive Summary

Background

Primary Care Trusts (PCTs) are responsible for the management of up to 80-90% of the total NHS budget. Our previous research demonstrated that the role of middle managers is very important in determining how the policy of Practice-based Commissioning (PBC) played out in practice. Whilst there is a wealth of research evidence demonstrating the important role of middle managers in organisations more generally, and some evidence about the role of middle managers in hospitals, there is little published research relating to the role of middle managers in PCTs.

Aims

The aims of this study were as follows:

1. To use qualitative case study methods to generate a detailed and theoretically informed picture of the ways in which PCT managers and GPs interact within the context of PBC, and to relate this to the progress that has been made in developing PBC structures and processes in the study site.
2. To use these results to:
   - Draw more general conclusions about the role of middle-grade managers in PCTs and their impact on the functioning of the organisations as a whole
   - Develop an understanding of the way in which GPs interact with managers and adopt managerial roles

Methods

Following a detailed literature review of the relevant literature relating to the role of middle managers, qualitative case studies were undertaken in four purposively chosen PCTs. The study focused upon the PCT directorate with responsibility for commissioning. Initial contacts with the sites explored the overall organisational structure, and data collection focused upon the roles of managers with responsibility for PBC and other commissioning managers. After informally shadowing a number of managers, researchers attended as many meetings as possible relating to commissioning (both PBC and PCT commissioning), and followed this up with interviews with managers and GPs. Interviews used a topic guide, and focused upon managerial roles and responsibilities. During these interviews issues from meetings were explored Data were analysed as the project proceeded, allowing insights to be explored in ongoing data collection. Analytic memos

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were written and shared amongst the team, and discussed, along with data coding issues, at regular team meetings.

Results

Overall, the study confirmed the importance of middle managerial roles in PCTs. Significant findings included:

1. The initial literature review identified a number of important concepts and issues relating to the role and identities of middle managers which informed the development of both the research questions and the focus of data collection. These included:
   - Managerial roles and behaviour
   - Managerial identities and the notion of 'identity work'
   - Middle managers' influence on strategy
   - 'sensemaking' as a theoretical framework within which to explore managerial work
   - The particular issue of identity for NHS managers with a clinical background or clinicians required to undertake managerial roles
2. The generic managerial work undertaken by PCT middle managers was found to be messy, fragmented and largely accomplished in meetings. PCT commissioning managers must also wrestle with the indeterminate nature of the *substance* of their role, in that 'commissioning' is neither clearly defined nor easy to divide into meaningful areas of focus. We found considerable variety in the ways in which PCTs divide up commissioning work, with evidence of confusion and overlap between the various commissioning teams and groups. Managers struggle with this and appear to try to compensate by dividing up their personal responsibilities into 'pieces of work' that can be defined, managed and completed.
3. We have identified a number of managerial roles enacted by PCT middle managers. Some of these are identifiable from the more general managerial literature, but in addition we have identified a unique role performed by PCT middle managers with a responsibility for PBC. These include:
   - Managing information downwards and sideways. Managers actively managed the distribution of information amongst their peers and work groups. Much of this work involved summarising and interpreting information, with the result that middle managers appeared to be in powerful positions, as their summaries and interpretations became the raw materials on which other managers worked.
   - Managing information upwards. Some middle managers were also observed actively managing the distribution of information to their

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superiors, ensuring that particular interpretations were disseminated to the top management team. Formal position in the hierarchy was less important here than personal, 'earned' legitimacy.

- Networking outside the organisation. Middle managers in PCTs enact important roles networking outside the organisation, with groups of GPs, with providers and with regional colleagues. These roles are demanding, with managers working with groups whose needs and aims are not necessarily aligned with those of the PCT. Managers demonstrated the flexible adoption of differing identities in performing this role. Managers had considerable autonomy, with few clear mechanisms within the PCTs studied to ensure that such work conformed to the overall PCT strategic aims. In addition it was observed that sometimes painstaking bottom-up commissioning work could be over-ridden by top managers.
- Networking inside the organisation. A large part of middle managerial work consists of networking with peers and subordinates within the organisation. Weick's concept of 'sensemaking' provided a theoretical framework within which to understand this activity. The enactment of this roles is dependent on individual agency, but can also be enabled or constrained by organisational practices such as the arrangement of meetings and office geography
- The 'animateur' role. We also identified a special role enacted by middle managers with responsibility for PBC. In this role some managers were observed to actively manage the GPs with whom they were working in order to ensure that specific action occurred. Individual agency played a part in this, but the adoption of this role could be enabled or constrained by organisational practices such as the inclusion or exclusion of managers from high-level meetings within the PCT. Formal grade did not seem to be an important determinant of this behaviour.

4. There was no clear association between formal grading and managerial behaviour in role.
5. Clinicians working as managers under PBC were reluctant to be identified as either 'managers' or 'leaders', in spite of acting in both of these capacities. We identified three claims to legitimacy offered by these managers:
   - Claims of expertise in a particular clinical area
   - Claims of experience in similar roles in the past
   - Claims based upon representativeness, usually as a result of election to office.
6. Organisational practices, such as the organisation of meetings or the office geography had clear and identifiable impacts upon the ways in

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which middle managers carried out their roles. Thus, for example, the practice of 'hot desking' was observed to have a negative impact on the ability of managers to interact with their peers. The importance of 'animation' (the existence of adequate fora within which managers can interact and 'make sense' of their work) and 'control' (the clear dissemination and active sharing of overall organisational aims and objectives) in organisational structures and processes have been highlighted.

Conclusions

The role of middle managers with commissioning responsibility is a difficult one, and the way in which it is performed can have a significant impact upon the overall performance of the commissioning organisation. As the 2010 White Paper, handing commissioning responsibility to groups of GPs, is implemented, these findings offer some insights which may be of value to those responsible for this process. These include:

- 'Commissioning' as a way of organising health services is by no means straightforward, and the training needs of GPs involved will need to be addressed. Our results suggest that in addition to commissioning 'skills', managerial behaviours could usefully be addressed.
- We have highlighted the 'animateur' role as an important one in the interaction between clinicians and managers with commissioning responsibilities. This has implications for the development of managerial support arrangements for newly set up GP consortia.
- The role of clinicians in commissioning is complex, requiring the adoption of roles and identities with which some GPs may not be comfortable.
- Organisational practices can have a profound impact on the ability of managers to function in role.

Further research is suggested in the following areas:

- The combination of methods used in this study provided rich and nuanced data about the work of commissioning managers. Data collection in future studies of commissioning should seek to go beyond interview evidence alone.
- Some of the complications and issues associated with 'commissioning' as a way of organising health services have been identified. These issues should be followed up in subsequent studies of the new commissioning arrangements in the NHS.
- The 'animateur' role is important in the accomplishment of commissioning management. This novel research finding requires further elucidation, including:

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- Further definition
  - Exploration of enabling and inhibiting factors
  - Exploration of the extent to which it can be taught or deliberately adopted
  - Exploration of its relevance in the new situation in which consortia may be 'buying in' managerial support from outside agencies.
- This study has highlighted the importance of enactment in the sensemaking process. The extent to which enactment can be consciously directed in order to improve organisational sensemaking should be explored.
- This study has highlighted the impact of organisational practices on managerial work. The extent to which active monitoring and adaptation of organisational practices is possible could be usefully explored.

The strength of this study lies in the depth and richness of the data collected. As a small study the results cannot be straightforwardly generalised to a wider population. However, data saturation was reached during the study, and there are grounds for suggesting that, whilst the results presented here may not represent an exhaustive study of all possible middle managerial roles in PCTs, the roles and behaviours that we have identified are likely to be of importance in other commissioning organisations.

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1 Introduction and background

Primary Care Trusts (PCTs) are responsible for the management of up to 80-90% on the total NHS budget in England. In addition to their role as commissioners of primary care services such as general medical services, optometry, dentistry and community pharmacy services, they are also responsible for the commissioning of hospital services, both urgent and routine, and for the provision of community services such as district nursing and health visiting. They thus play a key role in the management of NHS resources and in the planning and organisation of services, and it is somewhat surprising that there has been little research into their performance of this role. There has, however, been considerable adverse comment on the performance of PCT managers. For example, a recent report from the House of Commons Select Committee on Health (1) singled out PCT commissioning managers for criticism, arguing that the reported failure of 'commissioning' to make much impact on the provision of NHS services could, in part, be blamed upon a lack of 'managerial capacity' within PCTs. However, this assessment was based upon witnesses' opinions, with little corroboration, or empirical evidence in support of their claims.

It is in this climate of critical comment associated with a lack of good evidence that this research was conceived. The idea grew out of our previous research into Practice-based Commissioning (2), during which it became clear to us that the role of middle-level managers in PCTs was crucial to the implementation of the policy of PBC. Indeed, it could be said that the performance of the managerial role in support of PBC, and the interaction of PCT managers with GPs in managerial roles were key factors affecting local outcomes. Whilst the role of middle managers in organisations in the wider field of organisational studies has attracted considerable research interest (see chapter 2 for details), within the NHS such research has tended to focus upon managerial roles within hospitals. This present research was therefore conceived to fill that evidence gap by providing detailed evidence about the ways in which middle managers and clinicians with managerial roles behave and experience their working lives in a primary care setting.

1.1 The structure and organisation of PCTs

As mentioned above, PCTs have a number of different roles within the NHS, and there is no central blueprint as to how they should organise themselves to fulfil these roles. Thus, PCT organisational structures vary considerably, as do job titles and lines of accountability. However, the functions of PCTs can be loosely divided into four. Firstly, PCTs are responsible for the commissioning and performance management of a range of providers of primary care services. These include General Medical Services (general

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practice) services (which account for the lions share of the budget), but also dentists, optometrists and community pharmacists. Secondly, they are responsible for the provision of community services such as district nursing and health visiting. During the life of this project, PCTs were instructed to divest themselves of this function, transferring their community services either into a new, free-standing provider organisation or to an existing provider of some kind (3). Thirdly, PCTs are responsible for commissioning secondary care services, both routine and urgent or acute. Most PCTs have a directorate devoted to this function, often called the Commissioning Directorate, or sometimes the Directorate of Strategy. Finally, PCTs have support functions, including Public Health, concerned with the assessment of population health needs and status, human resources, data analysis and information management, finance, and clinical support such as prescribing and clinical guidelines.

PCT commissioning is of particular research interest for two reasons. Firstly, it is an area of activity within the NHS that is unique to PCTs, with no analogous function within hospitals or other providers. Secondly, it is an area that has been subject to a great deal of change in recent years, in particular in relation to Practice-based Commissioning (4), with PCT managers wrestling with the need to devolve commissioning responsibility whilst simultaneously being subject to an increasingly tight performance regime (5). This research therefore was designed to explore the roles of managers within the commissioning functions of PCTs.

1.2 Practice-based commissioning and the changing landscape of commissioning

Managers with responsibility for commissioning care in the NHS face a difficult challenge. Whilst the so-called 'commissioning cycle' (6) (see figure 1 p17) implies a straightforward separation of functions between needs assessment, service design and referring individuals for care, in practice these things are interlinked and on-going, with no possibility, for example, of halting referrals whilst services are redesigned. Furthermore, 'managing demand', entered as a box on the cycle, is in fact a complex activity that involves engaging with referrers in a context in which managers have few (if any) levers with which to bring about change.

Practice-based Commissioning (PBC) is a major policy initiative introduced in 2005, involving the devolution of indicative commissioning budgets to GPs by PCTs, with provision for the reinvestment of any savings. Uptake has been near-universal, and most GPs have banded together into an estimated 500 or more 'consortia' (7). It was hoped that by providing incentives for referrers to modify their behaviour the twin goals of more efficient use of resources and more effective service provision would be achieved (8). Whilst the activity is termed 'commissioning', it is clear that the lines between 'commissioning' and 'providing' care are somewhat

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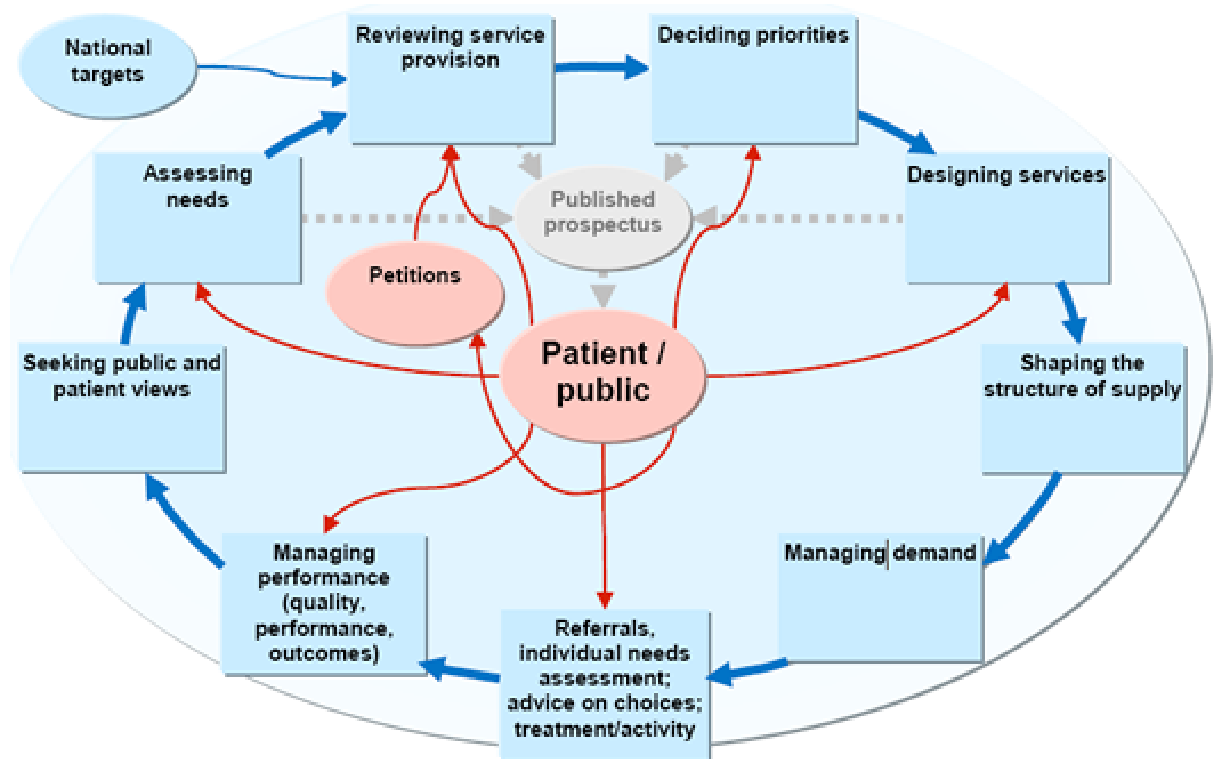
Figure 1. The Commissioning Cycle (6)



blurred, with PBC consortia providing new services themselves more often than they commission them from other providers (9). Official guidance required PCTs to devolve budgets for a variety of services to PBC groups, including all services covered by the Payment by Results tariff, community services, prescribing and mental health services, although many PCTs were slow to devolve this full range of services. They were also required to facilitate PBC, providing managerial support and ensuring that PBC plans were integrated with both PCT priorities and national priorities set out in the annual NHS Operating Framework (8, 10). Thus, PBC represented a new opportunity for PCT management to shape the priorities and direction of GP practices, whilst the GPs involved in the governance of consortia were required to 'manage' their peers and work closely with PCT managers. A recent study of PBC undertaken by this team showed that the relationship between PBC consortia and PCT managerial staff is one of the most significant factors affecting progress in implementing PBC (9). Such interactions are not necessarily straightforward, as general practice has been historically under-managed, with GPs often reluctant either to engage with the notion of management, adopt managerial roles or agree to change their practice in response to initiatives from 'outsiders', as PCT managers are often perceived (11). Furthermore, most of these interactions involve middle-grade staff, who may not be perceived as carrying much authority. Thus, the introduction of PBC provides an ideal opportunity to study how

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middle-grade managers cope with change, and how their actions influence the effectiveness of the PCT in implementing new policies. The interface between GPs, other practice staff and PCT managers in relation to PBC also provides a unique opportunity to examine both the interactions between them, and the journey travelled by GPs (and other professions involved) as they adopt new managerial responsibilities.

1.3 What is a 'middle manager', and why research them?

The evidence relating to the roles and impacts of middle managers on the organisations in which they work will be discussed in detail in Chapter 2. In this section it is our intention to set out the rationale for choosing this particular group of managers to research, and to explain the definition used in determining who to approach.

Managerial and organisational research is a very wide field, and the roles of managers in organisations have been extensively researched. One strand of this research takes the view that it is top-managers who determine the policies and strategies within organisations (12). However, it has been argued by others that such approaches fail to appreciate the complexity of managerial activity, and risk missing the rich and complex ways in which managers lower down in organisations may influence organisational activity and performance (13). Within PCTs, we found in our previous research into Practice-based Commissioning that the ongoing work relating to PBC was undertaken by what might be called middle-grade managers, and that these managers appeared to act with considerable autonomy and to have a significant impact on outcomes (2). This is in keeping with available research evidence in other settings (13), making what these authors have called a 'middle managerial perspective' a theoretically interesting one to adopt.

One characteristic of the literature relating to so-called middle-managers is the vagueness of the definition of the cadre of employees of interest (14). Furthermore, it is clear from the literature that middle managerial roles vary between different parts of organisations, between organisations in the same sector and between different sectors. It is, in fact, common within this literature to fail to define the term 'middle manager' at all (eg see (15)). In those papers which do provide a definition, it is generally a broad one, defining 'middle management' simply as managers who are below executive level, and above the 'front-line' of operations (eg see (16)). Wooldridge et al (13) put it thus:

> *'In the literature reviewed here, the term middle management is understood rather broadly. It extends to managers located below top managers and above first-level supervision in the hierarchy (e.g., Dutton & Ashford, 1993; Uyterhoven, 1972). The distinguishing feature of middle*

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management, however, is not where they sit in the organization chart. Rather, what makes middle managers unique is their access to top management coupled with their knowledge of operations.'

PCTs are relatively 'flat' organisations, with a board of directors at the top of the organisation, and managers occupying a variety of grades below this level. 'Agenda for change' is the uniform NHS pay and grading structure that was implemented in 2004. The NHS employers' organisation describes it like this on their website:

Staff are placed in one of nine pay bands on the basis of their knowledge, responsibility, skills and effort needed for the job rather than on the basis of their job title. The assessment of each post using the Job Evaluation Scheme (JES) determines the correct pay band for each post, and so the correct basic pay. Within each pay band, there are a number of pay points. As staff successfully develop their skills and knowledge they will progress in annual increments up to the maximum of their pay band, At two defined "gateway points" on each pay band pay progression will be based on demonstration of the applied knowledge and skills needed for that job.
http://www.nhsemployers.org/PayAndContracts/AgendaForChange/Pages/Afc-AtAGlanceRP.aspx (accessed sept 2010)

Within PCTs, managerial staff generally occupy Agenda for Change (AfC) bands 7-8, with band 8 further subdivided into 8a-d. Band 6 employees are generally regarded as administrative rather than managerial. In this study we found that it was not possible to use the AfC grading in any strict fashion to determine the staff of interest in the research. This will be further discussed in the results section. We thus followed the example of the wider managerial literature in this study, using a broad and essentially pragmatic definition of the employees of interest. We defined 'middle managers' as those below board level, who acted in managerial positions. In practice, most of our participants occupied AfC grades 7 or 8, although a small number of grade 6 employees were also included because of the managerial responsibilities that they had been given.

1.4 The research and the structure of this report

In the past few years PCT commissioning managers have been given new and onerous responsibilities, and criticised for their perceived 'failures' in carrying these out. Their roles are crucial, in that they are the main links between those trying to plan and organise care services, and the clinicians on the ground who shape service use by their referral decisions. The wider managerial literature suggests that middle managers play a potentially important role in the shaping of organisational behaviour and outcomes, but

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there is little or no research that focuses upon middle managers in PCTs. This research was therefore designed to investigate the roles and lived-experiences of middle managers in PCTs with responsibilities for commissioning, focusing upon those whose roles included engagement with PBC consortia, but also including managers with more general commissioning responsibilities in order to explore any differences between the two groups of managers.

It was noted in the referees' comments on the original research proposal that there is considerable research exploring the roles of middle managers, and that exploration of this literature would be valuable. An extensive literature search was therefore performed, and the results of this underpinned the project as a whole, providing a theoretical framework for the research as well as informing the topic guides used to structure the data collection and providing a structure within which the results are examined. This literature is disparate in both the theoretical approaches used and in the aspects of managerial work that are explored. Making sense of this complexity is not easy, and Chapter 2 of this report therefore contains an extensive discussion of the relevant literature. Whilst the length may seem a little excessive, it was felt that providing a clear synthesis of the literature that was explored is of considerable value in understanding the results of the research, and for this reason the review is included in its entirety. The following chapters describe the research methods and results and will discuss the findings in the context of this literature. Chapter 3 describes the methods used in the research. Chapters 4 and 5 set out the results, and the final chapter discusses these in the context of both the NHS and the challenges it faces and the relevant literature discussed in Chapter 2.

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2 Literature review

2.1 Introduction: the structure of this review

The literature relating to middle managers in organisations is broad and messy. It comes from a variety of disciplines, and covers a number of different theoretical viewpoints; categorising the literature in a way that makes sense of this complexity is not easy. If a topic-related approach is taken, such as 'middle managers' work' or 'middle managerial roles in strategy', then work from widely differing theoretical perspectives will be included in each category. If, on the other hand, a theoretical approach is attempted, classifying research in terms of its theoretical perspective, then it is difficult to draw out an overview of the topics under consideration. There is a degree of correlation between theoretical perspectives and the topics addressed: thus, for example, researchers concerned with what middle managers do on a day to day basis largely take an instrumental[1] view that seeks to maximise or measure organisational performance by analysing their work. Conversely, research that tackles the issue of managerial identity largely comes from either a social constructivist or a critical perspective, whilst the topic of 'managerial roles' encompasses both extremes. In this review, therefore, I have taken a hybrid approach, largely categorising the literature by topic, but within this both indicating the range of theoretical approaches and demonstrating where there is a significant body of work that takes a similar theoretical approach (for example, within the 'identity' literature). Throughout this section the wide definition of 'middle manager' discussed in section 1.3 (p18) is used.

[1] The literature discussed here is diverse, and it is difficult to clearly divide it into categories. Research that takes a 'social constructivist' or a 'critical' approach is relatively easy, as researchers from these traditions tend to self-consciously define themselves as such. However, a significant portion of the literature takes what is probably most accurately described as a 'positivist' approach. However, researchers from this tradition tend not to self-identify as such, taking the view that there is only one way of looking at the world. I have not used the word 'positivist' in this review, as it is often regarded as a term of abuse. Some of the reviews of the literature quoted later divide research into three broad categories: functionalist, seeking to link structure to function and looking for 'the best way' of achieving some end; social constructivist, understanding the world as a co-creation by actors, with research aiming to illuminate and understand why things are as they appear to be; and critical, which derives largely from the Marxist perspective, and which sees the managerial world in terms of exploitation and dominance, asking questions about whose ends are served by particular ways of doing things. Some of the work referred to in the first category does not fall within the technical definition of 'functionalist', which generally refers to 'the way various parts of the social system contribute to the continuity of society as well as the affect the various parts have on one another.' (http://www.socialsciencedictionary.com/functionalism). I have therefore preferred to use the term 'instrumental' to describe this body of research, which is defined as: ' a philosophy that the truth of an idea is defined by how successful the idea is in solving problems' (http://dictionary.babylon.com/instrumentalism.)

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2.2 Search strategy

The managerial and organisational studies' literatures are not well classified in terms of key words or search terms. A wide initial search strategy was therefore adopted. The areas of interest for the search included 'middle management' and 'clinicians as managers', and searches using these as both key words and as words in titles were performed. For the detailed search strategy used, please see appendix 1. In addition, relevant references and concepts found in retrieved papers were followed up, and relevant journals contents pages were hand searched. Throughout the project there was an ongoing scan of relevant journals, in order to ensure that newly published papers were accessed. In total, approximately 3000 papers were retrieved. The abstracts of these were read, and assessed for relevance. In total, 314 papers were felt to be relevant, and these were accessed and read. It was not intended that this would be a systematic review, as the topic of 'middle management' is a very wide one. The study as proposed is based upon a theoretical framework derived from the work of Weick (60) and on the concept of 'sensemaking', and the literature review therefore used this as an organising device to set the limits of the search. The 'sensemaking' approach is derived from social psychology, and regards organisations as social entities, in which reality is created and re-created by the interaction of the organisational members. Important concepts within this framework include: identity; enactment; and roles. The literature was therefore reviewed and papers included that addressed the following issues:

- Discussion of the nature of middle managerial roles
- Discussion of identities, both individual and organisational
- Discussion of the nature of managerial work, particularly relating to middle managers
- The microprocesses within organisations by which work is accomplished
- Clinicians as managers and in managerial roles

The papers accessed fell into three categories: theoretical papers, which use concepts from social science to address the roles of middle managers; qualitative case studies, which use techniques such as interviews, observation and diaries; quantitative studies that use large surveys to draw conclusions about factors which affect middle managerial roles. In this literature review, most of the studies assessed as being relevant fell into the first two categories.

2.3 Middle managers in the historical literature

During the 1980s, it was argued that the role of the middle manager should be attenuated or even phased out entirely. Responding to pressures such as globalisation, changes in capital markets and encouragement from shareholders to increase company value (17), the emphasis was upon moving away from bureaucratic, hierarchical models of organisation to become 'leaner' and more flexible, with a rhetorical call to 'empower' front line managers to become more entrepreneurial (18). Middle managers were

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seen predominantly as an obstruction, acting to prevent top manager's strategy from being carried out. For example, Peters (19: 758-759) argues: 'Middle management... is dead . . .It's over, d'ya hear? Over. Over. Over'. Organisational downsizing resulted in 'flatter' organisations, with fewer 'layers' – an alternative name for this process was 'delayering' (20). However, by the early 1990s the negative consequences of this process were beginning to be recognised in empirical studies (21, 22). Krau (23) studied middle managers in a number of organisations, and argues that 'delayering' and the loss of middle managerial roles causes: low morale, and consequent negative behaviours by remaining managers; loss of potential senior managers for the future; and paralysis of the organisation as those who know 'what works' are lost. By the early 1990s, commentators began to argue that reports of the death of the middle managerial role had been exaggerated (24-26). Since then, there has been considerable research into the role of middle managers in organisations. Wooldridge et al (13:1191), in a review of this literature, argue that: 'that middle managers are central to explaining key organizational outcomes', and describe their research as taking a 'middle management perspective'. In the following sections research which takes this perspective will be reviewed in more detail

2.4 Middle managerial work

One strand of the literature relating to middle managers takes an instrumental view, asking detailed questions about what it is that middle managers actually do, and trying to relate this to the firm's performance. Mintzberg (27) undertook the pioneering studies in this field, using structured observation and diaries to delineate hour-by-hour the work done by managers. Thus, for example, a typical observation sheet would record 'telephone call from x, purpose y, duration 0.5 hrs'. Hales (28) summarises this work, categorising managerial 'jobs' as falling into the following categories:

- Figurehead or representative of the relevant 'work unit'
- Monitoring the work unit and disseminating information to the work unit
- Networking inside and outside the organisation
- Negotiating 'up' with senior managers and 'down' with subordinates
- Planning work
- Allocating resources
- Work relating to human resource issues
- Directing and monitoring subordinates
- Problem solving
- Innovating
- Work relating to the manager's area of technical expertise

Overall, Hales argues that much of a manager's time is spent in the more or less 'routine' maintenance of the work system, ensuring that things 'flow' smoothly. Managerial work is, according to Hales:

- Interrupted and fragmented
- Dominated by verbal rather than written communications

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- Characterised by considerable tension and pressure

Furthermore, managerial work has indeterminate boundaries, and in practice managers tend to have discretion as to where these boundaries are drawn. O'Gorman (29) concurs with these findings, studying managers in small firms using Mintzberg's detailed methods and concluding that, 30 years after Mintzberg's classic studies, much managerial work remains indeterminate, chaotic and un-planned. Tengblad et al (30) used Mintzberg's structured observational methods to investigate the progress made by the so-called 'new managerialism' introduced in the 1990s, under which employees in downsized and de-layered organisations were supposed to be 'empowered' to devolve responsibility for the performance of their work group to their subordinates. Tengblad et al conclude that, in fact, in spite of the rhetoric of 'empowerment', middle managers felt no incentive to devolve responsibilities because they perceived that they would still be held to account for the results; devolution carried risks but few advantages. Top managerial rhetoric about a new paradigm of 'empowering' employees to act within an overall 'vision' set out from the top was therefore not borne out in practice. Thomas and Dunkerly (31) concurred with this. Studying middle managers who had survived the down-sizing of the 1990s, they found that their work had intensified, with a move towards adopting the role of 'co-ordinator' rather than as 'technical expert'. However, they had not devolved responsibility down to their subordinates, generally because they felt themselves to be subject to intensified regimes of performance management in which failure by 'empowered' subordinates would nevertheless be laid at the door of the supervising manager. Furthermore, career progression was seen to have worsened. In spite of these negative perceptions, surviving middle managers did, however, remain positive about their jobs, citing a sense of achievement associated with both 'surviving' and meeting difficult targets. Finally, Ashmos et al (32) undertook a large survey, the results of which suggested that measures of organisational efficiency increased if middle managers reported that they actively participated in decision making. The authors speculate that this may be due to the increased opportunities for networking that such activity provides.

In summary, therefore, the managerial literature sees the work of middle managers as fragmented, reactive and largely centred around verbal communications. Furthermore, although the 1980s and 1990s were characterised by powerful rhetoric about the 'empowerment' of front-line employees and the need to move away from top-down bureaucratic management, in practice life as a surviving middle manager changed little, with a continued perceived need to closely supervise subordinates in order to meet performance targets, and an intensification of work-related pressure.

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2.5 Middle managerial roles

'Role theory' is a significant strand in the managerial literature. Much of this work was pioneered in the 1970s by Katz and Kahn (33), who identified individuals as occupying defined 'roles' within organisations. However, these roles were not straight-forwardly related to job titles or to formal job descriptions. They concluded that a number of factors influence the actual behaviour of a manager in a given role. Firstly, there are the formal requirements of the role as set out in job descriptions. Secondly, members of an organisation have *expectations* of how a particular role will be performed. These expectations are influenced by past experience of how the role has been filled and by what is sometimes called 'organisational culture' – ie internal expectations about 'the way things are done' (34). These expectations are communicated to the role occupant via social interaction; Katz and Kahn call this 'role sending'. Thirdly, role performance is influenced by the personal characteristics of the role holder, and finally feedback occurs as role expectations change in response to interactions between the role holder and his/her colleagues. It is thus clear that 'role performance' is the outcome of complex social interactions, within an institutional context that is itself the outcome of ongoing interactions both within the organisation and with the surrounding social context (35 p31).

March and Olsen (36) argue that institutions are in part defined by the 'collections of interrelated rules and routines that define appropriate actions in terms of relations between roles and situations'. In other words, internalised norms and values allow individuals to determine, in any given situation, how a particular role should be fulfilled. They go on to talk about the existence of a 'logic of appropriateness' that shapes individuals behaviour within role, and argue that this is determined by the norms of the institution. Hales (37) argues that moves away from large, bureaucratic organisations towards more fluid or 'networked' organisational forms (38) were supposed to be associated with a greater fluidity of role, as rules and operating procedures were replaced by management based upon trust of 'empowered' employees, who had absorbed and internalised notions of appropriate behaviour in their role. However, in practice 'entrepreneurial' behaviour by employees was rarely empirically observed, and Hales explains this with reference to the role-related norms of behaviour noted by Katz and Kahn. Thus, according to Hales, when rules and rigid hierarchies disappear, ambiguity increases, and managers tend to fall back upon expected behaviours, enacting the role of 'manager' in the way that they have come to understand it as being constituted within that organisation, reducing the ability of the organisation to change.

Erera (39) focuses upon this 'role ambiguity', arguing that, within an American public welfare context, constant changes in policy and subsequent imposition of new regulations that appeared irrelevant to the work context, and unclear performance expectations combined to generate ambiguity and to consequently undermine performance. In a detailed ethnographic study

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of call centre managers, Houlihan (40) used ethnographic methods to study call-centre middle managers, and found that they are very aware of the structural constraints within which they work, managing their work and their subordinates in order to manage the conflicting demands between their perceptions of what top management require of their role and their understanding of what their role can deliver. Mantere (41) describes this as 'enacted role', and in a report of a large interview study of middle managers draws attention to the importance of individual middle managerial agency in determining how a particular role is enacted by a particular middle manager within a given social setting. Echoing Katz and Kahn, he argues that middle managerial agency in this process can be either constrained or enabled by the role expectations that top managers have of their middle managerial colleagues, and goes on to classify the ways in which the behaviour of top managers acts upon middle managers .

McConville (42) studied middle managers in three public services (the NHS, the Fire Service and the Army), and coins the term 'role dissonance' to describe the conflicts between middle managers' desires to act as 'empowered employees' and take ownershjp of new aspects of their role, and the constraints upon them in terms of time, work capacity and personal/professional values. McConville argues that 'role dissonance' is related to other concepts from role theory, such as role conflict (when individuals receive conflicting messages about the nature of their role) and 'role ambiguity', but is distinct from them. He argues that 'role dissonance' is similar in nature to the concept of 'cognitive dissonance' used by psychologists, and suggests that the distinctive feature is the involvement of moral confusion, as middle managers seek to reconcile what they are required to do with their professional values. This 'dissonance', he argues, is a distinctive feature of the 'middleness' of middle managerial roles, caught between the day to day demands to keep the organisation running smoothly and the need to innovate and expand their role in order to meet performance targets. Lacking the authority to make significant changes to the demands upon them, middle managers in their study experienced increased work-related stress. Currie and Proctor (43) identify both role conflict and role ambiguity as significant in the lives of middle managers trying to deal with change in the UK NHS. Conflicting 'cues' about the nature of their roles, combined with uncertainty about how they should adapt to meet demands from the Department of Health for a 'business-like' approach by managers to cause 'disillusionment, disaffection, reluctance and paralysis' (43 p1347) amongst middle managers. Furthermore, 'role transition' to a new role was in part impeded by the fact that many of the middle managerial staff involved were doctors or nurses by training, with a strong prior socialisation as 'professionals', who were able, at least initially, to resist a transition to a more 'business-like' approach. Bolton (44) uses Goffman's ideas of 'role analysis' in a study of nurses acting as middle managers, introducing the concept of 'role distance' to describe the 'enactment' of a role whilst remaining personally emotionally distanced from

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the 'virtual self' implied by that role. She suggests that the nurses that she studied embraced aspects of their new middle managerial roles, but maintained an emotional distance from those aspects which conflicted with their internal professional values. She concludes that the 'project' to 'socialise' nurses as managers prepared to adopt a managerial role and to manage their peers has been only partially successful.

In summary, 'role theory' suggests that individuals within an organisation or an institution enact roles. These enacted roles are the product of a complex interaction between social context, institutional rules and norms, the expectation of others and the agency of the manager concerned. Conflicts arise when there is an incompatibility between aspects of a role, ambiguity as to what a role should involve and dissonance between organisational expectations and an individual's own sense of what is right. Middle managerial roles have been explored by a number of researchers, and it has been suggested that: middle managers may be particularly exposed to role dissonance and role ambiguity because of their position in the 'middle' of an organisation; they must balance conflicting demands and structural constraints; their role enactment and ability to demonstrate agency will be constrained by the actions of their superiors; and they may enact a particular role whilst maintaining an 'emotional distance' from the 'self' that this implies. It is suggested that this latter may be a particular feature of middle managerial roles occupied by professionals required to adopt roles managing their peers.

2.6 Middle managers' role in strategy

A central concern of literature relating to the role of middle managers is the question as to how far they are able to influence the overall strategy of an organisation. 'Strategy' is defined by Quinn (45 p5) as: 'the pattern or plan that integrates an organization's major goals, policies and action sequences into a cohesive whole'. This definition embodies a number of rationalistic assumptions. In many ways this literature can be seen as a sub-category of the literature relating to role theory, focusing upon the role that middle managers play with respect to organisational strategy, with 'strategy' defined in a rather limited and rationalistic manner. The traditional view of middle managers, and the one prevalent in the drive towards downsizing and delayering noted above (18), is of middle managers as implementers of strategy that is decided by senior managers; the view of middle managers as 'blockages' to strategy implementation (46) that needed to be removed is the other side of this coin (47). Nielsen puts it thus:

> *'The role of middle managers is not strategy, but implementation of strategy; not to define the direction of the company but to translate it into something of relevance for a smaller unit of the company; not to choose direction and define organizational context but to interpret a chosen direction and defined context, inside and outside the organization, to have*

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the employees perform in a matter that complies with the goals of top management. For executives, the aim is not to have too much lost in translation.' (48 p47)

However, Wooldridge et al (13) argue that this characterisation is simplistic, ignoring the many ways in which middle managers can affect strategy. In a review of research focusing upon the role of middle managers in the strategy process, they give three reasons for focusing organisational research on the role of middle managers (p1191). Firstly, they argue that, with an 'intermediate position in the organisation, middle managers provide an important link between 'otherwise disconnected actors and domains'; secondly, modern, distributed organisations cannot be led by single actors or small groups of actors, requiring a more distributed model of leadership; and finally, they suggest that, by virtue of their closeness to the operational level, middle managers have a clearer view of the link between organisational activity and organisational performance. They characterise this literature as 'fragmented', with many authors identifying similar concepts, but using different terminology and failing to build upon each others work. Furthermore, they identify some difficulties in clarifying who exactly is a 'middle manager' in this context, and suggest that it is not necessarily clear what relevant outcomes might be in such research. However, they go on to argue that: 'the advantage of this [middle management] perspective stems from its potential to advance our understanding of the organisational processes underlying strategy formation in complex settings' (p1192). From this viewpoint, strategy formation does not proceed by those at the top of the organisation making rational choices about strategy; rather, it is seen as a social learning process, whereby interactions between actors within social settings generate strategic action. Given the fragmented nature of this literature, it is difficult to impose a clear analytical framework. Furthermore, studies that Wooldridge et al identify as taking a 'middle management perspective' take a variety of different theoretical perspectives, from what they define as a 'functionalist' approach (and which we have called here an 'instrumental' approach) that seeks to define the way to maximise 'effective' strategy (49), to a more interpretative stance that seeks to understand the lived experience of middle managers as they 'do strategising' (43). However, Wooldridge et al identify three broad topics in this body of research that provide a platform for further exploration: strategic roles of middle managers, and the factors that affect them; middle managerial cognition, its influence on strategy and the ways in which is influenced by strategy processes; and the impact of middle managerial activity on organisational outcomes.

In the first of these categories, some of the earliest work was done by Floyd and Wooldridge (50), who identified a typology of ways in which middle managers might influence strategy. Firstly, they may influence managers above them, by either *synthesising information* or *championing alternatives.* The former activity involves gathering information from within and without the organisation, and passing it upwards to senior managers; the latter

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involves searching for new opportunities, evaluating proposals from subordinates and proposing new programmes. Secondly, they may influence strategic activity downwards, by either *facilitating adaptability* or *implementing deliberate strategy.* The first of these involves providing an environment within which experimental or new programmes can be tried out and evaluated; the latter includes the traditional role assigned to middle managers of deliberately implementing goals determined by the senior management team. Subsequent authors have built upon this work with, for example, Dutton et al (51, 52) using the phrase 'issue selling' to cover similar concepts to those covered by the term 'championing'. According to Woolridge et al, these authors suggest that: 'how issues are packaged or framed, who is involved in the selling effort, the process used, and the timing of a selling effort all have a significant impact on the effectiveness of issue selling.' (13 p1203). Taking a functional and instrumental view, and focusing upon the role of middle managers in implementing deliberate strategy in a large firm, Huy et al (53) discuss they ways in which middle managers can work to maintain 'the emotional balance of individuals in the company and [attend] to emotion-management activities so that employees continue to be productive during radical change' (p31). Beatty and Lee (49) focus upon middle managerial leadership styles in three computer-aided design companies, arguing that a 'transformational' approach' which focuses upon encouraging and inspiring staff is more successful in a situation of technological change than a 'transactional' one which focuses upon technical issues.

Examining the factors that affect the role of middle managers in strategy, Marginson (54), focuses upon the role of top managers, investigating the control systems used to influence the behaviour of middle managers in a single large firm. He identified three types of control: values-based, in which senior managers sought to set out an overall vision for the company which provided a cultural control; administrative controls, whereby systems were set up that would enable entrepreneurial activity by middle managers; and performance management controls, with the development of key performance indicators. In the case study, the first two of these were seen as successful in introducing climate in which middle managers were both aware of the overall strategic direction of the firm, and felt empowered to act on their own initiative. The last, however, were seen to introduce conflict and tension. Mantere (41) similarly focused upon conditions imposed by top managers which affect middle managerial strategic agency in a very large study involving more than 250 interviews. He identifies eight of these conditions: narrating the origins of current strategy; explaining the context within which the strategy has arisen; allocated resources to the implementation of strategy; respecting the work done by middle managers; trusting middle managers to act autonomously; responding appropriately to information passed upwards by middle managers; including middle managers in strategy discussions; and making explicit judgements about the value of ideas passed upwards by middle managers (refereeing). Mair

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and Thurner (55) interviewed all the middle managers in a medium sized firm, and concluded that they varied in the degree to which they felt that they were able to influence strategy, with those who held revenue accountability more likely to report that they were able to influence strategy. In the health field, Carney (56) studied middle managers in the Irish Health Service, and concluded that organisational structure is important, with an overly hierarchical system with multiple layers of management acting to exclude middle managers from strategy making and to generate alienation. In a later paper based upon a large survey (57), she argues that 'organisational culture' is also important, suggesting that respondents who identified a strongly positive organisational culture with an emphasis on commitment to good quality patient care were more likely to report significant involvement in strategy formation. However, this study raises questions as to the direction of causality: it is possible that these results simply reflect the fact that managers who feel themselves to be involved in strategy (whether this is actually the case or not) are more likely to report that the organisation has a strongly positive culture. Overall, whilst this literature raises some interesting questions about the role of middle managers in strategy, much of the evidence relies upon asking middle managers about their perceptions of influence on strategy; this is, of course, not the same thing as actually exercising an influence. Schilit (58) tried to overcome these limitations using diaries kept by middle managers over a two month period, in which they were asked to keep a record of their interactions with their superiors and their perceived influence on strategy. He found that 'upward' influence of the kind identified by Wooldridge and Floyd was more likely to be successful: in situations identified as 'less risky' for the organisation; if the middle managers had a long term relationship with their immediate superior; and if they had particular personal characteristics, such as a desire for power.

A significant strand of research examines the micro-processes by which middle managers may be seen to act in the strategic process. Rouleau (59) uses theories of sensemaking (60) to examine how middle managers in a clothing company interpret and sell strategic change to key stakeholders. She identifies four micro-practices of sensemaking at work: translating the orientation, overcoding the strategy, disciplining the client and justifying the change (these concepts are discussed in more detail in section 8). These tactics were used by the middle managers in the study in a sophisticated way to ensure both that the message given was appropriate for the audience, and that the change was justified in a way that was in keeping with the client's wider objectives. This draws attention to the key role of middle managers in interacting with the external world, both bringing ideas back into the company, and ensuring that the company's self-presentation is functional and appropriate to the context. Lassen et al (61) confirm this, exploring the role of middle managers in a changing strategic context in a small firm, and arguing that the managers they studied were engaged in 'translating' information from the external context in a way that was

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meaningful for those inside the organisation. This required not only an understanding of the external context, but also a thorough understanding of the internal context as well.

The second category of research identified by Wooldridge and Floyd (13) involves what they call 'middle management cognition' (p1205). Much of this research again takes an instrumental approach, starting from the position that: 'unless middle-level actors understand and are committed to top management's strategic goals, they are unlikely to support strategy implementation, and no amount of top management agreement will lead to effective strategic change' (p1206). In an early study, Wooldridge and Floyd (62) found no correlation between consensus between middle and senior management about organisational goals and organisational performance, but found that if managers felt that they were uninvolved with strategy there was both less consensus about goals and poorer organisational performance. Laine and Vaara (63) used a discourse analytic approach to unpick this finding further, identifying a 'discursive struggle' between senior and middle managers in which strategic discourses are used both to assert and resist hegemony and as part of strategies to maintain viable organisational identities (see below). Later research in this strand has moved away from a purely functional emphasis on improving strategy by generating consensus, to explore the microprocesses involved in the development of individual and shared cognitions about organisational strategy using interpretative and critical theoretical approaches. Thus, for example, Balogun and Johnson (64) used the concept of sensemaking (60) to study interactions between middle managers in a situation of strategic change. They explored the ways in which interactions between middle managers in different sub-units of the organisation contributed, over time, to a reassessment of the change with subsequent adjustments in behaviour to make things work more smoothly. This highlights the importance of internal lateral interactions between middle managers, in addition to the external and vertical interactions discussed above.

Finally, Wooldridge and Floyd (13) identify a strand of research that focuses upon the link between managerial activity and organisational outcomes. In some ways this strand mirrors the literature identified above as focusing upon managerial *work*; questions commonly addressed include, for example, investigations of the impact of particular middle managerial behaviours on organisational financial performance (50). Whilst much of this literature identifies positive impacts of middle managerial behaviour (65, 66), some points back to the prevailing view of the 1980s of middle managers as employing 'blocking' behaviour (46).

In summary, therefore, this literature suggests that middle managers may influence strategy in a variety of ways, including both upward effects on senior managers and downward effects on their subordinates. There is some evidence that effectively involving middle managers in the strategy process can positively influence organisational performance, and that excluding

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them may generate negative outcomes and disillusion. Conditions that promote middle managerial strategic influence include: positive encouragement from senior managers; long term relationships between middle and senior managers; an organisational environment that encourages innovation; lateral interaction between middle managers; engagement of middle managers with the external environment; and the personal characteristics of the middle managers involved.

Much of the literature discussed in this section takes an atheoretical or implicitly instrumental approach, but some authors have looked at questions of middle managers and strategy from an interactionist or social constructivist viewpoint, investigating how strategy is realised in the social interactions that those who espouse this approach would argue combine to constitute 'the organisation'. This work has much in common with the idea of 'identity work' discussed below, and many of the concepts and approaches used (such as identity, enactment, sensemaking and discourse analysis) overlap. It will therefore be discussed in more detail in section 2.7 below.

2.7 Middle managerial identity and identity work

The categories of literature discussed so far suggest a view of middle managers that focuses upon what they do and how they do it. However, theories relating to roles in organisations have been criticised as being 'deeply rooted in functionalist assumptions of determinism and stability', too concerned with fixing what a role 'is' to be able to engage with the fluidity and change inherent in the modern organisation (67). Simpson and Carroll (67 p15) argue that: 'the concept of 'role' 'has been superseded by issues of identity and subjectivity which…. allow for a more dynamic and multi-faceted treatment of organizing'. These authors see an actor's 'role' as something that they adopt, change or discard in the process of identity construction, which is itself an ongoing and changing project, and argue that 'role' should be conceived of as a 'boundary object' (68) that offers a site for the negotiation of identity between different actors in an organisation, and for an individual exploring multiple potential identities. From this perspective, 'role' should be seen as something that an individual uses as they undertake 'identity work'. Sveningsson and Alvesson (69 p1165)) argue that 'identity work' refers to 'people being engaged in forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness'. Situations of organisational stability will give rise to the need for less identity work than situations of change or complexity, and, faced with a puzzling or difficult situation, at least part of a manager's response will be directed towards maintaining a coherent sense of self within the organisational context. Alvesson et al (70) survey the literature relating to identity within the discipline of organisational studies, suggesting that, whilst they believe that a focus upon identity within organisations can provide valuable

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theoretical and empirical insight, it is important to be aware that theoretical concepts such as this may be subject to the vagaries of fashion: the 1970s and 1980s were characterised by a focus upon roles and role theory, whilst subsequent 'fashions' in organisational studies have included 'organisational culture' and 'leadership'. Moreover, it may be the case that phenomena now attributed to 'identity' could equally well be explained using some of these earlier theoretical frames. Nevertheless, they conclude that identity – and more particularly, 'identity work' – provides a valuable theoretical lens through which to view the work of managers in organisations.

Alvesson et al discuss the different approaches to identity present within the literature. They identify three broad approaches: identity as a managerial resource, with the instrumental aim of improving outcomes; identity as a manifestation of organisational culture, of interest in itself regardless of any instrumental concerns; and a more critical approach, locating identity within a discourse of control and resistance, such as ideas about the 'governance of the self' (71) and adoption of an entrepreneurial identity prevalent in many modern managerial texts. In addition, Alvesson et al address the interaction between 'personal' and 'social' identities, arguing that it is most useful analytically to regard these two types of identity as being interlinked. Personal identity is fashioned by social interaction within a social context, with the question 'who am I?' implying 'who am I within this social situation?' Finally, Alvesson et al summarise three broad strands of literature that uses the notion of identity. Firstly, 'social identity theory', which they argue presupposes a relatively stable identity, defined by individuals' perception of how far they belong/do not belong to particular social groups or identify with the organisation in which they work. Secondly, they identify theories relating to the notion of 'identity work' as a particularly rich seam, with researchers using this approach asking questions about the processes by which individuals construct 'an understanding of self that is coherent, distinct and positively valued' (70p15). Such 'work' is particularly triggered in situations of change and stress, and provides a theoretical link between personal and social identity, as actors use social interaction as raw material with which to fashion an identity that enables them to be and to act within the organisation. Finally, they draw attention to studies which take a more critical approach, focusing upon the role of 'organisational elites and discursive regimes in orchestrating the regulation of identities' (70p16).

From this discussion it can be seen that the concept of 'identity' provides a theoretical lens which has the potential to both structure research and to make sense of empirical findings. Not surprisingly, this approach has been used in a number of studies of middle managers in a variety of contexts. In a large study of middle managers in a variety of industries, Dopson and Neumann (22) use data from 37 semi-structured interviews to assess what they call changes to the 'psychological contract' between middle managers and their organisation in the type of situations of 'down-sizing' and change discussed above. Whilst not focusing upon 'identity' per se, they argue that

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middle managers have experienced a change whereby they are less likely to be valued for their technical skills and more likely to be seen as 'generic managers', leading a team. Furthermore, whilst: 'holding one's 'real self' outside of the organization used to be expected; now it is considered undesirable to the survival and success of the company.' (22 pS62), with ideas of personal identity becoming inextricably linked with work identity. Holden and Roberts (72) also looked at the context of middle managerial 'depowerment', undertaking interviews with middle managers in public and private contexts in the UK, Sweden and the Netherlands. They identify managers as 'squeezed' between the demands of senior managers and the needs of those that they manage, and argue that middle managers need to establish a 'self-identity' because they feel remote from the identity of the organisation as a whole. However, the organisations involved in this research were all large (banks, hospitals and a large multinational corporation), and it seems possible that this remoteness is less an aspect of 'middleness' (as these authors argue) than it is of organisational size.

Taking an approach that could be said to fall into the more critical stream identified above, Beech (73) undertook a longitudinal ethnographic and interview study of middle managers at work in a cultural organisation. Focusing upon a particular manager in a situation of change, he argues that discourse between social actors is an important mediator of identity work. Individuals engage in dialogue with those inside and outside an organisation, incorporating narratives that 'fit' into their sense of self, whilst rejecting those that they do not like. In the organisation studied (a cultural organisation devoted to the management of artistic events) there was a conflict between the managerial identity espoused by the middle manager concerned and the identity desired by the more senior management. Attempts were made using dialogue to try to induce change in the manager's approach, but he remained wedded to the 'not-a-manager', artistic identity that he espoused as a result of his interactions with the artists with whom he worked. Eventually, change was brought about abruptly by a decision to remove some of the manager's responsibilities, something which he experienced as very negative and threatening to his sense of self. The author goes on to identify a number of factors which seemed to affect (in ways which could be either positive or negative) the potential of an individual to change his/her work identity. These included: emotional factors – how close the emotional engagement was between the actors concerned; cognitive factors, including rational arguments about the relative merits of different 'ways of being'; power dynamics, including both covert and overt aspects of power; and narrative forces, with the way in which narrative is used to construct (alternative) identities identified as having an impact on how the alternatives are perceived or adopted.

Currie and Brown (74) also focus upon 'narratives' as constituent of work identities, in a case study of middle managers in a UK hospital. They identify opposing narratives of change espoused by middle and senior managers, as the hospital senior management attempted to introduce a

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more ‘business-like’ way of working, using management consultants as facilitators. An initial polarisation, with middle managers actively resisting change, was followed, over time, with an accommodation as the opposing narratives were modified to take account of alternative view points. Contrary to the critical management studies discourse of senior managers manipulating or regulating middle managers using covert or overt forms of power, in this study senior managers listened to their middle managers’ narratives and modified their approach to take account of their objections. Both middle and senior managers reported a softening of stances, with moves towards a shared narrative identity as being ‘only here for the good of the patients’.

Taking a social constructivist approach, and seeking to understand managers’ experiences within organisations rather than to point the way to greater efficiencies, Watson (75) used the notion of ‘identity work’ in a study of middle managers. He takes used ethnographic and interview methods to examine at a micro level the experiences of two managers within an organisation. He conceptualises ‘identity’ as inherently unstable and as a source of conflict, introducing the notion of the ‘looking-glass self’, by which individuals shape their self presentation by how they imagine others see them, whether these ‘others’ are present or not. He goes on to identify five ‘ideal types’ of social identity: social category, including, for example, identities such as gender, class etc; formal role, including occupation role or rank; local-organisational identities, such as, for example, a ‘Boot’s pharmacist’ or, in the example from Currie and Brown above, ‘an NHS employee’, acting for ‘the good of the patients’; a local-personal identity, such as ‘the office clown’ or ‘the team’s provider of cakes’; and cultural stereotype, such as ‘a boring accountant’, or ‘a devoted mother’. Watson argues that managers doing ‘identity work’ as defined by Sveningson and Alvesson (69) draw on some or all of these different types of identity. In his subsequent case study of two middle managers, he identifies one of them as experiencing a conflict between the need to be comfortable with and to use bad language and aggressive speech in interacting with other managers in order to be taken seriously, and his natural personal identity as a mildly spoken man who dislikes ‘bad language’, particularly in front of women. He was seen to be particularly uncomfortable in meetings with women present, and Watson argues that the manager is undertaking ‘identity work’ in order to adopt a work identity that is at odds with his personal identity. Within the meetings there was a conflict between his ‘local-personal’ social identity as a gentleman who moderated his language in front of women (itself a cultural stereotype) and his local organisational role as a ‘good manager’ who could have a robust discussion of the issues.

Although they do not use the same categories as Watson, Thomas and Linstead (14) also identify middle managerial conflicts between different aspects of their identity. In a series of case studies which again take a social constructivist approach, they discuss in detail the experiences of four

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middle managers who all described a 'fragile' middle managerial identity (14 p77). One manager, whose organisation was restructuring in the ways discussed earlier, had seen his identity changed from that of 'expert' in a particular field to that of 'team leader'. He felt unclear as to what was expected of him in his new role, and used the interview with the researchers to try to define and redefine what it mean to be a 'middle manager' in his new context. A second manager described herself as a 'lucky imposter', having come into the organisation from the outside. She saw herself as juggling the identities of 'middle manager' and 'wife and mother', and felt that the fragile equilibrium she had built up might collapse at any time and she would be 'found out'. A third manager who worked in the NHS, (like those studied by Currie and Brown (74)), felt a strong identification with the organisation, but felt torn between a 'public service' identification learned from years in the job and the new 'managerial' discourse prevalent since the late 1990s. A final manager in a large organisation felt a strong identification with the organisation, but experienced the restructuring as indicating that middle managers were 'expendable'. Overall, Thomas and Linstead identify middle managers as holding a tenuous sense of identity in difficult situations of ongoing change. They conclude that managerial identity work consists of an ongoing search for legitimacy or stability, in which personal discourses of self need to be comfortably situated within the overall social structure of the company.

Mischenko (76) also focuses upon the 'struggle' involved in middle managerial identity work. As a middle manager in the UK NHS, she uses autoethnography to explore her search for a manageable managerial identity. Her story describes attempts to 'play' at resistance, in the face of perceived pressure to absorb managerial and entrepreneurial discourses and to enact an appropriate 'self'. The 'self governance' that results suggests a subtle form of managerial control. McDonald (77) found similar pressures affecting NHS middle managers in an ethnographic study of a newly formed Primary Care Trust. Commentators have argued that, since the late 1990s, public service organisations in the UK have taken up many of the themes addressed by private sector management a decade earlier. Focusing upon 'lean' management, with 'empowerment' of 'entrepreneurial'employees who are personally accountable for outcomes (78), the 'New Public Management' agenda (79) was enthusiastically adopted across the NHS, with calls for the 'modernisation' (80) of presumably outmoded institutions. Within McDonald's study site, this agenda was manifest in the recruitment of those middle managers nominated by their peers as 'influencers' to attend a training programme designed to 'empower' them to champion change within the organisation. Resistance was limited, with the course attendees accepting a characterisation of problems within the organisation as being due to 'deficient employees' rather than the environment. The majority attending the course internalised the need to develop an 'empowered' identity that only expressed positive opinions about the PCT, eschewing any 'negativity'

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that was equated by senior managers with being 'not grown up'. A small minority expressed resistance, and McDonald comments that this group tended to locate their expressed identity outside the PCT, arguing that they were working for 'the community' or 'our patients' rather than the PCT. Proctor et al (81) delineate some of the factors preventing middle managers in an NHS Community Trust from adopting an 'empowered identity', including some structural problems, such as lack of money, as well as more subtle issues including a perception of mixed messages from senior management. However, they are a little more positive than McDonald, suggesting that some middle managers had been able to use the 'empowerment' rhetoric to seize opportunities and to expand the scope of their roles. Harding (82) expresses a negative view of managerial identity work within the NHS, arguing that the 'project' to enact an identity as a 'rational and organised manager' within a large and unwieldy organisation such as the NHS is 'doomed' by the contradictions inherent in the nature of the work involved.

Halford and Leonard (83) take a different view, using discourse analytic techniques to explore the experiences of doctors and nurses in the NHS, including those with middle managerial roles. They suggest that the very size of the wider organisation allows staff to move between local NHS units until they find one that 'fits' their espoused identity. However, repeated NHS reorganisations and increasing numbers of national managerial performance targets such as those associated with 'World Class Commissioning' (5) suggest that the variability necessary for this to be a viable strategy for individuals to pursue is unlikely to endure.

In summary, this literature suggests that senior managers within the NHS seek to align middle managers' identities with those desired by the organisation, with an overall pressure to adopt entrepreneurial or empowered 'ways of being'. Outside the NHS, Nielsen (48) gives us some insight into the ways in which this might be achieved on the ground. Using conversation analysis, Nielsen examined discourses which took place in meetings in a large multinational organisation. She found that middle managers at all levels regarded it as their role to 'interpret' what was said within the context of the organisation as a whole, picking up utterances made by their junior colleagues and translating them into meaningful categories within the context of the organisation. Junior employees apparent 'misinterpretations' were corrected, and they were coached to use the correct organisational vocabulary. Nielsen concludes that 'organisational talk' is vital in the generation and transmission of meaning within organisations. This is consistent with McDonald's (77) finding that employees were coached to police their own talk to ensure that only positive messages about the newly formed organisation were conveyed.

Finally within this category of literature, there are some studies which, whilst not explicitly using theories of identity, cover some of the same territory and posit an opposition between a professional, clinical identity and

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a managerial one. In many ways the traditional opposition between doctors, self identified as 'only interested in the good of our patients', and managers, identified by others as 'only concerned with the bottom line' has a cartoonish quality, but it remains present in the literature, with, for example, several readers of the British Medical Journal responding to the question 'what to cut [in the NHS]?' with a vision of an NHS freed of the blight of managerialism (84). Hewison (85) interviewed managers and clinicians in the NHS, and suggests that the core values that motivate managers and clinicians are fundamentally different, and that clinicians who become involved in management will be seen to have 'gone native' by their colleagues. However, in more detailed discussions of their actions, managers were found to also believe that they were working for the benefit of patients, and, whilst Hewison does not use the term 'identity work', he suggests that managers seek to rationalise difficult decisions that they must make in terms of the 'greater good' of patients. Forbes and Hallier (86, 87) interviewed 18 doctors working as managers, and identified a clash between 'managerial' and 'clinical' identities. They identified two groups of clinicians, which they termed 'reluctants' and 'investors', with even the latter becoming disillusioned over time, as they were asked to act in ways that they felt would compromise their clinical values. The authors conclude that clinician-managers needed time and training to enable them to develop a 'managerial self' (p174). Using social identity theory, they argue that 'investors' and 'reluctants' differed in how far they saw the category 'manager' as a high status social grouping that it was worth their while to join. However, this theoretical approach sees social categories as relatively fixed and unchanging; the fluctuating reality observed in the study (with clinicians 'talking up' or 'talking down' their affiliation to the managerial world over time) would seem to lend itself more readily to an explanation based upon these doctors engaging in ongoing identity work over time. It seems likely that the personal conflict that the authors noted in their interviewees is a further case of the uncertainty and fluidity surrounding the middle managerial identity that was noted earlier, perhaps in a more pronounced form as a result of the heavy investment made by clinicians in their 'clinical selves' (88). According to Carroll and Levy (15), such a strong existing professional identity could be termed a 'default identity', with the new, more managerial identity an 'emergent identity'. These authors suggest that managers faced with adopting a new identity such as this must undertake extensive 'identity work' in order to establish a relationship between the two identities that can be sustained: 'In other words the emerging and desirable identity is embedded and intertwined with a default identity.' (p81). Bolton's (44) finding that nurse managers hold something of their 'real self' apart from their managerial role (or identity) suggests that this process is not always successful.

In summary, there is a significant body of literature that focuses upon the notion of managerial identity. The topic has been approached from a number of different theoretical viewpoints and by researchers from a

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variety of different traditions. The literature holds in common the notion of the existence of a 'social identity' which arises out of the interaction between a personal identity and the particular social context in which the individual finds him or her self. Where those from different theoretical traditions differ is in how far this identity is seen as fixed or stable, and how far it is regarded as fluid, changeable and the site of ongoing struggle. The notion of 'identity work' captures this more dynamic view. Within the NHS, there is evidence of attempts by senior management to encourage employees to adopt an 'empowered' or 'entrepreneurial' identity, with differing views as to how far this is seen as positive or as coercive depending upon the theoretical tradition espoused. Throughout this literature, discourse and the exchange of narratives and stories are seen as important tools in the ongoing project to establish and maintain identities. Finally, there is some evidence that clinicians who adopt managerial roles must do identity work in order to reconcile their new managerial identity with their traditional professional identity.

2.8 Microprocesses of middle managerial work

2.8.1 Strategy-as-practice

Cutting across several of the categories of literature listed above is a significant thread that focuses upon the microprocesses by which middle managerial work (including identity work) is accomplished. Coming from a largely social constructivist theoretical background, this work aims to explore the interactions between human agency, human action and the wider social context, focusing particularly upon 'explaining who strategists are, what they do and why and how that is consequential in socially accomplishing strategic activity' (89 p19). This work therefore is often exploratory, more concerned with understanding the reality of managerial lives and work than with explicit efforts to improve organisational function (90), although researchers from this tradition argue that a better understanding of how organisations work by those at the top of the organisation may well deliver improvements in overall function, particularly if it prevents actions or activity that is likely to be counterproductive. Much of this work can be categorised as belonging to the field of 'strategy-as-practice' as addressed by a growing community of scholars (http://www.strategy-as-practice.org/, accessed Oct 2010). Two points should be made here. Firstly, not all of the research that will be discussed self-consciously identifies itself as part of this tradition. However, it has been included because of the concurrence between the ideas explored and those addressed by this community of scholars. Secondly, whilst 'strategy' might seem to be a relatively limited field of organisational research to address (ignoring, as it seems to do, operations, personnel, finance, structure etc) the definition offered by the strategy-as-practice community is extremely broad: 'activity is considered strategic to the extent that it is

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consequential for the strategic outcomes, directions, survival and competitive advantage of the firm, even where these consequences are not part of an intended and formally articulated strategy' (89 p8). By this definition, much that goes on within an organisation will have 'strategic' consequences, and so is considered to be 'strategising', even though it is not formally defined as such nor rationally calculated to that end. The very breadth of this definition opens up much organisational activity to scrutiny, and the focus on *practices* liberates the researcher from a priori assumptions about whose role is or is not considered to be 'strategic'. It also provides a theoretical framework within which to address the question which can bog down middle managerial research, namely: 'do middle managers affect strategy?' by offering the answer that they do if their practices have strategic effects. By this definition, deliberate, top-down strategy embodied in mission statements and strategy documents is a limited and slightly unusual special case. Finally, it is worth considering methods and methodology. Taking the definition given above, it is clear that researching microprocesses or practices within organisations cannot depend solely upon interview evidence, and that survey evidence will have little role to play. Whilst the detailed stories that people tell about their work and their working lives provide valuable sources of data, it is also important that researchers have a chance to explore work in action using observational methods (91), which allow the researcher to explore social context and interaction as well as personal accounts. Thus, most of the studies discussed here offer detailed qualitative case studies in a limited number of sites. In the section that follows, the strategy-as-practice approach will be described in more detail, followed by discussion of research that takes this type of approach to studying middle managers.

Much of what follows derives from a summary paper by Jarzabkowski and colleagues (89) which introduced a special issue of the journal Human Relations devoted to the 'strategy-as-practice' approach. In studying strategy in this way, Whittington argues that three concepts should be distinguished:

- Strategy practitioners
- Strategy praxis
- Strategy practices

Strategy practitioners are 'those who do the work of making, shaping and executing strategy' (92 p629). These are not solely those who are regarded within the organisation as having a formal role in strategy, with the term also seen as encompassing anyone who, as demonstrated by Floyd and Wooldridge (50), may influence the making or executing of strategy. Furthermore, it may also include those outside the organisation who have influence inside, including, for example, external consultants, or communities of practice with whom organisational actors are associated. What these practitioners actually do is '*strategy praxis*'. However, according to Jarzabkowski et al (89) it is important to be clear that the term 'praxis' encompases more than the micropractices of individuals. For these authors,

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praxis 'comprises the interconnection between the actions of different, dispersed individuals and groups and those socially, politically and economically embedded institutions within which individuals act and to which they contribute' (p9). This is important, because it ensures that social and political context is not forgotten, even when human activity is studied at the micro-level. Praxis may therefore be operationalised at different levels; for example, one could study NHS reorganisation at the institutional level, asking questions about the political and social context and about the ways in which change is introduced, or one could study the micro-level behaviour of those charged with making the reorganisation work on the ground. The concept of 'praxis' encompasses both of these levels, and its use enables a study to take account of both within a single theoretical frame. Finally, *strategy practices* are routinised behaviour drawn upon by practitioners as they undertake praxis. Practices may be organisation specific, or they may be social practices deriving from the wider social or societal context. Meeting routines, Gantt charts, social customs such as coffee breaks or intra-organisational systems for ordering supplies would all fall under this heading. Exactly which practices are drawn upon by actors in different or similar situations, and how these affect praxis might therefore form a focus for study. Jazabkowski et al (89) argue that research into strategising might encompass all three of these concepts, or might focus predominantly upon one. However, they are interconnected, and so cannot be considered in isolation. For example, praxis will be affected both by the practices employed and by the characteristics of the practitioners. Similarly, practitioners will be influenced by the local practices prevalent in their organisation. Strategising, they argue, occurs at the nexus between these three elements.

One of the advantages of this approach is that it makes the question of who is or is not a strategist and in what circumstances a matter for empirical enquiry. Many of the studies discussed in section 2.6 try to establish definitively 'the role' of middle managers in strategy. However, focusing upon practitioners, practices and praxis enables the full complexity of situations to be explored, so that the question becomes: 'who is strategising in this situation, which practices are used, and how does the use of these practices affect what happens?' Thus, for example, a study might establish that, in a particular firm, middle managers were generally able to influence strategy, but that women managers were less successful in doing so than men. This would then open up questions about the practices involved in strategising, with a focus upon any gendered practices which limited the ability of women to contribute. Furthermore, it ensures that less obvious contributors to strategising, such as external consultants are not ignored, as the practices associated with their involvement will affect praxis and can be studied. Thus, who is invited to meetings at which management consultants' feedback is given, who receives circulated reports and who is invited to comment will all have an impact on the nature of strategising within the organisation. Whilst much of the research that takes this

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approach adopts a micro-level focus, the definition of praxis and practices given above also opens up more macro-levels of analysis. Thus, for example, the administrative procedures in an organisation or a group of similar organisations, or the way in which documents are circulated and used can all form the basis of enquiry.

Jarzabkowski et al finally go on to discuss what they call the 'so what' question, asking 'what does this type of analysis attempt to explain?' (p14). They argue that, whilst research that takes this theoretical approach does not usually seek to measure outcomes, it is certainly possible that such research might attempt to relate aspects of strategising to some aspects of the organisations overall performance. On the other hand, relevant outcomes might be more micro-level, such as asking how a particular piece of talk-in-action accomplished its goal in a particular situation. The multi-level nature of the analysis means that different outcomes can be chosen, depending upon the level of focus. They argue: 'we suggest that strategy-as-practice research may explain outcomes that are consequential to the firm at all levels from the most micro-details of human behaviour to the broader institutional levels' (p19). They go on to suggest areas for future research to focus upon:

- Practitioners –
  - how do those outside the firm impact on strategising?
  - what are the social processes involved in middle-level managers' strategising?
- Practitioners and praxis-
  - How does the 'who does strategising' question impact upon the nature of the strategising? Eg impact of gender, impact of other functional identities?
- Practices and practitioners
  - How and why are particular practices chosen to accomplish strategising? Eg why might meetings be particularly important or unimportant in particular settings?

Chia and MacKay (93) amplify some of this, arguing for the importance of concentrating on *practices* rather than on the conscious, cognitive process of individuals. They argue that whilst, particularly in situations of radical change or organisational breakdown, OR at the 'centre' of organisations (ie top management teams), conscious strategising and cognitive processes are important, most day to day strategising is instinctive and informed by 'immanent logic' of practice:

> *Most of human action takes place through this form of mindless practical coping and it is only when a breakdown of coping occurs that we then become aware of the cognitive boundaries between the actor and the object of action. p233*
>
> *Strategy-making does not always involve the necessary formulation of goals, mental maps or plans. It may well be true that when breakdown occurs, or when routines have*

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been established, deliberate purposefulness strategizing may occur. But this is more the exception than the rule. For the most part, strategy-making on an everyday basis takes place unreflectively, on-the-spot and in the twinkle-of-an-eye. p238

They criticise much of the research that adopts the strategy-as-practice label, arguing that researchers are too keen to look for conscious activity rather than instinctive. They also argue that focusing upon instinctive behaviour and patterns of practices makes it easier to incorporate an understanding of social context and institutional logic into the research. They make a strong argument for observation, arguing that interviews, whilst valuable, are subject to the danger of post-hoc rationalisation.

Overall, it would seem that there are two ways in which managers may engage in strategy praxis: by engaging in discourses, and by acting. Both come under the heading generally used in the strategy-as-practice literature of 'micro-processes of strategising'. These two are interlinked, and affect one another – the way that people talk about issues, situations, problems and the work context in general will affect how they act, and the ways in which people act will affect discourses and initiate new ones. However, there may be action without prior discourse and discourse without associated action. Furthermore, both may be conscious or unconscious, or a mixture of the two. In general, active cognition is more likely to be engaged in situations of major change/instability. There is more literature examining discourses than there is looking at action; acts tend to be taken for granted end points of discourse, rather than 'things' in themselves that should be considered. Enactment is interesting because, as Chia and MacKay point out, much action that affects strategising is unreflective and instinctive. How far it has been influenced by ongoing discourses is, of course, a moot point, and one that it might be possible to look at empirically. The relationship between enactment and what are defined above as 'practices' is to do with the seat of the action. Practices are routinised, patterned and repeated, and occur regardless of who is involved, whereas the enactment of praxis is influenced by the specific practitioner involved. Thus, for example, in a particular organisation there might be an established practice that meetings take place in a particular room which has no IT facility. This will structure the way people behave, because there will be no powerpoints. Individuals will respond to this in different ways, and the ways in which they act will affect strategising – for example, it may be that the ability to talk and think on your feet will give particular people an advantage which might not be there if meetings are structured around powerpoint presentations. Individual social identity is tied up with this – how people see themselves and how they want to be seen by others will affect how they interact with the established practices of the organisation, and some of the actions that they take will be driven by the identity work in which they are engaged.

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2.8.2 Examples of research that takes this approach

Sillince and Mueller (94) examine strategising in a multinational company. They looked at the interactions between top and middle managers, and found evidence of the activity which Floyd & Wooldridge call 'championing', with the middle managers (MMs) selling a particular new approach to their seniors. This was accepted, and the project went ahead. However, it became obvious during the project that it was not going to be a success, and the research team observed both top managers (TMs) and MMs 'reframing' their accounts of what the project meant. TMs engaged in a 'distancing' discourse, in which they minimised their own responsibility for the project, and the MMs developed a discourse which downplayed the importance of the project. The authors conclude that strategy by no means always emanates from top management, and that discourses which frame initiatives are an important part of the process by which both MMs and TMs protect themselves from the risks associated with initiating change. Furthermore, they argue that the extent to which MMs are prepared to assume responsibility for risk will be a determinant of their ability to impact on strategy.

Laine and Vaara (63) explicitly take a discourse analytic approach. They usefully summarise the approaches to discourse that have been taken in the strategy-as-practice literature: critical theory, exploring the hegemonic nature of strategy discourse; strategy as narrative, examining the ways in which stories constitute and reinforce/redirect strategy; and discursive practices, focusing upon the resources mobilised by actors to legitimate particular strategy discourses and to silence others. They argue that discourses are a source of struggle, as individuals seek to impose, resist or maintain viable social identities for themselves and others. They put it thus: 'Central to this perspective is the view that discourse and subjectivity are closely linked. On the one hand, specific discourses produce subject positions for the actors involved. On the other, actors employ specific discourses and resist others precisely to protect or enhance their social agency or identity'. (p30) They go on to argue that: 'discourses also create objects in the sense of legitimation and naturalisation of specific ideas, for example concerning the nature of strategy processes' (p35). Finally, they emphasise that: 'not all discursive action is fully conscious or intentional. This means that specific discourse can be reproduced almost automatically without the complete understanding of their implications. In this sense, top managers and other organisational actors can easily remain 'prisoners' of the established discourses and other social practices such as 'top-down approaches' or 'participation by command'(p52). Using these ideas in a study of strategic development in a large multinational company, Laine and Vaara describe how top managers used communication tools such as an in-house magazine and presentations at management training events to establish 'strategy' as a top-down process, led by top management and only requiring 'implementation' efforts from the middle managers. This was presented as being the 'natural order' of things, and as inevitable in an

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environment dominated by the need to generate value for shareholders. Middle managers, by contrast, provided evidence to the researchers of their 'work arounds', whereby new product development went on in secret. The middle managers presented themselves as the heroes, and as 'progressive strategic entrepreneurs' (p45) whose work was the real driving force behind the strategic direction of the company. Laine and Vaara highlight the discursive strategies used in this process, such as language that emphasises the distance between the real work done by the middle managers and the 'empty rhetoric' produced by the top management team.

Paroutis and Pettigrew (95) identify two broad types of practitioner behaviour: recursive, which includes recurrent, habitual and routinised activities, and adaptive, which includes exploratory, transformative and creative activities (p103). In a longitudinal study of a large utility company they identify changes in the balance between these types of behaviour over time, with an increase in adaptive behaviour associated with a perceived increase in operational effectiveness for the company. Effective interactions between those at the centre of the firm and those at the periphery were identified as crucial in allowing the more adaptive forms of behaviour.

A significant section of this literature uses Weick's (60) concept of 'sensemaking'. Whilst Weick's original concept predates the whole idea of 'strategy as practice', sensemaking fits in very well with the ideas associated with the strategy-as-practice perspective. Weick argues that, in thinking about organisations, it is more productive to think in terms of verbs rather than nouns – thus, organising, managing and strategising, rather than organisation, management and strategy. This emphasises the fact that organisational processes are dynamic, ongoing and often emergent rather than fixed, and reduces the level of abstraction inherent in discussions of 'management'. Weick argues that the central activity within organisations is 'sensemaking'. Organisational actors extract what he calls 'cues' from the surrounding context, and these provide triggers for sensemaking and thus for action. Members of an organisation act in ways that are determined by their previous experiences of action, by their interactions with others within the organisation and by their espoused social identities. Sensemaking is a social phenomenon, and occurs in the social interactions between organisation members, as they share stories, react to one another's behaviour and reflect on the outcomes of previous action. There is a continual cycle of sensemaking, as actions trigger new cues, which trigger ongoing sensemaking. Weber and Glyn (96) amplify Weick's description of sensemaking to take account of the influence of institutions on the processes of sensemaking. They argue that:

> *'in addition to providing a cognitive constraint on sensemaking, institutions act more directly to influence the process of sensemaking. First, institutions 'prime' sensemaking by providing frames and role expectations within which individuals both notice cues and act in response to those cues. Second, institutions 'edit' sensemaking, by providing the social*

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context within which groups of individuals negotiate shared sensemaking about the meaning of cues and actions by an ongoing process of interpretation and reinterpretation. Finally, institutions 'trigger' sensemaking by requiring a constant process of sensemaking in response to puzzles that arise as change occurs within institutions. Thus, as institutions adopt new working practices or reorganise their structures, sensemaking is required to reconcile old assumptions and identities with new realities.' (97) p2

Sensemaking provides a frame for thinking about the difference between 'recursive' and 'adaptive' behaviour discussed by Paroutis and Pettigrew (95). Weick suggests that active sensemaking will generally be triggered by a mismatch between assumptions about how things are or should be, and reality on the ground. This is sometimes called 'puzzlement', and Weick suggests that major change will trigger puzzlement, and therefore more active sensemaking. Finally, Weick emphasises that sensemaking is tied up with social identity, as actors censor their behaviour dependent upon their perceptions of what an acceptable identity is within a given context. This is in keeping with the 'identity work' literature, as it is possible to argue that the efforts of actors engaged in sensemaking to maintain an acceptable identity constitute 'identity work'.

One of the key problems in thinking about and using Weick as a theoretical framework for research is the question of how far sensemaking is conscious and cognitive, and how far it is instinctive. Weick himself emphasises the instinctive nature of sensemaking, going so far as to argue that much of the time action actually precedes sensemaking, as instinctive reaction to environmental cues provides the raw material of which 'sense' can be made. Some of the literature that uses sensemaking takes a more active view, suggesting that organisational actors consciously make cognitive sense of puzzling situations. Gioia and Chittipedi (98), for example, describe active 'sensegiving' by senior managers in their attempts to ensure that top down strategic change is successful. This concept encompasses behaviour as well as discourse, arguing that senior managers act to model the behaviour they wish to see from their subordinates. Another problem is that the word 'sensemaking' is used by some authors in its vernacular sense rather than in the technical sense employed by Weick, to suggest a process of rationalising and understanding a situation, implying that what emerges is both positive in outcome and consensual (99). However, Weick himself emphasises that sensemaking within organisations may be contested or may represent a working compromise rather than a consensus. Furthermore, he emphasises the potential for sensemaking to be maladaptive, with negative effects on the organisation's behaviour and outcomes (100).

With this as a background, there is a significant strand of the strategy-as-practice literature that uses sensemaking as a frame within which to investigate the microprocesses by which 'strategising' actually happens on

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the ground. Balogun and colleagues (64, 101, 102) report detailed research investigating the response of middle managers in a large organisation to major structural change. They identify how the change initially introduced puzzlement, as middle managers were faced with a completely new way of relating to one another and to the organisation as a whole. This puzzlement led to active attempts to make sense of the new situation, and this was mediated by the telling and retelling of stories, gossip and opinions about the change. The authors call this 'interpreting change intent', and argue that this is an important middle managerial activity. The change was interpreted negatively by the managers affected, and they developed a number of 'work arounds' that enabled business to continue as usual. However, this was a longitudinal study, and over time the researchers identified new 'cycles' of sensemaking occurring, as the negative consequences of their initial actions (which tried to maintain the status quo) became apparent. New sensemaking emerged from the ongoing interactions between the middle managers, generating more adaptive behaviour. This research largely takes a cognitive approach, emphasising the exchange of stories about the change between those concerned. This research emphasises the importance of lateral interactions between middle managers, as these are the sites at which sensemaking occurs. Raes (103) examines top managers' sensemaking about middle managers, and emphasises the unconscious use of negative metaphors to describe MMs in meetings and discussions, which in turn acted to structure the way that top managers behaved towards them. They observed the introduction of images of MMs into discussions, which were then gradually adopted by others until they were taken for granted as descriptions of reality. Furthermore, they found that these sensemaking images were self-confirming, in that they acted to structure TM-MM interactions in ways that generated MM resistance, which was in turn interpreted negatively by TMs. Finally, the sensemaking was confined to the top managerial team, and not shared outside the closed environment of TM meetings. This further acted to entrench the sensemaking, as it prevented any challenge which might have ensued if the prevalent image was tested against the reality. Currie and Brown (74) focus upon narrative as a micro-process of sensemaking, arguing that organisations are in part 'story telling mileux', in which group narratives not only help in establishing shared identities, but also form a basis for hegemony and legitimation. They emphasise the importance of understanding that there are a plurality of narratives within organisations, and suggest that the interaction and accommodation that occurs as these narratives interact and accommodate to one another is important in the process of adapting to change.

Maitlis (104) undertook an interesting study of sensemaking in three major orchestras. The orchestras were all under pressure as a result of reduced public funding, and she undertook a longitudinal study of sensemaking during this period. She identified two important dimensions of sensemaking activity. The first was how *controlled* it was. Highly controlled sensemaking

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occurred when senior managers or leaders kept a close control on what was happening. In these circumstances, management was dominated by highly controlled, formal processes, with, for example, meetings occurring between a restricted number of senior people, and any interaction with those lower down the organisation occurring in one to one interactions rather than in wider groups. Low control sensemaking occurred when there were far fewer formal meetings, with impromptu or ad hoc meetings of senior managers with those below them tending to dominate. The other dimension identified was *animation.* Highly animated sensemaking occurred when there were frequent opportunities for lateral interactions as well as top-bottom interactions and frequent opportunities for feedback. Ongoing, active interactions meant that sensemaking was constant and evolutionary, with development over time as new initiatives were gradually incorporated into the organisation. Low animation sensemaking occurred in situations with few lines of communication. New initiatives were discussed with a small group, with the details kept secret and only the outcomes communicated to those on the ground. Maitlis then goes on to identify the types of outcomes associated with the different sensemaking processes:

Figure 2. Organisational sensemaking (from Maitlis (104) p32)

	High stakeholder sensegiving	Low stakeholder sensegiving
High leader sensegiving	***Guided Organisational Sensemaking*** Process Characteristics: • High animation • High control Outcomes: • Unitary, rich account • Emergent series of consistent actions	***Restricted Organisational Sensemaking*** Process Characteristics: • Low animation • High control Outcomes: • Unitary, narrow account • One-time action or planned set of consistent actions
Low leader sensegiving	***Fragmented Organisational Sensemaking*** Process Characteristics: • High animation • Low control Outcomes: • Multiple, narrow accounts • Emergent series of inconsistent actions	***Minimal Organisational Sensemaking*** Process Characteristics • Low animation • Low control Outcomes: • Nominal account • One-time, compromise action

In other words, if there are multiple opportunities for those lower down the organisation to contribute to sensemaking, but leaders exercise little control, there will be fragmented action. On the other hand, if there are few opportunities for those lower down to interact and contribute, and high

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control from top managers, there will be a narrow view taken of the issues, with potentially limited ability to cope with changing circumstances. Overall, Matlis argues that the best outcomes result from situations in which leaders give a clear sense of direction, but there is also much 'animation', allowing those lower down the organisation to actively contribute to the sensemaking process. This study is interesting because it provides an explanation for the finding of more functionalist studies that encouraging interactions, both between middle managers and the top team, within middle managerial grades and between middle managers and the outside world tends to lead to better outcomes.

Rouleau (59) undertook a very detailed study of the work of retail managers responsible for presenting new fashion collections to suppliers. She identifies four discursive routines used by these managers in 'selling' the idea of the new collections, and identifies these as 'micro-practices of sensemaking and sensegiving' (p1414). She argues that these micro-practices are anchored in the tacit knowledge of the managers, rather than being wholly conscious or explicitly cognitive in origin. Thus, for example, they composed a new 'story' about the collection which best fitted the nature of the client to whom they were talking. This is called '*translating*'. Additional micro-practices included: *overcoding*, which refers to the active use of appropriate cultural codes to set the tone for the collection by, for example, using appropriate foreign language or gender references; *disciplining the client*, which involves the use of objects, images etc to set a tone which will influence the client's feelings; and *justifying the change*, by emphasising grounds for change that fitted with the managers existing knowledge about the beliefs, attitudes and aspirations of the client. Stensaker and Falkenberg (105) also focus at the individual level, arguing that variations in organisational response to change can, to some extent, be explained by differences in individual interpretations of that change, which are in turn related to individual social identities. They also argue that, over time, this individual sensemaking will come together through interaction and the sharing of stories to generate collective sensemaking, This approach is rather different from that of Weick, who argues that individual sensemaking occurs as a result of social interactions rather than as a personal cognitive act.

Overall, the literature that uses sensemaking as a framework tends to focus upon discursive practices such as story telling rather than actions or practices, although there are some implicit discussions of the role of action. Thus, for example, in Rouleau's (59) typology of managerial actions, disciplining the client implies the use of non-verbal means to influence clients' perceptions. There is little explicit examination of 'practices' within the sensemaking literature, although this could be potentially fruitful, as the nature of organisational practices will presumably reflect the dominant ongoing 'sense' that is made, and entrenched practices may act to hinder changes in sensemaking in response to changed circumstances. Maitlis's (104) study provides some insights here, as her depiction of 'highly

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animated' organisations generating multiple opportunities for sensemaking suggests that organisations where the established practices enact frequent interactions between middle managerial staff, or between middle managerial staff and top managers will be more effective than those that do not. Thus, for example, a PCT that has few meetings, or where it is the established practice that meetings are sparsely attended or frequently cancelled will generate fewer opportunities for sensemaking than one where meetings are seen as key events. There is thus potential for investigating what established practices within organisations tell us about the underlying dominant sensemaking, and how they constrain or enable future sensemaking.

In summary, 'strategy-as-practice' is a potentially fruitful way of investigating how the micro-level actions and discourses of organisational actors affect the overall strategising of the organisation. It is particularly useful in that it provides precise definitions, and conceptually distinguishes between the actions of individuals and the established, routinised ongoing *practices* which characterise all organisations. Focus upon practices helps to ensure that wider institutional and socio-cultural influences are not forgotten. Sensemaking research forms a subset of this work, with researchers examining the micro-practices of organisational sensemaking. Both this research and that in the wider strategy-as-practice field focuses upon discourses, with a relative neglect of practices, with researchers pointing to discursive struggles that take place around strategy making, as well as to the repeated telling and retelling of stories that facilitates sensemaking about change. Active sensemaking would seem to be associated with better organisational outcomes, and this seems to be facilitated by an environment where active 'sensegiving' by the top managerial team is coupled with multiple opportunities for middle managers to interact and generate new sense about potential change. There are two ongoing analytic puzzles in this literature: firstly, the interaction between discourses and action; and secondly the extent to which strategising in general and sensemaking in particular are instinctive and implicit or conscious and explicit.

2.9 Summary and conclusions

2.9.1 General findings from the literature

Overall, the literature relating to middle managers is diverse and adopts a variety of theoretical approaches. Whilst the 1970s and 1980s were characterised by a negative view of middle managers, with consequent efforts to 'delayer' organisations and to remove middle managers, subsequent research has concluded that such approaches had a number of negative consequences, and that the work of middle managers is important to the success of organisations. Middle managerial work is characterised as 'fragmented', and tends to be characterised by high levels of verbal

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interaction rather than written. One prominent stream of research examines middle managerial roles, and concludes that such roles are the product of interactions between social context, institutional rules and norms, the expectations of others and managerial agency. Middle managers are argued to be particularly subject to role dissonance and ambiguity. Studies of the role of middle managers in strategy formation have found that, rather than being simply implementers of strategy made by others, middle managers can influence strategy in a variety of ways, both upwards, by influencing top managers, and downwards by affecting the ways in which strategy is perceived by organisational managers and implemented. Conditions that have been claimed to promote middle managerial strategic influence include: positive encouragement from senior managers; long term relationships between middle and senior managers; an organisational environment that encourages innovation; lateral interaction between middle managers; engagement of middle managers with the external environment; and the personal characteristics of the middle managers involved. A further distinct research stream looks at the idea of managerial social identity, and argues that middle managers' identities are important determinants of behaviour. Researchers who approach this from differing theoretical viewpoints differ as to how far identities are seen as fixed, and how far they are seen as fluid and the site of ongoing struggle. The notion of 'identity work' captures the latter approach, with researchers arguing that middle managers engage in ongoing identity work as they respond to situations within organisations. The importance of discourse and narratives in this process is emphasised. Finally, there is an emerging stream of work that defines strategy more widely than the traditional notion of strategy as the plans made by top managers. From this perspective, strategy is seen as any activity that has an impact on the success (or otherwise) of the organisation. This approach switches the focus from how strategy can be influenced to ask questions about who is 'strategising' in a particular context. Within this research stream, a distinction is made between strategy praxis – which is the way in which individuals engage in strategising – and practices, which are the routinised and repeated patterns of activity that both embody organisational norms and structure ingoing activity. This stream of research focuses upon the micro-level ways in which middle managers engage in strategising, with sensemaking often used as a research framework. Much of the focus is again upon discourses and stories, with less attention paid to actions and unconscious behaviour. Research from this perspective has provided some explanations for the findings listed above, suggesting, for example, that organisational performance might be better when there are plenty of opportunities for employees below senior management level to engage in active sensemaking.

2.9.2 Specific evidence about middle managers in the NHS

Virtually all the research on middle managers (and clinical managers) in the NHS has taken place in hospitals. There are a small number of studies in

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Community Trusts, and only one study in a PCT (77). Overall, the evidence suggests that middle managers in the NHS are in a difficult position. Studies have shown: high levels of role dissonance, particularly for clinical staff who take on managerial roles; the engagement of middle managers in the NHS in significant 'identity work' in order to reconcile their espoused identities with the identities that they feel constrained to adopt; the rhetorical use of 'empowerment' by senior managers to encourage middle managers to 'govern themselves' and become good members of the organisation; the potential for entrepreneurial managers in the NHS to use the rhetoric of empowerment to expand their roles; and the role of narratives in the discursive struggle to manage change. There has been little research that adopts the strategy-as-practice approach within the NHS, apart from the work of Currie et al (74, 81).

2.9.3 Questions that emerge in the context of this project

The concepts that emerge from this review as having potential analytical power within the context of middle managers in the NHS include: identity work; strategising; discourses; practices; and praxis. Sensemaking is a useful framework which ties these together, arguing that managing (and strategising as a sub-category within this) consists of an ongoing process of extracting cues from the environment and acting based upon an assessment of these cues that may be conscious or unconscious (most often the latter). Actions generate further cues, and the whole process is tied up in the need to maintain a functional social identity. Sensemaking is a social process, and a number of different micro-processes by which it occurs have been identified. Existing work tends to focus upon discourses and story telling; there seems to be less work that looks seriously at enactment of sense and the interaction between individual actions and organisational practices in the process of strategising.

The aims of this research are as follows:

1. To use qualitative case study methods to generate a detailed and theoretically informed picture of the ways in which PCT managers and GPs interact within the context of PBC, and to relate this to the progress that has been made in developing PBC structures and processes in the study site.
2. To use these results to:

- Draw more general conclusions about the role of middle-grade managers in PCTs and their impact on the functioning of the organisations as a whole, and about the factors affecting the ability of PCTs to align the work of GPs in PBC consortia with wider PCT aims;
- Develop an understanding of the way in which GPs interact with managers and adopt managerial roles, and to investigate the factors that affect their effectiveness in these roles.

The original research questions set out in the proposal were as follows:

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- How do PCT middle managers with responsibilities for commissioning functions behave in role and what factors affect this?
- How do PCT middle managers interact with GPs and other professionals engaged in the management of PBC consortia? How do both parties 'make sense' of the new structures and processes?
- How is this sensemaking shaped by, and how does it shape managerial identities and roles?
- What legitimacy do the parties involved perceive each other to have in this context, and what are the factors that determine this?
- What is the relationship between the sensemaking taking place and early progress under PBC, focusing upon how successfully PBC structures and processes have been established, and on how far PBC objectives are aligned with those of the PCT?
- What does this tell us more generally about the roles of middle-grade managers in PCTs, and of GPs (and others) involved in the management of PBC consortia, and about the factors affecting their effectiveness in those roles?

In the light of the literature assessed here, these can be amplified as follows:

- How do PCT middle managers with responsibilities for commissioning functions behave in role and what factors affect this? How do they engage in strategising, and what are the microprocesses of sensemaking associated with this? What is the impact of organisational practices on this process?
- How do PCT middle managers interact with GPs and other professionals engaged in the management of PBC consortia, and what practices are involved? How does the engagement of middle managers across boundaries in this way affect their sensemaking and their strategising, and what identity work is engaged in by both managers and GPs? How do managers and GPs establish legitimacy for themselves?
- Is there a relationship between the strategising undertaken by the middle managers and early progress under PBC, focusing upon how successfully PBC structures and processes have been established, and on how far PBC objectives are aligned with those of the PCT?
- What does this tell us more generally about the roles of middle-grade managers in PCTs, and of GPs (and others) involved in the management of PBC consortia, and about the factors affecting their behaviour in those roles?
- What can we learn overall about the microprocesses of strategising by middle managers?

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3 Methods

3.1 Research design

The aim of this study was to develop a detailed and nuanced understanding of the lived experiences of middle-grade commissioning managers and of the clinicians with whom they interacted. A case study approach was therefore adopted (106), as this allows the exploration of work in context. The overall design was a compromise between the desire to collect as full data as possible from a range of settings, and the need to complete the study and report on the data within a timescale that would be of maximum value to the NHS. It was therefore decided to undertake four case studies, and in practice it was found that data saturation (107) was approached by the time the fourth case study was under way. Within the chosen PCTs, data collection focused upon the commissioning directorate, and within this on the team responsible for acute (ie hospital-based) and (in some PCTs) community care. In part this choice of focus was pragmatic, in that available resources required that data collection could not encompass the whole range of PCT activity. In addition, the identification of the implementation of Practice-based Commissioning as a key policy change, requiring PCTs to develop new ways of working, determined that this should be a focus. Our previous research (2) demonstrated that PBC and interactions relating to PBC are generally undertaken by teams responsible for commissioning secondary care, although in some PCTs these teams also had responsibility for community care. In general, it was our experience that joint commissioning, such as that involved in the planning of mental health, paediatric and specialised services such as renal dialysis, was not an area within which PBC was particularly visible. Whilst acknowledging that the roles of PCT middle managers in joint commissioning would be of considerable interest, it was felt to be outside the scope of this project within the resources available.

An extensive literature review was undertaken, the results of which have been described in Chapter 2. A meeting of the advisory group was convened at the start of the project, at which initial ideas and plans were discussed, and the precise research design was refined and developed. A further meeting of this group is planned in order to discuss the results and plans for dissemination.

Ethics approval was sought from the LREC. The PI attended the ethics committee meeting, who decided that the study did not require formal ethical approval. A chairmen's letter was issued and the University of Manchester acted as sponsor for the research. The main ethical issues relating to this research were to do with anonymity and confidentiality. As a result, in this report details have been changed in order to assure

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anonymity both for the research sites and for individuals. In particular, in the identification of quotes, staff are only identified as PCT manager, PBC manager or as a GP.

3.2 Sampling and recruitment

As outlined in the proposal, PCTs were purposively selected according to a number of criteria. These included:

- Experience of reorganisation
- Size
- Complexity of local health economy

All of the sites were in the north of England, situated in areas covered by several different Strategic Health Authorities. Site 1 had a relatively simple health economy, with a single PCT covering one urban area, served by a single main hospital trust. The PCT was co-terminus with the local authority, and had not undergone reorganisation in 2006. The PCT had received very good WCC scores in the first round of assessment, being one of the only PCTs to achieve any level 3 scores. The geographical context was that of a small down adjacent to a much larger conurbation. Site 2 by contrast had been formed in 2006 by a merger of two PCTs. It covered a relatively large geographical area, which encompassed a number of market towns and villages. Whilst some of the area was extremely prosperous, there were some significant pockets of deprivation. The PCT related to two main hospital trusts, and had a complicated relationship with a number of local authorities, which underwent a major reorganisation just before the research started. The WCC scores achieved in the first round of assessment were poor, and this was a major focus for the PCT. As a result of the drive to improve their position next time round a number of new initiatives had been set up. Site 3 covered a large town and a neighbouring rural area. There were two major hospital trusts, a single local authority and, although there had been a merger in 2006, this had not been too disruptive, as it reconstituted a combined organisation that had existed in the days of Health Authorities. The WCC scores achieved in the first round assessment had been good. However, this had led to a degree of complacency, and at the time of the research there was concern about the second round assessment. Site 4 covered a single large town, with a number of hospital trusts and a single local authority. There had been a merger in 2006. The WCC scores achieved in the first round of assessment had been poor, and this was a major focus for the PCT. Site characteristics are summarised in Table 1.

Recruitment involved initial email contact, followed by a phone call to an identified individual, usually the Director of Commissioning. Members of the research team visited the PCTs in order to explain the research, and once agreement was reached, research governance approval was sought. This is a complicated process, with each PCT requiring a different set of documents to be produced, and could have been a significant factor delaying the start

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of the research had we not been able to start the process before the official start of the project. Furthermore, significant delays were encountered whilst PCTs made the decision whether or not to agree to take part. This did not seem to be due to any reluctance, but rather due to the lack of any clear decision making process within the PCT. Directors of commissioning were generally enthusiastic when approached, welcoming the research and enthusiastic about the potential benefits. However, there then seemed to be some confusion as to which body had the authority to make the decision, with delays as the decision was passed around between the board, clinical executive and other internal bodies. In Site 3 this delay lasted from August, when initial contact was made, to January when permission was finally received to go ahead.

3.3 Data collection

Our conceptual approach to the type of data collected is based on a number of tenets. First, interview data alone are inadequate for the degree of depth that is required if we are to understand the complex worlds in which managers live (107). Research participants may for various reasons wish to create particular impressions of their work and/or organizations and there is no reason automatically to privilege these accounts. Our previous work in a number of different contexts (2, 9, 108) revealed various discrepancies between interview accounts and observed activity, and exploration of these discrepancies can be a valuable source of data. Second, a great deal of managerial work takes place in meetings, an observation that is especially true for activities (such as commissioning) that do not produce direct physical outputs. Thus the observation of commissioning meetings is essentially direct observation of central elements of commissioning work. The research team has considerable experience of this approach to data collection. Third, we have found in the past that the familiarity that develops as the researchers observe over a period of time enhances the interaction between respondents and researchers during interviews. This enables the exploration with respondents of behaviour that has been observed, allowing the researcher to test and expand any emerging interpretations.

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Table 1 Site characteristics

	Site 1	Site 2	Site 3	Site 4
Population (band)	200,000-300,000	400,000-500,000	400,000-500,000	500,000-600,000
GP practices	50-60	50-60	80-90	100-110
Geographic context	Single large town	Large geographical area, containing a number of small towns	Single large town, but also covering a neighbouring rural area	Single large town
Socio-economic context and ethnicity	Deprived area, with some pockets of affluence. Low BME population	Relatively affluent, with pockets of significant deprivation. Low BME population	Deprived area, with high BME population and pockets of affluence	Some parts of the PCT extremely deprived, others affluent. High BME population in the more deprived areas
Demographic context	High proportion of children and young adults compared to national average	High proportion of elderly compared to national average	High proportion of children compared to national average	High proportion of adults of working age compared to national average. Population growing more rapidly than national average
Local health economy	One major local Foundation Trust, several tertiary referral centres near by	One Foundation Trust serving half of the PCT area, one non-foundation trust serving the other half	One Foundation Trust serving the city area, one non-foundation trust serving the rural area	Three Foundation Trusts serving the PCT area
Local authority context	Co-terminus with a small LA	Recent local government reform, with merger of a number of small local authorities into 2 larger authorities. Boundaries not co-terminus	Largely co-terminus with a large LA, but covering some patients at the margins living in a different LA area	Co-terminus with a large LA
History	Present in current form since 2001	Formed from amalgamation of two PCTs in 2006	Formed from amalgamation of two PCTs in 2006. This returned the area to a previous configuration	Formed from the amalgamation of several PCTs in 2006
Practice-based commissioning	Single GP consortium	Four GP consortia	Four GP consortia	Three GP consortia
Finance	Historically in balance	Historically had a large deficit	Historically in balance	Historically in balance
WCC scores	Good	Poor	Good	Poor

In this study, therefore, data collection involved three activities. Following initial meetings with a senior member of the commissioning team at which

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the organisational structure and processes were mapped, one or more key members of the commissioning team were approached and asked if they would be prepared to allow a team member to spend some time shadowing them. This informal observation was used as an opportunity to gain an understanding of the day to day life of a commissioning manager in each context, and provided an opportunity for more detailed exploration of the processes and meetings involved in the work of commissioning. Permission was then sought to attend as wide a variety of commissioning meetings as possible. At each meeting attended the researcher was introduced, and the study was explained. Consent to observe the meeting was sought from those present, and written information was provided. One feature of this process was that, although participants were asked early on in the research to provide a list of all commissioning meetings, we often discovered during informal observation that there were other, relevant meetings taking place. Whenever this occurred, permission was sought to attend. Similarly, it often happened that during meetings, additional meetings would be mentioned, and in this 'snowballing' fashion the team were able to build up a picture of all relevant activity. Once a number of meetings had been observed, interviews were arranged with commissioning managers. A topic guide was developed, based upon issues that had been identified during the literature review. The experiences of the managers and their perceptions of their role were explored, and any issues identified during observation were followed up. Interviews were audio-recorded with permission, and fully transcribed. During periods of observation detailed contemporaneous fieldnotes were written, and subsequently typed up. When note-taking was difficult (for example during informal observation periods) notes were written up as soon as possible after the observation period. Table 2 lists the data collection undertaken in each site. Types of meeting attended included:

- PBC locality/consortia meetings
- PBC executive/board meetings
- Commissioning group meetings
- Financial recovery group meetings
- Service development meetings with providers
- Internal meetings of commissioning staff
- Meetings about community services

Table 2 Summary of data collected

Site	Meetings	Episodes of informal observation	Interviews - managers	Interviews - GPs
Site 1	10	6	7	3
Site 2	4	4	7	2
Site 3	11	2	9	3
Site 4	6	3	7	3
Totals (hours)	**31 (93 hours approx)**	**15 (60 hours approx)**	**30**	**11**

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3.4 Data analysis

Data were stored and managed with the assistance of Atlas.ti software. It enables the secure storage of data (on a University mainframe computer) and provides a medium through which team members are able to work together on the analysis. Fieldnotes taken during meetings and informal observations were coded alongside interview transcripts and relevant documents, and emerging themes and theoretical ideas were discussed and refined at team meetings throughout the research. Initial coding was based upon concepts arising from the literature review. In addition, novel concepts found in the data were also identified and codes allocated. Examples of this included the concept of 'pieces of work' and a novel role enacted by some of the managers. During team meetings there was ongoing discussion of precise definitions and uses of codes, so that team members were able to review and discuss each others' coding decisions, allowing continued refinement of the analysis. All of the data sources were combined to provide a 'thick description' of each case study site, focusing upon the roles and behaviours of the commissioning managers, and their interactions with clinicians. In parallel, analytical memos were written and shared in order to draw together emerging theoretical issues. Data collection and analysis for each phase of the study proceeded in parallel, allowing the team to modify and develop the data collection frameworks as appropriate, following up significant findings and seeking contradictory or confirmatory examples. Emerging concepts were explored with participants, and these insights were incorporated into subsequent iterations of the analysis.

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4 Results 1: case study summaries

4.1 Introduction

In this section, summaries will be provided of the organisational structure and processes of the case study PCTs. The intention is to give an overview of how commissioning work is actually done in these sites, in order to inform the cross-case analysis provided in the next section. Research such as this, involving detailed observation of managers as they go about their day to day work, can be sensitive. Obtaining access for the research is not always straightforward, and confidentiality and anonymity are important principles in this work. Thus, our participants were reassured that their organisation would not be identified by name, and that they would not be identifiable in research reports and publications. This can raise some difficulties in reporting the results, as in small organisations contextual details such as exact organisational structures, job titles, team names or job grading can lead to the identification of individuals or the organisation as a whole. In these case reports, therefore, the exact details of the organisational structure and team composition and organisation are not provided in order to conceal identities.

4.2 Case study 1

4.2.1 Overall context

Site 1 has a number of advantages. It covers a relatively compact geographical area, is co-terminus with the Local Authority and, most significantly, it avoided the disruption associated with reorganisation in 2006. There is a single Practice-based Commissioning (PBC) Consortium, which enhances liaison between those working on PBC and the wider commissioners within the PCT.

4.2.2 Commissioning structure

Commissioning is overseen by a Director. Underneath the director, commissioning is undertaken by a number of teams. These include joint commissioning for children and adults (including mental health, learning disability etc), acute and community care and primary care (overseeing GMS, PMS and APMS contracts). Data collection focused upon the team undertaking the commissioning of acute care, as this is the team that is charged with implementing and supporting PBC and which accounts for the largest proportion of the commissioning budget. This team is overseen by an Associate Director, who occupies Agenda for Change (AfC) grade 8c. Underneath this manager, a number of commissioning managers took

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responsibility for different areas of commissioning. Thus, one manager has responsibility for acute care and diagnostics, another for community care and long term conditions, and another for overseeing the implementation and running of the Choose and Book system for booking hospital appointments. A further commissioning manager took overall responsibility for PBC. These managers mostly occupied AfC grade 8b, but some managers carrying less responsibility were grade 8a or even grade 7. Most of these commissioning managers had some administrative support, and the manager responsible for PBC had four grade 7 'business managers', each supporting a group of GPs within the larger consortium. Cutting across this team structure, the practical work of commissioning was undertaken by a number of commissioning groups, which were generally speciality specific, including, for example, Urgent Care, Diabetes, Coronary Heart Disease etc. These groups each had a manager attached, usually a grade 8, but in some cases grade 7 or even grade 6, and each also had a clinical lead. Membership consisted of commissioning managers whose areas of responsibility fell into the clinical area concerned. Thus, for example, the CHD group contained managers responsible for Long Term Conditions, 'tier 2' services[2] and self-care, with clinical support from a GP, a nurse specialist and a member of the public health team. Information management support was also available for these groups. Some clinical leads were recruited from the PBC GPs, but some groups drew their clinical lead from the secondary care sector. The groups were responsible for drawing up commissioning plans relating to their speciality and were charged with designing new pathways and services. These plans were then submitted to the Clinical Executive and ultimately the Board of the PCT, who retained the final say as to which plans would go ahead. Contract management came under a different directorate, and so commissioning managers' responsibilities ended when a new pathway was adopted.

The PCT was initially in a strong financial position, but staff were acutely aware of the coming financial crisis. There was therefore an over-arching financial recovery programme, which cut across all the other commissioning groups, led by a Director, who was empowered to give priority to commissioning plans which were likely to generate savings. Plans given this priority were most likely to be accepted by the Board.

At the start of the data collection period, the directorate also had a number of external consultants providing project management support. However, during the project, moves were made to limit this in order to save money.

[2] 'Tier 2' services are services in the community that might in the past have been provided in hospitals. Examples might include a cardiology clinic provided by a GP with a Special Interest (GPSI) in cardiology, or a dermatology clinic provided by a GPSI in dermatology.

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4.2.3 Work processes and meetings

'Commissioning work' tends to take place in meetings. The important commissioning meetings and decision-making fora are summarised below:

- PCT Board – must sign off all commissioning decisions
- Clinical Executive (previously the Professional Executive Committee) – must also approve all high-cost commissioning decisions
- Contracts group – looks at commissioning business cases, and has delegated authority to approve small value commissioning projects
- PBC working meetings – small group which meets weekly. Includes the commissioning manager responsible for PBC, the PBC lead GP and deputy. PCT Chief Exec attends on occasion. These meetings are intended to ensure that the commissioning manager and GPs are fully aware of all that is happening in the PCT
- PBC board meetings – these take place monthly, and are attended by PBC local leads, the PBC commissioning manager and by PCT commissioning managers with other responsibilities in rotation. Also attended by staff from the Finance Directorate and other support staff such as information management and prescribing support. They represent the main business meetings of the PBC consortium, and are the forum at which decisions are made about priorities, and progress in the various work streams is reported back
- PBC local meetings – these take place monthly, and are attended by GPs, PBC junior managers and commissioning managers in rotation
- Senior managers meeting – these take place monthly, and are attended by all the Associate Directors with commissioning responsibility, along with the Director of Commissioning and the PBC commissioning manager. These are mainly focused upon communication between the different commissioning teams
- Financial recovery team meetings – these take place weekly, and are led by the Director of Finance. They are focused upon performance management of the prioritised commissioning projects. Commissioning managers leading these projects are required to attend in order to account for their progress.
- Commissioning group meetings – these are the groups responsible for the different work streams. The meetings are convened by strategy group managers, and vary in frequency. They have few delegated powers, but are expected to produce service redesign ideas that must be signed off by Clinical executive.

4.2.4 Data collection

- 16 meetings (approximately 54 hours), including examples of each of the meetings given above apart from the PCT Board, the Clinical Executive and the Contracts Group. Time spent shadowing an Associate Director and the PBC manager
- 10 interviews, including AD with commissioning responsibilities, PBC commissioning manager, other commissioning managers and GPs involved in PBC

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4.2.5 Significant issues at the time of data collection

The PCT was in the process of coming to terms with a much less secure financial future, after a number of years of net growth. Projects that seemed likely to save money were prioritised, whilst those which would not were side-lined. It is clear from the description given above of the structures and processes in place that there are a number of over-lapping bodies with commissioning functions, with considerable scope for duplication. Furthermore, the recently-constituted Financial Recovery Team is a powerful grouping, with the authority to control much of the work of the other commissioning bodies and groups. It has been noted before (2) that one of the significant issues facing PCTs in their implementation of PBC is the need to ensure that commissioning undertaken by GPs is co-ordinated with that undertaken by the PCT. In Site 1, this problem was tackled by having PBC GPs on each of the commissioning topic groups, and by ensuring that the PBC manager had an overview of all the commissioning activity that was taking place. This manager was nominally a Grade 8b, and therefore on a level with the other commissioning managers. However, in practice he/she acted above this level, attending senior manager meetings and representing the PCT on a number of different external bodies. This mismatch between formal grading and enacted role will be revisited in the cross-case analysis in the next chapter.

Finally, data collection in this PCT took place at a time when the Swine Flu epidemic was at its height. Commissioning managers were expected to take their turn in the various Tamiflu distribution centres, interrupting their commissioning work.

4.3 Case study 2

4.3.1 Overall context

Site 2 PCT was formed in 2006 by the merger of two neighbouring PCTs, one smaller than the other. The new PCT covers a large geographical area, containing a number of small towns and many villages. Many of the senior staff in the new PCT came from the larger of the two old PCTs, and it was widely regarded as a 'takeover' of one organisation by the other. PBC was undertaken by four PBC consortia, each of which had a geographical focus.

4.3.2 Commissioning structure

Commissioning is overseen by a Director. The commissioning functions of the directorate were divided into teams, covering Joint Commissioning, Contracting, Secondary care and Continuing health care. In November 2009 there was an internal reorganisation, and the 'Secondary care' team was renamed to reflect a focus on PBC. This team formed the focus of our research. The team was headed by an Associate Director, AfC grade 8d, and responsibilities were divided between a number of sub-teams, focusing

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upon areas such as planned care, urgent care, community care and PBC. Each of these teams was supposed to be headed by an 8c manager, known as a 'Head of', but at the time of data collection only one of these managers was in post. Each sub-team was made up of a number of 8b commissioning managers. Each PBC consortium had an associated PBC manager, AfC grade 8b. Most of these managers had some kind of administrative support. In addition to renaming the secondary care commissioning team, the reorganisation in November 2009 established a number of commissioning work groups. As in site 1, these tended to be organised around specialities, with examples including orthopaedics and stroke care, although some were also focused upon functions such as outpatient services and urgent care. These were in the process of being set up at the time of data collection. Each was headed by a relatively senior manager (eg Associate Director or Head of), with the support of a lower grade commissioning manager. It was intended that there would be a clinician assigned to each of these groups, with many of these coming from PBC consortia, but at the time of data collection these assignments had not been finalised. The work assigned to these groups included, for example, the review of orthopaedic services across the health economy, and the implementation of demand management to try to limit outpatient referrals. It was, however, at an early stage at the time of data collection, and many of the groups had not yet met. It was therefore unclear who would attend the meetings or how the work would be done.

4.3.3 Work processes and meetings

Important meetings and decision making bodies in site 2 included:

- The PCT board – responsible for signing off all commissioning decisions
- The Clinical executive - reconstituted PEC. The PBC consortia leads sit on this body, and it is seen as the main group for making decisions. However, these decisions still need to be ratified by the board
- Contracts group – this group is responsible for signing off small scale commissioning projects
- Leadership team – this is a high level group, consisting of all of the PCT executive directors. It was not clear exactly what the role of this group was, and how it differs from the role of the PCT Board.
- PBC consortia meetings. These took place at least once a month, and included the PCT managers supporting PBC along with the GPs with managerial roles.
- Commissioning groups. These were recently set up, and most had not met at the time of data collection. Their role was to redesign services, but their exact membership and role was to be decided.

4.3.4 Data collection

Data collection in Site two was relatively difficult compared to all of the other sites.

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- 8 episodes of observation, including some of the bodies mentioned above and informal shadowing with a number of commissioning managers (total approx 28 hours)
- 9 interviews, including commissioning managers and GPs

4.3.5 Significant issues at the time of data collection

Site two had been adversely affected by the merger of 2006. It had taken time for the two organisations to come together, and it was clear that the commissioning structure and processes were in a state of flux. Access to this site was very difficult, with many meetings and interviews cancelled at short notice. The PCT ran a 'hot desking' system, which meant that no one had a permanent desk or telephone. As a result, it was difficult to contact managers, and there seemed to be no administrative staff with an overview of managers' whereabouts or diary commitments. The PCT had a significant deficit carried forward from the previous year, and were very concerned indeed about their finances. As a result, the PBC groups had been told that they would not have any access to their savings from the previous year, and there was a great deal of focus on emergency cost-saving measures such as reducing referrals from GPs to hospitals or postponing such referrals into the next financial year. In this climate, many plans for service redesign had been put on hold, as there were no funds available for upfront investment to set up new services.

4.4 Case study 3

4.4.1 Overall context

Site 3 is a large PCT that was formed at the last reorganisation in 2006 by the merger of city-based and rural PCTs. There is not a great deal of resentment but it is not necessarily a very comfortable marriage, in that the rural and city parts of the patch have some different issues and problems. However, there is no feeling that there was any kind of 'take over'. Historically, the PCT was very well funded, in large part because they attracted significant amounts of 'deprivation' payments of one kind or another. They are not yet in the red, but are projected to be so in the next financial year, and they are working hard to save money. This is a new experience for the PCT. PBC was undertaken by four consortia, each with a geographical focus.

4.4.2 Commissioning structure

Commissioning is overseen by a Director. When PBC was first set up, it was decided that the role of PBC manager would be a crucial one, as these managers would be required to 'manage' a difficult relationship with powerful professionals such as GPs. As a result, the four PBC consortia in the PCT area each had a manager appointed to work with them at AfC

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grade 8c, reporting directly to the Director. Each manager had a deputy working with them, grade 8a. In addition to these four managers, there were two Associate Directors, grade 8d, responsible for different areas of commissioning. Our data collection focused upon the PBC managers and associated consortia and on the team led by the AD covering acute and community commissioning. This team consisted of a further 5 managers, with the job title of 'Head of', covering such areas as long term conditions, scheduled care, urgent care etc. As in other PCTs, the day to day work of commissioning was undertaken by commissioning groups, including areas such as acute care, planned care, long-term conditions, etc. At the time of data collection, each of these was headed by a 'head of' (AfC grade 8b) manager. Until recently, these commissioning groups consisted of PCT commissioning managers, working with GP 'clinical leads', most of whom were not involved with PBC. However, a recent decision had been made to involve the local main providers in these groups, with an apparent recognition that money will only be saved if they work constructively together.

4.4.3 Work processes and meetings

Key meetings include:

- PCT board – responsible for setting strategy and signing off decisions
- Clinical executive – the reconstituted PEC, also responsible for signing off commissioning decisions. In a state of flux at the time of data collection, in the process of negotiating a changed role and composition for this body
- Commissioning team – this is a monthly meeting and is a subgroup of the clinical executive. It consists of a Director, PBC managers and the PBC GP chairs. The aim of this group is to ensure co-ordination between the work of the PBC consortia and the PCT commissioning teams
- Management team – this is a monthly internal meeting for the commissioning team, and is mainly a 'reporting in' session. This is attended by the Director, PBC managers and ADs for commissioning.
- PBC managers meeting – this is a meeting between all PBC managers and their deputies. This meeting has no clinical input, but they discussed matters of substance relating to PBC.
- Full consortia meetings – these are monthly meetings between PBC managers and their local clinicians, at which PBC strategy and programmes of work are discussed
- Finance recovery team – this is a newly set up group similar to that recently set up in Site 1. Meetings take place weekly, and discussion focuses upon the progress of commissioning projects set up to try to save money. It is attended by the PCT Chief Executive, several directors, 'Heads of' managers and the PBC managers.
- Commissioning group meetings – these are monthly meetings of the different groups, focused upon service redesign and development.
- Service development groups – these are newly set up meetings between commissioning managers (led by the AD for commissioning acute services) and managers from the main local hospital trusts, focusing upon

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sharing information about planned service developments. Attended by PBC managers and GPs

4.4.4 Data collection

- 11 meetings (approximately 41 hours), including time spent shadowing an Associate Director and a PBC manager
- 12 interviews, including Director, Associate Directors with commissioning responsibilities, PBC managers, GPs involved in PBC and Heads of commissioning groups

4.4.5 Significant issues at the time of data collection

The PCT had recently made the decision to reorganise its internal structure, increasing the focus on major providers in order to align commissioning more closely with contracting. We were told that there was a recognition within the PCT that 'efficient and effective' commissioning requires detailed engagement with the largest local providers, and that this would be best achieved by allowing managers to develop close working relationships with their secondary care colleagues. They explained that historically there had been a gap between commissioning and contracting that was felt to be inefficient, with the contract team agreeing and enforcing contracts that they have had no part in developing. Under the new structure, commissioners and contractors would work together, with contracts monitored and enforced by the same team that had been responsible for developing them. One aim of the proposed reorganisation is to save on management costs. This reorganisation was unveiled early on in our data collection period, but was largely invisible in the day-to-day meetings that we observed, although individual staff members revealed some uncertainty and disquiet about how it would affect them. It had not been implemented by the time data collection ceased, and it remains to be seen whether or not this change will be pursued in the light of the major changes suggested by the 2010 White Paper, 'Equity and Excellence'.

4.5 Case study 4

4.5.1 Overall context

Site 4 PCT was formed in 2006 by the merger of three urban neighbouring PCTs with distinctive patient populations and issues. These geographical divisions have been maintained to preserve the historical relationship with the acute trusts in each locality and Practice-based Commissioning is undertaken by three consortia, each based in one of the geographical areas

4.5.2 Commissioning structure

Commissioning is overseen by a Director. Commissioning is undertaken through several teams, based around the geographical areas and the PBC

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consortia. Each PBC consortium is supported by a team of commissioning managers and there are also teams for Primary Care and Joint and Specialised Commissioning. Two of the PBC teams are overseen by an Associate Director of Commissioning at AfC grade 8d; the third team is overseen by a General Manager at AfC grade 8c. Below these ADs, clusters of commissioning managers have responsibility for urgent care, planned care, contracts, and medicines management. Each of these areas also has a clinical lead from the PBC Board. Commissioning managers are responsible for supporting GP practices within the PBC consortia although arrangements differ between consortia. The grades of these managers vary between grade 8b and grade 6. During the period of data collection there were significant numbers of staff vacancies due to maternity leave which had led to some of the more junior managers being seconded to the more senior posts. Additionally there is an Associate Director at AfC grade 8b/c (grade not yet determined) with responsibility for the strategic development of PBC across the PCT. This post was created to improve relations between PBC and the PCT. There is also an Associate Director at AfC grade 8c with responsibility for urgent care across the PCT. The PCT had a financial deficit in 2009/10 and created a Financial Recovery programme to review and identify areas for savings in order to create resources to cover the anticipated growth in 2010/11. This has meant that many of the planned commissioning projects have been stopped.

4.5.3 Work processes and meetings

Commissioning work is undertaken in meetings and also occurs using more informal communication processes such as email. The key commissioning meetings and decision-making fora are summarised below:

- PCT Board – must sign off all commissioning decisions
- PBC/PCT Executive Team – must approve all high-cost commissioning decisions
- Financial Recovery Group – these are led by the Directors, including Finance, the Public Health and Commissioning.
- PBC board meetings – these take place monthly and are attended by PBC leads for urgent care, planned care, long term conditions, contracts and performance, public health, public engagement, finance and budgets, the Associate Director of Commissioning and by other commissioning managers as necessary. Also attended by staff from the Finance Directorate and other support staff such as information management and prescribing support.
- PBC locality meetings – these take place monthly and are attended by locality GPs, PBC leads, Associate Director of Commissioning and commissioning managers.
- PBC briefing – the Associate Directors from each consortium and the Associate Director with PCT-wide responsibility for PBC meet fortnightly with attendance from other commissioning managers and PCT support services if necessary.

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- Commissioning groups – these are the boards responsible for the different workstreams, for example Urgent Care. Meetings vary in frequency and have few delegated powers. Commissioning managers meet with the lead clinician informally determined by need.

4.5.4 Data collection in site 4

- 9 meetings (approximately 30 hours), including examples of each of the meetings given above apart from the PCT Board, the Financial Recovery Group and the programme board and 3 informal periods of observation.
- 10 interviews, including the Associate Directors with PBC responsibilities, commissioning managers and GPs involved in PBC.

4.5.5 Significant issues at the time of data collection

One of the distinctive structural features of this site was the co-existence of managers with a PCT-wide remit for PBC and Urgent Care alongside commissioning managers based in the three PBC consortia. This created tensions in regard to roles and responsibilities and some uncertainty as to where boundaries lay. The Urgent Care role was created to improve PBC engagement with this area and the commissioning manager defined the role as one of leadership, support and shaping the general direction of travel. At consortium level however, the commissioning managers and clinical leads for Urgent Care believed some of the issues they faced arose because of the particular historical patterns of service provision within the locality. It was also apparent that each locality enjoyed different relationships with its acute trusts. The PBC post was created to improve relations between the PCT and PBC. The establishment of a PBC/PCT Executive Committee is one of several initiatives undertaken by the PBC AD. Commissioning managers and PBC GPs agree that relations have improved significantly and the post seems to have come to a natural end.

4.6 Summary and conclusions

A number of issues stand out from these case descriptions. Firstly, it is clear that there is no overall consensus amongst PCTs as to the appropriate grade for managers performing similar roles. Thus, for example, we observed managers occupying AfC grades from 6 to 8d performing similar types of tasks, although obviously the way in which they performed those tasks varied. This issue will be revisited in the cross case analysis. Secondly, our findings suggest that it is not always easy to clearly demarcate the different areas of commissioning work. Many of our sites had a structure that included overlapping teams and groups with responsibilities for different types of commissioning, and it was not always clear where responsibility lay, for example, for the commissioning of cardiac or diabetic services. Patients with these conditions will at times require care that comes under the heading of 'long term conditions', but at others will require 'acute' or 'urgent' care, with potential confusion over roles and responsibilities for

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commissioning managers. The strategies adopted by managers to cope with this level of indeterminacy will be discussed. Thirdly, at the time that this data was being collected, all of our study sites were struggling to come to terms with how to integrate the work being done under PBC with the wider commissioning work of the PCT. A variety of strategies had been adopted, from the development of new committees at which information could be shared to the subsuming of most commissioning functions into a structure focused around PBC consortia. Finally, it is clear that contextual issues such as historical patterns of service delivery, past histories of mergers and geographical features such as towns and villages all have a significant impact on the way in which services can be developed and commissioned.

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5 Results 2: cross-case analysis

5.1 Introduction

In this section, analysis across the cases will be used to answer the research questions set in Chapter 2. The focus of this analysis is upon drawing out issues that will be of interest to an audience of managers and those responsible for policy in this area. In addition to this analysis, the team is in the process of developing contributions to theory in this area that will be of more interest to an academic audience. These will be mentioned in the text, but are in the process of being developed into papers for submission to academic journals. Throughout this chapter, quotations and extracts from observational fieldnotes will be used for illustration where these are felt to add to the points being made. These have been chosen either because they illustrate particular issues or because they are typical of issues raised by a number of managers. In order to preserve anonymity, the site associated with quotations and fieldnotes extracts will only be given where this is relevant.

5.2 Who are commissioning managers?

All of the participants in our study were asked about their background and previous history. It had been anticipated prior to the study that most such managers would have come from a clinical background, but this was not the case (see Table 3)[3].

Table 3. Background of managers interviewed and observed

Background	**No. of respondents**
Clinical – nurses	10
Local government – social work, voluntary sector	3
Management training	2
Primary care management – FHSA, LA, PCG	4
Secondary care	3
Outside the NHS – eg law, engineering, agriculture, teaching, banking, pharmaceutical/chemical industry.	12
Total	34

Whilst a number had started their careers as nurses, rising through the ranks to become nurse managers and then moving into commissioning, a significant proportion of our study participants were career managers, many

[3] In this table, 4 managers are included who were observed but not interviewed (compare numbers with table on page 58)

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of whom had moved into the NHS from other industries. Others had previously worked at a lower grade in previous primary care organisations such as Health Authorities, working their way up over time into a managerial position. Some had come from a provider background, working as managers in hospitals or community providers, and it was claimed that this experience of a provider environment was a distinct advantage:

> *Um, and really commissioning is, in my opinion, um…what provider managers are often good at is they kind of know, um, when their counterparts are telling porkies really… and they can kind of, you know…whereas someone who's only ever done commissioning, um, has to take at face value everything the provider tells them about, you know, clinical procedures, processes, et cetera. Whereas if you kind of come from that side you…like I've got friends who are still there and you can test out or actually you can go well that's changed a lot since I last did it so why, so I kind of think, you know, um, there is certain logic in commissioners employing more providers, not less. [ID 22, PBC manager]*

Whilst many respondents voiced the view that a clinical background could be helpful for a commissioner, this manager disagreed:

> *Q: So you don't see they're actually, 'cos it's something that people say sometimes, 'it's a real advantage if you've got a commissioning manager who's got a clinical background', you'd say that's not actually true?*
>
> *A: I actually think that's quite dangerous. Um, you know, there is an element of danger, if you take a um, a commissioning manager who has a background in nursing who then becomes your long-term conditions manager um, if they developed the management skills and facilitative skills they can be the best possible commissioning manager. The danger is, they've had twenty years of being a nurse and they say, it must be done this way, I'm the commissioning manager and actually what I want them to do is actually not to drive the process, I want them to facilitate the discussion between the consortia and the practice GPs, the district nurses, input from the acute physicians, um, and actually step back away from it, the danger is they become too involved in the design of the service and their own views. [ID 17, PCT manager]*

Learning to 'do' commissioning seemed to be something that was generally accomplished 'on the job' rather than by formal training. Whilst a number of more senior managers reported attendance at one or more of the available academic courses about commissioning, this was by no means universal:

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Q: What sort of, training [in commissioning], did you get when you first arrived?

A: There wasn't anything formal in terms of you now work for the PCT in a commissioning role, therefore these are... And it's probably fortuitous that [training organisation] were running an advanced course at the time, as a sort of, formal qualification in commissioning, which is something I've been on, so I'm in the process of going through it. But not everyone in our team is on that course, so it's not a consistent way of training us. So the answer to your question would be no ultimately. [ID4, PCT manager]

5.3 *The nature of* managerial *work*

In keeping of the work of O'Gorman et al (29), we found the managerial work of PCT commissioning managers to be indeterminate, chaotic and generally difficult to plan. Managers whom we shadowed were rarely able to focus upon particular tasks for long, and were subject to constant interruptions. This manager described her policy of always being available:

I've come to accept that what my roles is, is to guide and support my heads and below, which means that um, I am quite flexible with my time; I am not precious about my time, so that if I think ten minutes of them disturbing me when I am trying to do something means that they can get on for the rest of the week with what they are doing, then I think that is really good valuable time. [ID 1 PCT manager]

As a result, when shadowing this manager we witnessed a number of informal interactions during which members of the team raised issues or concerns with the team leader. Within all of the PCTs studied, work-places were generally open-plan, with individual offices only allocated to the most senior of the commissioning managers. In some sites only Directors of Commissioning were entitled to an office, whilst in others managers at Associate Director level had their own space in which to work. However, in one of our sites even Directors took part in the 'hot-desking' scheme working at any available desk, booking 'meeting space' if this were required for one to one meetings. Such meeting spaces seemed to be at a premium, with all of the research team having experiences of managers being unable to find a quiet space in which to carry out our interviews. Overall, this generated a busy and noisy working environment in which individual managers sometimes seemed to struggle to concentrate upon their tasks.

Much of the day to day work of commissioning takes place in meetings, and many of these were at venues away from the main PCT site, for example in GP practices, in hospitals or in other buildings owned by the PCT.

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Commissioning managers therefore often spent a considerable proportion of their time travelling between venues. The role and nature of meetings will be discussed in more detail in section 5.8 (p96).

5.4 The nature of **commissioning** *work*

The case-study descriptions in the previous chapter demonstrate that the organisation and distribution of commissioning work is not straightforward. Whilst all of our study sites had a director with responsibility for 'commissioning', job titles varied, from straightforward 'Director of Commissioning' to a number of variations including 'Director of Strategy' and 'Director of Strategic Commissioning'. Furthermore, in many of our study sites there had been a recent change in title, often in the direction of adding in some reference to 'strategy'. These Directors generally led a team of commissioning managers, but again there seems to be little consensus as to how commissioning work should be divided up. In some sites, distinction was made between 'urgent' and 'planned' care, whilst in others so-called 'long term conditions' were separated out as a separate area of responsibility. Community care was sometimes located in the same team as 'acute', whereas elsewhere it was deemed to require a team of its own. Furthermore, all of our study sites had, in addition to these teams ostensibly responsible for commissioning in particular areas, a number of cross-cutting commissioning groups, variously called 'strategy groups'. 'programme boards' or 'change programmes', who seemed to have responsibility for the actual work of commissioning. This work tended to be disease or speciality specific – 'diabetes', 'coronary heart disease' or 'orthopaedics' – but also usually included at least one group focusing upon *type* of care, such as 'urgent' or 'planned'. There are obviously conflicts and contradictions here, as a significant part of the clinical work associated with 'CHD' will also be 'urgent'. This exchange in a meeting illustrated this:

> *PCT manager 1: the next item's stroke*
>
> *DoC: [jumps in] cast your eyes over the cardiac programme*
>
> *PCT 1: what about cardiac rehabilitation?*
>
> *PCT 2: have to separate cardiac from stroke*
>
> *DoC: they're separate in WCC, perhaps integrated respiratory work should go under Long Term Conditions? [Fieldnote ID 23]*

We attended a number of meetings of these groups, and in general their work seemed to be focused upon the development of new care pathways or services. Composition of the groups varied, sometimes including representatives of providers and sometimes not. The links and division of responsibility between the work of these groups and, for example, the work of the 'Urgent care team' were not always clear.

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Overall, therefore, our study suggests that 'commissioning work' is messy, with the boundaries between the various areas of responsibility unclear. Our respondents reflected upon this in interviews, with this manager suggesting that there had been some direction from the Department of Health which had complicated their decision-making in this area:

> *We have, we have a CHD, clinical working group we have a stroke clinical working group, the trouble is that um, they are set up largely because the Department of Health edict says thou shalt have a CHD workgroup, or you shall have an urgent care programme board, but actually um, they're not linked to what the priorities or the strategic priorities of the health economy. So what we're actually trying to do is dissolve those and say, if we have a major programme of work on um, improving cancer outcomes, then let's form a programme board to overview the delivery of those outcomes, but define the outcomes, define what we want to do, and then we'll set up the board depending on the outcomes. [ID 17, PCT manager]*

This 'messiness' is in contrast to the vision of 'commissioning' set out in official Department of Health documentation, in which the so-called 'commissioning cycle' is prominent (Figure 1 p17). In this idealised representation of the work involved in commissioning, 'services' appear as unproblematic 'things' which can be 'designed'. In reality, we found our commissioning managers struggling to clearly define where one 'service' ended and another began:

> *And urgent care is a huge, um, subject. It seems to be, um, a bit like the leak underneath the Gulf of Mexico, a bit like a leak that you can't turn off. Very complicated. I don't think anybody fully understands it. So it's not just...it's difficult because it's not just one disease, it's lots of organisations, lots of complexities there. [ID 33, GP]*

As a defence against this level of uncertainty, we found that there were frequent references to 'pieces of work', which seemed to be the way in which commissioning managers reduced the messy world of 'commissioning' to something more manageable. Rather than designing a 'CHD service' or an 'orthopaedic service', our study participants talked about doing a 'piece of work' in a particular area:

> *A: Yes. But then saying that, this year I've done the paper on new to follow-ups, consultant to consultant and you know, the prior approvals and they've all three been really well welcomed, you know.*
> *Q: And where do they go? If you say do a paper on new to follow-up [appointment ratios] that would go to the Board.*
> *A: No. It goes; it went to [AD commissioning]. And then it's gone to, I know for instance that the Chief Exec he's actually*

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sent that out in a letter. He sent out. So it's, you know, it's been passed around.
Q: Yeah. So it kind of, goes up through the...
A: And on to the Board. And then it's been sent out to the Trust from the Chief Exec. So, you know, he's on board with it and he wants it to happen and obviously thinks that it's been rated as good pieces of work, and that's what [line manager] was saying, you know, the pieces of work that you're doing are really, really good. [ID 13 PCT manager]

This formulation was naturalised to such an extent that attempts to discuss it in interviews were met with blank looks. However, this manager suggested that the virtue of a 'piece of work' is that it is something that can be completed:

Sometimes we do get to...to that point where something can be done in a day...and when it's done, um, an example of which I've been trying to get some patients seen urgently....lots of different telephone calls today, lots of people actioning different things, but it's sorted and the patients are going to be seen. So that's one thing that we can put to one side because that's been done. So there's pieces, lumps of work and...and things that can be done, quick fixes almost. [ID26 PCT manager]

In summary, the commissioning work undertaken by our participants is messy and indeterminate. PCT commissioning managers not only have to contend with the messiness that has been described as a feature of managerial work in general, but also must work in an environment in which their 'real work' is also confused and confusing. This is perhaps best understood in contrast to the work of managers within a hospital. For example, whilst an out-patient clinic manager will, like all managers, have to contend with *managerial* work which is chaotic and unpredictable, the *substance* and desired outcome of the work for which they are responsible is clear: the running of a functioning out patient clinic, with sufficient nursing and administrative staff to ensure that all runs smoothly. Commissioning managers, by contrast, are engaged in work which is far from clear cut. Boundaries are blurred, it is unclear where responsibilities lie, and the desired end point is rarely obvious or uncontested. This special quality of the work of commissioning managers is the subject of an academic paper currently in preparation.

5.5 Middle manager enacted roles

This analysis follows the work of Mantere (41) in focusing upon *enacted* role. This concept acknowledges that actual role-performance is the result of complex interactions between individual and organisational expectations and beliefs about appropriate behaviours, and that ways of performing particular roles are socially negotiated between actors in a particular

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context. In practice, during the data collection period, observers in meetings and during informal observations noted the managers' behaviour in role. Subsequently, during the analysis of the data, types of role-related behaviour were coded, comparing those seen with those present in the literature.

Early coding of fieldnotes and interview transcripts attempted to divide commissioning managerial roles into 'formal' or 'informal' roles. However, it emerged during the data collection that for many commissioning managers there is no clear formal definition of what commissioning is and what their role involves. For example:

> *So, em, the role also, I, where I struggle a wee bit with it is the extent to which it's commissioning and the extent to which it's performance. I think it's very blurry and I spend a lot of time on performance issues, so things like, em, A and E performance, ambulance performance, eh, stroke. Usually all the things that we're not doing tremendously well at have got my name next to them [laughter]. Eh, so that probably puts a greater focus on performance than you might otherwise think. Em, and as I say my role is either co-ordinating particular pieces of work around urgent care, or leading, and actually doing it myself. So there's a, a sort of a, a hybrid of things. [ID 34 PCT manager]*

It was therefore decided to classify the roles that we saw enacted in practice in terms of their key outcome or ostensible purpose. Many such roles are clearly recognisable from the existing managerial literature (28).

5.5.1 Managing information flows down and sideways

The middle managers in our study were often in a key position in the flow of information around the organisation. It was their responsibility to work on service redesigns, to meet with interested parties and to co-ordinate inputs from information analysts, public health staff and prescribing advisors. The outcome of all of this activity was information, often in the form of business cases, service outlines, meeting notes or minutes, or briefing papers, but sometimes also prepared as powerpoint presentations or delivered as oral briefings to superiors. Much of this activity was routinised; in other words it occurred automatically as a result of systems and processes that had been set up. Thus, for example, most established meetings had distribution lists for their minutes, so that once minutes had been prepared their final distribution was a matter of custom and practice. Indeed, it was our experience that, once added to such a distribution list (as we often were) copies of minutes and documents continued to be sent long after our research at the site had finished. In some cases minutes were recorded and distributed by an administrative staff member, who simply recorded what went on. In one of the sites, meeting minutes were quite formal, and had to be agreed at the beginning of subsequent meetings, with adjustments made

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if individuals were unhappy with what was recorded. However, we also witnessed many examples of what might be called more active information management. For example, in one of our sites the role of taking notes from some meetings was allocated to the PBC managers in rotation. We were told that this role had initially been interpreted as a traditional minute taking role, but that one of the managers had decided to make it a much more active one. Thus, a particular manager had decided that instead of recording notes of what was said during the meeting, the notes would consist of a list of action points. Comparison of the list of 'action points' generated following one such meeting with what was heard during the observation of the meeting suggested that, far from being a straightforward summation of the decisions taken in the meeting, the 'action points' in fact represented a particular interpretation of what had been said, and in places actually imposed a decision where none had been clearly taken. At the subsequent meeting this list was accepted as a record, and discussion started from the assumption that these 'decisions' had in fact been made at the previous meeting.

The other type of situation in which this kind of role enactment was clearly seen was in the way that managers presented information to their fellow managers or to clinicians with whom they were working. Thus managers were frequently observed presenting digested summaries of issues or situations which often represented a particular take or interpretation of an issue. For example, one PBC manager, recognising that GPs rarely have time to read documents in advance of meetings, presented a short set of powerpoint slides, each of which gave one or two sentences about the issue at hand, along with a brief note of the decision that needed to be made. This ensured that the discussion which subsequently took place was based upon the selected facts presented rather than on the issue as a whole. It was argued that this made meetings 'more efficient'. This extract from fieldnotes illustrates this in action:

> *Next item: Chronic Obstructive Pulmonary Disease*
> *PBC manager – in the past they have a tried an 'invest to save' scheme, but it didn't work. He/she passed out a handout with 4 questions on it:*
> ** What could we do to improve our approach?*
> ** Our admissions are high for COPD – what can we do?*
> ** Is there any technology that is proven to help*
> ** How could we standardise care across Practice Nurses?*
> *[Fieldnote ID 28, PBC meeting]*

These four questions then structured the subsequent discussion. It can be seen that this approach establishes both the fact that 'our admissions are high' and that this is something that requires tackling. The evidence upon which this is based is unstated and therefore not available to be challenged. This could be said to demonstrate the exercise of what Lukes (109) called the 'second dimension' of power: power as 'agenda shaping'. This approach

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was, perhaps, the most obvious example of active 'information management' that we observed, but milder forms of this activity such as the preparation of briefing papers and oral presentations of 'what is going on' or 'what this means' by managers in meetings were ubiquitous. Indeed, it seems clear that such interpretation, reinterpretation and summing up activities are vital if commissioning work is to be accomplished, given the huge variety of documents, directives, guidelines and circulars from the Department of Health that governed the work of PCTs at the time of the research. No one person could hope to be on top of all such documentation and the summing up and sharing of interpretations is therefore vital. However, it can be seen that this places middle-grade commissioning managers in powerful positions, as their digested and interpreted versions of relevant information became the raw material on which other managers then went to work. More formal processes relating to the agreement and distribution of meeting minutes acted at times to limit this power.

5.5.2 Managing information flows upwards

This enacted role was very similar to that noted above, but it has been singled out because it was both less ubiquitous and also had the potential to place the managers acting in this way in even more influential positions. The managers that we were studying were those below Director level. The PCTs that we studied were not clearly hierarchical, and although in many sites organisational charts existed which set out apparent lines of authority and communication, in practice these were blurred and altered by custom and practice. Thus, for example, whilst it might look on paper as if commissioning managers of grade 8b were expected to report to an Associate Director, who in turn reported to the board, in fact many such managers had direct relationships with one or more directors. Much of the activity that we observed in this category could be defined as relatively routine information sharing, with, for example, business cases for the development of a new service passed up to the Clinical Executive in order to be signed off. However, we also witnessed isolated acts of more active 'upwards' management of information. For example, this manager described the advantages of having more than one person to report to:

> *Which I had in my [previous] post. I … covered what were [multiple] PCTs at the time and I reported to a clinical lead. I [also] had a service improver manager that I reported to, but the national lead was also within [local area]. So I reported three ways, and I learnt there that, rather than it being something that was problematic, it was quite good to report to three different people, because you sound out first the person that will understand what it is you are trying to say and trying to do and then broach it and sell it to the other person. [ID 9 PBC manager]*

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In addition, we observed a relatively junior manager speaking up in a meeting in order to tell a Director of Commissioning what should be said at a subsequent area wide commissioning meeting. This raises interesting questions relating to formal grading and the acquisition of legitimacy that will be addressed later in this chapter.

We also observed examples in which managers tried to manage information upwards, but with unclear results. One manager reported how he/she had personally attended a meeting of the leadership team in order to attempt to persuade them to make a decision about a particular issue, but was not sanguine that this approach had been successful.

> *I was at leadership team this morning trying to get them to make a decision on something, which I think we've just about done although you never sometimes, not quite sure….You know, is this going to stick or not, you know, there's a few does and don'ts and it's, yeah, I think you know, we agreed what were going to do when I walked out but you never quite know whether just [they say] 'after you went we started to think about it and….' [ID 14, PCT manager]*

In one of the sites we heard a frustrated account from several respondents of how information arising out of an extensive review of a particular service had been altered in the process of being passed upwards to the Clinical Executive. This also illustrates how practical issues such as when meetings are held can have an impact on how information gets transferred:

> *I don't know whether it's just timing, but we tend to meet on the last Friday of the month and [clinical executive] I think, meets the first Wednesday of the month, it's something like that. I have in the past written a report from the [commissioning group], what we decided, that didn't get to the [clinical executive] in time and wasn't even looked at. And the last time, which was more of a disappointment really, was the person that sits on the [clinical executive] and sits on our [commissioning group], reported back what he wanted to happen and not what [had been decided]. [ID 8, GP]*

This was an unusual occurrence in this particular site, where in general we observed a willingness by senior managers to enable and support their commissioning managers in having a wider role. On this occasion the problem seemed to be due to the individual beliefs of the person concerned about the particular issue.

5.5.3 Networking outside the organisation

This enacted role is closely linked to the management of information flows, but differs in that it relates more to the development of relationships than it does to the passing around of information, although information sharing is one possible outcome of the development of such relationships. In general, networking activity outside PCTs involved Commissioning Managers interacting with PBC groups (who generally seemed to regard themselves as

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separate from, although linked to the PCT), secondary care providers, and supra-PCT groups such as regional commissioning groups and working parties. We did not focus our data collection on those involved with joint commissioning with Local Authorities, and so have no data about this activity. Our data collection in this area again involved observation, with subsequent discussion of the issues in interviews. We were able to observe a wide range of examples of networking activity, including attendance at a supra-regional working party at which we had been invited to report on some of our previous research.

All of the managers that we studied had some type of external networking role. PBC managers demonstrated this most obviously, occupying a sometimes uncomfortable middle ground between PCTs and GPs. We observed such managers negotiating this dual role, and were able to explore the issues it raised in our interviews. This manager expressed it well:

> *I'm accountable to, I'm accountable to [Director of Commissioning] and [chair of PBC consortium]. So theoretically I face [both directions] I have a bizarre job, I would say to, um, articulate the wishes and aspirations and desires of the [PBC consortium] to the organisation. I use those words on purpose, and at the same time to present to the consortium the, um, strategies and policies and objectives of the organisation. So I kind of use those...so kind of I've got two completely different...languages at play, um, with both groups, and trying to kind of make the consortium do what the PCT needs it to do but in a way that it makes sense to itself and they, and they understand it. [ID 22, PBC manager]*

In fulfilling this 'middle ground', PBC managers were seen to adopt a fluid identity, using personal pronouns flexibly and in ways which were situation-dependent. Examples included the use of 'I' and 'we' to indicate a shared, PBC identity, and 'them' to suggest that the PCT was in some way 'other':

> *PCT manager: the [referral management system] will help if **we** all start working towards the [local] list. **We** need to do the easy things because if not then **they'll** start on Local Enhanced Services and Directed Enhanced Services and that'll hurt more because it's income isn't it? [Fieldnote ID x PBC meeting]*

The issues that this raises with regard to middle managerial identities will be explored in an academic paper which is in preparation.

Non-PBC managers also enacted external networking roles. One prominent strand of these involved roles working alongside hospital colleagues in redesigning services, either working together in the formal environment of the commissioning groups discussed earlier, or more informally, using personal contacts to develop 'ad hoc' groups working on particular 'pieces of work'. The more formal of these contacts were characterised by significant tensions, as the interests of the two parties were not clearly aligned. For

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example, at the time of the research, PCTs were under significant pressure as they tried to break even financially. Achieving this often required the movement of services away from hospitals. This is illustrated in this extract from fieldnotes:

> *Item 2. procedures of limited value*
> *[These are items that are on the so-called 'croydon list[4]' as being things that could be decommissioned.]*
> *There was a brief discussion about whether or not it could be discussed in this forum without contracting present and without the director of public health.*
> *Hospital manager 2 said that it was difficult because it 'overlaps with contracting'. The view from contracting was that there would need to be a % reduction in these procedures, and they wanted to know what the PCT wanted. They wanted to know detail about which procedures were targeted, and what percentage reduction they were expected to achieve. They needed more clarity*
> *[PCT commissioning manager] said that it had already been discussed by the Director of Public Health, and she would make sure that a formal letter was sent.*
> *PBC manager put in here that there was an issue for them, because if myringotomy and tonsils were reduced then the ENT service at [local DGH] would become non-viable, which they wanted to avoid. It would not be worth the while for the visiting consultant to come.*
> *Hospital manager 2 agreed, saying that ENT would become 'non-viable'. [Fieldnote ID 33, meeting with provider]]*

In subsequent informal discussion the PCT manager chairing this meeting discussed the need to 'get the tone of the meeting right', explaining that it would be easy for such discussions to descend into confrontation. Furthermore, it was explained that meetings such as this between middle-level managers on both sides had no decision-making powers, and there was a danger that the painstaking process of discussing individual services in this way could be undermined by higher-level discussions between the Chief Executives of the two organisations who had in the past made agreements that failed to take into account this type of work.

A final 'networking' role that was observed involved managers taking part in meetings and fora between commissioning managers across the region. One interesting facet of this activity was that it tended to develop in an unplanned way, with individual managers volunteering to participate depending upon their individual interests and career aspirations. Once they were established in position on these supra-PCT fora, there seemed to be no mechanism within the PCTs either to ensure that the PCT was being

[4] This is a list of procedures authoritatively regarded as having limited clinical benefit, which should therefore be de-commissioned. It originated in this form with Croydon PCT, and is therefore generally known as the 'croydon list'

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represented in ways that were consonant with their overall strategy, or to enable the systematic transfer back into the organisation of any lessons learned. Both of these activities were dependent upon the behaviour and attitudes of the individual managers concerned. For example, in Site 2 a relatively low grade manager represented the PCT on a regional service-development forum, and he/she reported being left to develop the role as he/she saw fit. The activities engaged in seemed to be invisible within the wider context of the PCT.

In summary, networking outside the organisation was a prominent enacted role observed during the study. Within the context of PBC, this was a very important role, which entailed a flexible and sophisticated adoption of appropriate identities by the managers concerned. Networking outside the organisation over and above the PBC work involved engagement with commissioning managers across the region and with the managers of local providers. Two facets of this work stand out: evidence of an apparent lack of a systematic approach to either ensuring that managers were not simply following their own agenda or to capture lessons learned; and evidence that, on occasion, lack of delegated decision-making powers meant that high-level 'deals' could undermine the work done by commissioning managers

5.5.4 Networking within the organisation: sensemaking in action

In addition to their activities across organisational boundaries, the managers that we studied spent a considerable amount of their time networking within the organisation. This was accomplished in two ways: in formal meetings; and in informal contacts. In terms of formal meetings, we found differing patterns of such contacts across our case studies. In Sites 1, 3 and 4 there were what could be thought of as interlocking programmes of meetings. Observing over a period of 2-3 months in each site allowed us to observe how issues, programmes and service developments were discussed by different groups of staff in a number of different types of meetings. Each time a particular issue was discussed it was modified, so that when it next appeared in a different forum it had developed and moved forward.

This is perhaps best illustrated by describing the progress of a particular issue in one of the sites. Under PBC, PCTs were required to provide an incentive scheme (8), which was intended to incentivise desirable behaviour. In general these schemes involve a number of different elements including, for example, incentives to prescribe cost-effectively, incentives to scrutinise referrals to hospital and incentives to engage with the PBC processes and activities. In one of our sites we were able to observe the development and eventual adoption of one such scheme. At the start of the data collection process, two schemes were being discussed. One of these was a straight-forward incentive scheme, building upon a previous such scheme. The second involved a desire to develop some sort of direct incentive for practices to remain within budget. These two schemes were

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discussed at a number of different meetings, and two managers were delegated the responsibility for developing the second of these schemes. At each meeting that was observed, different issues and problems emerged, and on each occasion the next iteration of the scheme had been changed in order to adapt to these issues. Finally, at an unrelated meeting that was ostensibly devoted to entirely different issues, a group of managers decided that, in fact, the two schemes could usefully be combined, and that this combination would meet some of the issues and objections that had been raised. A quite radically different scheme was then presented to a combined commissioning meeting, agreed and then disseminated more widely.

Two aspects seemed to be important during this process. The first was that the inter-locking series of meetings (eg PBC general meetings, meetings between PBC commissioners and PCT commissioners, PBC managers' meetings, meetings between commissioning managers and more senior staff etc) provided a number of different fora in which 'sensemaking' about the proposal could take place (see chapter 2, literature review). This sensemaking was an active process; each description of the proposal prompted those taking part in the meeting to engage with the issues and, in discussion and conversation to actively shape it into something slightly different. In Weick's (110) terms, each iteration of the scheme provided the raw material which the social interaction within each meeting then tested and reshaped according to underlying schemata that were themselves the product of previous rounds of sensemaking. This process rested upon a notion of collective identity, which in turn shaped what kind of a scheme it was possible to envisage being enacted. Secondly, the wide variety of fora at which it was discussed ensured that, when the final scheme emerged and required dissemination, all those involved seemed to feel a degree of ownership. Indeed, a number of different managers told us that the scheme had been 'their idea' in the first place. Implementation would still be a difficult process, but the way in which the scheme had been developed seemed to have ensured that there was no danger that it would be rejected out of hand.

It was also interesting to note that the final meeting at which several informants suggested there had been a kind of 'revelatory' moment about the combination of the two schemes was not scheduled to be discussing it at all, and was not empowered to make that kind of decision. This fact was alluded to by some respondents, but it seemed that the process which had been followed, with the opportunity for many voices to be heard, ensured that this criticism was muted and did not impact on the overall outcome.

Site 2 provided a contrast, and illustrated the problems that occur when opportunities for sensemaking are limited. In Site 2, meetings did not occur as they did elsewhere. A significant number that we were scheduled to attend were cancelled – on one occasion the researcher travelled to the site for a meeting, to be told that it had been cancelled 'because no one had it in their diaries because it was in the new year and things hadn't been

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carried forward'. Rather than being rescheduled, the meeting was cancelled, with the next one booked for the following month. As a result, we found that in Site 2 it was much less clear how decisions were made or issues followed up and developed. One of the commissioning managers was keen to develop a new commissioning strategy in a certain specialty, and had written a paper setting out the issues in this area. It was hoped that, during data collection, we would be able to follow the development of the strategy as it was discussed and refined. However, after nearly two months of data collection, no meetings had been attended at which the paper was discussed. Further requests for information on this issue suggested that little progress had been made.

In addition to formal meetings, informal contacts were also important for internal networking. In this area, the physical characteristics of the working environment were important. Site 4, for example, was a large PCT, and operated over a number of different sites. This meant that opportunities for informal contacts were limited, and may have contributed to a central unease about the development of individual 'silos'. Attempts to respond to this included appointing staff with an over-arching city-wide remit, but this proved difficult, as the demarcation of responsibilities was not always clear. All of our sites had open-plan offices, with many middle-grade managers working at desks within a large room without partitions. In sites 1 and 3, teams working together occupied adjacent desks, and many informal discussions were witnessed in this environment. In site 2, by contrast, a policy of 'hot-desking' had been adopted. Under this policy, no staff were allocated permanent desks. On arrival, members of staff were expected to look for a 'free' desk using a central booking system, with mechanisms in place to route telephone calls to the correct desk. The stated objectives of this scheme were twofold: to maximise desk-occupancy and so minimise the number of desks needed; and to enable a democratic culture in which staff mixed outside their teams and worked alongside Directors and senior managers who also were not allocated individual rooms. However, staff told us that this system brought with it many problems. The telephone system did not seem to be able to efficiently route calls to the correct desk, making it difficult for outsiders to contact managers. This was experienced directly by the research team, as we struggled to get hold of managers to arrange meetings. Furthermore, whilst working alongside directors and members of other teams was acknowledged to be a strength of this system, our respondents argued that the benefits of this were outweighed by the disadvantages, as team members wanted to sit together and be able to interact more informally. This manager expressed it thus:

> *And that way you effectively have um, desks for about 70% of the actual staffing level because people are always moving around then you should be able to move the desk around. In principle it sounds great and I think in an organisation where people turn up to work, sit in front of a screen for eight hours and leave, and a paperless society like Carphone Warehouse, it works quite well. In the NHS it's a disaster. You see people*

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walking around pulling trolleys of paper and things around with them, and human nature is that you know, it was aimed to foster your people in public health sitting down with finance people and the commissioning people sitting with the performance people and actually, nature takes its course and everybody distils into their own area. Um, so, nice idea in principle hasn't been particularly successful in practice. [ID 17, PCT manager]

Some respondents told us that they worked at home as much as they could to avoid the perceived problems, further limiting opportunities for informal networking.

In interpreting these findings it must be remembered that in this study there was no attempt to formally measure 'outcomes' or judge success according to any measurable parameters. However, it was the aim of the study to try to link what we observed with evidence of 'success' in terms of the development of functioning PBC consortia. In the analysis of the data that we collected it was clear that site 2 was the site in which there were the fewest opportunities for staff to interact and 'make sense' of their worlds. It was also clear that progress in establishing PBC was slower in this site than in the other sites. However, it is not possible to draw a clear causal relationship between these two findings, and there were many other potential factors at work, including the geography of the area, the nature of the local hospitals and the overall financial situation. On the other hand, the active sensemaking that was observed in other sites, and the contribution that this made to the development of services and schemes, suggests that ensuring opportunities for internal networking both in formal meetings and informally could play a role in ensuring that progress is made in the future. It is interesting to note that many of the managers that we interviewed across all of our sites complained about the number of meetings that they were required to attend, and these were often disparaged as 'mere talking shops'. Our study suggests that, in fact, such 'talking shops' are a vital part of a functioning commissioning organisation.

This analysis has echoes in the sensemaking literature. As discussed on page 48, Maitlis (104) characterised organisations according to two characteristics: animation; and control. 'Animation' referred to the availability of opportunities for sensemaking, both formal and informal, and could be said to correspond to our finding that an active programme of inter-locking and mutually referential meetings was a positive influence on the sensemaking process, as was the opportunity to mix informally. 'Control' referred to the degree to which senior managers kept control of decision making processes. Maitlis argues that 'high control, high animation' organisations are most likely to produce rich (in terms of their ability to incorporate a variety of insights) but internally consistent actions. Our study sites were 'high control' in the sense that there was little devolved decision making. However, there was some evidence that overall organisational aims were not always fully understood below board level:

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[Extract from meeting discussing forthcoming assessment against World Class Commissioning targets] PCT manager 3 agreed, saying that things needed to be visible to staff so that they understand the overall vision
PCT manager 2 said that she thought it was sad if they had to show people things that should be an integral part of their job.
PCT manager 1 disagreed, saying that it would be sad if people didn't recognise the things that were put up, but that she felt that they probably would. Some staff were not happy that they weren't involved with developing the [strategic] plan, but...
PCT manager 2 butted in, saying that it reflects the level of buy in to WCC. 'We' understand, but do the rest of the staff?
PCT manager 1 agreed that that was fair. They need to take a more collaborative approach. People need to understand the contribution that their job makes to the overall direction.
DC said it is our responsibility to make sure that the rest of the staff know – we must cascade it via our teams. [Fieldnote ID 33]

Where such dissemination had occurred, as in the example of the development of the PBC incentive scheme discussed above, those lower down the organisation were able to proceed with a rich process, secure in the knowledge that once they had developed their scheme it would be adopted by the organisation. We were told that, on other occasions, middle-grade managers had devoted considerable amounts of time and effort to develop schemes that were deemed not to be consonant with the overall direction of the PCT, and were subsequently dropped. It would therefore seem that 'high animation' and 'high control' environments also require effective mechanisms for the communication of overall organisational objectives between the top team and the 'animated' middle managers if their full potential is to be realised.

These findings will be further developed for an academic paper addressing the micro-processes of sensemaking in commissioning organisations.

5.5.5 The 'animateur': a special role for PBC managers

The 'enacted roles' discussed so far are all recognisable from the managerial literature. In addition, we also identified the enactment of an additional role for which there did not seem to be any precedent in the literature. We have called this the 'animateur' role. This role was enacted exclusively by managers responsible for PBC, who were managing actors over whom they had no formal authority. The enactment of this role was observed in sites 1, 3 and 4 but not in site 2. The essence of it is a very active management of disparate groups of people, working to align objectives and to ensure that the right people behave in the right ways at the right time, and contribute to a particular overall objective which is mutually determined, whilst being influenced by hierarchical concerns. It has some overlap with what Goia (98) has called 'sensegiving', which is defined as the active dissemination of

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a particular vision of how an organisation 'is' and 'should be' in the future via the use of symbols and symbolic action to demonstrate that the prevalent interpretive scheme should change (p434). However, the animateur role differs from this in that 'sensegiving' is described as an activity undertaken by senior managers within an organisation wishing to bring about change that has been decided from the top. The animateur role, by contrast, is enacted by middle grade managers, who, although acting in ways that may be consonant with the official organisational 'line', were not seen to be constrained by this, bringing in their own conceptions of what should be happening in addition to following official policy. Furthermore, the animateur role is essentially active, aimed not simply at changing perceptions but also at bringing about specific concrete action in a specific time frame by a group of actors over whom the manager has no direct control. The characteristics of this enacted role seem to be:

- The managers who enact this role seem to identify with BOTH their PCT and their PBC group, seeing themselves as actively part of both. Thus, for example, such managers were more likely than their non-animateur colleagues to use personal pronouns such as 'we' and 'they' in a flexible manner when talking to different audiences in order to convey 'belonging' to a particular group.
- It is visible when the managers are acting to achieve specific goals and actions rather than having the more general aim of getting the group members to work together.
- It goes further than diplomacy, in that it involves the generation of specific action that is unlikely to have occurred had this role not been enacted.

The clearest example of this type of behaviour was demonstrated by the PBC manager in one of our sites. There was due to be an important meeting with one of the local providers, at which PBC GPs would be present, along with the manager. Relationships with this provider were slightly strained, and it was regarded as important that some concessions should be won in a particular service area. One of the GPs described how, prior to the meeting, the PBC manager had drilled and rehearsed the GPs, discussing and illustrating an opening negotiating stance, fall back positions and a final 'bottom line', and going so far as to assign roles to team members within the negotiation and providing 'crib sheets' to be used during the meeting. This approach resulted in a successful renegotiation around the key issues. What was particularly striking about this episode was how it had not only fed back into the GPs' perceptions of what management is and how it is done, but also fed into the wider PCT perceptions of the effectiveness of PBC. In other words, in addition to achieving the desired outcome, the manager had fed into a new round of sensemaking for the GPs involved, prompting them to re-evaluate and alter their perceptions of their role, and had also influenced the sensemaking about PBC of the more senior PCT managers. This same manager further demonstrated this role-related behaviour when he/she became concerned that GPs were not reading emails and contributing to discussion of documents distributed in this way.

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He/she 'let it be known' that email discussions were being monitored and contributions noted, prompting an immediate increase in engagement from the GPs concerned, An example from one of the other sites involved a PBC manager who wished to decommission a particular service. The GPs involved were not keen on this, and, over a series of meetings and in informal discussions with the manager we observed the use of a number of active strategies to ensure that this end was achieved without any confrontation or serious opposition.

The term 'animateur' to describe this role was coined by one of the research team, and adopted by the group. It is an appealing metaphor to use in the current context, because it ties in well with the earlier discussion of the work of Maitlis (104), with its emphasis upon 'animation' as a key determinant of organisational sensemaking. According to Maitlis, if there is little in the way of formal and informal interaction between groups within an organisation, then there will be little effective sensemaking. In this conception, sensemaking requires that actors are able to interact in both formal and informal ways, sharing ideas, discussing them and generating new approximations that can become material for the next round of sensemaking. Following this through, then one of the roles of PBC managers as 'animateurs' is to direct and organise these interactions, making them happen but also ensuring that when they do happen they are effective in generating new 'sense'. Animateurs, therefore, 'animate' sensemaking, rendering it more effective.

5.6 The relationship between enacted role and formal grade

Implementation of the 'Agenda for Change' (111) grading system started in 2004. The essence of the programme was to transfer all NHS staff (apart from doctors) onto a common pay scale. All jobs were to be assessed, and allocated to a grade, based upon a number of generic characteristics such as levels of responsibility, qualifications required etc. By the time this research was carried out, all PCT managers had been allocated to an agenda for change grade.

Overall, the roles performed by the managers that we studied were similar across organisations. However, Agenda for Change (AfC) grades varied considerably, with managers working with PBC groups occupying grades 8a-8c, and PCT commissioning managers occupying an even broader range of grades from 6-8d. Whilst there was a general pattern that managers in larger organisations tended to occupy higher grades, this was not universal. Furthermore, whilst those managers that we observed taking the most responsibility tended to be those on higher grades, this was by no means always the case. Thus, for example, in Site 1 a grade 6 manager was undertaking a role that elsewhere in the organisation was occupied by staff on grade 7 or even grade 8a. In some cases this was regarded as an individual 'acting up', and this was seen as a positive career move:

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I mean, I sort of, saw it as a development opportunity for myself. I was working as a band six previously, but sort of, clinical audit was a bit of a dead end and I wanted to sort of, expand my horizons. So I sort of, took it as a sideways jump. But coming in here I think I am aware that probably band six is quite low, and certainly would be looking, I know that there are opportunities around PCT and elsewhere for higher bands, basically the same job I do. Some of it's probably because of my own doing, because I wanted to take on more and um, you know, perhaps if I was a different person, so much wouldn't be expected of me, perhaps and there would be more support available. There are certainly other people who are perhaps on band sevens who are doing exactly the same job. [ID 6, PCT manager]

On the other hand, higher gradings were sometimes seen as important in terms of the messages that those grades conveyed to the outside world. Thus, in one of our sites, PBC managers were given a high grade because of the message that conveyed about the work that they were doing:

Um, and I think [Director of Commissioning] has chosen to do that for whatever political reasons he's chosen. I think that, um, we look at his two Associate Directors, if you put PBC [under] one of those I think it would have got lost you know, and it would have sent a message to the GPs that says actually we don't really value this as much as we say we do. So we report [directly] to [Director of Commissioning] because it's actually sending a political message outside, you know... We create structures that kind of send messages. [ID 22, PBC manager]

However, the GPs who were supposedly on the receiving end of these messages were in fact often oblivious to the process. None of the GPs involved with PBC that we interviewed were aware of the AfC grade of the managers with whom they worked, and when asked about it, they were far more concerned with the behaviour of the managers in role; 'getting things done' was regarded as a key characteristic:

Q: Would that be your definition of, er, of sort of what makes a good manager, is somebody who, who does things that they say they're going to do?
A: Yes. Or, maybe gets people to do things, rather than just talking about that. And we've talked about all sorts of things and it just...it keeps going round and round and round. There's another meeting, another meeting, another meeting. And that might be the system, but [PBC manager] seems to get things done a bit. [ID 10, GP]

Several senior managers suggested to us that, for managers whose job it is to interact with clinicians such as GPs, having a higher grade could provide a degree of confidence, allowing the managers to be challenging or more directive if that were to be required.

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In summary, therefore, there was no clear correlation between formal grade and actual work responsibilities. Grading could be used strategically to prefer legitimacy upon a manager, but lower grade managers were seen to act to earn this legitimacy for themselves, often by being seen to 'get things done'. This manager regarded the whole system of AfC as part of the problem:

> *A: I think agenda for change has been a total disaster. Um, it's basically shifted everybody's salaries up and it's done nothing around challenging the levels and skills of the individuals in place. Um, I have an organisation where I have um, eight band eight commissioning managers and one band seven and nothing else.*
> *Q: Yeah. So you've got nobody to do the donkeywork?*
> *A: Correct. So I have a mixture of um, good commissioning managers at the right pay scale, who are unable to do the job they're capable of because they have no infrastructure to support them, they have no project managers, they have no information support people, in some cases no admin support, they do their own admin, and then I have other commissioning managers who are very busy but are actually only working at a level of a band seven. And those are generally those that have been, in very simple NHS terms, rewarded for longevity in the NHS. [ID 17 PCT manager]*

5.7 Clinician managerial roles

It was one of the aims of this study to explore the roles of clinicians as managers in the context of PBC. In the early stages of data collection in each site, the local configuration of PBC was explored and relevant 'GP managers' identified. These GPs were observed during meetings, and as many as possible were interviewed. However, arranging interviews was often difficult, due to pressures of work. In total, eleven GPs with lead roles in PBC were eventually interviewed. Whilst no strong claims to representativeness can be made, our respondents covered a range of contexts, and provide at least some indication of the issues facing GPs adopting these roles. Many of the issues raised were common across contexts and between different PCTs, suggesting that, whilst not necessarily representing the full range of problems facing GPs in the context of PBC, the factors identified here represent things which could be usefully explored in the context of the proposals in the 2010 White Paper (117) relating to GP roles in commissioning.

In the literature review (p32), the notion of 'identity' was identified as a useful lens through which to explore the roles of clinician managers. This concept was explored in interviews, and used as a framework within which to examine the behaviour of GPs in meetings.

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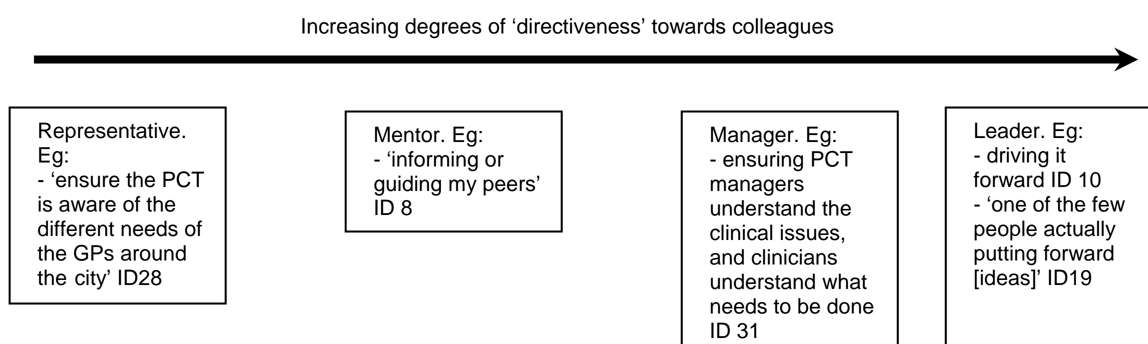
5.7.1 Questions of identity: who am I?

All of the clinicians interviewed were asked whether or not they regarded themselves as 'managers' within the context of PBC and commissioning. In addition they were asked to self-define the nature of their role. Most of them rejected the idea of 'being a manager', preferring to identify themselves as either *representatives,* trying to present the 'GP view' within the context of commissioning, or, less commonly, as *leaders.* In fact the range of self-characterisations could be visualised as a spectrum, from 'representative' at one end, to 'leader' at the other, with a small number of GPs identifying other positions along the spectrum such as 'mentor and guide' and 'manager':

Figure 3. Clinical managerial roles



In exploring these identities it was clear that GPs often espoused a number of these identities simultaneously, describing themselves at different times in the interviews in different ways. Thus, for example, the GP who most clearly identified himself as a 'leader' also described the need to manage colleagues and to represent their interests, and the GP who initially rejected the notion of 'managing' colleagues subsequently said:

> *'Although I might have to manage them this week, because I have to go and see a couple who are not performing well.' [ID 8, GP]*

In exploring the identities adopted by clinician managers in hospitals, Forbes and Haller (86) concluded that clinicians working in hospitals varied in how far they saw the identity of 'manager' as being one that they felt that they wished to adopt. In our limited sample, it would seem that GPs are perhaps more reluctant than their hospital counterparts to adopt this identity, with virtually all of our interviewees describing themselves as still 'primarily' a GP:

> *I enjoy the sort of management side of things, but I'm also still [laughingly] enjoying being a GP. I don't know whether I want to do more on the management side of things, it's, um, it's difficult.... Because I'm like, I'm like, er, a lot of GPs, I still, you know, I work ten sessions a week, eight sessions a week as a GP, so I'm very much, yeah, still a GP [ID 31, GP]*

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Furthermore, when asked to reflect upon their managerial role, many of our interviewees described it as an extension of their role as a GP, casting commissioning as being an extension of the core GP role:

> *I'm a, first and foremost, I'm a GP, and that's the role I love and I've always been very happy with that. I'm increasingly a GP, I think from within the practice, I mean, I'm the senior one there by virtue of seniority, age, and so I've had to, I don't particularly like being seen as a leader, but I've had to become a leader in that situation And I think I do see myself as a leader with the [PBC group], so yes, and I'm very interested in, not so much in commissioning, as such, but just getting the best deal for patients in the most cost effective way, using the money that we've got for the benefit of, to get as much benefit for everybody from the limited pot of money, and that's what intrigues me about commissioning really.[ID 8, GP]*

In this meeting, engaging with commissioning was cast as an almost moral responsibility for GPs:

> *GP: there's a fear that clinical judgement will be overridden, and we're being challenged on whether it will save money. Really there are a number of qualitative issues that are important, get people to use the pathways etc. I think the biggest selling point is it's a major policy driver, as GPs part of our contribution is to work as effectively as possible, it's not a choice, it's a duty [fieldnote ID 41, PBC meeting]*

Overall, whilst GPs tended to reject the label of 'manager' in discussions, in meetings it was clear that, whilst they often acted as a spokesperson, putting the view of their colleagues, they also enacted managerial roles in practice, working with their managers in order to ensure that decisions were made and proposals implemented. Indeed, it was sometimes felt by observers in some meetings that an outsider who had not been introduced might have found it difficult to identify which participants were GPs and which were managers. This was more likely to be the case where relationships between GPs and their PBC managers were close, and the managers were regarded as effective by the GPs. This distancing of themselves from the 'managerial' role, whilst simultaneously acting to perform that role echoes Bolton's (44) findings about role 'distance'; like Bolton's nurses, the GPs we studied seemed to be enacting the managerial role whilst remaining distanced from the 'virtual self' that that role implies.

5.7.2 Questions of identity: PBC, PCT or both?

Many of the GPs in the study echoed the PBC managers in describing a dual identity, straddling the boundary between general practice and the PCT. Words used to describe this included being a 'go-between', a 'conduit' and a 'bridge'. This GP put it like this:

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Within the PCT, okay, my main role of the, of the [PBC] Chair, is to represent the other practices, which are part of my consortium, take their views on board in terms of the commissioning arrangements, that's the responsibility I have to them. The responsibility I have as a corporate member of the PCT is to make sure that for my particular patch, their commissioning decisions that are appropriate for that, for that population. So when I'm actually working with the PCT my hat is in terms of doing what's best for the individual practices and making sure they don't lose out in terms of opportunities. At the same time ensuring that the practices are working towards, we… are injecting an equality in any project they do, is steering them towards that and from the other side, informing the practices and actually, maybe sometimes encouraging them to accept some of the of the PCT's roles as well and, and the PCT's objectives and helping to assist facilitate that role, so it's a combination. [ID 23, GP]

Several respondents talked about 'wearing two hats', and described how they would try to make it clear to their colleagues which hat they were wearing at any particular time. This was also witnessed in a number of meetings, with GPs sometimes announcing that they were 'speaking for the PCT' with regard to a particular issue.

Some GPs also expressed concern that their PCTs were not always clear what role they wanted the GPs to adopt. Complaints were made by a number of GPs that PCTs seemed to want to have a 'token GP' on all their commissioning groups, with no clear idea of what the role should involve.

5.7.3 Legitimacy, authority and expertise

Many GPs told us that they had been reluctant to take up the role as PBC lead, but accepted because someone had to do it:

I think to be fair, someone had to drive it forward, and I think I did drive it forward. I still think PBC has a lot going for it and I suppose I would do, it's my job. However someone actually had to get involved in it and get stuck in and do it, and I suppose it was me. [ID 10, GP]

These professions of reluctance may have been related to the also often-expressed reluctance of these GPs to accept that their role involved any kind of 'management' of their colleagues. It seems that, whilst being a 'clinical leader' is officially lauded as being important and desirable (112), some GPs acting as leaders at a local level have a cultural reluctance to accept the label. This may be related to the notion of 'collegiality' amongst clinicians (113), in which all are regarded as equals, who are all equally competent. Whilst it has been claimed that such notions have been threatened by moves of clinicians into management, (114) our limited

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evidence suggests that, for these GPs at least, claiming special competence or leadership capability was seen as taboo.

Overall, we found three linked claims upon which the GPs we interviewed based their legitimacy to act on behalf of their colleagues. These were:

- A claim to expertise, usually based upon additional training or experience in a particular topic such as surgery, emergency care etc, and the exercise of this expertise on relevant commissioning groups
- A claim to experience, often within previous incarnations of GP commissioning such as fundholding, or in other leadership roles such as working on the Local Medical Committee
- A claim to representativeness, based upon having been elected to the leadership position

On occasion PCTs used other GPs not involved with PBC to provide clinical advice or expertise to particular commissioning programmes. This GP regarded this approach as lacking in legitimacy:

> *We had a meeting last week or the week before and some manager that I've never seen before turned up to talk about, erm, eh, child, eh, a children's plan about, eh, I can't remember what it was now, it was about some new policy around health visitors and midwives and, you know, there's a nought to five plan, there's a five to fifteen plan, and there's all these new targets, never seen this guy before, you know, he's obviously been doing huge amounts of work on this, but which clinicians was he connected to? You know, didn't seem to be connected to any of the clinicians on the committee. He probably has a little GP somewhere that, that, you know, comes in for one session a month and sits with him but who knows who that is or where that person has come from. And I think one of the big issues is I think there's a, there's a, the clinicians are used very badly in the PCT and I think there's no real structure to how the clinicians are used. [ID 19, GP]*

This particular GP had been asked by the PCT to take over as chair of one of the new commissioning groups being set up. However, he was concerned that there was a complete lack of clarity over his role, his authority and his accountability. He argued in the interview that the PCT did not seem to have a clear idea of what the role of clinicians should be. Other PCTs were also wrestling with this, with one of our sites in the process of reorganising all of the clinical input into the PCT so that PBC was seen as the main mechanism by which clinicians would be involved. This was seen as important if changes to commissioning pathways were to be successfully made and money saved.

All of our GP respondents told us that it was very difficult to perform their role in the time that they had available, but many also expressed reluctance to reduce their clinical sessions as this was seen to take them further away from their core identity as a GP. Some also expressed frustration at their lack of training for their roles. What training that there was available tended

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to relate to the substantive business of commissioning rather than to learning how to be a manager. The Department of Health runs programmes of training for 'clinical leaders', but none of our respondents appeared to be aware of this, in keeping with their reluctance to identify themselves as 'leaders'.

5.7.4 Interactions with managers

Many of our GP respondents described a close relationship with their PBC managers, which was generally seen as a 'partnership' rather than either 'managing' the other. However, GPs were not necessarily hostile to the idea of being managed:

Well, [PBC manager] is the one who's controlling us.
Q: Is that what it feels like?
A: I'm saying she organises everything for us. Keeps us updated, what's going on and what action need to be taken, what we need to be discussing in our board, what needs to be discussed in our other clinical leads meetings, meetings with [providers]. Those meetings, or meetings with executives. She arranges all those ones and updates us.
Q: And do you feel that she's, she is very supportive?
A: Yeah, she is very, very supportive. [ID 3, GP]

Indeed, there was evidence from both interviews and observation that when GPs experienced 'good management' (often when PBC managers acted as 'animateurs') this fed back into their expectations of what management was, and provided them with a template against which to judge other managers and to develop their own role. Where managers were not acting in this way, GPs tended to see them as occupying a 'support' function, doing what one GP called 'the donkey work' whilst the GPs did the more strategic work of commissioning.

5.8 The impact of organisational practices

In section 2.8.1 (p39) of the literature review, the role of organisational practices in structuring managerial work and in defining what can and cannot occur in particular situations was discussed. The work of those scholars identifying themselves as studying 'strategy as practice' was highlighted (92). The role of one such organisational practice in determining how managers behave has already been highlighted in the discussion of the impact of 'hot desking' in one PCT in section 5.5.4 (p83). In this section other practices, including the role and nature of meetings and organisational geography will be discussed with regard to the ways in which these can both enable and constrain managerial work.

Each of our research sites had an established schedule of meetings and a broadly comparable range of groups. Nevertheless, our observations showed wide variation in the role and nature of meetings particularly with regard to decision-making. In Sites 1, 3 and 4 meetings were generally

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well-organised with dates and papers being disseminated ahead of time and were understood by managers to be the bedrock of managerial work. Indeed in Site 3 where managers viewed meetings as vital to the work process, the repeated cancellation of a meeting scheduled to prepare for the WCC assessment led managers to assume that the work was already under control.

> *It was a shock to all concerned to find that the cancellation of the meeting had actually resulted in no work being done. When this was revealed, there was a sense around the table that the person responsible had somehow not been playing the game properly.[Field notes ID M33]*

In Site 2, as noted earlier, meetings were frequently cancelled at short notice. Here the lack of opportunities for collective sensemaking made it difficult for the organisation's strategy to be operationalised among managers. This seemed to create a disconnection between organisational objectives and day to day managerial work. Some managers responded to these difficulties by 'getting on with the job' but at times work undertaken in these circumstances was later abandoned in favour of more important priorities. The formality of meetings varied across sites and in Site 1 where processes were strictly adhered to, managers signalled their desire to speak by putting up a hand rather than butting in. Here we also observed managerial hierarchies being enacted in a meeting to which junior managers were called to attend for just a short period. A lack of chairs caused them to stand at the back of the room and this practical difficulty seemed symbolic of their lower place on the managerial hierarchy. Managers in this site spoke of finding meetings 'intimidating' when they first arrived at the PCT. Nevertheless the clarity and adherence to the meetings schedule across the organisation has created a clear and collective understanding of the different meetings and their purpose.

> *All the meetings are linked and there's far more accountability in reporting structures, which I think is missing in some of the PCTs. Like the senior managers' meeting here, it has a specific role and place. Whereas if you look at the one that happened when I was at [another PCT], it was just information dissemination. It didn't have any role or purpose apart from that, like it didn't make any decisions. [ID 9 PBC manager]*

As noted earlier, 'getting decisions made' is a critical part of the middle managerial role and a manager's legitimacy within an organisation relies heavily on demonstrating this skill. Managers working in an organisation where the decision-making process is both embedded and enacted in a defined sequence of meetings appear to have a much better opportunity of achieving their goals. We found in Site 2 that although the decision-making process was formally embedded in a sequence of meetings, the practice of decision-making was more ambiguous. This created uncertainty and difficulties for managers requiring a formal decision on projects and such discussions often resulted in the arrangement of another meeting with

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managers left unclear as to where the ultimate authority for decision-making lay.

> *the question is, when we've had our meeting I don't think we'll actually have the authority to not to go back to the leadership team and say we've had our meeting, this is what we've now decided we need to do and then we may end up going around in circles.[ID 14 PCT manager]*

Problems were also caused if there was an imbalance in the frequency of meetings of different groups. In one PCT, the executive team met weekly whereas the business management group, comprising senior managers, met monthly. This resulted in much activity having to be initiated informally through email and corridor conversations and managers believed that this made it more difficult to keep track of work. Conversely many of them were appreciative of the informal nature of this organisation which made it a pleasant work environment. Furthermore, as noted earlier the timing of meetings relative to one another was important – if one meeting occurred just before another, there was no time for briefing notes to be prepared and passed on.

Creating a new meeting group in a PCT was a common method of signalling changed organisational priorities and is a further example of the way in which routine practices can generate sensemaking. Each of our sites had created new groups to spearhead financial savings/recovery during the past 18 months or so. In some sites managers had applied this financial worldview to all areas of their day to day work suggesting that the new groups had succeeded in establishing the new strategic priorities. Managers also noted that inclusion in or exclusion from meetings impacted on their ability to perform. One PBC manager, tasked to troubleshoot project delays with commissioning managers, struggled to win cooperation until a weekly meeting, led by the Director of Commissioning and Director of Finance had been set up. Here the establishment of a routine meeting and the inclusion of the manager as one of the core team sent out strong messages about his/her authority and legitimacy, allowing him/her to speak with authority in meetings with GPs and be in a position to promise that issues would be brought to the attention of the relevant senior staff. Another example of the symbolic importance of meetings was found in Site 4 where the creation of a PBC/PCT Executive Group had reassured PBC GPs that PBC was regarded as an integral part of PCT processes.

The variety in the geographical and demographic make-up of our research sites was discussed in section 3.2 (p55) and we observed earlier how all managers spoke of the time-consuming nature of meetings. Managers working in PBC consortia located on different sites from the PCT were particularly affected and often experienced frustration when travelling especially if they encountered traffic congestion and difficulty with car-parking. They also noted that they sometimes felt 'out of the loop' because of the physical distance from the PCT. Nevertheless, they also found

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advantages, not just in terms of being less accessible to demands on their time but also as a means of establishing their allegiance to PBC.

> *I think if practices think that we are PCT then we've failed…You know, I could literally be on an elastic band to [PCT] and I've tried to restrict myself to one day a week at [PCT], so I try to have all my meetings booked on a Tuesday at [PCT] so that I'm not up and down because I think it's time consuming [ID 42 PBC manager]*

This is discussed further in section 5.5.3 (p80) discussing the role of PBC managers

In conclusion we found much evidence for the ways in which organisational practices can constrain or support managerial work especially in relation to the ways in which these practices provide opportunities for and inform collective sensemaking. Managers working in organisations with formal meeting processes and well-defined decision-making practices were able to develop a stronger and more coherent sense of strategic priorities than managers working in less rigorous organisations. These findings will be developed into an academic paper on the nature of organisational practices and their relation to sensemaking.

5.9 Summary

In this section the rich and detailed data that we have gathered relating to middle managerial roles, activities and interactions with clinicians has been set out in some detail. In the next section these results will be related back to the original research questions.

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6 Discussion and implications

6.1 *Introduction*

In the previous chapter, analysis across the cases was used to analyse those aspects of middle –grade managers roles and behaviours that seemed to be important in performing their role as commissioners, and to explore the experiences of GPs in managerial roles. The combination of observation and interviews used in the study allowed a detailed exploration of the interactions between individuals and the contexts that acted to facilitate or limit their performance in role. In this chapter we will return to the original research questions, and discuss the insights that have been gained from the study. This will be followed by some reflections on the strengths and weaknesses of the study as well as on the methods used. A final chapter will discuss the implications of these for practice, research and policy.

6.2 *Research questions*

Following the extensive literature review, the following expanded and amplified research questions were posed:

- How do PCT middle managers with responsibilities for commissioning functions behave in role and what factors affect this? How do they engage in strategising, and what are the microprocesses of sensemaking associated with this? What is the impact of organisational practices on this process?
- How do PCT middle managers interact with GPs and other professionals engaged in the management of PBC consortia, and what practices are involved? How does the engagement of middle managers across boundaries in this way affect their sensemaking and their strategising, and what identity work is engaged in by both managers and GPs? How do managers and GPs establish legitimacy for themselves?
- Is there a relationship between the strategising undertaken by the middle managers and early progress under PBC, focusing upon how successfully PBC structures and processes have been established, and on how far PBC objectives are aligned with those of the PCT?
- What does this tell us more generally about the roles of middle-grade managers in PCTs, and of GPs (and others) involved in the management of PBC consortia, and about the factors affecting their behaviour in those roles?
- What can we learn overall about the microprocesses of strategising by middle managers?

In the sections that follow, these questions will be addressed, drawing on the evidence presented in previous chapters.

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6.3 PCT managers' role-related behaviour

This study has generated a rich and detailed account of PCT commissioning managers' role-related behaviour. It is clear from this that such managers can have a significant impact on the overall strategy enacted by the PCT, if 'strategy' is defined as discussed in the literature review 2 (p21) as activity that impacts upon the overall performance of the PCT. Thus, for example, managers were observed to have a significant input into the enactment of PBC, PCT priority setting, and the development of services. Overall, our evidence suggests that there is considerable scope for middle-grade commissioning managers in PCTs to actively manage their worlds, having a significant impact both on overall strategy as enacted in the organisation and on the behaviour of those with whom they work. Factors which seemed to influence this included:

- Individual 'praxis': those managers who were most active in managing information flows and in developing networking opportunities had the most apparent influence. This in turn seemed to be a product of individual choices, personality and role-interpretation, and did not seem to be the product of education, training or active processes of personnel development within the PCTs
- Organisational practices, such as the number, frequency, organisation of and attendance at meetings, as well as more apparently mundane issues such as internal office geography and the existence of multiple PCT offices in different parts of the town. The impact of these practices was felt within the organisations (eg the negative impact of 'hot-desking' in Site 2), but we did not find any obvious mechanism by which lessons could be learnt and practices changed.
- Processes relating to the distribution of information. The existence of formal procedures such as the formal agreeing and distribution of meeting minutes acted in some cases to limit the ability of individual managers to exert influence, whereas more informal procedures acted to enable such individual influence by allowing managers to use the distribution of information to actively further particular ends.
- Formal authority could be facilitative, but was not always necessary. Individuals could transcend an apparently low formal grade, and a senior grade did not always carry with it automatic authority. It seems that there is an important and complex interaction between formal grading and individual behaviour in a particular role that affects how far any given individual middle manager can influence what goes on. Being seen to 'get things done' allowed managers of lower grade to earn legitimacy, both internally within the PCT and externally in interactions with GPs and others.
- Whilst middle manager activity could have a significant impact on the overall performance of the PCT, this could be limited by executive action by the top managerial team (directors). Even the most pro-active and apparently influential managers reported experience of executive-level action that cut across the detailed work being done in commissioning groups and between teams of commissioning managers and their hospital counterparts. This was reported as being demoralising, particularly when

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the rationale for such action was unclear. Some of these accounts described dramatic action that occurred apparently out of the blue ('deals' done between chief executives, for example), but in addition there were more routine and day-to-day accounts which focused on the failure of PCTs to delegate any decision-making powers to working groups. In all of our study sites, managers complained that once plans had been made and services developed there were a number of 'layers' of decision-making at executive level that had to be negotiated, and in some sites these processes and the time that the took were experienced as having a negative impact on the overall work of the PCT. In some of our sites there seemed to be a degree of disconnect between formally espoused organisational priorities, aims and objectives and the practical 'aims-and-objectives-in-use' underpinning the work done, and it may be that if these two were better aligned, these frustrations would be less likely to occur.

We identified specific difficulties associated with working as a commissioning manager, relating to the difficulty in defining the internal boundaries between different aspects of the work and the indeterminate nature of the outputs of such work. This indeterminacy contributes to a situation in which individual managers have considerable scope to define for themselves the exact nature of the role that they perform, whilst simultaneously making performance of that role difficult. Existing Department of Health guidance on commissioning focuses upon the 'skills' required, including the following:

• Strategic analysis.

• Understanding of the supplier market.

• Financial acumen.

• Knowledge of negotiating techniques.

• Specifying services.

• Contracting skills.

• Political awareness.

• Ability to involve service users and build partnerships with providers. (115:p3)

This research suggests that, in addition to acquiring *skills* such as these, successful commissioning requires the enactment by managers of sophisticated managerial *behaviours* in order to negotiate this complexity. These sophisticated managerial behaviours were most evident in situations where managers were expected to work across boundaries, in particular between PBC groups and the PCT. Whilst the scope of this project was such that we were unable to extend our research to explore the actions of managers involved in other forms of joint commissioning, for example, with Local Authorities, it seems likely that such behaviours would also be relevant and important there.

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6.4 Interactions between GPs and managers

Whilst our sample of GPs was relatively small, we found some evidence that GPs are wrestling with the nature of the role that they play in commissioning. From the GPs perspective, the issues were as follows:

- Time is short for these actors, and all our interviewees were devoting more time to their role than they were formally allocated. This has the potential to cause problems with their colleagues in their practices. 'Buying out' GP time is expensive, and no doubt this will be an issue that arises of rthe new GP consortia set up under the White paper proposals
- There is a particular issue with identity. Most resisted the notion of being a 'manager', possibly because of the negative connotations of that term. Some reported that they regarded themselves as 'representatives', whilst others had (reluctantly) taken on the role prominent in documents produced by both the Department of Health and the BMA of 'clinical leader'. There appeared to be some cultural reluctance to claim to be a 'leader', and perhaps as a result of this none of our respondents had accessed any of the 'leadership' training available from the Department of Health. We found some evidence of GPs enacting what Bolton (44) called 'role distancing', continuing to see their GP identity as their 'real' identity.
- There did not appear to be a clear or universally agreed understanding of what the role of clinicians in commissioning should involve, with most of our respondents describing themselves as occupied with the day to day performance of tasks rather than having a clear strategic vision of what was to be accomplished. PCTs also seemed to be unclear as to what they wanted from their 'clinical leaders'. There was little training available or opportunity for personal development.
- Our GP respondents reported themselves to be particularly frustrated with the speed of decision making within PCTs, and also by the failure of PCTs to delegate any decision-making powers. This is understandable in organisations subject to a tight performance regime such as that imposed upon PCTs, with a myriad of targets and performance measures to meet, but may be counter-productive; a number of GPs reported to us delay in implementing schemes with significant potential to save money overall because the decision-making process was so tortuous.
- In common with the managers, GPs involved with PBC must straddle two worlds. The GPs that we interviewed and whom we observed at work in meetings varied in how far they indentified themselves with the PCT. Many described themselves as 'wearing two hats', and on occasion in meetings would announce which 'hat' they had donned at any particular moment. In general, where the GPs had taken the step to regard PCT problems as belonging to them and their PBC consortium, rather than as being the 'PCT's problems', there was most likely to be progress in terms of the development of a functioning PBC group that was beginning to address wider commissioning concerns.

In examining the relationship between PCT middle managers and the GPs with whom they worked under PBC, we have identified an enacted role which, when present, seemed to have a positive influence on overall

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progress. We have called this role ‘animateur’. In relation to this role, we found that:

- It was not a role that was actively promoted by more senior managers, and available training did not address the issues involved, focusing rather upon the substantive parts of the ‘commissioning’ role.
- Adoption of the role was therefore a personal choice, arising out of the individuals’ background, previous experience and personal characteristics.
- We did not find any association between formal grade and enactment or non-enactment of this role.
- Organisational practices within the sites may have been facilitative or inhibiting in this process. For example, the inclusion of middle managers in high-level meetings at which overall strategy was discussed seemed to facilitate their ability to adopt this role whilst their exclusion from these fora may have made it difficult. In part this seemed to be because attendance at high level meetings put them in a position where they were aware of overall strategy and were able to act to influence this, but there was also some evidence that, in addition, they gained a degree of legitimacy in the eyes of their GP colleagues by virtue of the fact that they seen to be trusted by the PCT hierarchy and were able to feed messages from PBC in at the highest level.
- Those GPs working with ‘animateur’ managers tended to express positive opinions about the managers concerned.
- Whilst the activity that we observed which we judged to fall into this category was generally directed at goals consonant with the overall strategic direction of the PCT, we did not witness any structures or processes designed or capable of ensuring that this was the case. For example, whilst individual managers described ‘line management’ arrangements that included the setting of objectives, in general these seemed to be more likely to relate to concrete ‘pieces of work’ than to be focused upon the ways in which the particular manager’s role was enacted. All of our study sites had high-level strategic goals and priorities, but many accepted that ‘ownership’ of these by managers lower down in the hierarchy might be problematic.

Overall, GPs expressed the view that a ‘good’ manager was one who ‘got things done’, and that legitimacy was earned in this way rather than being conferred by any formal grading. Indeed, GPs were largely oblivious to the grade of the managers with whom they worked. Although our sample was small, we did not witness any expression by GPs of resentment at ‘being managed’; rather, there was a pragmatic acceptance that ‘success’ under PBC required good management, and that GPs themselves were unable to deliver this. Furthermore, in those areas where PBC managers were not enacting the ‘animateur’ role, we did not see any evidence that ‘GP leaders’ were acting to compensate for this. This is perhaps unsurprising, as GPs had little time and no training in the roles they were adopting.

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6.5 Summary: the role of middle managers in PCTs

The wider managerial literature suggests that middle managers can play an important role in the overall performance of an organisation, and has highlighted some of the micro-processes by which this role is played out. In this study we have demonstrated that many of these micro-processes are also present in the work of PCT middle managers, including, for example, the active management of information and networking both within and without the organisation. In addition, we have identified an additional role which is required of middle managers working across the boundary between PCTs and GPs undertaking PBC. We have called this the 'animateur' role. The successful performance of this role seems to be associated with improved performance, at least in terms of the initial establishment of functioning PBC consortia. We have further highlighted the difficult nature of the 'commissioning role', in particular in relation to unclear boundaries, definitions and indeterminate outcomes. In terms of determinants of managerial behaviour, we have highlighted the impact of organisational practices, in particular relating to office geography and meeting organisation and processes. In addition, we have argued that both action by top executives and limited delegation of decision-making powers can act to limit the strategic impact of middle managerial work in PCTs. However, in day-to-day action, particularly when taking part in supra-PCT bodies such as regional commissioning fora, PCT middle managers are able to act with considerable autonomy, with our study PCTs apparently lacking mechanisms by which to control this activity. Finally, we have identified the complexities surrounding the role of 'clinician manager' involved with PBC. This includes the adoption of multiple identities and unclear expectations of what the role should involve. GPs were reluctant to adopt the word 'leader' to describe what they did, falling back upon claims to be 'representatives' of their colleagues to provide legitimacy for what they did.

6.6 Sensemaking by middle managers

The proposal and the literature review both highlighted the notion of 'sensemaking' as a theoretical framework underpinning the research. Throughout the data collection, this concept was kept at the forefront of the analysis, with researchers constantly asking the question 'how is sense being made?' in each observed situation. The results have highlighted the importance of 'enactment' in the sensemaking process, both in terms of routine enactment as driven by organisational practices (eg the fact that the timing of meetings affects whether or not the outcome of one meeting can influence what happens in subsequent meetings) and more conscious enactment of particular behaviours by managers. Observation confirmed the role of such enactment in determining the way in which future rounds of sensemaking occurred. Whilst Weick himself is clear about the importance of action in sensemaking (60), subsequent empirical analyses based upon Weick's work have tended to focus upon what might be called 'cognitive

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sense', with emphasis upon story-telling and discourse (for example see (74, 99)). Clear and detailed empirical evidence relating to the micro-processes by which enactment contributes to sensemaking therefore represents a distinctive contribution to the literature from this study. This will be written up and submitted as an academic paper.

6.7 Reflections on methods, strengths and limitations of the research

This study has demonstrated the value of combining detailed observation of work-in-practice with exploration in interviews of the issues involved. Many insights would have not been available had we depended only upon actors' explanations of their roles, and it is unlikely that interviews alone would have allowed, for example, the identification of the 'animateur' role. In keeping with our previous experiences using these methods (9, 108, 116), we found that, once initial access had been negotiated, most sites were happy for the team to attend a wide variety of meetings, and both managers and GPs quickly became accustomed to the researchers' presence. Indeed, many participants expressed their satisfaction that their work was considered to be of interest, particularly in view of negative commentary in the press, and all four sites have requested feedback meetings in order to explore the implication of the research findings for their organisations. The disadvantage of this approach is the fact that it is time consuming. In particular, negotiation of access took far longer than was expected, and in one of the sites data collection itself took longer than expected because of infrequent and frequently cancelled meetings. For a research topic such as this, combining complex contexts and processes with a focus which is difficult to define and observe, this disadvantage is offset by the richness and depth of the data collected. This calculation may be different when researching more straightforward topics.

This was a small study, which focused upon depth of insight rather than breadth. As such, claims to representativeness must be treated with caution. However, by the time the fourth case study was underway, data saturation had been reached, with no new enacted roles or managerial identities in evidence. This suggests that those roles and identities that we have identified represent common features of middle managerial life in PCTs, whilst accepting that other, less common roles may exist elsewhere. Our initial identification of the 'animateur' role in Site 1 was treated with caution, as we were aware that it may simply be a role adopted by an exceptional individual. However, subsequent case studies demonstrated a range of managers acting in this way, whilst Site 2 provided a counter-example in which no such activity was found, allowing us to explore the factors that seemed to facilitate or discourage this behaviour. Further research is required to elucidate how far this role can be 'learnt' and propagated across organisations.

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6.8 *Implications for practice and research*

6.8.1 Introduction

This project was conceived at a time when the continued existence and longevity of PCTs was unquestioned, and the role of PBC was under scrutiny, leading to a focus upon middle-grade commissioning managers and clinicians involved with PBC. In July 2010 the new Coalition Government published a White Paper (117), setting out the plans for the abolition of PCTs and the establishment of free-standing GP consortia, taking over full responsibility for commissioning all services by 2013. The focus of this section will therefore be upon the implications of the research in this new environment, drawing out those findings which have most to say in the context of consortium development and ongoing management. What follows is divided into two, focusing firstly upon practice and secondly suggesting new avenues for research arising from this project. Under each heading, findings will be highlighted and their implications explored.

6.8.2 Implications for practice and practitioners

In this section 'practice' is taken to mean the management of commissioning, and 'practitioners' includes clinicians and managers with this responsibility.

- *Some of the complications and issues associated with 'commissioning' as a way of organising health services have been identified*
    - GP consortia taking on responsibility for commissioning will be new organisations, and those involved will vary both in their previous experiences and in their level of understanding about the nature of commissioning. This has implications for the NHS Commissioning board responsible for enabling the setting up of consortia, and for managers supporting the consortia
    - Our evidence suggests that, whilst managers and clinicians involved in consortia may require training in specific commissioning skills such as negotiating and financial management, managerial behaviours could also be usefully addressed
- *The 'animateur' role has been highlighted as important in the interaction between clinicians and managers in the management of commissioning*
    - The managerial arrangements associated with GP commissioning consortia are unclear at present, and may involve employed staff or staff contracted in from external organisations. It remains to be seen how far our findings will apply to these new arrangements. It seems likely that managers capable of acting as 'animateurs' would be of value to newly set up consortia.
- *The role of clinicians in commissioning is complex and nuanced, requiring the adoption of roles and behaviours with which some GPs may not be comfortable*
    - GP roles in commissioning will become more important and arguably more difficult, as new incentive regimes enact new and

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mutually dependent relationships between GP practices. Personal development and education, alongside time to reflect and develop new roles will be important.

- *Clinically-led commissioning appears to work best when GPs and managers develop a close and mutually supportive relationship*
    - This may have implications for the new managerial arrangements developed by GP consortia. For example, such relationships may be more problematic if managerial support is bought in from larger organisations with significant staff turnover. Consortia may find it difficult to formulate their requirements in this regard, and support will be required for this process.
- *Organisational practices can have a profound impact on the ability of managers to function in role*
    - As new organisations, with little top-down direction about structures and processes and without the constraints imposed by organisational history, custom and practice, GP consortia will have considerable scope to develop their organisational practices to suit themselves. The importance of apparently mundane aspects of organisations such as office geography and the nature and frequency of meetings, as well as the value of mechanisms to assess the impact of such practices over time could usefully be disseminated to GP consortia and to bodies set up to provide managerial support. Consideration of this will be incorporated into the programme of outputs from this research.
- *'Animation' and 'control' (in terms of clear dissemination of overall organisational aims and objectives) are important enablers of sensemaking in organisations*
    - The White paper (117) suggests that GP consortia will have significant scope to develop their own priorities and programmes of work, with performance management focusing upon outcomes rather than processes. This research suggests that the mechanisms by which these are developed, and the extent to which all consortia members feel 'ownership' of them as a result of these mechanisms will play a part in determining the extent to which consortia are able to act collectively in pursuit of these priorities.
    - Our evidence suggests that meetings contribute to the accomplishment of management over and above their ostensible purpose by enabling sensemaking. The establishment of a range of fora such as meetings and working groups within which ideas can be discussed may therefore be of value to developing consortia.

6.8.3 Implications for management education and development in primary care

- *Key managerial behaviours (eg adoption of the animateur role) appeared to be instinctive and in this study were dependent upon the agency of individuals.*

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    - Future education of managers taking on roles within GP consortia could usefully explore the animateur role. Whilst further research is required in order to elucidate exactly how such behaviour can be fostered, discussion of the complexities of managing professionals over whom managers have no authority may be of use.
    - One of the key common features amongst managers adopting this behaviour appeared to be a deep and nuanced understanding of the nature of primary care in the UK. Whilst many managers engaged by consortia may have this experiential knowledge, for those without, education and training should include an historical account of the development of primary care in general, and general practice in particular, including a discussion of previous incarnations of GP commissioning such as Fundholding and Primary Care Groups.
- *GPs adopting roles within GP consortia were ambivalent about their identity, fluctuating between seeing themselves as 'leaders', 'representatives' or 'mentors' of their colleagues*
    - Training and development for GPs undertaking commissioning roles could usefully include a discussion of potential identities. Whilst notions of 'leadership' are currently fashionable, not all of our respondents saw themselves in those terms. It may be useful to explore how GP commissioners see themselves, and in particular how they see themselves in relation to their peers. This may be particularly important if governance arrangements for new consortia involve some form of election, as this may have implications when it comes to making difficult or unpopular decisions. Clear agreement in advance about the limits and responsibilities associated with executive roles will be important if disputes are to be avoided.

6.8.4 Implications for research

- *The combination of methods used in this study provided rich and nuanced data about the work of commissioning managers.*
    - 'Commissioning' as an activity is relational in nature, taking place in social interactions between managers and clinicians. As such, data collection about commissioning should seek to go beyond interviews.
- *Some of the complications and issues associated with 'commissioning' as a way of organising health services have been identified*
    - The issues identified in this study relating to the nature of commissioning and the factors that affect it should be followed up in subsequent studies of the new commissioning arrangements in the NHS.
- *The 'animateur' role is important in the accomplishment of commissioning management*
    - This novel research finding requires further elucidation, including:
        - Further definition

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        - Exploration of enabling and inhibiting factors
        - Exploration of the extent to which it can be taught or deliberately adopted
        - Exploration of its relevance in the new situation in which consortia may be 'buying in' managerial support from outside agencies.
- *This study has highlighted the importance of enactment in the sensemaking process*
    - The extent to which enactment can be consciously directed in order to improve organisational sensemaking should be explored.
- *This study has highlighted the impact of organisational practices on managerial work*
    - The extent to which active monitoring and adaptation of organisational practices is possible could be usefully explored.

6.9 Outputs from the research

A short paper relating to the complex nature of commissioning work was presented at the meeting of the Health Politics and Policy Network at Oxford University in September 2010. A number of academic papers based upon this research are in preparation, and the subjects of these have been highlighted in the text. In addition, papers will be submitted to practitioner journals such as the Journal of Integrated Care, focusing on aspects of the results of interest to managers and practitioners, such as the impact of organisational practices on the work of managers. It is intended that abstracts will be submitted for presentations at international conferences, including the Society for Academic Primary Care and the annual joint Health Services Research Network / SDO Network conference. All four sites have requested site-specific feedback, and research team members will be undertaking this in the next few months. In addition, we will explore the options for a more focused dissemination of some of the findings relating to the importance of organisational practices. This may include, for example, the preparation of a briefing paper for an audience of managers/GP consortia.

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References

1. House of Commons Health Committee 4th report of Session 2009-2010. Commissioning. The Stationary Office; 2010.

2. Coleman A, Checkland K, Harrison S, Dowswell G. Practice-based Commissioning: Theory, implementation and outcome. Final report. University of Manchester: National Primary Care Research and Development Centre; 2009.

3. Smith MK. 'Animateurs, animation and fostering learning and change'. The encylopaedia of informal education; 1999, 2009.

4. Department of Health. Putting Commissioning into Practice: Implementing Practice-based Commissioning Through Good Financial Management. . Audit Commission; 2007.

5. Department of Health. World class commissioning: vision. 2007.

6. Department of Health. Health reform in England: update and commissioning framework. London: The Stationary Office; 2006.

7. Coleman A, Harrison S, Checkland K, Hiroeh U. Practice-based Commissioning: report of a survey of Primary Care Trusts. University of Manchester: National Primary Care Research and Development Centre; 2007.

8. Department of Health. Practice Based Commissioning: practical implementation. London: The Stationary Office; 2006.

9. Checkland K, Coleman A, Harrison S, Hiroeh U. Practice-based Commissioning in the National Health Service: interim report of a qualitative study. University of Manchester: National Primary Care Research and Development Centre; 2008.

10. Department of Health. Health reform in England: update and commissioning framework. Annex: the commissioning framework. London: The Stationary Office; 2006.

11. Checkland K. Management in general practice: the challenge of the new General Medical Services contract. British Journal of General Practice. 2004;54(507):734-9.

12. Hambrick DC, Mason PA. Upper echelons: The organization as a reflection of its top managers. Academy of Management Review. 1984;9(193).

13. Wooldridge B, Schmid T, Floyd SW. The Middle Management Perspective on Strategy Process: Contributions, Synthesis, and Future Research. Journal of Management. 2008;34(6):1190-221.

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14. Thomas R, Linstead A. Losing the plot? Middle managers and identity. Organization. 2002;9(1):71-93.

15. Carroll B, Levy L. Defaulting to management: Leadership defined by what it is not. Organization. 2008;15(1):75-96.

16. Herzig SE, Jimmieson NL. Middle managers' uncertainty management during organizational change. Leadership & Organization Development Journal. 2006;27(8):628.

17. Wai-Kwong FY, Priem RL, Cycyota CS. The performance effects of human resource managers' and other middle managers' involvement in strategy making under different business-level strategies: the case in Hong Kong. International Journal of Human Resource Management. 2001;12(8):1325-46.

18. Kanter RM. World Class: Thriving Locally in the Global Economy. New York: Simon and Schuster; 1995.

19. Peters TJ. Liberation Management. NY: Macmillan; 1992.

20. Littler C, R. , Wiesner R, Dunford R. The dynamics of delayering: Changing management structures in three countries. The Journal of Management Studies. 2003;40(2):225.

21. Ebadan G, Winstanley D. Downsizing, delayering and careers--the survivor's perspective. Human Resource Management Journal. 1997;7(1):79.

22. Dopson S, Neumann JE. Uncertainty, contrariness and the double-bind: Middle managers' reactions to changing contracts. British Journal of Management. 1998;9:S53.

23. Krau E. Disempowering and downsizing middle management? The International Journal of Sociology and Social Policy. 1995;15(1,2,3):91.

24. Dopson S, Stewart R. Information technology, organizational restructuring and the future of middle management. New Technology, Work, and Employment. 1993;8(1):10.

25. Dopson S. Middle management's pivotal role. Target Management Development Review. 1992;5(5):8.

26. Huy QN. In praise of middle managers. Harvard Business Review. 2001;79(8):72-9.

27. Mintzberg H. Structured observation as a method to study managerial work. Journal of management studies. 1970;7(1):87-104.

28. Hales C. Why do managers do what they do? Reconciling evidence and theory in accounts of managerial work. British journal of management. 1999;10(4):335-50.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 08/1808/240

29. O'Gorman C, Bourke S, Murray JA. The nature of managerial work in small growth-orientated businesses. Small business economics. 2005;25(1):1-16.

30. Tengblad S. Is there a 'new managerial work'? A comparison with Henry Mintzberg's classic study 30 years later. Journal of management studies. 2006;43(7):1437-62.

31. Thomas R, Dunkerley D. Careering downwards? Middle managers' experiences in the downsized organization. British Journal of Management. 1999;10(2):157-69.

32. Ashmos DP, Huonker JW, McDaniel RR, Jr. Participation as a complicating mechanism: the effect of clinical professional and middle manager participation on hospital performance. Health Care Management Review. 1998;23(4):7-20.

33. Katz D, Kahn RL. The social psychology of organizations. 2 ed. New York: John Wiley and sons; 1978.

34. Meek VL. Organizational culture:origins and weaknesses. Organization Studies. 1988;9(4):453-73.

35. Peters BG. Institutional theory in political science. London: Continuum; 2005.

36. March JG, Olsen JP. Rediscovering institutions. New York: Free Press; 1989.

37. Hales C. 'Bureaucracy-lite' and Continuities in Managerial Work. British journal of management. 2002;13(1):51.

38. Ferlie E, Pettigrew A. Managing through networks: Some issues and implications for the NHS. British Journal of Management. 1996;7:S81.

39. Erera IP. Role Ambiguity in Public Welfare Organizations. Administration in Social Work. 1989;13(2):67.

40. Houlihan M. Managing to manage? Stories from the call centre floor. Journal of European Industrial Training. 2001;25(2/3/4):208.

41. Mantere S. Role expectations and middle manager strategic agency. Journal of Management Studies. 2008;45(2):294-316.

42. McConville T. Devolved HRM responsibilities, middle-managers and role dissonance. Personnel Review. 2006;35(6):637-53.

43. Currie G, Procter SJ. The antecedents of middle managers' strategic contribution: The case of a professional bureaucracy. Journal of Management Studies. 2005;42(7):1325-56.

44. Bolton SC. 'Making up' managers: the case of NHS nurses. Work Employment and Society. 2005;19(1):5-23.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 08/1808/240

45. Quinn JB. The strategy concept. In: Mintzberg H, Quinn JB, Ghoshal S, editors. The Strategy Process, European edn. London: Prentice Hall; 1995.

46. Guth WD, Macmillan IC. Strategy implementation versus middle management self-interest. Strategic Management Journal. 1986;7(4):313-27.

47. Floyd SW, Wooldridge B. Dinosaurs or dynamos? Recognizing middle management's strategic role. The Academy of Management Executive. 1994;8(4):47.

48. Nielsen MF. Interpretative management in business meetings: Understanding Managers' Interactional Strategies Through Conversation Analysis. The Journal of Business Communication. 2009;46(1):23.

49. Beatty CA, Lee GL. Leadership Among Middle Managers - An Exploration in the Context of Technological Change. Human Relations. 1992;45(9):957.

50. Floyd SW, Wooldridge B. Middle management's strategic influence and organizational performance. Journal of Management Studies. 1997;34(3):465-85.

51. Dutton JE, Ashford SJ. Selling Issues to Top Management. Academy of Management Review. 1993;18(3):397-428.

52. Dutton JE, Ashford SJ, Oneill RM, Hayes E, Wierba EE. Reading the wind: How middle managers assess the context for selling issues to top managers. Strategic Management Journal. 1997;18(5):407-23.

53. Huy QN. Emotional Balancing of Organizational Continuity and Radical Change: The Contribution of Middle Managers. Administrative Science Quarterly. 2002;47(1):31-69.

54. Marginson DEW. Management control systems and their effects on strategy formation at middle-management levels: evidence from a U.K. organization. Strategic Management Journal. 2002;23(11):1019-31.

55. Mair J, Thurner C. Going global: how middle managers approach the process in medium-sized firms. Strategic Change. 2008;17(3/4):83.

56. Carney M. Middle manager involvement in strategy development in not-for profit organizations: the director of nursing perspective – how organizational structure impacts on the role. Journal of Nursing Management. 2004;12(1):13-21.

57. Carney M. Understanding organizational culture: the key to successful middle manager strategic involvement in health care delivery? Journal of Nursing Management. 2006;14(1):23-33.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

58. Schilit WK. An Examination of Individual Differences as Moderators of Upward Influence Activity in Strategic Decisions. Human Relations. 1986;39(10):933.

59. Rouleau L. Micro-practices of strategic sensemaking and sensegiving: How middle managers interpret and sell change every day. Journal of Management Studies. 2005;42(7):1413-41.

60. Weick KE. Sensemaking in organizations. Thousand Oaks, Ca.: Sage; 1995.

61. Lassen AH, Waehrens BV, Boer H. Re-orienting the Corporate Entrepreneurial Journey: Exploring the Role of Middle Management. Creativity and Innovation Management. 2009;18(1):16.

62. Wooldridge B, Floyd SW. The Strategy Process, Middle Management Involvement, and Organisational Performance. Strategic Management Journal. 1990;11(3):231.

63. Laine PM, Vaara E. Struggling over subjectivity: A discursive analysis of strategic development in an engineering group. Human Relations. 2007;60(1):29-58.

64. Balogun J, Johnson G. Organizational restructuring and middle manager sensemaking. Academy of Management Journal. 2004;47(4):523-49.

65. Floyd SW, Wooldridge B. Middle Management Involvement in Strategy and Its Association with Strategic Type - A Research Note. Strategic Management Journal. 1992;13:153-67.

66. Boyett I, Currie G. Middle Managers Moulding International Strategy: An Irish Start-up in Jamaican Telecoms. Long Range Planning. 2004;37(1):51-66.

67. Simpson B, Carroll B. Re-viewing `Role' in Processes of Identity Construction. Organization. 2008 January 1, 2008;15(1):29-50.

68. Star SL, Griesemer JR. Institutional Ecology, 'Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. Social Studies of Science. 1989;19(3):387-420.

69. Sveningsson S, Alvesson M. Managing Managerial Identities Organizational Fragmentation, Discourse and Identity Struggle. Human Relations. 2003;56(10):1163-93.

70. Alvesson M, Lee Ashcraft K, Thomas R. Identity Matters: Reflections on the Construction of Identity Scholarship in Organization Studies. Organization. 2008 January 1, 2008;15(1):5-28.

71. Foucault M. Madness and civilization : a history of insanity in the age of reason. New York: Vintage; 1988.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 08/1808/240

72. Holden L, Roberts I. The depowerment of European middle managers: Challenges and uncertainties. Journal of Managerial Psychology. 2004;19(3):269.

73. Beech N. On the nature of dialogic identity work. Organization. 2008;15(1):51-74.

74. Currie G, Brown AD. A narratological approach to understanding processes of organizing in a UK hospital. Human Relations. 2003;56(5):563-86.

75. Watson TJ. Managing identity: Identity work, personal predicaments and structural circumstances. Organization. 2008;15(1):121-43.

76. Mischenko J. Exhausting management work: conflicting identities. Journal of Health Organization & Management. 2005;19(3):204-18.

77. McDonald R. Individual identity and organisational control: Empowerment and modernisation in a Primary Care Trust. Sociology of Health & Illness. 2004;26(7):925-50.

78. Boyett I, Finlay D. The quasi-market, the entrepreneur and the effectiveness of the NHS business manager. Public Administration. 1995;73(3):393.

79. Hannigan B. Assessing the new public management: the case of the National Health Service. Journal of Nursing Management. 1998:307-12.

80. Local modernisation reviews: background information. London: The Stationary Office; 2001.

81. Procter S, Currie G, Orme H. The empowerment of middle managers in a community health trust: structure, responsibility and culture. Personnel Review. 1999;28(3):242-57.

82. Harding N. The inception of the National Health Service: A daily managerial accomplishment. Journal of Health Organization and Management. 2005;19(3):261.

83. Halford S, Leonard P. Place, Space and Time: Contextualizing Workplace Subjectivities. Organization Studies. 2006;27(5):657.

84. What to cut: readers' suggestions. BMJ. 2009 April 29, 2009;338(apr29_1):b1765-.

85. Hewison A. Managerial values and rationality in the UK National Health Service. 2002.

86. Forbes T, Hallier J, Kelly L. Doctors as managers: investors and reluctants in a dual role. Health Services Management Research. 2004;17(3):167-76.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

87. Forbes TOM, Hallier JERR. Social identity and self-enactment strategies: adapting to change in professional-manager relationships in the NHS. Journal of Nursing Management. 2006;14(1):34-42.

88. Dent M, Radcliffe J. Reconfiguring health care professions: management and professional legitimations. Guest editorial introduction. International Journal of Public Sector Management. 2003:106-9.

89. Jarzabkowski P, Balogun J, Seidl D. Strategizing: The challenges of a practice perspective. Human Relations. 2007;60(1):5-27.

90. Bettis RA. Strategic Management and the Straightjacket: An Editorial Essay. Organization Science. 1991;2(3):315-9.

91. Adler PA, Adler P. Observational techniques. In: Denzin NK, Lincoln YS, editors. Collecting and interpreting qualitative materials. Thousand Oaks, Ca.: Sage; 1998.

92. Whittington R. Completing the practice turn in strategy research. Organization Studies. 2006;27(5):613-34.

93. Chia R, MacKay B. Post-processual challenges for the emerging strategy-as-practice perspective: Discovering strategy in the logic of practice. Human Relations. 2007 January 1, 2007;60(1):217-42.

94. Sillince J, Mueller F. Switching strategic perspective: The reframing of accounts of responsibility. Organization Studies. 2007;28(2):155-76.

95. Paroutis S, Pettigrew A. Strategizing in the multi-business firm: Strategy teams at multiple levels and over time. Human Relations. 2007 January 1, 2007;60(1):99-135.

96. Weber K, Glynn MA. Making Sense with Institutions: Context, Thought and Action in Karl Weick's Theory. Organization Studies. 2006 November 1, 2006;27(11):1639-60.

97. Coleman A, Checkland K, Harrison S, Hiroeh U. Local histories and local sensemaking: a case of policy implementation in the English National Health Service. Policy and Politics. 2010;38(2):289.

98. Gioia DA, Chittipeddi K. Sensemaking and Sensegiving in Strategic Change Initiation. Strategic Management Journal. 1991;12(6):433.

99. Landau D, Drori I. Narratives as sensemaking accounts: the case of an R&D laboratory. Journal of Organizational Change Management. 2008;21(6):701-20.

100. Weick KE, Sutcliffe KM. Hospitals as cultures of entrapment: a reanalysis of the Bristol Royal Infirmary. California Management Review. 2003;45(2):73-86.

101. Balogun J. Managing change: Steering a course between intended strategies and unanticipated outcomes. Long Range Planning. 2006;39(1):29-49.

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

Project 08/1808/240

102. Balogun J, Johnson G. From intended strategies to unintended outcomes: The impact of change recipient sensemaking. Organization Studies. 2005;26(11):1573-601.

103. Raes AML, Glunk U, Heijltjes MG, Roe RA. Top management team and middle managers - Making sense of leadership. Small Group Research. 2007;38(3):360-86.

104. Maitlis S. The social processes of organizational sensemaking. Academy of Management Journal. 2005;48(1):21-49.

105. Stensaker I, Falkenberg J. Making sense of different responses to corporate change. Human Relations. 2007 January 1, 2007;60(1):137-77.

106. Yin RK. Case study research: design and methods. 3rd ed. Thousand Oaks: Sage; 2003.

107. Murphy E, Dingwall R, Greatbactch D, Parker S, Watson P. Qualitative research methods in health technology assessment: a review of the literature. Health Technology Assessment. 1998;2(16):1.

108. Checkland K. Understanding general practice: a conceptual framework from case studies in the UK National Health Service British Journal of General Practice. 2007;57(534):56-63.

109. Lukes S. Power: a radical view. Basingstoke: Macmillan Press Ltd; 1974.

110. Weick K. Sensemaking in organizations: small structures with large consequences. In: Murnigham JK, editor. Social psychology in organizations: advances in theory and research. Englewood Cliffs, NJ: Prentice-Hall; 1993.

111. NHS Confederation. Agenda for change: What will it mean for you? A guide for staff. London: The Stationary Office; 2004.

112. National Leadership Council Annual Report. The first year: the foundation. London: Department of Health; 2010.

113. Freidson E. The reorganisation of the medical profession. Medical Care Review. 1985;42(1):11-35.

114. Coburn D, Rappolt S, Bourgeault I. Decline vs. retention of medical power through restratification: an examination of the Ontario case. Sociology of Health & Illness. 1997;19(1):1-22().

115. Bamford T. Chapter 2: Who are the commissioners? Made not born - developing skills in commissioning. Commissioning ebook, Department of Health. http://www.dhcarenetworks.org.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap2TBamford.pdf, http://www.dhcarenetworks.org.uk/BetterCommissioning/Commissioninge-book/. 2006 (accessed Oct 2010).

© Queen's Printer and Controller of HMSO 2011. This work was produced by Checkland *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health.

116. Checkland K, Harrison S, McDonald R, Grant S, Campbell S, Guthrie B. Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract. Sociology of Health & Illness. 2008;30(5):788-803.

117. Department of Health. Equity and Excellence: liberating the NHS. London: The Stationary Office; 2010.

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Appendix 1 Literature search

SDO Middle managers literature search process

Search Results

2 closely related searches of the literature were carried out:

1. For original research on the role and definition of the middle-manager
2. For original research on the topic of physicians as managers

Search 1

There were 3395 records from search 1. 810 records removed (668 duplicates and 142 confounding records) to leave 2585 for search 1.

Search 2

There were 2903 records from Search 2. 2151 duplicates and confounding records were removed and 752 identified as potentially relevant

The records from Search 1 and Search 2 were combined into a final database with 3337 records. The duplicates (110) and confounders (288) were removed to leave a total of 2939.

Search Strategies:

Search 1. Middle Managers

The following databases were searched for relevant research: ABI/Inform (via Proquest) ABI/Inform Archive Complete 1905-1985, 28/February/09: ABI/Inform Global 1971 – 28/February/09): ABI/Inform Trade & Industry 1971 – 28/February/09); Science Citation Index Expanded (via MIMAS Web of Knowledge service) 1945-28/February/09; Social Sciences Citation Index (via Web of Knowledge) 1956-28/February/09; Arts & Humanities Citation Index (via Web of Knowledge) 1975-28/February/09; Conference Proceedings Citation Index- Science (via Web of Knowledge) 1990-28/February/09; Conference Proceedings Citation Index- Social Science & Humanities (via Web of Knowledge) 1990-28/February/09; CSA ASSIA (Applied Social Sciences Index) (via Cambridge Scientific Abstracts) 1987 – 02/March 09; EMBASE (via OVID SP 1980 to 2009 Week 09, 02/March/2009); HMIC via OVID SP (Department of Health Library and Information Services Database (DH-Data) 1983 - January 2009-03-03, Kings Fund Database 1979 - January 2009-03-03), 02/March/09; MEDLINE via OVID SP 1950 to February Week 3 2009, 02/March/09); MEDLINE(R) In-Process & Other Non-Indexed Citations via OVID SP March 2, 2009, 02/March/09); MEDLINE Via OVID SP Daily Update March 2, 2009, 02/March/09; OLD MEDLINE via OVID SP 1948 to 1965, 02/March/09); COPAC (Copac National, Academic, & Specialist Library Catalogue) searched using Z39.50 interface from within Reference Manager version 11, 03/March/09;

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28th February 2009

A search of the Online e-book **Blackwell Encyclopedia of Management** (**eISBN:** 9780631233176) via the JRULM showed no entry for middle management in any volume of the work. A definition was found in **Wikepedia.** The term appeared within entries in the Blackwell Encylopedia and these were recorded.

5 records downloaded

The SDO funded review **Managing Change and Role Enactment in the**

Professionalised Organisation by Louise Fitzgerald et al…2006 pdf copy was searched and records cited near to the term middle manager were downloaded to see if any indexing patterns could be identified on medical or buisiness/management databases

http://www.sdo.nihr.ac.uk/files/project/21-final-report.pdf

3 records downloaded

28th February 2009

ABI-(Abstracted Business Information) Inform Search

Search of ABI-Inform (Proquest interface) (databases as below) for subject terms (Middle Management or First Line Supervisors) results limited to scholarly journals, all years

ABI/INFORM Archive Complete (ID 10767)

Business, Finance, Economics: historical journals

Search respected historical business journals for a unique perspective on topics covering corporate strategies, management techniques, accounting, marketing, advertising, ethics, case studies, and much more. Deep backfiles encompass full runs of some of the most important business journals of the last century, all in cover-to-cover full page images, just as they were printed. more info...

Coverage: 1905 – 1985 (date searches run 28th February, 2009)

ABI/INFORM Global (ID 3)

Business, Finance, Economics: journals, company profiles, Wall Street Journal

Most scholarly and comprehensive way to explore and understand business research topics. Search nearly 3000 worldwide business periodicals for in-depth coverage of business and economic conditions, management techniques, theory, and practice of business, advertising, marketing, economics, human resources, finance, taxation, computers, and more. Expanded international coverage. Fast access to information on 60,000 + companies with business and executive profiles. Now includes The Wall Street Journal. more info...

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Coverage: 1971 - current (date searches run 28th February, 2009)

ABI/INFORM Trade & Industry (ID 5820)

Business, Economics: trade and industry periodicals

Search more than 1200 business periodicals with a trade or industry focus. Provides users with the latest industry news, product and competitive information, marketing trends, and a wide variety of other topics. Contains publications on every major industry, including finance, insurance, transportation, construction, and many more. more info...

Coverage: 1971 - current (date searches run 28th February, 2009)

Search results

637 documents found for: *SU(Middle management or First line supervisors) OR TITLE(First line supervisor* or first-line supervisor*) OR TITLE(middle manage* or middle-manage*) OR TITLE(first-line manage* or first line manage*) OR TITLE(middle grade manage* or middle-grade manage*) OR TITLE(mid-grade manage* or mid grade manage*) OR TITLE(lower-level manage* or lower level manage*)*

Web of Knowledge Search

28th February 2009

All years, all languages, all document types

All Citation databases as follows:

Science Citation Index Expanded (SCI-EXPANDED)--1945-present

Social Sciences Citation Index (SSCI)--1956-present

Arts & Humanities Citation Index (A&HCI)--1975-present

Conference Proceedings Citation Index- Science (CPCI-S)--1990-present

Conference Proceedings Citation Index- Social Science & Humanities (CPCI-SSH)--1990-present

1,102 hits saved as Keyword WOK SEARCH

27 1,102 #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1

Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years

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#	Results	Query
# 26	40	TS="First-line supervisors" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 25	17	TS="first-line supervisor" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 24	319	TS="middle-management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 23	462	TS="middle-managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 22	84	TS="middle-manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 21	0	TS=midmanager *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 20	1	TS=midmanagers *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 19	2	TS="mid-manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 18	2	TS="mid-managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 17	9	TS=mid-management *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*
# 16	2	TS=midmanagement *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*

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#	Results	Search		
# 15	15	TS="middle-level management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 14	58	TS="middle-level managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 13	1	TS="middle-level manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 12	30	TS="lower-level managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 11	8	TS="lower-level management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 10	1	TS="lower-level manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 9	0	TS="mid-grade management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 8	0	TS="mid-grade managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 7	0	TS="mid-grade manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 6	0	TS="middle-grade management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 5	0	TS="middle-grade manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐

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# 4	0	TS="middle-grade managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 3	19	TS="first-line managers" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 2	112	TS="First-line management" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐
# 1	5	TS="First-line manager" *Databases=SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Timespan=All Years*	☐	☐

ASSIA search

2nd March 2009

Cambridge Scientific Abstracts (CSA) Assia

Data years 1987 – current

Mon Mar 2 4:58:24 EST 2009

CSA

Multiple Databases

Query: DE=middle management OR DE=middle managers OR DE=practice nurse managers OR DE=practice managers OR DE=supervisors OR DE=supervisor-subordinate interactions OR KW="First line manager" OR KW="First line management" OR KW= "First line managers" OR KW="Middle grade manager" OR KW="Middle grade management" OR KW="Middle grade managers" OR KW= "Mid grade manager" OR KW="Mid grade managers" OR KW= "Mid grade management" OR KW="Lower level manager" OR KW="Lower level managers" OR KW ="Lower level management" OR KW="Middle level manager" OR KW= "Middle level management" OR KW="Middle level managers" OR KW= midmanagement OR KW=midmanagers OR KW="Middle manager" OR KW=

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“Middle managers” OR KW=“Middle management” OR KW=“First line supervisor” OR KW=“First line supervisors”

Record 1 of 419

Medical and Healthcare databases

all searches run 2nd March 2009

OVID EMBASE 1980 to 2009 Week 09

OVID HMIC January 2009-03-03

OVID MEDLINE 1950 to February Week 3 2009

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations March 2, 2009

OVID MEDLINE Daily Update March 2, 2009

OVID OLD MEDLINE 1948 to 1965

Medline, Embase and HMIC were examined for thesaurus terms specific to middle management. No specific thesaurus terms could be found in these databases for the concept of middle management, so a free-text search of the title and abstract of the databases was carried out using the following search strategy containing synonyms for middle management:

1. middle management.tw.
2. middle manager$.tw.
3. first line manager$.tw.
4. middle grade manager$.tw.
5. middle grade management.tw.
6. mid grade manager$.tw.
7. mid grade management.tw.
8. lower level manager$.tw.
9. lower level management.tw.
10. middle level manager$.tw.
11. middle level management.tw.
12. (midmanagement or midmanagers or mid management or mid manager$).tw.
13. first line supervisor$.tw.
14. or/1-13

No date or language restrictions were applied to any database

OVID MEDLINE 1950 to February Week 3 2009

409 records

Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations March 2, 2009

10 records

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Ovid MEDLINE(R) Daily Update March 2, 2009

0 hits retrieved

Ovid OLDMEDLINE(R) 1948 to 1965

0 hits retrieved

EMBASE 1980 to 2009 Week 09

156 records

OVID HMIC January 2009

205 Records

COPAC search

Search run 3rd March 2009

A series of internet search of COPAC from within Reference Manager version 12 were conducted for the following terms in the title of the document.

middle manager OR middle managers OR middle management

358 records

First line manager OR first line managers

58 records

middle grade manager OR middle grade management OR middle grade managers OR mid grade manager OR mid grade managers OR mid grade management OR lower level manager OR lower level management OR lower level managers

1 record

middle level management OR middle level managers OR middle level manager OR midmanagement OR midmanagers OR midmanager OR mid management OR mid manager OR mid managers OR first line supervisor OR first line supervisors

31 records

Search 2. Physician as Manager

The content of key journals identified from a previous literature review (Learmonth, Mark. Making health services management research critical: a review and a suggestion. Sociology of Health and Illness 2003;25(1):93-119) covered by ABI-Inform and Web of Knowledge were searched for records to papers in these journals which also included the term “nhs” or “national health service” in the title, abstract or keywords. Results were downloaded and scanned for studies relevant to the search topic.

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Project 08/1808/240

ABI/Inform (via Proquest) ABI/Inform Archive Complete 1905 – 1985, 10/March/09); ABI/Inform Global 1971 – 10/March/09); ABI/Inform Trade & Industry 1971 – 10/March/09); Science Citation Index Expanded (via MIMAS Web of Knowledge Service) 1945-11/March/09; Social Sciences Citation Index (via Web of Knowledge 1956-11/March/09; Arts & Humanities Citation Index (via Web of Knowledge 1975-11/March/09; Conference Proceedings Citation Index- Science (via Web of Knowledge) 1990-11/March/09; Conference Proceedings Citation Index- Social Science & Humanities (via Web of Knowledge) 1990-11/March/09; MEDLINE via OVID SP Ovid MEDLINE(R) 1950 to March Week 1 2009,12/March/09; EMBASE via OVID SP, EMBASE 1980 to 2009 Week 10, 12/March/09; Social Science and Medicine (ISSN: 0277-9536) 1981 – 13/March/09 searched online through Elsevier Science Direct; HMIC via OVID SP (Department of Health Library and Information Services Database (DH-Data) 1983 - January 2009-03-03 Kings Fund Database 1979 - January 2009-03-03), 16/March/09; The Journal Sociology, January 1967 – February 2009, (ISSN 0038-0385) was searched online via Sage Journals Online http://soc.sagepub.com/ 11/March/09 ; The journal Social Science and Medicine 1981 – present was searched online via Elsevier Science Direct, http://www.sciencedirect.com/ 13/March/09; Clinician in Management (now The International Journal of Clinical Leadership) (ISSN 0965-5751) was searched via OVID SP (HMIC Department of Health Library and Information Services Database (DH-Data) 1983 - January 2009-03-03 Kings Fund Database 1979 - January 2009-03-03), MEDLINE(R) 1950 to March Week 1 2009, EMBASE 1980 to 2009 Week 10, British Nursing Index 1994 to March 2009, 17/March/09; Applied Social Sciences Index (ASSIA) via CSA Illumina, 1987 – 18/March/2009.

Search run 13022009

Key journals identified by Learmonth review which databases were searched to retrieve indexed content from:

British Journal of Management

Human Relations

Journal of Management Studies

Organization

Organization Studies

Sociology

Critical Social Policy

Policy and Politics

Public Administration

Public Money and Management

Health Care Analysis

Health Policy

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Health Services Management Research

Health Services Research

International Journal of Health Planning and Management

Journal of Advanced Nursing

Journal of Health Organization and Management (formerly Journal of Management in Medicine)

Social Science and Medicine

Sociology of Health and Illness

ABI search

Journals from key titles list with coverage on ABI-Inform with "nhs" or "national health service" in title or abstract (hits for search in brackets)

British Journal of Management (17)

Human Relations (9)

Journal of Management Studies (14)

Organization (0)

Organization Studies (5)

Public Administration (30)

Public Money and Management

Health Services Management Research (28)

Health Services Research (12)

Journal of Health Organization and Management (formerly Journal of Management in Medicine) (133)

Web of Knowledge Search

Journals from key titles list with coverage on Web of Knowledge. Search for publication name AND Topic = "nhs" or "national health service"

Critical Social Policy (9)

Health Care Analysis (33)

Health Policy (109)

Health Services Research (8)

International Journal of Health Planning and Management (21)

Journal of Advanced Nursing (248)

Policy and Politics (47)

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Project 08/1808/240

Public Administration (73)

Public Money and Management (88)

Social Science and Medicine (109)

Sociology of Health and Illness (59)

British Journal of Management (7)

Human Relations (9)

Journal of Management Studies (13)

Organization (4)

Organization Studies (9)

The Journal Sociology ISSN 0038-0385 was not indexed on either database so a search of the journal online via Sociology Online (Sage journals) was conducted across the journal contents for articles with “nhs” or “national health service” in title or abstract – 10 records resulted which were also saved

1084 records were identified, including duplicates

OVID Medline search

Run 12032009

Ovid MEDLINE(R) 1950 to March Week 1 2009

Saved Search Strategy = Medline Physician as Manager

Medline Physician as Manager

1. State Medicine/og

2. nhs.tw.

3. or/1-2

4. exp Great Britain/

5. england.tw.

6. uk.tw.

7. united kingdom.tw.

8. scotland.tw.

9. wales.tw.

10. northern ireland.tw.

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11. or/4-10
12. Professional Autonomy/
13. Professional Competence/
14. Health Facility Administrators/
15. Health Services Administration/
16. Hospital Administrators/
17. Physicians Role/
18. Administrative Personnel/
19. Evidence-Based Medicine/
20. executive.hw.
21. executives.hw.
22. professionali?ation.tw.
23. deprofessionali?ation.tw.
24. managerial$.tw.
25. de-professionali?ation.tw.
26. clinical director$.tw.
27. or/12-26
28. 27 and 3 and 11
29. editorial.pt.
30. letter.pt.
31. or/29-30
32. 28 not 31
33. nursing.jw.
34. health service journal.jn.
35. or/33-34
36. 32 not 35

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37. limit 36 to (english language and humans)

584 records downloaded

OVID Embase search

Search run 13022009

EMBASE 1980 to 2009 Week 10

Saved Search Strategy = Embase Physician as Manager

Embase Physician as Manager

1. National Health Service/

2. "36".ec.

3. 1 and 2

4. nhs.tw.

5. or/3-4

6. United Kingdom/

7. england.tw.

8. uk.tw.

9. united kingdom.tw.

10. scotland.tw.

11. wales.tw.

12. northern ireland.tw.

13. or/6-12

14. (Professional adj Autonomy).tw.

15. Professional Competence/

16. administrator$.tw.

17. Health Care Management/

18. Hospital Administrator/

19. Physician Attitude/

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20. Administrative Personnel/

21. Evidence-Based Medicine/

22. Manager/

23. professionali?ation.tw.

24. deprofessionali?ation.tw.

25. managerial$.tw.

26. de-professionali?ation.tw.

27. clinical director$.tw.

28. or/14-27

29. 5 and 13 and 28

30. editorial.pt.

31. letter.pt.

32. or/30-31

33. 29 not 32

34. nursing.jx.

35. 33 not 34

36. limit 35 to (human and english language)

291 records downloaded

Social Science and Medicine (**ISSN:** 0277-9536) 1981 – 13/March/09 searched online through Elsevier Science Direct for (autonomy or managerialism or professionalism) in title

11 records saved as potentially relevant

HMIC search

Search run 16032009

Saved Search Strategy = HMIC Physician as Manager

HMIC Physician as Manager

1. NHS.hw.

2. NHS.tw.

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3. or/1-2

4. Professional Autonomy/

5. Professional Competence/

6. Professional Behaviour/

7. Professional Practice/

8. Professional Accountability/

9. Interprofessional relations/

10. Evidence-Based Medicine/

11. Professional Role/

12. autonomy.tw.

13. or/4-12

14. Management Competence/

15. Management Role/

16. Administrative.hw.

17. Administration.hw.

18. Administrators.hw.

19. Managers.hw.

20. executive directors/

21. non executive directors/

22. professionali?ation.tw.

23. deprofessionali?ation.tw.

24. managerial$.tw.

25. de-professionali?ation.tw.

26. clinical director$.tw.

27. or/14-26

28. 3 and 13 and 27

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29. health service journal.jn.

30. 28 not 29

160 hits downloaded (including duplicates across DH and KF records)

17032009

Clinician in Management (now The International Journal of Clinical Leadership)

Sample issue on ingenta Clinician in Management

http://masetto.ingentaconnect.com/vl=1124343/cl=15/nw=1/rpsv/cw/rmp/09655751/v11n1/contp1.htm

4 records saved from the free sample issue (Volume 11 Number 1 2002)

a search was conducted of the Journal Clinician in Management across OVID medical databases HMIC, Ovid MEDLINE(R), EMBASE, British Nursing Index for records to papers containing key terms relevant to the topic

Saved Search Strategy = Clinician in Management

Clinician in Management

1. International Journal of Clinical Leadership.jn.

2. Clinician in Management.jn.

3. 1 or 2

4. autonomy.tw.

5. managers.tw.

6. professionali?ation.tw.

7. deprofessionali?ation.tw.

8. clinical director$.tw.

9. managerial$.tw.

10. management competence.tw.

11. management role$.tw.

12. evidence-based.tw.

13. (administrative or administration or administrators).tw.

14. executive director$.tw.

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15. non-executive director$.tw.

16. chief executive$.tw.

17. physician$ role$.tw.

18. or/4-17

19. 3 and 18

170 records were retrieved

ASSIA search

Search run 18032009

CSA Illumina

No limits specified to data

Search Query #9 ((DE=("**health services**" or "**ambulance services**" or "**chiropody**" or "**community health services**" or "**dentistry**" or "**maternity services**" or "**maternity waiting homes**" or "**mental health services**" or "**community mental health services**" or "**psychiatric services**" or "**psychiatric units**" or "**psychological services**" or "**support bed units**" or "**national health services**" or "**commission for health improvement**" or "**health authorities**" or "**district health authorities**" or "**family health service authorities**" or "**health councils**" or "**community health councils**" or "**local health authorities**" or "**regional health authorities**" or "**health boards**" or "**national health trusts**" or "**primary care trusts**" or "**strategic health authorities**" or "**occupational health services**" or "**ophthalmology services**" or "**regional health services**" or "**sexual health services**" or "**student health services**" or "**student mental health services**")) or(DE=("**national health services**" or "**commission for health improvement**" or "**health authorities**" or "**district health authorities**" or "**family health service authorities**" or "**health councils**" or "**community health councils**" or "**local health authorities**" or "**regional health authorities**" or "**health boards**" or "**national health trusts**" or "**primary care trusts**" or "**strategic health authorities**")) or(KW=(**nhs**)or DE=(**primary care trusts**) or KW=(**NHS Direct**) or KW=(**NHS Foundation Trusts**) or KW=(**NHS Trust Federation**))) and((KW=(**Clinical Services Managers**)or KW=(**Clinical Directors**) or KW=(**Medical Directors**) or KW=(**Management Teams**) or KW=(**Middle Managers**) OR KW=(**Resource Managers**) or KW=(**Senior managers**) or KW=(**Administrators**) or KW=(**Chief Executives**) or KW=(**Executives**) or KW=(**non-executive directors**) OR KW=(**Evidence Based Medicine**) OR KW=(**Clinical Management**) or KW=(**Clinical Risk Management**)) or(KW=(**professional status**) or KW=(**professional skills**) or KW=(**professional attitudes**) or KW=(**professional competence**) or KW=(**professional culture**) or KW=(**professional identity**) or KW=(**professional identification**) or KW=(**professional image**) or KW=(**professional judgements**) or KW=(**Interprofessional approach**) or

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KW=(**Role clarity**) or KW=(**Autonomy**) or KW=(**Job autonomy**) or KW=(**Professional autonomy**) or KW=(**Management Style**) or KW=(**Management techniques**) or KW=(**Middle Management**) or KW=(**New Public Management**) or KW=(**Deprofessionalization**) or KW=(**Deprofessionalisation**) or KW=(**Managerial authority**)))

Resulted in 645 hits

Confounding records

For both searches duplicate and confounding records were removed for the final database. Confounding Records were classed as:

- Reportage – i.e. 1-2 page non-peer reviewed material in professional journals (HSJ, NHS Magazine, Modern Hospital)

- Monographs "Guide to X for middle managers", that is publications for practicing middle managers as oppose to those about middle managers being a subject of study.

- Editorials
- Letters
- Nursing Journals, items with nursing in title but not removed if nurses were only 1 population studied among others
- Clinical supervision or "first-line" supervision of particular clinical or non-managerial work
- Social Work supervision and case work

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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.

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