Continuity and tension in the definition, perception and enactment of the first-line management role in healthcare

Executive Summary

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Executive Summary

Background

The study reported here sheds light on the first-line management (hereafter ‘FLM’) role in healthcare which is regarded as central to implementing and monitoring health policy, delivering front-line services and determining the quality of patient care.

There is some debate about whether the FLM role has changed from its traditional focus on direct supervision and operational implementation of policy through routine planning, scheduling and monitoring of work and dealing with unforeseen operational problems. On the one hand, it is claimed that, with the ‘empowerment’ of work teams and decentralisation of decision-making, the FLM role has become either a residual one of ‘team coordinator’, facilitating the work of teams that manage themselves, or an enhanced one of ‘business unit manager’, with responsibility for the performance of an organisational unit. On the other hand, recent workplace studies show that, despite the rhetoric and aspiration, the traditional role has not altered significantly (1, 2, 3).

Broader trends in management in the NHS have ramified intoconcomitant developments at the level of first-line management. However, there remains limited evidence on how these management roles are defined, experienced and enacted. This was recognised in Theme (iii) of the 2008 SDO call for further research to build the evidence base on the roles, behaviour and lived work experience of junior managers in healthcare organisations.

Aims

The study sought to answer the following questions:

1. How is the FLM role in healthcare defined, both formally and in terms of others’ expectations?

2. Within that role, what is the balance between professional work and managerial work and between routine supervision, performance management, team leadership and wider resource responsibilities and what are the tensions between these?
3. How do managers with first-line responsibility interpret, experience and enact their role?

4. What are the areas of overlap and conflict among others' expectations of the role and between others' expectations and FLMs' own interpretations and sense-making of their role?

5. How do FLMs resolve these conflicts enacting their role in practice?

Methods

A comparative diagnostic case study was undertaken, focusing on two distinct FLM roles - a 'line' role (Service Managers) and a professional role with de facto FLM responsibilities (Ward Sisters) – in two acute care trusts (Alpha and Beta), with the primary focus on the Ward Sister role where tensions in first-line management in healthcare are a priori likely to be more acute and the more unambiguously Service Manager role used as a comparator.

The study employed a multi-paradigm and mixed methods approach, blending critical realist analysis of how FLM positions are shaped by wider institutional structures with sense-making analysis of FLM practices and experience. Institutional context was investigated through a combination of secondary sources and internal documents.

The two FLM roles were investigated through 37 semi-structured interviews with role set members and 30 semi-structured role perception and sense-making interviews with FLMs themselves.

How FLMs enacted their role was investigated further through work shadowing 7 FLMs and observation of four Ward Sister ‘Study Days’ at Beta.

Results

The growth of the management cadre as a mechanism of coordination and control in healthcare has spawned an assortment of first-line management positions. Two in particular are evident. Firstly, de facto FLM positions, such as that of ‘Service Manager’, have been created, largely as adjuncts to General Managers with ad hoc responsibility for assisting with planning, monitoring and measuring operational performance against targets and budgets. Secondly, front-line senior clinicians, notably Ward Sisters, who always had a leadership role at ward level, have acquired additional formal managerial responsibilities.
The interpretation and enactment of these two roles show similarities and differences. For Ward Sisters, the division of responsibilities specified in organisational structures and transmitted through others’ expectations defines their role as a ‘practitioner-manager’ - a complex blend of hands-on nursing, professional ward leadership and, increasingly, organisational management. The combination of clinical and organisational demands so created gives rise to tensions and ambiguities in the role, expressed in the divergent, often conflicting, expectations of nurses, doctors and managers. The inherent role-conflict in being, simultaneously, a clinician, directly engaged in patient care; a clinical leader, overseeing, mentoring and developing junior nurses and ensuring clinically-defined high quality patient care; and a manager, responsible for monitoring and reporting work performance against business criteria, is coupled with role-ambiguity over the distinction between the Ward Sister and Matron roles and the dissonance between greater managerial accountability without a commensurate increase in managerial authority.

Despite pressure to become, think, speak and act like managers, Ward Sisters continue to value, embrace and prioritise their nursing and clinical leadership roles. They perceive themselves as both part of the clinical team on the ward, with hands-on responsibility for ‘their’ patients, requiring the credibility and professional authority that comes from maintaining their clinical expertise, and as leaders on the ward, with 24-hour responsibility for ensuring continuity of care. They see both roles as threatened by growing managerial responsibility for HR management, clinical auditing, performance management and budgets and for following the formal procedures which these entail.

Ward Sisters have to reconcile their professional priorities with a growing range of role expectations. They do so by: re-affirming their identity as uniquely competent senior nurses, delivering patient care and developing junior nurses; delegating management tasks perceived as routine and tangential to patient care; and juggling those that remain by giving priority and attending to immediate clinical matters, whilst formally complying with unavoidable targets and procedures.

In contrast, the Service Manager role in the two trusts is more conventionally that of first-line management, in that it is formally defined as responsible for a discrete clinical specialty or service and subsumes day-to-day operational coordination of work, supervision of administrative and clerical staff, monitoring performance against targets and solving ad hoc work-flow problems. In practice, however, the role is weakly defined. Clinical Directors and General Managers, acting in concert, are principally accountable for operational and financial performance. The Service Manager role is more of a constructed, operational-level adjunct to the General Manager than a distinct role in its own right. As such, it is an attenuated version of first-line management, comprising an assortment of ad
hoc monitoring, supervisory and information collecting tasks - routine work which General Managers wish, or need, to off-load.

The inherent structural ambiguity and uncertainty which this creates comes through, in Service Managers’ experience, in the dissonance between organisational targets and operational constraints. Service Managers see their credibility and position as managers as dependent on meeting senior managers’ expectations that they ‘make a difference’ to organisational performance by meeting targets, whilst working with financial constraints, limited capacity and limitless demand, with few staff whom they can manage directly and with little authority over the senior clinicians and other staff with and through whom they work. In the absence of this authority, they develop a subordinate ‘working relationship’ with consultants, going out of their way to avoid conflict and provide support, if necessary by undertaking routine administrative tasks.

To cope with this, Service Managers construct an identity as ‘hardworking employees’, thriving on ad hoc, reactive problem-solving in demanding circumstances and enact a role as ‘conformist administrators’, doing what they have to do without questioning senior managers or alienating consultants.

Conclusions

The emerging Ward Sister role is an unenviable one, given its multiple and often competing elements. It is constituted in such a way as to require its incumbents to reconcile clinical, leadership, and organisational demands. This is especially challenging given that Ward Sisters have trained as nurses, with a professional mind-set, orientations and values.

That Ward Sisters cope with this role is testimony to their resilience and creativity but, from an organisational point of view is problematic if Ward Sisters are acting in ways that are organisationally sub-optimal. If by prioritising clinical work, Ward Sisters relegate management control to formal compliance and ‘box-ticking’, they may be failing to bring sought-for management disciplines to nursing activity on the ward. The practical implication of this is that either Ward Sisters be left to get on with patient care– with management of wards the responsibility of another, more explicitly managerial position – or they receive training and development which cultivates the skills required to finesse the competing demands and priorities. If the former, the Matron role is the obvious candidate to undertake a more explicitly managerial function, given that the division of responsibility between Ward Sisters and Matrons is currently unclear.
The Service Manager role is not an explicit, well-defined FLM role with clear responsibility for front-line supervision and performance management, but a rag-bag of ad hoc activities which assist General Managers. That Service Managers themselves make themselves useful by providing information and owning others’ problems and are busy doing so are weak grounds for retaining the role. Equally, there are no obvious training and development solutions since the problem lies less with how the role is undertaken, more with the role itself. Rather, the role should either be removed, with General Managers taking greater responsibility for front-line management, or replaced by a more clearly-defined FLM role.

Effective first-line management in the NHS requires more coherent, focused and credible FLM roles.