The Role of Middle Managers in the NHS: The Possibilities for Enhanced Influence in Strategic Change

Volume II

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Chapter 5

The Role of Middle Managers in the Business Planning Process[32]

5.1 Introduction

This chapter reports upon the case of business planning in Florence Hospital. It is the first of four successive cases of strategic sub-systems represented in this thesis, which provide an empirical illustration of the role of middle managers in strategic change in the NHS.

As discussed in 4.2.1(b), business planning is viewed as strategic because resource allocation decisions into which this process feeds may significantly influence services offered. Business planning, as an area of strategic change, was selected because it was an activity which middle managers spent a great deal of time engaged in - for example, in producing the business plan and monitoring performance against the business plan. Additionally, the content of the business plan and the process by which it was produced was likely to be contested between middle managers and executive managers. More importantly, in the light of this thesis, it potentially represented a mechanism through which middle managers could shape strategic change, since they could propose investments in their area - for example, to provide a new service - and make a business case for investment in this. At the same time, it also potentially represented a mechanism by which executive management could control the

[32] A version of this chapter was published in the *British Journal of Management* (Currie, 1999b)

implementation of deliberate strategy through middle managers. Therefore, business planning was likely to illuminate the more general question of the role of middle managers in strategic change.

The chapter is structured as follows. The limited literature about business planning in the NHS is reported upon. This stresses that it is likely to be contested between executive and middle managers in the NHS, particularly given that it appears to be a private sector model of resource allocation, which is transferred to the NHS. The process of business planning within Florence Hospital is then outlined. Before reporting upon the business planning case, there is a brief summary of a previous case of management education in Florence Hospital. Although, such a section may seem oddly placed, it is important to outline the main findings of the management education case given the methodological emphasis upon successive cases and the increased level of understanding of the research proposition following each case (Eisenhardt, 1989). It is best placed before the case of business planning because the themes drawn from the management education case were elaborated upon in the business planning case, which immediately followed.

Three themes in particular emerged from the management education case, which are investigated in the business planning case. The three themes are - (1) top-down rational planning and generic transfer of managerial and organisational practices from private to public sector (2) the ability of middle managers to resist the implementation of deliberate strategy (3) the relationship between the centre and periphery in connection with executive management and middle management and also, between central government and individual trusts. The empirical findings of the business

planning case are structured into two narratives - executive management and middle management - that discuss these three themes.

5.1.1 Business Planning in the NHS

Business planning is a concept drawn from the private sector. In this context a business plan is, 'a statement of the actions and resources required by a business to sustain and develop a discrete area of commercial activities over time' (Coopers and Lybrand, 1996: 1). However in the NHS there are a number of contextual characteristics which impact upon business planning and mean that the business plan differs from that seen in the private sector (Thompson, 1996). In particular, sources of income are relatively inflexible - there is a great deal of political intervention from national level of government and the medical profession is a major cost driver and definer of services provided.

Despite the distinctive characteristics of the NHS, WfP reforms (DoH, 1989a) necessitated that NHS trusts prepare strategies on the basis that they are business units, which should provide services that meet purchaser needs, attract income and be financially viable. The DoH stressed that business plans were seen as crucial to being business-like. In the initial applications by health care organisations for trust status, the 'quality' of the business plan was one of the main criteria for the award or otherwise of trust status[33]. The NHSME also requires an annual plan from NHS trusts setting out its strategy for the ensuing financial year in detail and a further two years in draft form. In addition trusts have to submit a five-year strategic direction

[33] The Chief Executive of Florence Hospital described the poor integration of clinicians into management and a poor business plan as the reasons why the hospital was turned down in its initial application for trust status.

document every three years. Given that the business planning process is imposed upon trusts by central government we should firstly consider the impact of centre-periphery relations upon the influence of middle managers in business planning.

That it is a top-down initiative is important since this is likely to restrict any upwards influence of middle managers in the business planning process and also one that they are likely to contest. This is confirmed by other studies. For example, Langley (1986) raised the issue of control and the importance of negotiation and persuasion in her study of formal planning in hospitals. She asserted that hospital plans are a blunt instrument of control since they are strenuously resisted lower down the organisation. Langley *{ibid.)* considers a critical point to be that a plan should raise tensions between stakeholders and be open to discussion between all stakeholders if it is to be any use at all in a hospital. She concludes that the top-down approach, which the business planning framework demands, should be put aside in favour of a process encouraging a greater degree of participation from all stakeholders. This includes the middle management group, which control the individual clinical directorates. Where the planning process remains a top down process may mean that its outcome, the business plan, is consigned to 'gather dust' by middle managers (McTaggart 1994) since there are multiple definitions of a problem and contradictory objectives in the NHS (Clarke and Newman, 1997).

Clarke and Newman (1997) also argue that processes such as business planning, partly because they lack sensitivity to context, 'internalise' managerialism so that frameworks are narrowed for the evaluation of public services to assessments of their 'performance' and 'efficiency' as a business. Sheaff (1991a) further suggests that lack

of attention is paid to language in the NHS and that, '[one pitfall is] simply re-describing existing NHS activity in marketing jargon, for example renaming existing NHS plarming business planning' (Sheaff, 1991a: 31). A question to be considered, in connection with this, is the extent to which crude transfer of practices or models from private to public sector, as raised in chapters 2 and 3, impacts upon the influence of middle managers in business planning.

Yet business planning is necessary for NHS trusts because the government demands it for trusts. Despite this, beyond the above, there is little written academically about its impact. Much of the focus in the academic literature relates to policy issues regarding the management of public sector performance. In contrast, micro practices such as business planning which institutionalise attempts to manage public sector performance through performance indicators are insufficiently studied. Special editions of journals testify to the emphasis in academic debate upon policy rather than practice - for example, special editions of *Public Money and Management* (Jackson, 1993a) and *Health Services Management Research* (Lemieux and Champagne, 1998) are devoted to debate about performance measurement in the public sector. This debate emphasises that the performance indicators upon which business plarming is based are problematic and that, like the implementation of business planning, the implementation of performance indicators is a 'top-down' initiative (Jackson 1993a, 1993b).

Therefore, on the basis of the above, it appears that the case of business planning is likely to illustrate the impact of a top-down rational planning approach to strategic

change, in which generic transfer was embedded, upon the role of middle managers and the subsequent realisation of strategic change.

5.1.2 Business Planning in Florence Hospital

The hospital in which the case study was based - the Florence Hospital - was one whose initial application for trust status was turned down on the basis that its business plan was not viable and that clinicians were not sufficiently integrated into the management structure. However it was accepted for trust status in a second wave of trust applications, having addressed these issues and gained trust status in 1992. It employs 3000 staff and dealt with 37,000 inpatients and 63,000 outpatients in 1996/97. As well as a Surgical Services Directorate, Medical Services Directorate, Trauma and Orthopaedics Directorate, Critical Care Directorate and Radiology Services Directorate, it has an Accident and Emergency Directorate within its portfolio of services.

Each of the clinical directorates is headed up by a General Manager who works in conjunction with the Clinical Director, although in most cases the latter takes a '*hands off* [General Manager: Medical Services] role in the management of the directorate. The Service Manager, who takes operational responsibility for the directorate, is the main support for the General Manager. In most cases the General Manager and Service Manager have a professional background appropriate to the directorate activity area. For example, in Medical Services, both the General Manager and Service Manager were nurses.

The annual business planning cycle at Florence Hospital begins in August with the production of a template for the business plan produced by the Business Development Department which the individual clinical directorates have to work to in producing a business plan. Having produced a business plan which fits in with the template, the General Manager and Service Manager consult the Ward Sisters or Team Leaders, before putting it forward to the Trust Board for consideration. Usually the individual clinical directorates are asked to modify their business plan by the Trust Board before they finally accept it in February. However, the contracts with the purchasers for health care provision are not agreed until the end of the financial year in March. Thus the business plans are developed before contracts are agreed and are necessarily based on the previous year's contracts.

There are two main narratives identified by the researcher in the case study in relation to the business planning process described above:

(1) The Central Directorate or executive management (Business Development Department & Executive Directors).

(2) The middle management (Service Managers & General Managers).

However, before launching into description the empirical findings around the issue of business planning, it is worth outlining the understanding that was brought to bear upon this case following earlier investigation, by the researcher, of a competence-based management education programme aimed at middle managers in the Florence

Hospital. It is useful to outline findings from this since a number of themes emerged, which were elaborated upon in the case study of business planning.

5.1.2 The Competence-based Management Education Programme[34]

The competence-based programme was derived from an assumption that management skills and knowledge can be generically transferred between all sectors and industries. The structure of the programme was like a family tree, with a main stem divided into smaller branches. The main stem, the key purpose of management, is divided at into key roles (Managing People, Managing Information, Managing Operations, and Managing Finance) which are then further split into 9 Units of Competence, 26 Elements, and finally 163 Performance Criteria. In addition Range Indicators are given to give an idea on the context in which the behavioural outcomes should take place. The competence-based management education programme aspired to enhance the role of middle managers - Service Managers - in the trust.

A new university won the contract to deliver the programme. A qualification of evidence of competency would be awarded, following production of a portfolio as evidence of competent performance against the generic standards. The facilitators expected that the portfolio would be completed by participants 12-18 months after the programme began. There was a series of development workshops and assignments associated with the workshops to facilitate this. At the front end of the programme all participants took part in a one day event, which was labelled a 'development centre', from which they identified their strengths and weaknesses as they related to the generic competences. Development workshops were interspersed with one-to-one

counselling workshops every two months that facilitated development of the portfolio of evidence for qualification purposes. The completion of portfolios for most participants would take place following the delivery of the formal element of the programme.

However, the programme was a 'failure', this judgement[35] being based upon poor attendance, resistance exhibited during delivery and subsequent high non-completion rates (only 2 participants from 35 completed the programme). Analysis of the programme suggests a number of important issues that adversely impacted upon its aims.

Firstly, the approach adopted towards change in this case was one of top-down rational plarming, where formulation and implementation of strategy were separate, and strategy was deliberate rather than allowing for any emergence (Mintzberg and Waters, 1985). Therefore the implementation of the competence-based management education programme provided an illustration of how ineffective a top-down rational planning approach to change might be. Executive management in the Central Directorate made the decision to utilise competence-based management education, without involving the middle managers in the clinical directorates in that decision. Further, the competence-based management education programme assumed generic competencies across all organisations rather than being tailored to the NHS context. Subsequent resistance from participants and failure of the programme suggest, that the top-down way in which the programme was implemented and the assumption that competences were generic across private and public sectors, was inappropriate.

[34] See Currie (1999a) for fuller description and analysis of the competence-based management education programme in question.

In Floyd and Wooldridge's (1992, 1994, 1997) terms, the influence of middle managers was limited to that of implementing deliberate strategy. However, within this role, middle managers can still have substantial downward influence in modifying deliberate strategy (Quinn, 1978, 1980, 1982). The result of the imposition of the programme upon participants in the Florence Hospital was that an implementation gap was created at the local level as middle managers resisted the deliberate strategy. Service Managers in the Florence Hospital, in contrast to the the designers and deliverers of the programme, did not view the generic management approach inherent in competence-based programmes, as the *'obvious way to do things'* [Lead Facilitator of programme]. Therefore the participants contested the legitimacy of the management knowledge within the programme on the basis it was insensitive to context. Yet there was no attempt by executive management or facilitators to engage in persuasive argumentation with middle managers to convince them otherwise (Pettigrew et al, 1992).

Therefore, to summarise, a number of important issues emerged in the investigation of the management education programme that informed data-gathering in the business planning case -

(1) The role of middle managers in strategic change, particularly their ability to resist the implementation of deliberate strategy.
(2) The relationship between the executive management and middle management in the case. Connected to this is the problem of top-down rational planning and

[35] This view was shared by the researcher and those who commissioned the programme at Florence Hospital, although the facilitators from the new university were reluctant to admit failure.

associated with this, at least in the case, an assumption that generic transfer of private sector practices into the NHS was appropriate.

These issues alongside two other issues that emerged from the case of business planning - the relationship between central government and trusts and features of inner context such as organisational structure and organisation/management development - are now discussed.

5.2 The Chanee Narrative of Executive Management

5.2.1 The Resistance of Middle Managers to Deliberate Strategic Change

As far as objectives are concerned the main function of business planning is to allocate resources. In addition, it is seen by the Central Directorate as a way to raise the profile of certain issues and gain the commitment of middle managers to these issues. For example, the Clinical Effectiveness Manager is responsible for developing what she calls, *'more qualitative performance indicators'*. The business planning process is a mechanism in which the move towards qualitative indicators is embedded:

'The Chairman and Chief Executive said we are sick of seeing performance indicators as the only measures of quality in the organisation. They suggested that I use the business planning process as a way to get managers on board with this' [Clinical Effectiveness Manager].

However, executive management in the Central Directorate do view the local context as important and that middle managers are best placed to recognise this. For example,

the Director of Nursing, who often distanced herself from other Board members by priding herself that she is the only executive who really understands what goes on at the 'coal-face', described how knowledge of the coal-face may lead to resistance from middle managers towards the business planning process:

'*Florence Hospital has 65 per cent occupancy while City Hospital has 95 per cent [these are the 'bare' statistics within the business plan]. However, other figures [often not in the business plan] show Florence Hospital in a more favourable light. At Florence Hospital trolley waits are 2 hours because of lower occupancy rates. At City it may be 24 hours. Occupancy statistics don't mean a thing. Board members just don't know the coal-face, whereas they [local middle managers] see this and are cynical about targets in the planning process*'.

That local context is likely to impact upon the business planning process is clearly evident in interviews with executive management in the Central Directorate. For example, executive management recognised operational 'reality' means the success of the business planning process is dependent upon the characteristics of each directorate:

'The core work of medical services is admissions ... the development of lots of business plans linked to their different areas doesn't work as well as general surgery. In surgery areas are quite discrete and they can develop discrete business plans which are brought together by an overall strategic theme' [General Manager: Medical Services].

'*In orthopaedics local managers and clinicians don't want to get into the business planning game. They've got long waiting lists*' [Chief Executive].

The perception by middle managers that the standardised business planning process and framework does not fit easily with local context is recognised by the Central Directorate who feel that this contributes towards a great deal of ambiguity in middle manager roles:

'They [middle managers] are closest to patients. They see the dilemmas and paradoxes of having to match the demands made to them by patients in beds and by relatives who don't feel they can cope with the patients at home with the performance criteria imposed upon them in the business planning framework such as bed utilisation and contract targets. If anyone is the jam in the sandwich, it is them' [Organisation Development Manager].

Executive management recognise that there are significant local contextual differences, which allow middle managers to resist the implementation of business planning. However, they still view the business planning process as representing a mediating strategy towards the management of the middle management group so that the ends prescribed by the Central Directorate are met:

'The end product is partly about control ... Decisions made about resource allocation then become the basis for performance indicators for the next year' [Chief Executive].

'Business planning is a strategy which allows us to manage professionals ... but allows us to manage the means towards managerially prescribed ends' [Organisation Development Manager].

5.2.2 Relationship between Executive Management and Middle Management

In its initial stages (1993/94) the Chief Executive felt that there was a receptive context for the introduction of business planning. This was due to the scope allowed for middle managers within clinical directorates to include their own internally generated developments in the business plan - such as capital projects - alongside indicators set at national level and purchaser level. To facilitate the skills of middle managers to make a case for business development, one day workshops were held to introduce them to the rudiments of strategic analysis. An external consultant was

utilised. He outlined generic strategic analysis frameworks to the middle management group - for example analysis of strengths, weaknesses, opportunities, threats (SWOT analysis) and portfolio analysis. The Business Development Manager who helped the middle managers apply the frameworks to business development proposals followed this up. He felt that this opportunity was taken up at the clinical directorate level by middle managers and in the first set of business plans strategic analysis was emphasised.

In addition, a receptive context for the implementation of business planning had been assured by the perception of Florence Hospital as 'second rate' by its own employees because it had been turned for trust status in the first wave of applications while its nearest 'competitor' had been successful. One of the reasons, cited in an interview with the Chief Executive, for its trust application being turned down was that, '*we did not have business planning in place.*'

This has changed over time. Evidence of diminished scope for middle managers at clinical directorate level to gain support for internally generated developments in the business plan is provided in documentation. In October of each year the Chief Executive sends out a memo to clinical directorate managers setting out targets for the next financial year which would form the basis of the business plan for that year. The framework set out has become more prescriptive over time. In the memo prior to the 1993/94 business planning cycle there are general statements that, 'I [Chief Executive] want to discuss CIP [cost improvement targets] and possible areas for next year including market testing, materials management and inter-provider targets'. It also states that, 'I wish to discuss and assess performance over the first four months of

the current financial year'. Whereas, very broad statements framed the business plan for 1993/94, in the following financial year, the framework prescribed by the Central Directorate became tighter. In 1994/95 the framework set out for the business plans is one which emphasises, 'critical success factors', as laid down by national and regional level bodies as well as purchasers. The memo lists these and 'asks' that business plans be constructed with reference to these. At the same time, strategic analysis became a less important part of the business planning documentation.

As a reflection of this, summary reports are now produced for each clinical directorate and specialties within each directorate which provide feedback on national, regional and purchaser defined performance indicators throughout the financial year. These are then aggregated and summarised in the business plans produced for the next year to show the benchmark against which clinical directorates intend to make improvements. For example, a memo sent out by the Chief Executive prior to the 1994/95 business plarming round states that:

'These objectives are core objectives and in the main they are based upon national and regional guidance ... in some cases I have not assigned targets as I will assume these will be on the basis of our discussions with purchasers'.

As a flavour of these objectives, there are performance indicators, which have been well publicised in national league tables, such as waiting times. In addition to these, there are targets for increasing the percentage of day case surgery in relation to specific interventions such as varicose vein stripping (expected to be 37 per cent in 1994/95 business plan but revealed to be 49 per cent in 1995/96 business plan for surgery). Under 'resource utilisation' appear figures for bed percentage occupancy

and throughputs. The list goes on of such criteria within the business planning framework.

That business planning remained a top down initiative is emphasised by one of the Business Development Managers with responsibility for business plarming:

'The Central Directorate wanted clarity around the objectives of the organisation and to put a performance framework around it and the business planning process facilitated this. They wanted to co-ordinate the different services so that they were moving in the same direction towards these set objectives. They regarded the business planning framework as a rational decision-making system because it was transparent, shifted the focus from professional interest to patient interest, and recognised resource constraints within a longer time horizon than was traditionally the case'.

5.2.3 Relationship between Central Government and Trusts

That some outcomes of the process are not what they could be is blamed, by executive management, upon external factors as well as the disjunction between the targets set in the business planning framework and operational 'reality':

'We didn 't get the integration of [business planning in to] directorates quite right ... this was linked to the fact that purchasers didn't set contracts until the last two weeks in March ... the health authority were very reluctant to give clear decisions on priorities ... so there was no time for internal dialogue between areas' [Chief Executive].

An additional external constraint is the unpredictable nature of government directives, such as requests for efficiency gains or managerial restructuring. This is particularly so because the third strand of the business plarming framework, that of internally generated initiatives, is compromised by financial constraints:

'To start with we were actually able to deliver a lot of the things set out in the business plans ... such as the WIN Project [a customer care programme] ... / would say for the first three years this was possible but less so in later years ... financial constraints set by the government were very tight' [Chief Executive].

Government requests for efficiency gains in costs provide a good example of outcomes of externally prescribed criteria that are taken on board via the business plarming process. In the memo which went out from the Chief Executive prior to the 1994/95 business planning round it was stated:

'Finally, you will be aware of the efficiency targets the hospital is required to meet. In 1993/94 this was 2 per cent and until the announcement in the autumn, I am assuming it will continue at 2 per cent. I would therefore like to discuss your contribution to this'.

The extent to which the environment is unpredictable is also reflected in the business planning round of 1995/96. Following agreement of business plans in March 1995, there was a subsequent statement by the government in the Autumn of 1995 where the Health Secretary at the time, Stephen Dorrell, asked for a specific two per cent efficiency gain in management costs at middle manager level. This had not been included in the business planning framework since it was an unexpected political intervention.

5.2.4 The Middle Manager: Medical Group Interface

In a previous section 5.2.1 it was evident that the medical group was likely to significantly influence strategic change. As discussed in chapter 2 and 3 (sections 2.2.3 and 3.4.5) this was likely to significantly constrain the role of middle managers.

However, as was also suggested, middle managers may have some opportunity to influence the medical group.

A number of executive management recognised medical group power but they also suggested that, while it was not necessarily a straightforward case of power being re-allocated from the medical group to general management, that the latter group may have influence over medics under certain conditions. Much of this was due to the impact of resource constraints:

'*I think the reforms have shifted the balance more towards the patients and managerial interests and slightly away from the professional interests. The managerial interest is now more to the fore. By that I mean there is much more concern for resource constraints'* [Organisation Development Manager].

'*I think the doctors are being challenged as professionals. They are being held to account and asked to consider whether the care they are giving is the best way of doing things, particularly with respect to resources. They are being told that they can't have a piece of kit because it is too expensive. That's a real shock particularly for the older ones who feel they have this god-like status'* [Clinical Effectiveness Manager].

For example, in Pathology at Florence, that general managers may influence the medical group was evident as a result of the impact of WfP reforms:

'*Our pathology service here has been exposed to market forces longer than any other area and is very much externally focused, has a super customer orientation and just about all the 10 consultants within the area work closely with general management to provide services that GPs can afford'* [Business Development Manager].

In addition, general manager influence extended beyond individual directorates in Florence as a result of middle manager participation in Board awaydays:

' We had some time out recently with the Board to discuss strategic direction. It used to be just the Board and the Clinical Directors but we now invite the General Managers. In fact, although the Clinical Directors do the presentations, they are prepared by the General Managers' [Director of Nursing].

5.3 Change Narrative of Middle Management

5.3.1 The Resistance of Middle Managers to Deliberate Strategic Change

It is useful to examine some of the outcomes of business planning. On one hand, it illustrates some reasons for middle managers scepticism about business planning. On the other hand, it also illustrates some middle manager influence upon strategic change.

There is evidence that the middle managers are taking note of the narrow performance measures to which they are subjected, in constructing the business plans. A feature of the influence of middle managers is that they bid for extra resources through the business plan showing that the extra resources would be used to meet targets set in national policy initiatives. In some areas, such as Genito-Urinary Medicine, problems are addressed of a uniquely contemporary nature, such as HIV/AIDS infection into which money is being directed from national level. Therefore, managers in this area have greater leverage in putting forward a business case for extra resources in their business plan because they are aware of additional funding opportunities. In this case, the middle manager spends a great deal of time attending network meetings outside the hospital that involve organisations outside as well as inside the NHS.

In Surgical Services funding for an improvement in the outpatients clinic has been gained so that the percentage of day care patients as a proportion of surgery increased. This reflects the past and present government desire that day care surgery increase so that bed utilisation becomes more efficient. This, in turn has resulted in cost improvements for surgical interventions. The development of an outreach clinic proposed in the business plan of Trauma and Orthopaedics has been supported on the basis of the argument from middle managers in the area that this was what GP fundholders, the main group of purchasers within the health authority area want. Trauma and Orthopaedics have also made a successful case for extra resources to support a Patient-Focused Care[36] pilot that has been driven at a national level and has pump-priming funding attached.

There are some 'humorous'[37] stories about patient care within the hospital which show the extent to which business planning indicators drive activity. While, descriptions of top management being from the *'Planet Zanussi'* [Service Manager: Trauma & Orthopaedics] suggest resistance to the transfer of generic practices such as business planning, that elderly patients are routinely described as '*bedblockers*', because they impact adversely upon the bed throughput indicator in the business plan, suggest that middle managers have internalised (Berger and Luckmann, 1967) many of the new practices. In one instance, an elderly patient went to the toilet and on his return he found a new patient in his bed. This was a product of local managers desire to increase bed throughputs[38].

[36]Patient focused care is based upon a philosophy and set of practices that mean the patient and their experience provides the focus around which health services are organised. For example, the patient will be x-rayed next to the consulting room.

[37] Such stories abounded in Florence Hospital and were used to ridicule performance indicators and other managerial practices. While middle managers laughed at such stories, they also exhibited distress that such instances should happen. We can also assume that the relatives of elderly patients and the patient themselves were not amused.

In another example, a middle manager describes how practices within the Accident and Emergency Department have been modified to take account of indicators imposed upon the area. A key indicator for Accident and Emergency is how quickly patients are seen on arrival. A new post has been created whereby a 'nurse' (trained in a competence-based approach to NVQ Level Two therefore not fully qualified) takes patients details immediately upon arrival. However, such changes in practice may be seen as *'cosmetic not real'* [Service Manager: Critical Care] because, while being greeted and logged very quickly initially, patients are still experiencing lengthy waits in a subsequent waiting room before they see the consultant. Despite this view substantial resources are being used to support the changes in practice in the Accident and Emergency area. That the business plan indicators are given such an emphasis in Accident and Emergency may be due to the need for this area to improve its internal and external reputation in the face of criticism. This contributes towards a 'five-star' rating the Accident and Emergency Department obtained in the 1997/98 national league tables, since 'percentage of patients assessed within five minutes of arrival' is the main performance indicator for this area.

However, in some other areas business planning indicators do not receive such an emphasis and the uneven implementation of business planning is again evident. For example, where *'business'* is generated from other directorates within the hospital, such as for Critical Care Services, the managers have no discretion over their activity and are not inclined to review the business plan once produced *'unless forced to by the centre'* [General Manager: Critical Care Services]. Where there are lengthy waiting lists, such as for hip replacements, managers are also likely to regard the business planning process as a paper exercise only. Even in those areas favourably

[38] As a mitigating circumstance, the patient was due to be discharged that morning, but only after seeing a consultant.

disposed to business planning, managers admit that they have reservations about business planning. However, there is evidence that such reservations can be reduced by executive management paying attention to meanings attached to the business plarming process:

'It's taken me a long time to think like this. It's only because I've worked closely with the Business Development Manager that I see the sense of it all' [General Manager: Surgical Services].

5.3.2 Relationship between Executive Management and Middle Management

Middle managers express a view that much of the content of the business plan is produced by them to satisfy the requirements of the template, prescribed by the Central Directorate. They feel that it does not represent a working document for the next year of operations. Middle managers suggest that information on which business planning was based is very poor. This is despite attempts by the Business Development Department to build up a database of information gathered from other hospital trusts to assist in the planning process. As a result market analysis and income and expenditure forecasts are described as superficial. Middle managers claim that they only carry out these forecasts to meet the requirements of the business planning template:

'I just give them [executive management] what they want ... to be honest some of it [what executive management want] I don't understand what use it is to them. I know what's important, they don't, but if that's what they want [General Manager: Medical Services].

The business plan remains confined to the bottom drawer of the middle managers desks in their office in some instances. This was vividly illustrated in two interviews

where the middle manager opened the bottom drawer of their desk and only produced a copy of their business plan after a great deal of shuffling around in their drawer because the business plan had disappeared under other documentation. As a reflection of the lack of importance attached to the business plan by the middle managers, a middle manager in one directorate commented:

'Paula [General Manager] does it [business plan] at home and we [Service Manager and Clinical Director] sign it without knowing what's in it. It doesn't matter because it's not relevant' [Service Manager: Medical Services].

Despite seeming to pay only *'lip service'* [Service Manager: Trauma and Orthopaedics] to the business plarming process, it still remains the case that they spend a great deal of time developing and writing up business plans to satisfy the Central Directorate. They are also subject to an interim review of progress towards objectives set in the business plans and at an individual level, *'I'm judged on whether I've met my objectives through my IPR [Individual Performance Review] ... but it never amounts to much extra money'* [Service Manager: Trauma and Orthopaedics].

Certainly, the middle managers differentiate between *'them and us'* and regard business planning as something, *'they've imposed upon us without consultation'* [Hospice Manager}. For example, middle managers regard the Central Directorate, and those at national, regional and health authority levels, as not understanding what goes on at the *'coal-face'*. They emphasise that the business planning process does not reflect local clinical and managerial practice since it is difficult to standardise clinical interventions in the way demanded by the business planning framework:

'You don't know what is going to come through the door, particularly with the elderly. Maybe their partner has died or even their cat and they want the doctor's attention. They can tell him and it does have a bearing on their physical condition. It does!' (Service Manager: Outpatients Medical Services).

Thus it remains difficult to allocate 20 minutes to each 'consultant episode', as is asked for in the business planning framework. However, the middle managers are forced to do this and then manage the consequences of clinics overrurming when providing reports about business plan targets. Many areas exceeded contract agreements because they are reluctant to turn patients away and then find that funding doesn't follow the patient despite costs incurred. Again the middle managers are told *'it is your problem'*. In one instance a ward in Surgical Services was closed down temporarily because the area had been *'too efficient'* (General Manager: Surgical Services) in throughput terms and GP fundholders had spent their budget by November. Thus physical space and consultant time and expertise remained largely under-utilised until the new financial year began in the following April. To one middle manager, at least, this didn't seem *'very businesslike'* (General Manager Medical Services).

In addition, to a large extent, services provided remain professionally defined and this has an adverse impact upon business measures of performance:

'The problem here is that we are more specialised in vascular surgery as opposed to general surgery. They stay longer in hospital, need more expensive kit. It's an expensive specialty and we get squeezed because Midland Hospital Surgical Services have better throughputs in beds and FCEs [Finished Consultant Episodes]. The reason [for the choice of service provided] is we have two vascular consultants' (Service Manager: Surgical Services].

Middle managers criticise the type of indicators that are included in the business planning template imposed upon them. They feel that they have to put a *'a very good business case'* for service development to the Central Directorate. To obtain extra resources it is necessary to emphasise efficiency gains in making a *'business case'.* Quality issues, as defined by middle managers often on the basis of their professional backgrounds, for example in nursing, are described as secondary. A further problem is the fragmented nature of business planning. Middle managers feel that they carry out their business planning in isolation from other directorates:

'For instance before the pharmacy business plan is signed off we ought to have some input. If we are looking at providing a new treatment that has a drug implication it can have massive effect upon their budget' (Service Manager: Physiotherapy).

Finally, and importantly, the business planning process is criticised because it lacks sensitivity to the *'caring'* aspect of the health service. In a management development workshop, the Hospice Manager, while accepting a need for processes such as business planning, *'because we must manage resources more effectively in trustland',* comments:

'However, it's about caring for people so we can 't follow the cost-cutting principles of management as promoted in the industrial model'.

5.3.3 Relationship between Central Government and Trusts

A further reason cited by middle managers for the irrelevance of the business plan is that there is difficulty of planning ahead in the face of unpredictable changes in the environment, particularly at national level:

'We try to push the service forward and ensure resourcing meets service provided. But then suddenly you hit a brick wall when massive cost improvements are demanded by the government' [General Manager: Therapy Services].

That the external environment is also likely to be unstable is seen in the hospital's relationship with the purchasers of healthcare services, and the business planning process does not represent a mechanism for dealing with this:

'I think there has got to be a little more stability on the contracting side and things like that. Each year there has been so much change and you can't get any sense of the trends in the market ... It makes any sort of planning like business planning enormously difficult' [General Manager: Surgical Services].

In addition, the potential to develop business in the clinical directorates and for obtaining extra resources by expansion of business has diminished, not just in the face of government financial constraints, but also through host health authority intervention:

'We've been actively discouraged from taking any more GP direct access service business by the health authority. There's a limited pot of money and other directorates within our hospital or other hospitals lose out' (Service Manager: Physiotherapy).

That this is the case is exacerbated with the recent announcement by the host health authority that there was to be a proposed rationalisation of services in the city. Many of the clinical directorates within the Florence Hospital are to be adversely affected, despite performing well in the league tables. For example, the Accident and Emergency Department was awarded 'five stars', the top rating possible, yet it was to be moved to the site of a neighbouring hospital.

Increasingly over time, both the host health authority and GP fundholders have asked for business planning documentation in renewing or switching contracts. This increases the feeling of middle managers that they are squeezed in their roles. On one hand, they are clinicians. On the other, they are general managers, who construct business plans along narrow conceptions of performance which may take them away from spending time on clinical work:

7 need to plan what might be called the business. There is a part of me which asks, why did I do my three years training and ten years working as a physio to push bits of paper around. What should I really be doing?' (Service Manager: Physiotherapy).

Middle managers also feel *'disempowered'* by their relationship with the Central Directorate within the hospital. Therefore, perhaps not surprisingly, in the face of similar empirical evidence in other organisational contexts, much of the attention upon middle managers focuses upon their 'reluctance' (Scase and Goffee, 1989) or 'paralysis' (Westley, 1990). Any opportunity for mediating disempowerment, reluctance or paralysis that the talk of a move from clinical directorate arrangements towards 'Strategic Business Units' offered, was unlikely since this has *'been put on the backburner'* [Chief Executive] because there is not yet *'a critical mass of support'* [Chief Executive] (see section 6.2.3). As a result middle managers face a situation where there is still a great deal of central control:

'There are so many things I have to refer back on and say, can I do this? I don 't have any money where I can say, well I am going to make that decision to develop outpatient services' (Service Manager: Outpatients Medical Services).

On a more positive note that the *'centre'* imposes criteria in the business plarming framework, gives rise to certain emergent operational practices which, rather than

being dysfunctional, may lead to more effective patient care. An example of this is the attempt, in isolation, by a middle manager (Service Manager: Medical Services) to reduce nurse absenteeism in line with the target of 3.5 per cent set in the business planning framework. This has been imposed by the centre upon all directorates at the suggestion of a non-executive director from a multinational manufacturing concern in the area because it mirrors their policy towards absence. Thus, the Service Manager spends a large proportion of her Monday morning undertaking 'return to work' interviews to manage absence towards this target. That such an approach is successful in Medical Services means that in the subsequent years the 'return to work' interview process has become a policy imposed by the Human Resources Department upon other middle managers.

Despite the concerns of middle managers, some of them feel that business planning potentially is beneficial to the whole hospital as well as individual directorates because it is fairer in terms of the resource allocation process. Many of those areas marginalised as *'unimportant'* [Therapy Services Manager] under previous resource allocation processes have obtained leverage for extra resources under the new system. For example, Occupational Therapy invokes 'safe discharge' for patients to bid for extra resources. The Private Patients Department can show revenue gains for the hospital from investment in additional private patients' facilities. However, in some cases potential benefits are not realised and the business planning process is seen as largely symbolic. This is explained as follows:

7 think it's good ... that we've moved from a situation where those who shout the loudest get the resources towards one where a business case needs to be put ... Although I think we go through the motions sometimes of putting a case through

business planning and in reality the court remains the same' [General Manager: Trauma and Orthopaedics].

5.3.4 The Middle Manager: Medical Group Interface

While executive management felt that middle managers enjoyed some influence over the medical group, middle managers were less optimistic and highlighted the power of the medical group, through clinical autonomy, to constrain the ability of middle managers to determine service development:

' With contract specifications trying to standardise a package of care so that the patient gets 2 consultant ward rounds, 1 nurse on a daily basis, a physio 3 times pre-op and 3 times post op and it will cost this much - it's impossible because of freedom clinicians have to determine what happens' [Service Manager: Therapy Services].

In particular, in many cases performance indicators in the business plan by which the middle managers were judged remained outside their control:

'You can 't keep to the business plan indicators. Consultants say that, "you can 't quantify what the patient needs beforehand" I feel terrible going to those consultants and saying, 'Look only 30 per cent of your patients were seen within 30 minutes last week but as a manager I have got to trying to achieve it as the trust is judged on that' [Service Manager: Outpatients].

'{Regarding some of the audits by which the business plans is judged] we fail this audit all the time because in surgery you have to put 14 days notice of coming in for an operation - that's the standard by which our performance is judged so they get 100%. In medicine perhaps someone comes in as an out-patient but the doctor wants them admitted as an in-patient now so on my audit I fail but I'm offering a really good service to patients' [Service Manager: Medical Directorate].

However, a few middle managers suggested that the influence of the medical group had diminished:

'I find that the senior manager tend to treat consultants as any other employee. I'm employed to the job of managing the department and I'm allowed to do that whereas a few years ago what the consultant said went' [Service Manager: Theatres].

Although this may have been dependent upon the Clinical Director in question:

'It depends on your Clinical Director. Dr. M., is very power conscious. I think that stems from previous historical dealings he has had with the trust and things. He wants to make decisions for himself on everything so to some extent you could say that as a General Manager you are nothing more than a glorified administrator. With Dr. A. it was different. He let me run the directorate' [General Manager: Medical Services].

5.4 Discussion

The case of business planning illustrates a number of themes, which relate to the role of middle managers in the realisation of strategic change in the NHS. Firstly, the role(s) that middle managers take up in the business planning process is illustrated. Secondly, the relationship between certain features of strategic change, such as 'strong' centre relative to the periphery and an emphasis upon a top-down approach to strategic change, is emphasised as an important influence upon the role of middle managers. This includes consideration with both the executive management-middle management relationship and the central government-trust relationship. Thirdly, the impact of features of irmer context, such as organisation structure and organisation and management development, upon the role of middle managers, is illustrated. Each of these will be taken in turn, starting with the main research question, the role of middle managers and then considering conditions - centre-periphery relations and organisation structure and organisation and management development - that facilitate or inhibit an enhanced role.

5.4.1 The Role of Middle Managers

A number of important points can be made about the role of middle managers in relation to business planning. Business planning has the potential to facilitate an upward influential role for middle managers of 'synthesising information' (Floyd and Wooldridge, 1992, 1994, 1997), which can be a precursor to a divergent upward influence role of 'championing alternatives' (Floyd and Wooldridge, *ibid.).* However, any divergent role is unlikely, since any such role takes place within a framework prescribed by executive management, itself increasingly prescribed by central government. Any upward influence is also unlikely as both the content and process of business planning becomes tightly prescribed by executive management over time. Executive management in the Central Directorate view business planning as a control mechanism that will mediate middle managers resistance to change, and thus overcome their potential conservatism, by framing their objectives regarding service operations and development within a rational decision-making system. Increasingly, middle managers find that their influence is diminished in any potential role of 'synthesising information' (Floyd and Wooldridge, *ibid.),* because they can't put their '*spin*' (General Manager: Medical Services) on information presented to the Central Directorate. Further, any discretion in their role of 'implementing deliberate strategy' (Floyd and Wooldridge, *ibid.)* is less likely because the template for business planning becomes tightly prescribed by executive management and there is less scope for any service development due to financial constraint.

On one hand, resistance may remain confined to the expression of reservations about the business planning process in interviews with academic researchers or corridor

conversations since middle managers must exhibit behavioural compliance in the face of these conditions. On the other hand, it is important to obtain 'buy in' from middle managers because of their importance (Likert, 1961; Kanter, 1982; Frohman and Johnson, 1993; Nonaka, 1995; Smith, 1997) in the organisation. They are close to the operations of the business and are able to bring important information to bear through the business plarming process that informs the strategic change process. However, the conditions of financial constraint, which lead executive management to take an increasingly prescriptive stance, is likely to militate against 'buy-in' from middle managers to the business planning planning process. As a result, in Florence Hospital, it was illustrated that middle managers can comply with the requirements of the business planning process without necessarily bringing important information about operational context, which may inform the strategic change process, to the attention of executive management. Such a contribution from middle managers was rendered less likely by the structural positioning of middle managers (see section 5.4.3).

Only initially, because the trust fails in its application for trust status and as a result is positioned as second rate compared to its rival in the city, is business planning viewed in a more favourable light. The crisis that the failure to gain trust status causes, creates a receptive context for the implementation of business planning. However, executive management do not pay attention to 'managing meaning' (Pettigrew et al, 1992) and this receptive context is not built upon. The deteriorating financial climate and resultant intervention from government means that the context for business planning becomes less receptive. This manifests itself in some resistance to the business planning process. For example, the business plan is drawn up to satisfy the Central Directorate and then consigned to the 'bottom drawer'. When middle managers

explain such behaviour they question the legitimacy of the business planning process, particularly by drawing upon characteristics of the individual directorates. So for example, middle managers in Medical Services, whose activity is mainly driven by demand from Accident and Emergency, pay lip service to the business planning process. Similarly, in the outer context, the purchasing health authority is described as being slow to make decisions, so that business planning is seen as less useful. Thus, over time the business planning process becomes an ineffective mediating strategy to manage middle managers towards a greater business orientation as desired by the Central Directorate.

Therefore, generally and increasingly over time, business planning is undertaken with a lack of commitment by the middle management group with the result that it ceases to be a working document for clinical directorate operations or one that orientates them towards a more business-like frame of reference. Interestingly, the area that has adopted a greater orientation towards the external environment, the Pathology Department, has produced *'poor'* business plans in the view of the Business Development Manager. However, in this case the external environment is one which threatens the survival of the pathology department as rival trusts and private service providers attempt to gain increased market share. Thus middle managers in this area feel obliged to take action in an 'facilitating adaptability' (Floyd and Wooldridge (1992, 1994, 1997) mode to ensure their survival, although not necessarily via the business planning and documentation. Instead they carry out what might be termed 'marketing practices' in relatively informal ways such as visiting GP fundholders.

Initially when business planning was implemented there was considerable discretion for middle managers to have an upward influence upon resource allocation decisions through 'synthesising information' (Floyd and Wooldridge, 1992, 1994, 1997) via the business planning process, albeit within considerable constraints imposed by medical group power to define service. If middle managers can retain such discretion then they are likely to be more favourably inclined towards business planning because they see the more rational framework within the business planning process as a fairer method of allocating resources than previous less structured mechanisms. Even in the less receptive context that became apparent over time there remained examples of upward influence of middle managers. Importantly such influence converged with corporate strategy and government policy. So middle managers attempts to influence upward via, for example, making requests for additional outpatient or outreach clinics, were framed within a rationality imposed by executive management. Further, receptiveness was enhanced by favourable government policy that additional funding - for example in relation to HIV/AIDS infection - providing that middle managers are aware of additional funding opportunities.

5.4.2 Centre-Periphery Relations

The case of business planning illustrates the impact of top-down planning further down the organisation and the influence of middle managers within this. Over the time of the existence of business plarming in the Florence Hospital, it appears that executive management increasingly view middle managers as mere implementers of strategic change and business planning is a mechanism to facilitate this. Strategy is

formulated higher up the organisation in response to increasingly directive policy statements from government level.

The top-down nature of business planning is increasingly evident as the government's agenda prioritises financial constraint in what Ferlie et al (1996) described as an 'efficiency drive'. Strategic management becomes more deliberate and allows less scope for emergence (Mintzberg and Waters, 1985), and hence any middle manager influence beyond the implementation of deliberate strategy is compromised. Even within this role there is little discretion for middle managers.

It also appears that the executive management exhibit insensitivity to operational context in their attempts at strategic change The business planning process and the template imposed upon middle managers exacerbates this because it is insensitive to aspects of the NHS that middle managers feel is important in their work. This lack of sensitivity causes middle managers to view executive management as being from 'another planet'. To an extent, this is linked to the debate about the applicability of private sector practices to the public sector (Ackroyd et al, 1989; Pollitt, 1990; Hood, 1991, Stewart and Walsh, 1992; Pettigrew et al, 1992). For example, in talking of 'throughputs' or 'occupancy rates' or even more generally of 'customers', the language used in the business planning framework is one that sits uneasily with many middle managers.

Further, the context for business plarming is rendered less receptive by very visible, poor utilisation of resources in Surgical Services where ward closure provides a cue that the business planning process is not businesslike - that is, (in)consistent cues

(Brown, 1995a). Again, this is a feature of an uncontrollable external environment since, in this example, the GP fund-holders ran out of funds to pay for elective surgery in the face of the 'efficiency' with which the Florence Hospital 'processed' their patients. In another example, the host health authority managed competition so that middle managers in the physiotherapy area were forced to hold back offering their direct access service. Significantly, following these examples, marketing efforts were tailored to the NHS context, so that an element of 'de-marketing' (Kotler and Levy, 1971; Mark and Brennan, 1995) was implemented (see section 6.3.3). In de-marketing Florence Hospital sought to dampen down or regulate demand for services so that it was spread throughout the year. Thus, at least there is some evidence of learning over time, shown by the increasing sensitivity in transferring generic managerial practices from private to public sector.

Despite an unreceptive context for business planning in many cases, there are few illustrations of executive management attempting to influence perceptions of the middle managers towards the business planning process by attending to 'management of meaning' (Pettigrew et al, 1992). Only in the cases of Surgical Services and the Accident and Emergency Department (see chapter 6 - marketing at Florence Hospital for evidence of this) do we see executive managers managers from the Central Directorate working alongside and trying to influence middle managers in the clinical directorates. Coincidentally, these two are areas where the business planning process is seen to lead to changes in practices that contribute towards improved performance indicators.

In terms of any policy implications, contextual features mean the performance indicators on which business planning is based are problematic for middle managers. This problem is reinforced because they are externally imposed upon middle managers. The contemporary quest for improved performance in the public services sees the Government, facilitated by the host purchasing health authority and the Central Directorate in the case study trust, imposing 'relevant' performance indicators to which middle managers are asked to work. The middle management group, while agreeing that a business case needs to be made in allocating resources, question the validity of the imposed efficiency measures and other proxy measures of effectiveness of health care particularly because they do not reflect operational practices. Mutual adjustment and negotiation is not allowed for. In any case it would be difficult, since to allow for negotiation of performance indicators at the trust level with middle managers, may mean that attaining excellent performance against the rather managerialist narrow performance indicators (Clarke and Newman, 1997) set at national level would be compromised. This may threaten the trust's survival.

Finally, an important feature of context of the Florence Hospital, which may have provided one reason for an increasingly prescriptive business planning framework cascaded down by executive management, was that a merger between Florence Hospital and a neighbouring institution was the subject of a public inquiry. Ironically, the Florence Hospital 'lost out' despite performing well in national league tables - for example, it was given a five-star rating for its Accident and Emergency Department.

5.4.3 Organisation Structure and Organisation and Management Development

There is some support for the implementation of business planning through organisation and management development. For example, business planning is supported in its initial introduction by workshops, which an external marketing consultant delivers, aimed to support middle managers in the strategic analysis process. Service Managers also participate, albeit belatedly, in a Certificate in Management programme (see section 5.1.2), in which finance and accounting and performance management is a significant part.

However, organisation structure inhibits an influential role for middle manager. For example, in the organisation and in relation to how the business planning process is rolled out during the business planning cycle, each of the middle managers develops the business plan for their area in isolation from others. Thus, one feature of business planning is that it is inconsistently applied across directorates, and this is exaggerated by variations in the contexts of directorates within the hospital. For example, the business plarming process is accepted as appropriate in areas, such as Surgical Service, where there is a high degree of elective work. In other areas, such as Medical Services or Critical Care, whose patients come from other directorates within the hospital, it is claimed that little attention is paid to business planning.

The lack of boundary spanning opportunities because of middle managers structural positioning, militates against an influential role for middle managers as 'linking pins' (Likert, 1961) that would enhance the effectiveness of the business planning process. They do not span boundaries within the organisation and develop business plans in isolation from each other even though the realisation of one business plan may depend upon another. Similarly, few middle managers are positioned to span boundaries

outside the organisation and are unable to influence purchaser-defined targets for example. For these middle managers, one described their experience as *'like being in the trenches'* (General Manager: Medical Services). Where middle managers have networks outside the trust, for example, in the HIV/AIDS area, these middle managers have a greater influence in the business planning process because they are able to bring together their knowledge of operational context and external funding opportunities.

5.5 Summary of Business Planning Case

In conclusion, initially business planning offered potential for an enhanced role for middle managers within constraints imposed by medical group power to define service. However, over time the middle manager's role becomes limited to that of implementing deliberate strategy in business planning. Even within this there is little discretion for middle managers. In their implementation role, middle managers exhibit resistance to the process and content of business plans. It may be argued, on one hand, that such resistance is only expressed in interviews and that middle managers exhibit behavioural compliance to meet the demands of the business plarming process. Such behavioural compliance may be sufficient for the realisation of strategic change since the role of middle managers is that of implementing deliberate strategy. On the other hand, middle managers could make an important contribution to the business planning process because they have knowledge of local context and organisational performance is likely to be improved should such knowledge be brought to bear. However, to bring middle managers local knowledge to bear may require a role for middle managers that moves beyond implementation of

deliberate strategy, which merely requires behavioural compliance. For example, the role of 'synthesising information' (Floyd and Wooldridge, 1992, 1994, 1997) for middle managers may be necessary.

In Florence Hospital, business planning was less effective than it could have been. There existed an implementation gap, which was the result of a top-down plarming approach taken by executive management. While less than the 'chasm' suggested by Harrison et al (1992), it certainly appeared to be significant here. Claims that the NHS was characterised by more sophisticated implementation policies (Ferlie et al, 1996) were not borne out. The deteriorating financial climate, which led to increasing intervention from government meant that the context for business planning became less receptive over time. As a result, the business planning process became an ineffective mediating strategy to manage middle managers towards a greater business orientation that executive management desired. In ascertaining why this may be so, it is enlightening to focus upon conditions under which middle managers implemented the business planning process.

The case illustrated that the relationship between the centre and periphery at both government-trust and executive management-middle management levels had a large part to play. An increasingly prescriptive business planning framework, which set ends and means, was formulated higher up the organisation in response to increasingly directive policy statements from government level, which prioritised financial constraint in what Ferlie et al (1996) described as an 'efficiency drive'. Business planning has the potential to facilitiate an upward influential role for middle managers of 'synthesising information' (Floyd and Wooldridge, 1992, 1994, 1997)

and this can be a precursor to a divergent upward influence role of 'championing alternatives' (Floyd and Wooldridge, *ibid.).* However, this was unlikely since there was a framework tightly prescribed by executive management. Instead, middle managers were viewed increasingly by executive management as mere implementers of strategic change, who should not even decide the means of implementation. Further, the top down plarming approach acted against any enhanced influence for middle managers.

Under these circumstances, it might be expected that executive management might attempt to overcome external constraints by paying attention to internal stakeholders and thus mediate potential resistance from middle managers. However, there was little evidence of this - for example, there are few examples of executive management attempting to influence perceptions of the business planning process by attending to 'management of meaning' (Pettigrew et al, 1992).

Finally, it should also be noted that there is a significant additional constraint upon an enhanced role for middle managers in the case of business planning at Florence Hospital - that of medical group dominance. This was highlighted in the review of the literature about strategic plarming in the public sector (see section 2.2.3) and of the interface between middle managers and the medical group (see section 3.4.5). It appears difficult for middle managers to impact upon decision-making in the medical domain through business planning. There were some examples of middle managers taking on an enhanced strategic role in decision-making arenas in the Professions-Allied to - Medicine (PAMs) domain. For example, services were developed in pain management and physiotherapy and occupational therapy services were combined in a

new service offering to nursing homes. However in the main service provision remained defined by the medical group. For example, business plarming in orthopaedics was described as a 'paper exercise' on the basis that surgeons in this area had long waiting lists for operations. Vascular surgery, despite being expensive, remained part of Florence Hospital's service portfolio because two experienced vascular surgeons were employed. In addition, standardising health care activity through contract agreements was made difficult, if not impossible, because discretion remained with medics, for example, to determine the length of time spent with each patient. As a result the indicators against which middle managers were judged by executive management, for example, service activity levels, remained beyond the control of middle managers.

However, there were some illustrations of influence exerted by middle managers upon the medical group and service development generally although this varied with individual Clinical Directors. For example, General Managers were now invited on Board away-days and prepared presentations for the Clinical Directors. In addition the medical group was more likely to listen to middle managers' concerns about cost in the face of resource constraints.

Therefore, on the one hand, the power of the medical group should not be ignored as imposing considerable limits to the influence middle managers. On the other there may be scope for middle managers to overcome this constraining force.

Chapter 6

The Role of Middle Managers in the Emergence of Marketing Activity

6.1 Introduction

In the second of the empirical chapters in this thesis - the case of marketing in Florence Hospital - the understanding of strategic change in the NHS and the role of middle managers in its realisation that was gained from the previous case of business planning, is brought to bear. Marketing activity, as an area of strategic change, was selected because it illuminated strategic change within the NHS.[39] In particular, it may illustrate an enhanced role for middle managers and the conditions necessary for this. It may also further illuminate the issue of generic transfer and provide an interesting contrast with the previous case of business plarming because, unlike business planning, there was a lack of prescription from central government regarding marketing activity.

In the introduction to this chapter, before the primary data is presented, the question of the meaning of marketing in the NHS context is considered. Whereas little has been written about business plarming generally or specifically in the NHS, as evident in the last chapter, a great deal has been written about marketing generally and specifically about the internal market and marketing in the NHS. However, this has

concentrated upon theorising the internal market and examines the implementation of the internal market at a relatively high level of abstraction in a debate about the efficacy of the internal market (for example, Walsh, 1991; Ferlie, 1992). For example, much has been made of the fact that the internal market in the NHS does not mimic full markets (Scrivens, 1991) and that when considering market-driven change in the NHS the tension between markets and planning mechanisms should be recognised (Baggott, 1997; Ranade, 1997).

There has been some research, which addressed the issue of the implementation of marketing strategy at an organisational level that is relevant in relation to the focus of this thesis. Most relevant amongst this is the work of Whittington et al (1994) and the work of McNulty et al (1994). It is these pieces of work the introduction to this chapter concentrates upon.

The wide range of activities encompassed by marketing makes a definition difficult (Scrivens, 1991). Despite this difficulty, the researcher suggests that there are three basic approaches taken. Firstly, it has been described as strategic marketing (Hooley et al, 1990; Laing and Galbraith, 1995, 1996; Walsh, 1991) that incorporates business planning where there is a rationalistic process of analysis of the basic direction an organisation is to follow. Secondly, it has been described as relationship marketing (McNulty, et al, 1994), which stresses keeping customers as much as it does getting them in the first place (Christopher et al, 1991). As far as professional services are concerned, at the heart of relationship marketing is that there is a willingness on the part of the providers to meet the desire of those responsible for purchasing the service

[39] Ferlie et al (1996) argued that the introduction of the internal market model would have far-reaching consequences for the way in which strategic change processes come to be understood in the public sector.

to work with them as distinct from merely for them (Yorke, 1990). In Ranade's (1995) analysis of the practice of managed competition, she found that, 'even at an early stage of internal market reforms, managers were conceptualising the market on 'relational' lines, with more progressive districts already talking of developing 'preferred providers' based on some form of accreditation' (Ranade, 1995: 256). Thirdly, the definition of marketing is one that focuses upon internal marketing (Piercy, 1991; Walsh, 1991). Internal marketing is an approach that shows concern with organisational culture, something that is emphasised in the NHS reforms since 1983. Internal marketing comes from the simple observation that the implementation of external marketing strategies implies changes of various kinds within organisations - in the allocation of resources, in the culture of 'how we do things here', and even in the organisational structures needed to deliver our marketing strategies effectively to customer segments (Piercy, 1991).

In the case of Florence Hospital, marketing was conceived in all three ways - strategic marketing, relationship marketing and internal marketing - since various conceptions of marketing may collapse into each other in an NHS setting, while others are divided between several organisations and different stages of the service contracting cycle (Sheaff, 1991a). Further, it is difficult to draw a boundary between where business planning, the issue under investigation in the last chapter, ends and marketing begins (Sheaff, *ibid.).* In Florence Hospital, as in many trusts, business plarming and marketing comes under the remit of the same department, often called a 'Business Development Department'. In addition, many academics do not distinguish clearly between business planning and marketing (for example, McNulty et al, 1994, see

business planning and marketing as part of the same process of implementing marketing in the NHS).

For the purposes of this thesis, there is a distinction drawn between business plarming and marketing. The distinction that can be formally drawn in the case study is that business planning, at least potentially, is a precursor to marketing activity. It is a formal process that follows a timetable from August through to February and results in documentation that is a statement of intent regarding development of business over the next year. Actions that follow business planning to realise that intent or actions that may lie outside that intent, but develop business, are viewed as marketing in this thesis. This may include elements of strategic marketing, relationship marketing and intemal marketing.

The case study gives a basis for this division along these lines. In Florence Hospital responsibility for marketing across the hospital was given to one Business Development Manager while responsibility for business planning across the hospital was given to the two other Business Development Managers. However, in addition, as was evident in the last chapter, what emerged in the business planning strategic subsystem was that it constituted a framework for managing performance rather than a framework for marketing activity. Thus, business plarming and marketing in the Florence Hospital can be seen to be more distinct than might be formally assumed because over time, business planning moved away from being a precursor to marketing activity. In the empirical sections 6.2 and 6.3, what constitutes marketing in the Florence Hospital is elaborated upon. It consists of elements of a marketing philosophy, marketing process and marketing function (McNulty et al, 1994).

6.1.1 The Implementation of Marketing in the NHS

Despite a preponderance of literature that examines the response of the medical group towards market-driven reforms, there are some suggestions that middle managers could potentially take on an important role in market driven change. For example, according to Dawson et al (1992), a critical element in market-driven change in the NHS is decentralising responsibility to clinicians in middle management roles. Whittington et al (1994) claims that this decentralisation fundamentally changed middle management roles, with an increased responsibility for the revenues as well as the costs of their areas. Thus, middle managers roles within these market-based intemal structures moved from professional co-ordination to business management. While they focused upon the medical group as middle managers in their Clinical Director roles, they suggested that dependence on markets was eroding traditional professional hierarchies, with middle managers usually central in the processes of market driven change and that this was worthy of further research. McNulty et al (1994) further emphasised the importance of groups outside the marketing function as 'part-time marketers':

'Senior managers currently undecided about the rate and pace at which they may devolve such contacting and marketing responsibilities to those individuals closest to the point of service delivery, such as clinical directors and nurse managers, need to think less about whether these individuals should have these responsibilities, and more about what level of responsibility they have, how this can be best organised and how non-clinical individuals, such as business managers and directors of contracts, can best support these part-time marketeers in carrying out these responsibilities (McNulty et al. 1994:55).

Here, McNulty et al (1994) raise the question of control. This links to the point raised by Whittington et al (1994) about the micro-politics of organisations and Ranade's

(1995) concern with mobihsing context in the market-driven change process. Whittington et al (1994), for instance, opine that, because line management is transformed into a pivotal business role, an important task for executive managers is the development of strategic direction and control. However, as Baggott (1997) reports about the implementation of the intemal market, the refusal to consult and compromise at the policy formation stage stored up problems for the later implementation stage. As will be become apparent in the empirical section of this chapter, this was reflected in the Florence Hospital case, where only belatedly, did executive management realise that ultimately change can only come about through persuasion.

Thus, there are a number of questions raised in the literature, which examine the implementation of market-driven reforms in the NHS, that link to the earlier questions set out in chapter 3. In this chapter of the thesis the issue of the unintended consequences of market driven change is addressed as well as those consequences intended by policy-makers and executive management. This chapter focuses upon the implementation of a marketing strategy as well as the content or formulation of such a strategy. It does so at an organisational level, focusing upon middle managers, in order to address the research gaps identified above by Whittington et al (1994). In particular the contention that middle managers have an important role in strategic change, which was raised in chapters 1,2 and 3, is examined.

In relation to these questions, a three-dimensional framework set out by McNulty et al (1994) is useful to distinguish what marketing activity is occurring and how marketing is being implemented and this provides a framework to stmcture the

empirical findings in sections 6.2 and 6.3. They distinguished between marketing philosophy, marketing process and marketing function. Marketing philosophy referred to a prescriptive business philosophy for managing exchanges in the market place (Houston, 1986). Marketing process is the range and sequence of activities used to turn the philosophy into action (Sheaff, 1991a, 1991b). The marketing function refers to the organisation and allocation of marketing responsibilities throughout the hospitals including the role of the formal marketing department.

6.1.5 Marketing in Florence Hospital

Of the Executive Directors (apart from the Director of Business Development), the views of the Chief Executive, Director of Medical Education, and Director of Nursing were relevant to the issue of marketing in the Florence Hospital, since these were the executives charged with implementing market driven change in the Florence. The reason for this was that they were responsible for two of the major employee groups - the medical group and nursing group respectively. The Organisation Development Manager was also an important informant in the Central Directorate team in relation to attempts to develop the marketing and business planning strategy because one of his concerns, which he raised in interviews, was that Florence Hospital, *'should have a more business-like emphasis.'*

Responsibility for the development and implementation of a marketing strategy as part of the process of market-driven change, or a 'business development' strategy as it was labelled in the Florence Hospital, lay with the Business Development Department, which was part of the Central Directorate. As far as setting the agenda

for marketing activities was concerned, a focus upon the Director of Business Development and Business Development Manager with responsibility for marketing was relevant. Additionally, the views and insight of the extemal marketing consultant, brought in by the Business Development Manager to advise the Business Development Department and to facilitate marketing workshops, offered an insight into the process of legitimising marketing frameworks.

6.2 The Chanee Narrative of Executive Management

The primary data is presented in two sections - the change narrative of executive management and the change narrative of middle managers. Each section is stmctured around the framework set out by McNulty et al (1994) that considered market-driven change in the NHS under three headings - marketing philosophy, marketing function and marketing process. In the discussion that brings the narratives together, the questions set out at the end of chapter 2 will be re-visited in the light of the case of marketing in the Florence Hospital.

6.2.1 Marketing Philosophy

From 1994 onwards the emphasis upon marketing increased and in 1995 a Business Development Manager was appointed with specific responsibility for marketing in the hospital. He was given the post because he had successfully *'re-positioned the pathology department in the face of competition'* (Business Development Manager's own words). Initially, as a precursor to closely working with managers in the clinical directorates, he planned to put on a number of marketing workshops aimed at

managers in the clinical directorates. He employed the services of an extemal marketing consultant for this purpose and they jointly delivered the first workshop.

In the first marketing workshop, the Business Development Manager articulated his marketing philosophy, using the generic marketing language of, for example, *'strategic marketing'*, *'market segmentation'*, and *'the customer'*. The marketing consultant then took over the facilitation of the workshop. His inputs mirrored the generic marketing language that the Business Development Manager had used in his introduction to the workshop. The initial workshop was little more than an introduction to some marketing concepts. However, despite intentions that there would be a series of workshops that would build on the first introductory one, the Director of Business Development cancelled plans for any more on the basis that their content in the first one had been, *'too much marketing and not enough health service'*, and that the Business Development Manager was *'pushing too hard and pushing too fast on marketing'*.

The Business Development Manager continued to use the services of the marketing consultants in other aspects of his work - for example, working with individual directorates. Both the Business Development Manager and the marketing consultant, viewed a marketing orientation as a superior view of the world that represented *'commonsense'* within the environment faced by the trust. They attempted to influence the middle managers so that they saw a marketing orientation as a perspective and set of tools which was a necessary feature of public sector managerial life. For example, the marketing consultant, who was brought in by the Business Development Manager, talked of the necessity for a:

'strategic marketing orientation ... marketing is a different way of looking at things. Instead of looking at it from what you do and your problems and being reactive, you have to be more proactive and look at how you are going to meet the needs of the market' [Marketing Consultant].

The marketing consultant and Business Development Manager regarded middle managers as taking a *'very narrow view'* of what marketing means and this meant marketing activity was slow to take off Instead of conceiving marketing as the Business Development Manager does above:

'I think they [local managers] still see it as very much about promotion, communication and to a lesser extent market research and intelligence ... some people fail to see the relevance of if [Business Development Manager].

Therefore the Business Development Manager and marketing consultant felt that they had to manage meanings (Pettigrew et al, 1992) attached to marketing in order to establish legitimacy for their view:

'You have got so many people who probably perceive marketing as a very commercially orientated function. This presents trust managers with a lot of problems because they see it as irrelevant. For example, you could do a seminar about marketing to a group of Consultant Pathologists and be fairly safe but with a group of Consultant Orthopaedic Surgeons you would be on very thin ice and would spend the first half of the meeting justifying the role of marketing in the health service' [Business Development Manager].

Despite a slow take-up of a marketing orientation within the hospital, the Business Development Manager and marketing consultant felt that progress had been made between 1995 and 1997:

'I think we have made some progress in the last eighteen months but with 3000 staff many of whom are nurses and doctors with no training in marketing or business planning it is quite a task' [Business Development Manager].

They cited changes in the language across the hospital as evidence of progress made:

'There is clear recognition that market analysis is an important precursor to the business planning process and terms such as benchmarking and critical success factors are now freely used across most areas of the hospital' [Business Development Manager].

Certainly in attempting to orientate middle managers towards marketing, sensitivity to language was important in persuasive argumentation. That marketing language may be insensitive to operational 'reality' was forcibly expressed by one of the Executive Directors, who was also a clinician:

'/ don 't think marketing is a word which fits well with the health service. I have never liked the word because in a way when you are like me and have a long waiting list you are desperately trying to stop people getting on your waiting list. Marketing implies that I am going out looking for work and that is the last thing I am doing' [Director of Medical Education].

On the one hand that it may be wiser for those who seek to move the organisation towards a marketing orientation to use the rhetoric of, *'quality and patient care'* [Business Development Manager] was recognised by the Business Development Manager. On the other both the marketing consultant and the Business Development Manager continued to use the language of generic marketing (examples given earlier) on many occasions. Their claims that they were sensitive to language and attempted to persuade managers in clinical directorates that marketing was important, rather than impose their view of the necessary prescriptions for organisational success, was questionable in the light of the closure they exhibited around language use.

6.2.2 Marketing Process

One of the Business Development Managers was given responsibility for the marketing process in the hospital, as described above. The Director of Business Development tended to involve herself more with the contracting process and business plarming. Therefore the Business Development Manager was allowed a good deal of discretion in choosing how to carry out his role. As was mentioned earlier one of his choices was to bring in an extemal marketing consultant. His other choice revolved around what clinical directorates to work with. This choice was influenced by whether or not he viewed it likely that the managers in a clinical directorate would be receptive to the philosophy and processes of marketing, which in tum was influenced by other factors such as electiveness of service. For instance, he chose to build a close working relationship with the General Manager for Surgical Services on the basis that, *'there's room for competition in that area at least around the margins of our [geographical] boundaries'* (Business Development Manager). However, he did not attempt to build the same relationship with Critical Care or Medical Services. In working with individual directorates, as discussed in the previous section, his initial efforts were aimed at mobilising the outer and irmer contexts of potential marketing activity in the Florence Hospital to give the marketing drive a legitimacy in the eyes of the middle managers.

This was a more difficult problem in the Accident and Emergency area, who claimed that their service was *'demand-led'* rather than elective, but with whom the Business Development Manager was forced to work because of pressure from the Board. The

Board put pressure on the Business Development Department to develop the marketing orientation of the Accident and Emergency Department because:

'It was the visible fiagship of the hospital and therefore it was important that external stakeholders [such as the public or the host health authority] see it in a positive light' (Business Development Manager).

To overcome the unreceptive context that the Accident and Emergency Department represented, the Business Development Manager legitimised marketing by claiming it could potentially solve operational problems. He drew upon the irmer context of the Florence Hospital:

' While the Accident and Emergency Directorate was probably the least amenable to marketing because it is a walk-in service, internally is perceived as having a poor reputation and being unattractive to Consultants. It has a Clinical Director with a presentational problem and internal conflicts with its staff. Embracing a marketing orientation solves the problems of team identity and poor presentation, both of which impact upon budget allocation.'

He reinforced that Accident and Emergency was amenable to marketing by drawing upon features of outer context:

'Although GPs are not the gatekeepers here as in other directorates and that almost 100 per cent of work is non-elective therefore there is only one purchaser- the host health authority - marketing is still important because we need to keep the health authority sweet. Our A and E services help that relationship because it's the one that the public is most likely to complain about.'

He also attempted to influence context to overcome what he described as a *'cultural lag'* so that the Accident and Emergency Department was more receptive to the adoption of a marketing orientation:

'In A and E, after an Audit Commission report, we appointed Carol Bakewell as General Manager. She is enthusiastic regarding the need for marketing. There followed a significant marketing emphasis. A project team of 'marketing champions' was set up. A greater customer orientation was encouraged via customer care programmes, awareness raising, teambuilding, communications improvements. I established a corporate identity and told them what the world was like in terms of market facts.'

The Business Development Manager was described as *'marketing mad'* by the Director of Business Development:

7 have to hold him [Business Development Manager] back. Things like...our GP fundholders went broke last year. They can't afford to pay for what they want, therefore we need to manage our marketing. It's not all about developing business'.

In this case, it was the Surgical Services Directorate that suffered. As described earlier in the business plarming case (chapter 5), wards were closed and consultants under-utilised because Surgical Services had undertaken so much activity in the first half of the financial year that GPs had no budget left to fiind activity in the second half of the year. The Director of Business Development was not *'dead set against marketing'* Instead she expressed the view that:

'Much of marketing is about good management and it seems to me that marketing pulls together some management themes to give it a cohesion. It's the application of commonsense but only where it makes commonsense in a hospital.'

However, she fiirther questioned the generic transfer of marketing concepts from private to public sector:

'I'm not sceptical about marketing but its application. You have to do it with some sort of intelligence, to take what is important and positive from marketing and to adapt to our circumstances which are slightly different' [Director of Business Development].

It is illuminating to focus upon one initiative, which was implemented, driven from the Board and championed by the Chief Executive - the WIN (Welcoming, Informative, Non-institutional) Project - as reflecting some important issues around the emergence of strategic change in the Florence Hospital. The WIN Project was an example of a customer care ethos, which manifested itself in redesign of physical arrangements in the hospital. The notes that the researcher took, recording his observations when he first visited the hospital, provide a description that speaks for iself. The WIN Project represented a very visible manifestation of the ways in which the hospital environment was being re-shaped to take account of a greater marketing orientation. Therefore, it is useful to re-iterate the description at length[40]. The WIN Project produced a very corporate feel to the hospital with its uniform carpets, piped music, standard door fumiture and signs:

'The doors of the hospital slid silently open and I entered a carpeted foyer. On one side of the entrance foyer there was a birch veneered reception desk staffed by uniformed employees. They were dressed in blue suits. They handed me a map and gave me directions to find the Organisation Development Manager. The map looked like one that might be found in atlases produced by the Automobile Association, showing motorway junctions and destinations at each of the junctions. At junction 4 the mission and values of the hospital - the Florence Way - were displayed prominently. Halfway down the corridor at Junction 14 there was another staffed reception desk opposite which there was some lounge type seats surrounded by tall plants. There were many signs pointing in different directions to different destinations, each with a white typeface on a blue background. I was unsure I was heading in the right direction and hesitated. Someone with a name badge stopped. She engaged me with eye contact and a smile and asked me if I wanted help ... I felt I was the target of a concerted customer care strategy' [Notes of author taken after having visited the hospital for the very first time to gain access for research].

[40] While this might appear a rather lengthy description, the notes taken emphasise the surprise that the researcher felt at what he felt was an alien environment for a hospital. Staff felt similarly, but like the researcher, also felt it was a customer-focused environment, which was familiar from other settings.

The Chief Executive championed the project. The Chief Executive, in supporting the WIN project with training, recognised the need to build a receptive context for the initiative:

'The WIN Project is something I look upon as an achievement in the trust. The WIN Project and associated customer care training when integrated help create a focus upon the customer. There was initial scepticism from some who saw it as being a waste of money.'

Many of those who were sceptical were middle managers in the clinical directorates. The Chief Executive admitted there were grounds for their scepticism because, *'having to manage within tight budgets means they question any budget put towards anything other than direct patient care.'* However, by ensuring that cues were consistent (Brown, 1995a) across the organisation in support of greater customer orientation, he claimed that a receptive context was created:

'However, they [middle managers] are now the people who want to do the same in their areas. The physical changes such as signposting and greeting for patients were put in place whilst those in the area were away on customer care training. When they came back to the area they were enthusiastic about the changes. Physical changes such as the new reception desk when backed up by customer care training help create more customer-orientation'.

The physical changes offered a very visible symbol for a greater customer orientation and while it had been initially imposed upon the more public areas of the hospital, middle managers in other areas *'are asking for the same changes and you can see, the WIN Project gathers momentum.'*

With the WIN Project, a number of themes raised in the literature review are combined. There is recognition of a need to create a more receptive context for a move towards a greater marketing orientation and thereby reduce any middle manager

resistance in their role in implementing deliberate strategy. One of the main elements of this is that symbols are manipulated to create a greater customer orientation This is complemented by customer care training so that the capacity of individuals to change towards a greater customer orientation is enhanced.

As evident in this section and the last one (6.2.1), the power of the medical group to resist strategic change in the marketing area was evident. However executive management felt that *'with care and by that I mean political sus'* [Chief Executive] there was some scope for managerial influence as a result of intemal market arrangements:

'Concerning commercial pressures, in the past managers and clinicians have sailed their own course but now it's more like a catamaran with the managers in one bow and medical staff in the other and the managers are gaining power now and there is a sort of link between the two with people like myself, Clinical Directors and the Chief Executive' Medical Director].

'My job is to create some sort of commercial flavour to consultants' decisions. For example, I might argue to consultants, "If you say to GPs which do they want - varicose veins or cardiac catherisans, they will say they want the latter. However, if they refer it all to you then we go bankrupt so let's have a plan to disinvest from doing varicose veins to cardiac so that we don't go bankrupt' [Director of Business Development].

As in the case of business plarming at Florence, reported in chapter 5, any managerial influence may be dependent upon certain conditions being present. The Chief Executive noted this, having left Florence Hospital and taken up a similar appointment in a teaching hospital:

'The situation's different here [at teaching hospital]. As I said before Florence was in crisis when I arrived so the general management philosophy had a better chance. This hospital (teaching hospital] is like the Titanic to turn around because it has a big,

powerful medical group because it's a teaching hospital I can't begin to do the things I want to do here that I did at Florence' [Chief Executive].

6.2.3 Marketing Function

Those in the Central Directorate concerned with managing marketing activity emphasised that middle level managers should focus inwardly rather than outwardly. They regarded the middle managers as, *'just implement[ing] things'* [Director of Business Development]. They asserted that the boundary-spanning role with the environment was best performed by those in the medical group rather than for instance, middle managers, because:

'We don 't want everyone [middle level managers] running around like lunatics. One of our strengths is our consultants and if we have purchasers giving us a hard time about a specialty then they will listen to the clinical director if we take them out [and not necessarily the middle managers]' (Director of Business Development).

In considering the interaction of the Central Directorate with middle managers it is also illuminating to focus upon the concept of Strategic Business Units (SBUs), because the middle managers viewed SBUs as offering them some scope for influencing strategic change beyond their traditional role of implementing deliberate strategy. SBUs come under the remit of the Business Development Department and is seen by the Business Development manager to be part of the move towards encouraging a greater marketing orientation. SBUs were described as a *'development of the current directorate structure'* (Chief Executive). Beyond this broad statement, the Chief Executive did not articulate how precisely SBUs would differ from the current directorate arrangements. However, SBUs remained as an unarticulated

concept and were not implemented, despite being championed by the Chief Executive, on the basis that the context for its implementation was not receptive:

7 don't think the time is right to push ahead on the initiative [Strategic Business Units] at present. There's not the critical mass of support there yet. It's still a path the Trust Board wish to follow but at the moment it's on the backburner' [Chief Executive].

The lack of a critical mass of support for SBUs was not down to resistance from the middle manager in the operational directorates. In fact they were supportive of SBUs. Rather it was down to resistance from Executive Directors. In interviews they claimed that SBUs were an idea imported from the private sector and this was, *'inappropriate in the NHS '* (Director of Business Development). Alongside this, some were concemed that SBUs might lead to anarchy. They argued that it is necessary to strengthen the hand of the Central Directorate at the expense of individual clinical directorate autonomy:

' I was very concerned about SBUs because I think giving everybody autonomy leads to anarchy if you are not careful and you have to have a corporate framework in which people work' [Director of Nursing].

In comments such as this, we can see any enhanced role for middle managers may threaten executive management. As such executive management may resist the implementation of such initiatives.

As well as being concemed about losing control, the issue of consistency of implementation across directorates and between the different initiatives was frequently commented upon by some in the Central Directorate. For example, it was claimed that the SBU initiative is *'out of sync'* [Organisation Development Manager]

with other changes in the organisation. In talking of the lack of integration of SBUs with other changes the Organisation Development Manager made a general point about a need for integration in facilitating strategic change:

'My middle name is integrated. Frankly I'm sick of saying it now because nobody seems to understand what I mean. I don 't think it's because it's not a valid point to make. [However] it's quite a difficult point to make in terms of offering convincing evidence of where there is a lack of integration because examples of it are very fleeting' [Organisation Development Manager].

Here we see that the Organisation Development Manager expressed frustration at the lack of integration. He further suggested that executive managers consciously narrow their viewpoint to consider a single or limited number of initiatives because, '*either they are totally ignorant of the total picture or it's just too complex for them to understand.'*

The business planning process provides an interesting example of a lack of integration of strategic subsystems even where the same department, the Business Development Department, drives them. Earlier it was suggested that the business planning process is a precursor to marketing activity. It might be expected that the business plans might facilitate a move towards a greater marketing orientation. Thus, we might expect that they will be focused upon the extemal marketing environment, that they recognise and focus upon purchaser as well as patient needs, and have a stmctured assessment of the 'market place' and resource requirements. Critical references which evidence this may be, for instance, the identification of market segments in the business plan.

However, this was not necessarily the case, particularly as the business plarming process developed in the Florence Hospital. As was evident in the last chapter, over

time the plans exhibit less and less evidence that a marketing orientation is being adopted because they are increasingly focused upon extemally prescribed performance indicators. Also even where the plans include marketing headings such as 'competitor analysis' and 'market analysis', the content is still heavily focused upon clinical rather than business issues. For example, in the business plan for Surgical Services an additional consultant is argued for on the basis that it complements the expertise of existing consultants and adds further to the clinical excellence of the Florence in the vascular surgery area. Yet, as suggested in the previous chapter, the Service Manager for Surgical Services felt that it not make business sense to further expand vascular surgery since there was no further demand for vascular surgery.

In addition, the business plans show very little, if any, connection between the extemal environment the directorate is operating in and their own decisions. Little indication is given as to how resources are to be targeted or how the directorate wants to be positioned extemally. This is despite *'us keeping a database of benchmarking information of things like prices of different clinical interventions across hospitals'* (Business Development Manager). Thus, although the Business Development Department built up a fairly comprehensive and detailed (researcher's view) of such information, the use of it by the managers in the clinical directorates is *'fairly limited ...the odd one or two managers use if* (Business Development Manager).

Finally it is worth noting further evidence that the Central Directorate seeks to fialfil a boundary-spanning role rather than allowing managers in the clinical directorates to carry this out. For example, executive management in the Central Directorate seek to

manage both relationships with the public at large and GP fundholders, rather than rely on the medical group or the managers in the clinical directorates:

' We did a roadshow in the city centre two years ago. For two days in January we stood there and people actually came to talk to us' [Patients Representative Manager].

In this case it was those from the Central Directorate, such as the Patients Representative Manager, who 'manned' the stall. Further, in the case of relationships with GPs, middle managers were involved but their involvement was managed:

'We invited the GP fundholders to lunch with the managers from Surgical Services because they wanted to discuss prices. You could see people beginning to understand other people's perspectives on things and talk about problems. We 've done this in some other cases where GPs have flagged up concerns... [for example] about referral times. GPs and General Managers feel that they get a lot of value from these' [Director of Business Development].

Interesting in the above boundary-spanning activities are the various conceptions of the customer - the public and the GP fundholders. To this, we can add a third 'customer' - the host health authority (the debate about who the customer is in the NHS is also discussed in section 6.3.3). Regular meetings were held with health authority representatives about service levels and prices. In this case, the Director of Business Development and Director of Nursing, occasionally accompanied by others such as the Chief Executive, carried out the boundary-spanning role. In addition, *'you mustn 't forget, that to a large extent, the business plan is for the health authority'* (Director of Business Development).

Thus, what we see in the above is that a great deal of effort was put into the relationships with the various customers, in the main to *'keep business'* (Director of

Business Development). Maintenance of this and retaining positive perceptions of the hospital by extemal stakeholders became increasingly important as debate about rationalisation of services in the city continued'*'. However, any boundary-spanning activity that this entailed was something from which executive management sought to exclude middle managers (see section 6.3.3 for further discussion).

6.3 The Chanee Narrative of Middle Management

6.3.1 Marketing Philosophy

The views of middle managers towards the executive management attempts at strategic change are reflected in their feelings about the WIN Project. They revealed other aspects of the WIN Project, beyond the researcher's description in an earlier section:

'Things like the WIN Project reflect the new approach. For example, a new main entrance has been opened, a colour scheme has been chosen. [In addition] we have been given instructions about how you should type your letters out. You must begin eight millimetres away from the trust logo and you mustn 't photocopy the trust logo because it has to be in colour ' [Service Manager: Medical Services].

The Chief Executive's feeling that there was support for the WIN Project from manager and other staff was home out, despite their initial reservations about the labeling of such initiatives:

'Things like the WIN Project make you want to say; 'Oh, for Pete's sake, it sounds like another of those American things ... we'll be selling burgers next.' It's like a 'have a nice day' concept and you feel 'pass the vomit box.' But when you walk down the corridor and you see how welcoming the environment is, how clean the corridor

[41] In 1998 it was finally announced that Florence Hospital was to merge with another hospital in the city.

looks, how nice the information desks are in relation to the sign boards, the outward and visible signs of WIN are really good It is just the word 'WIN' makes you feel 'have a nice day' [Service Manager: Medical Education].

The Service Manager re-iterated the feelings expressed by the Director of Medical Education earlier that the hospital was becoming rather like MacDonalds although she admitted that it was a *'warm feeling'*. However, she resents the labelling of the project as the WIN Project, thus emphasising that language is important in managing meanings attached to initiatives.

However, not all middle managers express positive views about the WIN Project and drew upon a public service or professional ethos to argue against it:

'You see money being spent on making the buildings pretty which doesn't seem to contribute to patient care and then you see money being cut from patient care' [Service Manager: Occupational Therapy].

Particular scepticism from the middle managers towards marketing concepts was reserved for those marketing concepts that they feel have shortcomings when applied to health care activity in the hospital:

'We're not making baked beans[42] *as has been suggested to us [in the marketing workshop for middle managers]. We don't make anything. We provide health care to vulnerable people. It's serious. These marketing ideas aren't relevanf* [Service Manager: Medical Services].

In particular, middle managers felt that the ethical and clinical dimensions of health care are not considered in generic marketing models. Thus the advocates of a generic concept of marketing - the Business Development Manager and marketing consultant

[42]William Waldegrave, a former Health Secretary in the previous Conservative administration also commented that NHS reformers were in danger of losing sight of the difference between a hospital and a supermarket (cited in Scrivens, 1991).

- often found themselves in conflict with the middle managers who did not fully endorse the marketing concept, its professed orientation or its view of how organisations should be managed.

As a result of their misgivings about marketing, middle managers mobilised features of irmer and outer context, to show that a marketing orientation was less relevant than claimed by the Business Development Manager and marketing consultant. Their attempts at mobilising context against a marketing orientation appeared more effective arguments than the case set out by the Business Development Manager and marketing consultant, who also attempted to mobilise context. For example, middle managers argued that the intemal market was heavily regulated and that this made the introduction of marketing principles extremely problematic. In addition, the emergence of a marketing orientation was particularly influenced by the sensitivity of the individual clinical directorates to the intemal market, which in tum was determined by the extent to which their activity is elective. The view of the middle managers was that there would remain areas where marketing activity may be inappropriate. Often this was due to the professionally-defined nature of health services offered. For instance service offered may be dependent upon clinical expertise available:

'It [health care delivery] is partly determined by consultants. We don't have a good position in neurology and dermatology and we are aware of that and we would improve on those areas if we could but we can 't. [Also] if you have something you have been doing for a number of years with a consultant they are going to be reluctant to drop if [General Manager: Medical Services].

Some marketing frameworks to which directorates are asked to work are described as not relevant on the basis of that a true market does not exist:

'We're asked to do PEST and SWOT analysis and all this but at the end of the day patients are not coming to you outside your catchment area. GPs are still fairly local. They 've got their old boy networks and they refer to consultants they 've known for ages' [General Manager: Medical Services].

In another example, despite the respondent being in favour of marketing, she expressed frustration that she could not carry out marketing activity because of the ethical dimensions of health care that were reflected in a widely held view in the NHS that private patients have no place in NHS hospitals[43]:

'It [marketing] is even more difficult with private patients because there are so many people out there with a biased opinion about private patients in an NHS hospital and we can't be seen to make a profit of any description' [Private Patients Manager].

Despite these examples, some of the middle managers were able to take on board those marketing concepts they saw as relevant and carried out marketing activity. Here, marketing concepts and models were more likely to be well received if, for instance, they were tailored so that they were linked to operational context. In general, middle managers saw the success of the application of marketing as being dependent upon developing a robust and relevant understanding of marketing within the health service:

'I think that marketing per se as a function cannot be transposed into the NHS ... because there are concepts and models that don't fit. Because we are not a profit-making organisation we have ethical and clinical dimensions of selling and promoting our services. But there are some concepts that are applicable to the NHS such as looking at market segments, what position you are in the market, are you the market leader, are you just somebody who bubbles along sort of bread and butter stuff, and being more articulate in that sort of way' [General Manager: Trauma and Orthopaedics].

Interestingly, some middle managers ascribed a rationality to the market in contrast with how decisions were made before:

'It focuses our decision-making on whether we are going to increase contracts or not on a rational basis rather than a gut feel' [General Manager: Trauma and Orthopaedics].

However, even where middle managers have been positive about marketing, this has taken some time for them to recognise, and has involved closely working with the Business Development Manager:

7 have seen marketing now (having worked closely with Business Development Manager) in a much wider sense; as the total package of care, the total quality, the total projection of the hospital to patients and GPs and actually I think it has got some advantages. I think we ought to project the hospital and look at it as a whole process in marketing and not just going out there with particular goods to sell... we 've introduced things like one-stop clinics and more day care because that's what GPs want' [General Manager Surgical Services].

6.3.2 Marketing Process

The first exposure many middle managers had to marketing was being invited to the marketing workshop, organised by the Business Development Manager, and involving the extemal marketing consultant. Their misgivings about marketing in the NHS were reflected in many choosing not to attend. Those that did attend, were there in many cases, *'to see what's going on. One of us [middle managers in the directorate] always goes to these things to find out what they [executive management] are up to'* [Service Manager: Medical Services]. Therefore, most directorates sent only one representative along, and this tended to be the Service Manager (the more

[43]This view goes back to the pay beds dispute of the 1970s. Klein (1995:106-112) describes the confrontation between government and medical profession over pay beds as the most bitter dispute in the NHS since its inception.

junior middle manager concemed with operations of the directorate to a greater extent) than the General Manager. There was one directorate, the Surgical Services Directorate that sent most of its managers along, including first line managers (ward managers). This directorate, as earlier described, was one that was more sensitive to the competition. Any participation from middle managers centred around a debate about who was the customer in the NHS. This varied between directorates, as described earlier, but there was some consensus that:

'Look, at the end of the day, we provide health care to patients. That's what it's about and we should not lose sight of that. All this purchaser stuff is just a diversion. Most people in this room came into the NHS to serve the public, the patients' [Hospice Manager].

Following a 15-minute discussion of who the customer might be in the NHS, the Business Development Manager and consultant talked about market segments and relationship building with customers. However, this promoted relatively little questioning from participants and even less discussion. Instead the inputs of the Business Development Manager and marketing consultant were greeted with relative silence and a few audible 'gmmbles'. For example, one of those present commented that the idea of market segments was *'a load of rubbish.'* Another, reflecting others negative feelings about the workshop, described it as, *'one of these things the centre thinks is a good idea which you feel obliged to go along to to show your face but [which] personally I think is a load of [rubbish]'* (General Manager: Critical Care). As a result of such comments coming to the attention of the Director of Business Development plans for further workshops were cancelled.

Despite evidence of negative feelings towards the content of the workshops, over time, some middle managers took on the role of 'part-time marketers' (Whittington et al, 1994; McNulty et al. 1994). There was evidence of some significant marketing activity that is emergent from middle managers. Contrary to the view of the Director of Business Development that middle managers should not undertake boundary-spanning into the extemal environment, there was evidence that such boundary-spanning was taking place. Any marketing activity undertaken by middle managers tended to focus upon building relationships with 'customers', both inside and outside Florence Hospital, of service areas. By accident rather than design, through such emergent boundary-spanning, marketing became decentralised to those in middle management roles (Dawson et al, 1992). The medical group, including clinical directors, despite being better placed in a boundary-spanning role with GPs and the health authority, did not take up marketing activity beyond what they had done previously, prior to the intemal market, where they tended to build relationships with particular GPs. A common example of marketing activity, which emanated from middle managers (although respondents did not label it as such) was taking up that liaison role with GPs who were fund-holders. In this case, the focus of the relationship was upon the tmst matching environmental demands:

'My particular experience [of setting the agenda] is actually being given the opportunity to go out and speak to the customers [GPs] ... we set up a pain management programme and visited a lot of GPs who were all very keen' [Service Manager: Pain Management].

'We opened a brand new unit and invited GPs in to come into the hospital and have a look around. If that is called marketing I'm all for doing that' [Service Manager: Theatre Services].

In the above middle managers viewed the GP as the customer. The reason for acceptance of the GP as customers whose views may be sought, may be that the GP is perceived as a professional who is able to exercise the required clinical judgement. Also noteworthy is that, again, activity was not necessarily viewed as 'marketing' activity by middle managers. In other instances some areas, which regard their activity as being generated by other directorates within the hospital, seek to build close relationships with other service areas in the hospital:

'We have regular meetings with General Managers in other areas and what we are trying to do is relate the activity that we are doing and how we do it to their pressures such as waiting lists. So, for example, (I might say to them) I am funded to provide you with 13 sessions per week but you are only using nine. Commercially that is costing you a lot of money. What do you want to do about it? Whereas before we just couldn 't have those debates. We would have continued doing the same thing forever' [General Manager: Critical Care].

The complexity of the health service is reinforced in the above statement. In common with many directorates, Critical Care perceives itself as different, as an area that needs to take less heed of generic marketing models. They define the customer as other directorates and their marketing activity is focused on communicating with other middle managers in the tmst.

Middle managers identified purchasers other than GPs or the host health authority as potential customers and sought to undertake boundary-spanning activity to market services to private nursing and residential homes:

' We have got two members of staff who are actually ergonomics trained, one in physiotherapy and one in occupational therapy. The combination of their skills is excellent. We put together a package and sent it to a variety of businesses [nursing and residential homes] in the area. We invited people along to a study day and

showed them what the package was, explained what was on offer and then picked up contracts from there' [Service Manager: Therapy Services].

In another example, they marketed directly to the patient:

'*Aromatherapy Services are now being offered to patients. In fact this was picked up by the local news programme and gives further promotion to the hospital'* [Service Manager: Therapy Services].

That Therapy Services is relatively innovative in its adoption of certain marketing practices provides an interesting illustration of the effect of different experiences of professions within the NHS and the influence of antecedent factors upon organisational change (Whipp and Clark, 1986). At the inception of the NHS, and for a long time following this, therapists worked outside the NHS and were often self-employed. Currently many remain self-employed or move in and out of NHS and private sector employment. This may contribute towards a greater commercial awareness and take up of commercial practices such as marketing activity from this group. However, as described earlier, in the first of these examples, the host health authority heavily discouraged expansion of services. Therefore, again, inconsistent cues were evident in the promotion of a marketing orientation.

Finally, as with the case of business planning in chapter 5, middle managers were less optimistic about their influence over the medical group in the face of medical group power to define service. In the case of marketing, it was stressed that middle managers could only market those services to which medics were committed and that the services offered remained to a large extent professionally-defined:

'The purchaser may want x amount of contracts this year and I might agree to this. However sometimes I can 't achieve what I agreed because the medical staff won't commit themselves' (Service Manager: Theatres].

'The reputation of the consultants is important. For example, we have a good hand unit that has a good reputation and a lot of people come in from different areas. We have one or two consultants who have good reputations for sports injuries so we get a lot of referrals for thaf [Service Manager: Trauma and Orthopaedics].

However, as noted earlier in this section 6.3.2, with respect to realising marketing strategy, middle managers have some influence in some areas, as illustrated in the development of pain management and therapy services. With respect to these services and even more so with other services where the medical group was more dominant, political skills of persuasion and negotiation were emphasised. Using such skills gave some scope for middle manager influence in the development and marketing of services:

'A lot of the stresses I'm going through at the moment is because we 've got this grating between a professionally-based service and a contracting service. I have to work hard influencing consultants, using waiting list referral patterns to argue for changes in surgical specialties we offer' [General Manager: Surgery].

'The mistake we made with getting them [consultants] to think more commercially was asking them to commit themselves in front of their colleagues without lobbying beforehand. What appened when I addressed them as a group was that there was a lot of silent "nos"' [General Manager:Surgical Services].

6.3.3 Marketing Function

The way in which the marketing function might organise itself is illuminated by focusing upon SBUs. Many middle managers were positive about the concept because it would grant them the autonomy of decision-making that was absent but which

would complement the accountability and responsibility they felt the centre imposed upon them. In middle managers eyes the move towards SBUs meant that decision-making would be de-centralised to a large extent down to the level of what were formerly clinical directorates and that managers at this level would have more control over budgets and business development.

However, though supportive of SBUs in principle, middle managers were rather confused about what was happening. In addition they viewed it as an initiative that was not reflected in local practice. The idea of SBUs and the existence of a Business Development Department was seen as *'trying to make us a business'* [General Manager: Medical Services] but being more business-like was not confirmed for the middle managers,' *by what's happening at the coal-face'* [Service Manager: Medical Services]. They saw it as a managerial myth that the Hospital was a business. They wondered, *'what happened to the SBU initiative?'* [Service Manager: Critical Care]. The Chief Executive's comments that SBUs were currently on the backburner had not filtered down. For the Critical Care Manager and others, the rhetoric of SBUs was still around and they expected the SBU idea to be implemented. However, they were not too sure what they or other managers were meant to do under the new arrangements.

'We've seemingly moved on now to SBUs. They said all along that there are SBUs now and we would have training and so on. I don't know what has happened but we are supposedly now an SBU. Yes, we are SBUs now but training so that everybody understands the ground rules has been very poor' [General Manager: Radiology].

In addition they saw it, alongside other past initiatives, as something the organisation had focused upon briefly before moving on:

'They are constantly shifting the goalposts...they start playing cricket when we 're still playing football' [Chaplain - who was one of the 'middle managers' who participated in the competence-based management education programme].

Finally but importantly, they felt, *'they 're [executive management] not going to give us freedom to be business units and do what we want, make our own decisions'* [General Manager: Medical Services]. Instead they felt that clinical directorates would continue to be very closely controlled from the centre via a business plarming process that imposed a narrow conception of effective performance upon them, as was evident in the previous chapter.

Overall, while the WIN Project was a very visible manifestation of customer-orientation, that there existed a Business Development Department headed by an Executive Director, and that there was the rhetoric of 'SBUs', there remained a lack of 'consistent cues' (Brown, 1995a) necessary to support a greater marketing orientation. Particularly inconsistent cues were provided in two cases. These were, firstly, when resources were poorly utilised in Surgical Services due to GP fundholders mnning out of money and secondly, health authority intervention to curtail expansion in the physiotherapy area, both of which were described in the previous chapter. As one manager commented, *'it just doesn't make sense'* [Service Manager: Therapy Services]. In these examples we see that the tension between planning and the market (Baggott, 1997) was glaringly apparent.

6.4 Discussion

The two narratives represent different views of the appropriateness of marketing in the Florence Hospital. In addition, even within executive management a shared view of the appropriateness of marketing and a strategy to take marketing forward in the trust was not in evidence. In the Central Directorate, whilst the Business Development Manager and the extemal marketing consultant were 'marketing enthusiasts', the Director of Business Development, Director of Medical Education and the Director of Nursing were more sceptical about the appropriateness of marketing in the NHS. Similarly middle managers expressed strong reservations about marketing when cmdely transferred from the private sector. Nevertheless, they initiated marketing activity at local level, although did not necessarily label it as such.

The discussion will start with the main theme of the thesis - the role of the middle managers - then consider the conditions that facilitate or inhibit an enhanced role. In considering the conditions that influence the role of middle managers, discussion will firstly analyse the extent to which there was generic transfer of organisational and managerial practices from private to pubhc sector and the impact of this. Secondly, it will discuss the distinctive contextual features of the NHS that render any such generic transfer problematic. Thirdly, drawing upon the case study evidence, there will be discussion of the way in which context can be rendered more receptive for change. Finally, following a postscript related to the marketing case, there will be a cross-case comparison of the business planning and marketing case studies to complement the within-case analysis so far carried out (Eisenhardt, 1989).

6.4.1 The Role of Middle Managers

Middle managers' role in resisting the implementation of deliberate strategy (Floyd and Wooldridge, 1992, 1994, 1997) was most evident. In this role, on one hand, middle managers were able to resist top down marketing initiatives which were crudely imported from the private sector- for example, SWOT and PEST analysis. On the other hand, some aspects of the deliberate strategy were realised - for example, the Accident and Emergency Department exhibited a greater marketing orientation and the WIN project encouraged attitudes and behaviours, which supported a greater customer focus.

However, more importantly, that strategy was emergent as well as deliberate (Mintzberg and Waters, 1985), and that middle managers had a role beyond implementing deliberate strategy (Floyd and Wooldridge, 1992, 1994, 1997), was also evident. There was as much, if not more emergent marketing activity than deliberate marketing activity. In the main, this came from middle managers, who took on the role of 'part-time marketers' (McNulty et al, 1994; Whittington et al, 1994) although it was not necessarily labeled 'marketing'. Emergent marketing activity occurred where middle managers thought it addressed operational problems (Sheaff, 1991a, 1991b) and where it fitted with their perception of important contextual features (Pettigrew et al, 1992; Ranade, 1995) - for example, the meeting of patient desires. However, it should be noted that one outcome of this was inconsistency across the tmst in the marketing activity that was implemented. Thus, the issue of control and the potential tension between 'plarming' and 'markets' (Ranade, 1994; Baggott, 1997) is raised again. This was a particular worry of some of the executive directors and

they used this argument to suggest any further discretion given to middle managers, for example via SBUs, would result in chaos. The suggestion here is that, when the Chief Executive talked of there not being a '*critical mass*' to support the implementation of SBUs, he was referring to resistance from executive directors.

That there is scope for emergence of marketing activity was influenced by the relationship the centre had at national level with individual tmsts in connection with this issue and then, at a lower level, the relationship the tmst board had with middle managers in connection with this issue. To a large extent, marketing activity was neither prescribed for tmsts by the DoH or NHSME nor prescribed for middle managers by the tmst boards. Instead, at the level of the DoH relationship with tmsts, the framework within which tmsts should carry out marketing activity was defined by the implementation of an intemal market and to some extent by nationally prescribed performance indicators. At the level of the relationship between the trust board and middle managers, while middle managers must consider the intemal market and performance indicators, they had the discretion to carry out marketing if they saw fit and to develop marketing activity, occasional health authority intervention permitting, according to local circumstances. In this case, that the intent of the centre, at national and at tmst board levels, did not extend to closely prescribing activity at lower levels of health care delivery, potentially allowed middle managers to take up an enhanced role.

A particular feature of the emergence of marketing activity from middle managers is that middle level managers undertook boundary-spanning roles (Floyd and Wooldridge, 1997) between the intemal and extemal environments of the Florence

Hospital, which had not been formally prescribed by the organisation. For example, they liaised with GPs or with the general managers of other directorates. However, while they took on a role beyond the implementation of deliberate strategy in some cases, it was in the role of implementing deliberate strategy that they exerted a greater influence than was evident in the previous case of business planning. Any deliberate strategy was vague in the area of marketing activity. The strategic theme was one of executive management encouraging a greater marketing orientation as an end with middle managers left to decide upon means. This gave middle managers a relatively substantial amount of discretion, when compared to the case of business planning, within the role of implementing deliberate strategy. Therefore, within the role of implementing deliberate strategy, there appears to be differences in the influence that middle managers can exert upon the realisation of strategic change and scope for an enhanced role even within this narrow role.

There also appeared to be some middle influence in their role of 'facilitating adaptability' (Floyd and Wooldridge, 1992, 1994, 1997). In this role, they nourished initiatives that lay outside the plan embedded in deliberate strategy - for example, expanding services in the area of Surgical Services and Therapy Services was not articulated by executive management as part of the strategy of Florence Hospital - and were stimulators of emergence. In a similar vein, in building relationships with GPs, they were going against the wishes of the executive directors. However, the emergent strategic change that resulted from such middle manager influence caused executive management some concem. For example, in building relationships with GPs and encouraging them to send their patients to Florence Hospital for surgery, middle managers in the Surgical Services area found that they had to close ward areas

because GPs ran out of fiinds. Similarly, in Therapy services, executive management, driven by advice from the local health authority, asked middle managers in the area to stop competing with other tmsts in their expansion of services. It may be that allowing a role for middle managers in which their influence may realise strategic change that is divergent from corporate strategy causes problems. This is particularly so where the central government is increasingly prescriptive about strategic change and corporate strategy is necessarily based upon this prescription. It is to the characteristics of strategic change that this summary now turns

6.4.2 Characteristics of Strategic Change - Inner Context, Generic Transfer and Legitimacy

6.4.2(a) Inner Context

The distinctive nature of the NHS is reflected in the contentious issue of 'who is the customer?' and marketing activity which follows from the definition of the customer, as described above. Much marketing effort was put into building and maintaining relationships with GP fundholders, for instance. A re-alignment of service activity following market analysis - for example, more day care and one stop clinics in Surgical Services - reflected GP fundholder preferences rather than patients.

The Director of Business Development appeared to be more sensitive to the application of marketing in the NHS and emphasised the importance of relationship marketing (McNulty et al, 1994). For example, she was particularly concemed that GP fimdholders and the General Managers of Clinical Directorates understood each other's problems. She focused effort on managing the market and managing

relationships between GPs and clinical directorates so that business remained in steady state. She suggested there was an absence of the necessary conditions for consumerism within the health care environment - for example, well-informed customers or purchasers. Here we see that she mobilised characteristics of the outer context (Pettigrew et al, 1992) of the Florence Hospital to argue that generic marketing concepts were inappropriate. She argued that directorates should engage in activities trying to limit entry to services - 'de-marketing' (Kotler and Levy, 1971; Mark and Brennan 1995) - rather than expanding business, which is the traditional conception of marketing. She recognised the necessity for a skilful implementation of marketing as a framework that fitted with the NHS context. By skilful implementation she suggested that, as well as sensitivity to context, '*champions*' of a marketing orientation with the requisite political skills are necessary to emphasise the continuity of the changes to the General Management Group. She also emphasised, in criticising the speed with which the Business Development Manager tried to force change, that incremental steps were the way forward rather than radical ovemight change. Her conception of strategic change seemed to fit with that of logical incrementalism (Quinn, 1978, 1980, 1982) or the work of Pettigrew et al, 1992 rather than that of the Classical School (Whittington, 1993). Whether this is an appropriate conception of strategic change is highlighted in section 9.4 as worthy of further research.

The influence of antecedent factors (Whipp and Clark, 1986) was evident at the individual level of the Florence Hospital upon organisational change. For example, career histories of those concemed with strategy, played a part in influencing views and actions of the main actors in the Business Development Department. The Director of Business Development exhibited greater sensitivity to context due to her career

background that was nursing. In contrast, the enthusiasm of the Business Development Manager for marketing, was influenced by his *'success in repositioning pathology'* (his words) to recover from the jolt of losing a contract from a GP fundholding practice. The marketing consuhant had worked in a manufacturing organisation before he had taken up his present post as a lecturer at a new university. Therefore, like the management development consultants described in the last chapter, he was not sensitive to the distinctive nature of the NHS and readily transferred generic concepts from private to public sectors.

Generally middle managers had a clinical background themselves, commonly in nursing, and hence felt that the clinical dimensions of health care were not considered in generic marketing models. Therefore, the advocates of a generic concept of marketing- the Business Development Manager and marketing consultant - found themselves in conflict with the efforts of other specialists who did not fully understand, share or endorse the marketing concept, its professed orientation or its view of how organisations should be managed. Consultant expertise and willingness to take up work still to a large extent professionally define health care activities. The historical evolution of the NHS and the professional nature of the services which it delivers, are underpirmed by ideas of citizenship rather than consumerism, so that the individual patient is not the focus of marketing activity.

Despite the above, some of the middle managers were less critical and saw the application of some marketing concepts as relevant. A particularly progressive service area was that of Therapy Services which provided support across directorates. They developed new activity such as aromatherapy and residential home services. This may

be influenced by the history and elaboration of the two main professions in the area - occupational therapists and physiotherapists. These groups have the tradition of being employed outside the NHS and offering their services both to the NHS and other organisations in the public and private sectors. This point illustrates a need for a robust understanding of directorate differences and differences between professional groups so that one can evaluate what marketing models and concepts might be applied in the NHS. As a result generic transfer of practices from private to public sector is likely to be inappropriate. The next section discusses this in more detail.

6.4.2(b) *Generic Transfer*

One important influence upon the role of middle managers in strategic change was the tendency for the Business Development Manager and the marketing consultant to advocate generic marketing prescriptions. Both of these viewed the problem of the Florence Hospital as being one of an insufficient marketing orientation. However, their efforts to re-orientate directorates, despite their claims otherwise, exhibited a lack of sensitivity towards the contexts in which generic marketing concepts were being introduced. This reflects the problem of of over-mechanistic transfer of concepts from private to pubhc sector (Ackroyd et al, 1989, Pollitt, 1990; Hood, 1991; Pettigrew et al, 1992; Stewart and Walsh, 1992). This has been highhghted as a particular problem with marketing concepts (Scrivens, 1991; Sheaff, 1991a, 1991b; Walsh, 1991). Yet the Business Development Manager continued to stress the need for middle managers to see marketing as a perspective and set of tools which was a necessary feature of public sector managerial life. The activities undertaken by the Business Development Manager and marketing consultant to promote a greater

marketing orientation in the hospital represented an ontological project to bring marketing concepts into existence for middle managers. However, it was an approach that did not exhibit the robust understanding of marketing that was necessary for its successful implementation across the tmst since they attempted to universalise and naturalise the use of marketing in a way which Brown (1995b) refers to as 'marketing megalomania'.

The cmdeness with which marketing was promoted was most evident in the marketing workshop, where the analogy of making baked beans was used for health care delivery. This reflected a former Health Secretary's fear, reported earlier, that the language of commerce was being overdone in the NHS. That a particularly robust understanding of marketing is required in the NHS, which takes account of the way NHS staff view their services as for instance, a public service or one in which the relationship between them as professionals and the patient is important, is most obvious when one considers the question of who is the customer? This varied according to directorates and was variously conceived as, the GP fundholder, other directorates, host health authority or patients. The patient was emphasised as the customer by most middle managers. In spite of this, the Business Development Manager and marketing consultant, differentiated between purchaser and consumer of service. They suggested that emphasis in marketing activity be put upon the purchaser rather than the patient. They based this claim on the argument that *'the GP, health authority or other directorates were the decision-makers about purchasing health care not the patienf* [Business Development Manager]. This cut across the view of middle managers that the patient was the customer *'at the end of the day'* [Floor Manager: Surgical Services].

The limited amount of marketing activity specifically aimed at the patient was notable. The WIN Project, albeit a very visible initiative, was one of the few marketing activities which recognised the patient as a customer. On another level, the executive management in the Central Directorate attempted to build a powerful, support group hamessing public opinion to represent Florence Hospital as the *'people'shospital'* [Chief Executive] via, for example, its roadshows. The Director of Medical Education was one of the only informants to touch upon communication with patients, but he regarded it as matter of education - for example, influencing patient demands for particular care paths rather than a case of responding to their wants. Unsurprisingly, given that most middle managers had professional backgrounds in clinical disciplines such as nursing, they placed the patient more centrally and were uncomfortable about putting emphasis upon the purchaser. As a result of this, some of the generic marketing concepts and models were, therefore, more likely to be well received if, for instance, they were linked to an emphasis upon the individual patient and his or her rights. Thus, there appeared to be limited marketing activity of the hybrid nature identified by Sheaff (1991a, 1991b), where there was interaction between users and providers, unless we regard this as also covering interaction between purchasers and providers.

That certain generic marketing concepts may be more relevant than others and that the application of marketing concepts varies with context, is evident in the data as discussed in the previous section. For instance, the concept of de-marketing (Kotler and Levy, 1971; Mark and Brennan 1995), where marketing activity is aimed at managing and regulating demand for services, may be more applicable to Therapy

Services in the face of host health authority advice to curb competition or to Surgical Services in the face of GP fundholders mnning out of money. Relationship marketing (McNulty et al, 1994), which is more concemed with maintaining existing business, seems appropriate for many directorates and they may seek to liaise closely with GPs in planning and delivering services. The concem of the Business Development Manager that a greater marketing orientation was necessary suggests that intemal marketing may be relevant (Walsh, 1991), in this case for Accident and Emergency, for instance. Finally, that the host health authority increasingly managed competition meant that competition for business was only ever likely around the margins of health care delivery. This raises the question about the nature of the intemal market as not mimicking a full market (Walsh, *ibid.)* Therefore strategic marketing, as described by Walsh *{ibid.),* may be less relevant than was claimed by the Business Development Manager and extemal marketing consultant.

Context can be rendered more receptive where attention is paid to the political element of strategic change (Pettigrew et al, 1992). That persuasive aspects of implementing market driven change are important is an issue recognised in academic literature (McNulty etal, 1994; Whittington etal, 1994; Baggott, 1997). Attempts at persuasion so that legitimacy is created for strategic change can mediate resistance from middle managers. This requires executive management firstly, to recognise the influence of middle managers in resisting or modifying deliberate strategy and secondly, to put effort into managing the meaning of context (Pettigrew et al, 1992). The intention of this thesis is not only to illustrate the role of middle managers in strategic change, but also to provide some broad prescription for executive management to take account of this. Therefore, the next section of this chapter

examines attempts by executive management to create legitimacy for their change in the area of marketing activity.

6.4.2(c) Legitimacy - Managing the Meaning of Context

On one hand, the efforts put in by the Business Development Manager and marketing consultant in particular, to develop a greater marketing orientation in the organisation through the middle managers, were resisted to a large extent because they were top-down with a strong emphasis upon generic ttansfer. One of the reasons may be due to the gap the middle managers perceive between the rhetoric and reality of the intemal market (Klein, 1995). Despite this marketing activity went on, and whilst the middle managers perceived marketing, in some instances, as inappropriate because it aped private sector practices, some of the managers were taking on board those marketing concepts they see as relevant.

For some of the middle managers the acceptance of the legitimacy of a marketing orientation took time. This was facilitated by context - for example, the proportion of activity in Surgical Services which was elective surgery, and therefore sensitive to the market. The middle managers stressed the need for an approach that was sensitive to directorate differences, as well as the health service context, if the clinical directorates were to take on a greater marketing orientation.

On the other hand, context is not necessarily an '*objective, inert entity'* (Pettigrew et al, 1992; Ranade, 1995). That context is important, but that its meaning can be managed so as to render it more receptive, was evident in Accident and Emergency.

The introduction of a marketing orientation into this area represented a notable success for the Business Development Manager. On one hand it represented an unreceptive context for marketing concepts because it was demand-led. On the other hand, factors such as a poor intemal reputation of the department, and the importance of the department to the hospital as the 'flagship' of the Florence Hospital in persuasive argumentation around merger proposals, gave some leverage for encouraging a marketing orientation. This was only after the Business Development Manager had set some processes in action and given some broad vision. Importantly local management in the area were given discretion regarding marketing activity so that responsibility was decentralised for marketing to middle managers (Dawson et al, 1992; McNulty et al, 1994; Whittington et al, 1994).

It was not always possible to decentralise responsibility to middle managers. The attempt by the Chief Executive to realise SBU arrangements was met by resistance from executive management. As a result the move towards SBUs has been put to one side. While this thesis emphasises that middle managers can make an enhanced contribution to strategic change, the middle management group does not exist in isolation from other more powerful groups in the organisation. In the example of SBUs, although potentially it offers scope for an enhanced role for middle managers, the resistance exhibited by executive maagement towards the idea of SBUs, causes the Chief executive to de-emphasise the initiative.

In another illustration of the importance of creating a receptive context, in the WIN Project potential resistance was overcome by integrating physical changes with

customer care training. In addition it was hoped that further emergent change in promoting a marketing orientation would be realised following the WIN Project.

6.5 Summary of Marketing Case

The realisation of strategic change in this area was mixed. On one hand, where the role of middle managers was limited to that of implementing deliberate strategy in which there was a high degree of generic transfer, change was compromised by a lack of sensitivity towards the operational context. The particular knowledge which middle managers had of the professional and operational issues in their areas allowed them to ignore the call for an increased marketing orientation by executive management. This was particularly so because there was no prescription from government or executive management in relation to marketing activity. Therefore, middle managers were not even required to exhibit behavioural compliance in relation to the aspirations of the Business Development Manager.

On the other hand, where middle managers were allowed a role beyond the implementation of deliberate strategy, or more discretion within this role, some of the middle managers were less critical and saw the application of some marketing concepts as relevant. In some of these cases they took up a role of 'facilitating adaptability'.'*'* In these cases there was some emergent strategic change in the marketing sub-system. However, this was divergent from corporate strategy and caused problems, which in tum caused the discretion allowed to middle managers to be taken back by executive management.

The argument that little change was realised, is supported by a narrative, which shows the advocates of a generic concept of marketing- the Business Development Manager and marketing consultant - in conflict with the efforts of other specialists who do not fully understand, share or endorse the marketing concept, its professed orientation or its view of how organisations should be managed. Both the Business Development Manager and the extemal consultant viewed the problem of the Florence Hospital as being one of an insufficient marketing orientation. However, their efforts to develop a greater marketing orientation in the organisation through the middle managers, were resisted to a large extent because the approach adopted by the Business Development Manager was top-down with a strong emphasis upon generic transfer. Generally middle managers have a clinical background themselves, commonly in nursing, and hence feel that the clinical dimensions of health care are not considered in generic marketing models. In their role of 'implementing deliberate strategy' (Floyd and Wooldridge, 1992, 1994, 1997) middle managers are able to exert considerable influence upon the realisation of deliberate strategy, to a large extent by ignoring the demands of deliberate strategy.

The argument that some significant change was realised, was borne out by illustrations of marketing activity initiated by middle managers when implementing deliberate strategy, which was convergent with corporate strategy, but also by that strategic change that was unintended and emergent, in their role of 'facilitating adaptability' (Floyd and Wooldridge, 1992, 1994, 1997). Such activity flowed from the characteristics of the outer and inner context which middle managers saw as

[44] In some cases it is difficult to distinguish between the different roles that middle managers take up in relation to the typology of Floyd and Wooldridge (1992, 1994, 1997). Some comment is made about this in the final chapter, where the need for further

legitimate. For example, it might follow from the definition of the customer by middle managers. Therefore, much marketing effort by middle managers was put into building and maintaining relationships with GPs. In addition, some of the generic marketing concepts and models were more likely to be well received if, for instance, they were linked to an emphasis upon the individual patient. This may be one of the reasons why the WIN Project, which focused upon the patient as a customer, was well received.

As another example of the influence of a receptive context, if health care was elective, such as some areas of surgery, it was likely to be more sensitive to the market. Therefore, this represented an area in which adoption of a marketing orientation, was more likely to be realised. However, even here, the acceptance of the legitimacy of a marketing orientation took time and was facilitated by the Business Development Manager working closely alongside middle managers in the same way as Personnel Advisors worked with middle manager in Edwards Hospital (see chapter 8). In addition, it was also evident that context is something whose meaning can be managed, so as to render it more receptive - for example, this was illustrated in the case of the Accident and Emergency area. However, in many other cases, the Business Development Manager and the marketing consultant did not successfully mobilise the outer and irmer contexts of the hospital to establish legitimacy for a marketing orientation. In fact the middle managers were much more successful in mobilising irmer and outer contexts to argue against a marketing orientation.

A particular feature of the successful emergence of a marketing orientation was that middle level managers undertook boundary-spanning roles which had not been

research is identified.

formally prescribed by the organisation - for example, they liaised with GPs or with the general managers of other directorates. Also cmcially, marketing activity was neither prescribed for tmsts by the DoH or NHSME nor prescribed for middle managers by the tmst boards. This potentially allowed middle managers to take up an enhanced role. Thus, the emergence of a marketing strategy in the Florence Hospital emphasised that middle managers are both purveyors and recipients of change.

Again, as in the business planning case, the power of the medical group to define services and constrain middle manager influence was evident. For example, marketing, as a concept, was described as difficult to 'sell' to consultant orthopaedic surgeons because of the long waiting lists for each of their services. In another illustrations of sports injuries, the availability of consultant expertise allowed services to be developed, while in neurology or dermatology middle managers in Florence couldn't develop service provision because there was little consultant expertise. Further middle managers could not reduce services, for example in vascular surgery where there was an overabundance of consultants. In another example of power exerted by the medical group, the SBU initiative was postponed because it did not have a critical mass of support from the medical group. Therefore, despite middle managers' desire that SBU status was granted to their areas because it would give them more discretion over decision-making, the medical group power of veto meant SBUs were 'put on the backburner'.

Yet there were some illustrations that middle managers could influence service provision as a result of 'commercial' pressures of the intemal market arrangements. In Surgical Services, the General Manager marketed the directorate so that his area

gained business from other tmsts and increased the rate of surgical intervention. While he did not comment upon his interaction with the medical group in persuading them of this plan, on the basis of the literature discussed in section 3.4.5. we can guess that had they disagreed that they would have exercised the power of veto by not contributing their labour. In another example, the presence of some form of crisis - for example, the poor extemal presentation of the Accident and Emergency Department or the need to reposition pathology in the face of competition or resource constraints more generally - created a more receptive context for strategic change (Pettigrew et al, 1992) and may allow for more influence for middle managers upon service provision. Finally, the importance of political skills in exerting influence over the medical group was again evident, as it was in the case of business plarming. This was described as *'political sus'* by the Chief Executive and middle managers commented that utilising information, such as referral pattems, could be used to persuade the medical group of the need for change.

Therefore, as in the case of business plarming, on the one hand, the power of the medical group should not be ignored as imposing considerable limits to the influence middle managers. On the other there may be scope for middle managers to overcome this constraining force.

6.6 Florence Hospital - A Cross-Case Comparison

The processual hterature (Mintzberg and Waters 1985; Pettigrew et al 1992), in conjunction with the typology of middle manager's involvement in strategic change developed by Floyd and Wooldridge (1992, 1994, 1997), allows us to gain a nuanced

understanding of the influence of middle managers upon organisational practices, such as business planning, marketing, and management education.

That reliance upon top-down rational planning as the main thmst of strategic change is inappropriate, is most apparent in this first case of business planning. Business plans cease to be a working document for service activity and development because it lacks fit with middle managers' perception of inner context. This feature of resistance is magnified because executive management do not recognise this and continue over time to prescribe templates, which institutionalise performance indicators with which middle managers do not agree, in a top-down rational plarming way. Thus, the realisation of executive management intent in the implementation of business plarming is influenced mainly downwards by middle managers as they modify the implementation of deliberate strategy. However, to what extent they can successfully achieve this is questionable. Although they express negative feelings about the process and content of business planning and in many cases consign the business plan to the bottom drawer of their desk, they are forced to go along with the process. Mainly this is because financial constraints and subsequent intervention from the NHSME become an increasing feature of the environment for health tmsts. Persistent, increasingly prescriptive intervention from government means that middle managers have to comply with the requirements of corporate strategy in which national policy is embedded.

However, there are hints, even within the constraints of the business planning process which adopts a top-down rational plarming approach, that middle managers can potentially have upward influence where they synthesis information, so that initiatives

proposed by middle managers are realised. For example, middle managers in the Genito-Urinary Services obtained resources for additional clinics to deal with dmg users, as did Surgical Services for outpatient clinics. A notable feature of any successful bid was that they were convergent with the thmst of central government policy in the area. The suggestion is that, in order to have a greater influence upon strategic change at tmst level, middle managers may need to take account of government policy in the areas for which they are bidding for extra resource to fund additional services. This may require a greater degree of boundary-spanning on their part with extemal agencies than they might usually undertake.

In this second case of marketing activity the deliberate element of strategic change is less in comparison and there is significantly more evidence of an enhanced middle manager role. Firstly, they enjoy more discretion when implementing deliberate strategy because they largely determine the means by which an increased marketing orientation is realised. Secondly, they are able to resist aspirations of executive management should they feel such aspirations to be contextually insensitive. An increased marketing orientation is more successfiilly realised in areas where middle managers perceive the context as receptive although even here some efforts may need to be expended from top management to create legitimacy. Thirdly they initiate emergent strategic change in their role of 'facilitating adaptability' (Floyd and Wooldridge, 1992, 1994, 1997), alongside their more traditional role of implementing deliberate strategy. In this second case of marketing, there is less evidence of central government and executive management prescription than there was with the first case of business planning and this contributes to an enhanced role for middle managers. Strategic change in the second case reflects some features of an umbrella strategy

(Mintzberg and Waters, 1985) and begs the question as to what is the appropriate balance between top-down rational plarming from executive management and discretion for middle manager influence in strategic change beyond this.

It is also worth commenting upon the case of management education, which preceded the other two cases, since it also illustrates the importance of negotiating strategic change with middle managers and emphasises politics as an element of strategic change. That middle managers have power, and are able to resist a deliberate change attempt with which they do not agree, is a strong feature of this case. The suggestion from the findings here is that any strategic framework must be flexible enough to accommodate the responses to change of any stakeholders. Whilst this thesis recognises that every organisation is unique, the history and professional elaboration of groups in the public sector make a hospital particularly unique. The weaknesses of the competence approach and insensitivity of delivery to context reinforce the ideological gap between managerial and professional values. Thus the importance for strategic change to be sensitive to context is emphasised here since middle managers knowledge of context is likely to give them some power in resisting deliberate strategy. Again, this raises the question of the balance between deliberate and emergent strategic change and the role of middle managers within this.

To summarise, the three cases drawn from the Florence Hospital emphasise the importance of middle managers in the UK NHS in influencing strategic change and go some way towards addressing a research gap. They also suggest there is a balance between rational planning and political elements of strategic change, and top-down and bottom-up or middle-out, if there is to be discretion for an enhanced role for

middle managers to take account of their influence. In addition, generic transfer of managerial practices and the persistent intervention at national level, which inevitably accompanies a top-down approach to strategic change from the centre, adds to the tendency to exclude middle managers from strategic change beyond its mere implementation.

Finally it should be noted that in both cases, not only does central government policy significantly constrain the influence of middle managers, but that medical group exerts significant power over middle managers' role, particularly in developing service provision. However, under certain conditions - for example, through negotiation and persuasion of the medical group or because of a crisis - there may be some scope for middle managers to influence services offered.

These themes revealed in the Florence Hospital across the three cases are now taken forward in the next part of the thesis. In particular, given that the cases above tended towards inductively generating theory, there still remains a need for further empirical research in this thesis that investigates the conditions under which middle managers influence strategic change. For example, one particular suggestion in the case of marketing is that an enhanced role for middle managers is likely to be facilitated where there is potential for boundary-sparming inside and outside the organisation. Therefore, the emergent themes from the strategic subsystems investigated at Florence Hospital will be further elaborated upon in the two subsequent case studies - City Community Health Tmst (CCHT) and Edwards Hospital. These chapters examine the realisation of human resource strategy. This is an interesting strategic subsystem in which to examine the role of middle managers in the realisation of

stiategic change in general. The reason for this is that there is a good deal of literature that encourages the Personnel function to take up a strategic role (for example, Caines, 1992; Storey, 1992) and some discussion of the implications for the role of the middle manager in this (for example, Poole, 1990; Sisson, 1990).

Chapter 7

The Role of Middle Managers in Human Resource Strategy at CCHT

7.1 Introduction

In the last two chapters, the case studies have both been located in Florence Hospital. In these cases, a number of themes have emerged, such as the potential for an enhanced role for middle managers, characteristics of strategic change that support or inhibit this and the impact of centre-periphery relations and inner context upon the role of middle managers. The next two chapters - human resource strategy at City Community Healthcare Tmst (CCHT) and human resource strategy at Edwards Hospital - will elaborate upon this.

Two change narratives will be considered in each chapter. Respectively these are the change narrative of middle managers and the change narrative of those executive managers at the corporate centre. Both will focus upon the realisation of human resource strategy. The first question of the role of middle managers will be considered using the framework of Floyd and Wooldridge (1992, 1994, 1997) set out in chapter 2. The relationship between government and tmsts and that between executive management and middle management in the realisation of strategic change will be considered. Within this, the role of the Personnel function, laid out in the next section 7.1.1, will be examined. In addition, the impact of other characteristics of stiategic change upon the influence and role of middle managers will be assessed. Finally whether there are supporting mechanisms for an enhanced role for middle managers is

considered, particularly those of organisation stmcture and organisation and management development.

Firstly, in the introduction to this chapter, the literature that examines the role of the Personnel function in organisations generally and the NHS specifically, will be briefly reviewed. The development and organisation of the 'Personnel and Development Directorate', henceforth referred to as the Personnel function, at CCHT will then be described. Following this, the two change narratives - of middle management and executive management or the corporate centre - will be described and analysed. Data representation is stmctured around four human resource issues - local pay, management development, recruitment and selection, and skill mix. At the end of this chapter, findings are drawn together to illustrate the possibility of an enhanced role for middle managers and the conditions necessary for this.

7.1.1 The Interaction of Personnel with Middle Managers in the NHS

There has been a preoccupation in some of the more prescriptive HRM literature with the Personnel function taking on a strategic role, fiaelled by Storey's (1992) work that suggested the Personnel function aspire to such a role. The implication of such an aspiration is that the Personnel function would formulate human resource strategy, while other stakeholders, such as middle managers, merely implemented it. However, it is also worth noting, in relation to the research questions set out in this thesis, that within the HRM literature, the importance of the middle manager specifically has also been emphasised. Poole (1990: 3), for example, emphasises that HRM 'involves all managerial personnel (and especially general managers)', in his introduction to the

International Journal of Human Resource Management. In addition, in the same year, Sisson (1990: 5), argues that 'the locus of responsibility is now assumed by senior line management', in his introduction to the *Human Resource Management Journal.* Storey's work also reveals that, 'contrary to speculative reports about the demise of the middle manager, occupants of these roles were exercising authority across a greatly expanded territory' (Storey, 1992: 214). Further, Bamett et al (1996), argue that taking on any change-maker role for the Personnel function is dependent upon a process of `negotiated evolution' which involves 'credibility building, agenda management, continuous delivery and other influencing techniques' (Bamett et al. 1996: 36) with other stakeholders, such as line managers.

More recently, the idea that the Persormel fimction carries out its role in collaboration with middle managers, has gained more prominence from publicity afforded to Ulrich's (1997) book, *Human Resource Champions*. In this book, Ulrich (1997) sets out multiple roles that the Personnel function should take on. These are operational as well as strategic, with the potential for the latter dependent upon effective discharge of the former. This multiple role model carries with it implications for the Personnel professionals relationship with 'line management'.[45] Most importantly, Ulrich recognises the role line managers can play in the delivery of HR policy. Thus although in this model the Personnel fimction is responsible for the accomplishment of the deliverables, it does not have to do all the actual work. Instead, the work will be shared in varying proportions with line management, employees, extemal consultants and other groups. For example, regarding the role of 'management of transformation and change', Ulrich *{ibid.)* sees a typical distribution of responsibility as being 30 per cent to HR, 40 per cent to line managers and 30 per cent to extemal consultants. In the

NHS, in the face of financial constraints, it might be expected that line managers take on an even greater responsibility for the realisation of HR strategy than 40 per cent, because consultants are less likely to be employed. In addition, Ulrich *{ibid.),* suggests that the stiategic partner role has been over-emphasised at the expense of other roles. In particular, he argues that the effectiveness of the Personnel function is determined by its competence around developing the capacity of the organisation and individuals, including line managers, within it for change. Therefore the importance of organisation and management development is highlighted as a facilitator for the line manager role in the realisation of stiategic change.

When examining the role of the Persormel function in the NHS, the process of reform following the Griffiths Report (DHSS, 1983), appeared to offer the Persormel function in the NHS a good chance to take on a more strategic role (Bach, 1994). The role of management was in general being enhanced, tmsts were being established and were encouraged to act autonomously, and labour costs, flexibility and pay were high on the agenda. For Eric Caines, the former NHS Personnel Director, this 'amazing opportunity' for personnel managers was one they failed to grasp because the function was not mature enough in the NHS (Caines, 1990: 12).

Apparent support for Caine's (1990) view was provided a number of surveys undertaken in the early 1990s (Guest and Peccei, 1992, 1994; NHSME, 1993; Stock eLal, 1994). On the basis of comparison with private sector organisations, Guest and Peccei (1992), for example, were pessimistic about an enhanced role for the Personnel fimction in the NHS, arguing that it faced significant additional constraints. Case studies throw further hght on the development of a stiategic role for the Personnel fimction in the NHS. For example,

[45] Ulrich (1997) uses this broad label of 'line managers'. The researcher takes this to include middle managers.

Bach's (1994) study of a district general hospital showed how in a highly divisionalised structure the Personnel Manager's influence was concentrated within the divisions at an operational level. The cential Personnel function had at the same time failed to develop a stiategic role. To explain this Bach stiessed the difficulties caused by a series of erratic and unpredictable policy interventions on the part of cential government. The prospects for the Personnel function, he concluded, 'must remain at best uncertain' (Bach, 1994: 113).

The impact of erratic governmental intervention upon the realisation of stiategic change is illustiated in the case of local pay. On one hand, the devolution of pay bargaining has been part of successive Conservative Governments attempts to expand the role played by market forces. For example, within the *1990 Health Service and Community Care Act* (DoH, 1990), the provision of health care became the responsibility of NHS tmsts, each tmst being able to agree pay and conditions with its own employees. Those in favour of reform argue that local managers would be able to exercise contiol over costs, that local labour market conditions can be adapted to, and that the performance of staff can be rewarded. In practice, change in the direction of local pay has been difficult to effect. Industrial relations in the NHS has long been based on a highly centralised and very complex Whitley stmcture, and regulations governing the tiansfer of undertakings protect agreements reached prior to the establishment of tmsts. Corby's 1992 (Corby, 1992) survey found that although a majority of the earliest tmsts had established local bargaining procedures these were not being used to determine pay. Surveys by the Industrial Relations Service (1993) and the NHSME (1993) confirmed this. In the latter survey, for example, only 8 out of 68 tiaists had adopted local pay determination. In a later survey (reported in *Health Service Journal*, 7th August, 1997: 3) DoH statistics

show that in 1996, only 12 per cent of NHS staff were on purely local contracts, while another 20 per cent were on local contiacts that followed national conditions. Bringing the statistics up-to-date shows little progress. According to Incomes Data Services (1998), fewer than 20 tiaists have local grading structures that are different from national grades. One of the reasons cited for this is the uneven hand of government. Encouragement to implement local pay has been compromised by government directives for year-on-year efficiency gains. Further the government has sought to impose pay settlements upon tmsts where tmsts are directed to top up nationally agreed pay rises by a set percentage. In addition, the present Labour Government adds to the difficulties of implementing local pay because its intentions in this area are unclear.

However Bamett et al (1996) offers some way forward for the Persormel function. They suggest that those extemal constiaints upon the Personnel function in the NHS, that compromise its ability to realise its stiategic intentions, can be overcome by attending to the concems of intemal stakeholders, such as line managers[46]. In their analysis, the influence of line managers upon the realisation of stiategic change is highhghted. Further, they emphasise that legitimacy should be estabhshed by the Personnel function for its activities. Therefore, perhaps the effects of erratic government intervention in the area of local pay can be offset by recognising the importance of middle managers and negotiating change with them, rather than imposing it upon them, since managers values can represent an impediment to the implementation of local pay (Corby and Higham, 1996).

In conclusion, academic literature raises questions about the influence of other stakeholders, including middle managers. In contrast to assumptions embedded in the

framework set out by Storey (1992), more recent literature (Bamett et al. 1996; Ulrich, 1997) stress that the role the Personnel fimction takes up is not a matter of choice. Generally there are significant constraints upon realising a deliberate planned strategy, emanating from the top, in the area of human resources, both generally in organisations and specifically in the NHS. Regarding the latter, on one hand, some argue that there are significant additional extemal constraints upon the Personnel fimction in the NHS (Guest and Peccei, 1992, 1994; Bach, 1994). On the other hand, some argue that these constraints can be overcome. This may occur, for example, by negotiating a role with other stakeholders in the organisation, such as middle managers (Bamett et al, 1996). It could also occur by realising human resource strategy through middle managers, a process in which developing the capacity of the organisation and individuals within it to change may be cmcial (Ulrich, 1997).

In the two chapters that follow, these issues around the influence of the middle manager in the realisation of the intent of the Persormel function are now investigated, utilising the conceptual framework outlined in chapter 2. The first case study took place at CCHT and the relevant characteristics of the organisation are now laid out.

7.1.2 CCHT and its Personnel Department

The case study upon which this chapter is based, CCHT, serves a population of 620,000 and has an annual income of approximately £30 million. It delivers community health services to the local communities, most of whom are concentrated within the city or heavily populated surrounding boroughs. It became a tmst in 1992 and now employs 1150 full time staff.

[46] Bamett et al (1996) also used the term 'line manager' which encompassed middle managers.

The Director of Operations gave an account of the development of the Personnel function in CCHT:

'At this time of course there was no directorate structure [when Director of Operations was appointed in 1984]. Nearly all the work of the organisation came under a senior nursing position. We made a Personnel appointment here to provide support. This was a nurse but she obtained training and qualifications in Personnel - mainly empoyment law. The post grew and eventually we appointed a person with a Personnel background. She left and we recruited a Director of Personnel. This was just after the creation of directorates where Personnel became a department in its own right - the Personnel and Development Directorate.'

The present Director of Personnel had been in post since 1995. He claimed that he was appointed on the basis of his successful implementation of initiatives in a previous post in a community health tmst, the most prominent of which were a move towards local pay and the implementation of competence-based frameworks for recmitment and selection. The formal position is that he was one of 2 executive directors who do not have voting rights on the board, although the Chief Executive claimed that in practice the Persormel Director was not limited by this status. The Persormel and Development Directorate is staffed by 16 employees. It is based in the corporate headquarters, and thus physically removed from the operating sites, which were spread across the area covered by the tmst. To cope with this, there are 3 Personnel Officers who were each linked to a specific geographical area of responsibility covered by an Assistant Director in the Operations Directorate.

The middle managers in our study are located in this Directorate of Operations. This is the largest directorate in terms of employee numbers and budget, accounting for more around two-thirds of the annual total of around £30 million. A Director of

Operations into whom 3 Assistant Directors report heads the Directorate. Each Assistant Director covers one of 3 geographical areas. These are fiirther split into 13 localities, and within each locality there operates at least one primary care team, consisting of, for example, district nurses, health visitors, midwives, paediatricians, speech therapists and dentists. The members of the primary care health teams report into one of the 13 Locality Managers, who themselves report into one of the Assistant Directors. All the Locality Managers were professionally trained as nurses and many of them retain their nursing registration.

It is worth distinguishing here between those managers who seek to manage contributions of others, very much following a corporate line and those who are operational managers concemed with managing the delivery of health care. As was noted in chapter 1 (Dopson and Stewart, 1990), there is a need to be more exact with our definitions of the middle manager when making assertions about their future. In the context of this community healthcare tmst, it is the Locality Managers who are the 'middle managers' as defined by Smith (1997). Within this case, Assistant Directors are viewed as part of executive management in the corporate centre rather than as middle managers themselves, on the basis of their distance from direct involvement with health care delivery geographically and in management terms and that they had opportunities via their position for boundary-spanning intemally and extemally. For example, they were heavily involved in the contracting process.[47]

An important feature of the extemal context within which the personnel function carried out its work was that the budget of £30million, which was allocated to CCHT,

[47] Interestingly, in the light of the question for an enhanced role for middle managers, there was some talk in CCHT, towards the end of the data-gathering period, of another re-structuring in which the Assistant Directors positions might disappear.

was relatively small for a tiiist. A neighbouring mental health tmst had a budget of £50 million and the CCHT Board of Directors felt that, in a climate of reconfiguration of healthcare delivery services, there was a serious threat of a merger with the neighbouring mental health tiiist, which *'to all intents and purposes would be a takeover'* (Chief Executive). In order to counter this threat they put considerable effort into ensuring that they were seen as a progressive tmst by important extemal stakeholders, such as the host health authority.

It is also worth noting that the thmst of the stiategic change attempts in CCHT and Edwards Hospital differed from that of the Florence Hospital. In CCHT, compared to the Florence Hospital (chapters 5 and 6), there is less of a concem by executive management with the concept of 'cultural change'. This may be a consequence of the emphasis that the Chief Executive at the Florence Hospital put upon culture change and organisation development (he was later to employ a Director of Organisation Development at another hospital where he took up the post of Chief Executive). On the other hand, it may also be of consequence that research in CCHT and Edwards Hospital took place 1997-1998 (compared to 1995-1997 at the Florence Hospital). Over this time period, the preoccupation with culture management by Personnel practitioners may have declined both generally in organisations and specifically in the NHS.

7.2 **The Findings**

The findings are organised into four separate issues - local pay, management development, recmitment and selection and skill mix.[48] The issues that are reported upon represent issues that were felt by the researcher to best provide insight into the ways in which the Personnel department carves out roles for itself through middle managers.[49] This chapter considers the questions set out in chapter 3 and the themes discussed above (in 7.1.1) that are cormected to these - the role of middle managers in the realisation of human resource strategy, centre-periphery relations and other characteristics of strategic change and the influence of organisation stmcture and organisation and management development upon the role of middle managers - in analysing the empirical findings. Within each of the sections, in this chapter, the change narrative of those executive management is compared and contrasted with the change narrative of middle managers.

7.2.1 Local Pay

7.2.1 (a) *Executive Management Narrative*

From the point of view of the Personnel function, local pay was seen as an area in which a great deal had been achieved. The Personnel Director stressed that what they were aiming at was not local pay in the sense that the term was normally used - [i.e. local bargaining within a national framework] - but for the tmst to mn its own system

[48] The term skill mix refers to the mix, or ratio of skills employed in a particular area. Most commonly skill mix in the NHS is expressed as a ratio of qualified to unqualified staff More generally, skill mix refers to 'the adaptability and mobility of employees to undertake a range of tasks and/or employ a variety of skills (Blyton and Morris, 1992: 120)

quite independently. This he saw as a key part of government reforms that encouraged a tiiist *`to stand on its own two feet'*. However, given that there was continuous but inconsistent intervention from national government level around the issue of local pay, it must be questioned to what extent this was attainable.

The Director of Personnel felt that the flexibility offered by local pay would solve the operational problems that Locality Managers faced and that, therefore, Locality Managers were likely to be receptive to local pay. He argued that increased flexibility offered by local pay would:

'solve their [Locality Managers] operational problems within the constraints of budget ... they can solve recruitment shortage by offering competitve pay rates and they can break down some of the frustrating demarcation problems' [Director of Persormel].

However, there was little evidence that the Director of Personnel tried to persuade Locality Managers of this. Instead his persuasive efforts were focused upon fellow Executive Directors, most notably the Chief Executive himself

The Personnel Director saw his department's role as central to the development of local pay:

'We're leading it, both championing it and braving it, and doing all the work; influencing other managers, and particularly the trust board, to take a supportive role in it; negotiating job evaluation; employee relations; the whole lot.'

[49] A fifth intervention of 'Strategy Project Groups' was going to be considered. These represented a 'diagonal slice' of the organisation brought together to consider themes fi-om corporate strategy. However, these never got off the ground. The reason for this, was claimed by the Director of Operations, to be that *'operational priorities'* were more important.

The Personnel Director linked the role of Personnel in local pay to more general considerations of change in the NHS:

'One of the things about the Health Service is that driving things is quite easy, because there usually aren 't too many barriers to stop anybody who wants to actually do something ... It's true, because there's no history of people taking initiative with the Health Service. Anyone who says, `I'm going to introduce local pay or a management development programme,' the mechanisms for stopping them doing it are not there.'

The Director of Operations was more cautious in her assessment of the success of local pay. What her caution may reflect is that amongst the directors she was the closest to what was happening at middle and junior management levels. As we get closer to operations - Assistant Director (AD) level - the assessment of the success of local pay is one that tends more towards the negative. One of the Assistant Directors [AD1], who prior to starting at the tmst two years earlier had worked outside the NHS, saw local pay as very much a personal initiative of the Persormel Director. He was clear in his support for the idea that what local pay offered was the chance to pay more than the national rates in areas such as physiotherapy, where it was very difficult to attract staff, and even pay below basic rates where recmitment problems did not exist. However he felt that there was little enthusiasm for local pay amongst Locality Managers and that the Locality Managers were not convinced that local pay offered flexibility, which would solve their operational problems:

'When it was discussed with Locality Managers, none have said local pay is great' or `I'm really pleased we've got it' or 'it's something we pushed for'. Unlike other things, where they might say 'yes, I really want to do this', I haven't got that feeling from staff ... I would be surprised if you went round and people said 'yes, it's something we really pushed for'; it's not something that's been transmitted to me' [ADl].

7.2.1 (b) *Middle Management Narrative*

When we move further down the organisation we see many of these differences of perception emerge more clearly. One Locality Manager [LM3] stressed the trouble caused by its implementation. Offering those going on to tmst contracts a slight pay increase - of the order of 0.5 per cent - had, she said, generated a great deal of suspicion. She offered an explanation for professional suspicion of managerial initiatives:

'People thought they were being bribed, and they thought once they got over on to trust terms and conditions they would all be changed. You have to work with the NHS culture, which is that someone is going to do one across you. That's standard NHS culture ... that there must be a catch to this. Somebody offers you a 0.5 per cent pay rise, they want something from you.'

To overcome such suspicion, the Director of Personnel assured staff that at any time they could retum to Whitley - and only after this had been repeated and put in writing - did the majority move over. There were still those who, *'on moral grounds'* [LM3], had not moved over, said the Locality Manager, and the differential in pay between national and local conditions had proved very divisive.

From the Locality Manager's point of view, local pay was something, which had been imposed upon them and mainly for this reason, they were negative about it. One Locality Manager [LM5] said simply:

'We weren 't particularly involved in that. I suppose it was a bit like another of things that's a fait accompli that they've introduced. What tends to happen in this organisation is that Personnel make unilateral decisions and introduce new policies, new ways of working, without any kind of warning or consultation.'

Local pay was seen as raising problems in practice as well as in principle. Locality Managers were best placed to illustrate these problems, yet their contribution to the development of local pay frameworks was not asked for. One Locality Manager [LM2] pointed to the confusions introduced by the new pay scales. This applied particularly to nurses, by far the largest single group of employees, whose nationwide grading stmctures were familiar and well-understood:

'When you advertise a job and you put 'circa £18,000', people ring up and say, 'Is that an F Grade?' and you have to say, 'No, its circa £18,000.'

The same Locality Manager saw similar confusions arising from movements within the single pay scale:

'There is a single pay-spine and of course your ceiling could be £24,500, even though you are on a minimum of £20,000, and people start saying, 'How do I get to £23,500?'. Of course, you don 't get to £23,000, do you? You 're just within this pay spine. People say, `I don't understand it, I've gone through my increment' — Oh, we don 't have increments any more' - 'but you have this natural progression' — 'so you do have increments' - 'Oh, well, we don 't call them increments.'

Indeed, the confusions appeared to arise not from great differences but from the close similarities between the old and the new systems. In reference to the national nursing grades, a Locality Manager [LM2] said *'Even Personnel use these terminologies. It seems a lot of effort for little change, window dressing'.* Further, he argued:

'People are still being paid basically what their Whitley grades were, so they don 't understand what the whole purpose of this was, besides it shows on paper this single pay spine, and within this pay spine you're still on what has always been the equivalent of an E, F, G, H I,whatever grade you 're on.'

The marginal differences between local and national pay, that local pay did not match operational contexts nor solve operational problems as claimed by the Personnel Director, and that Locality Managers devoted considerable energy to managing the impact of local pay, meant that Locality Managers felt negatively about local pay. However, despite their negative feelings about local pay, Locality Managers were forced to accept its imposition, however flawed the framework. They seemed to have little power in this case.

7.2.2 Management Development

7.2.2 (a) *Executive Management Narrative*

While local pay represents the issue with regard to which the Personnel function could most convincingly portray themselves as strategic changemakers, management development, to which we now tum, was an area in which they felt they had achieved little. Any impact here was more difficult in the health service, the Director of Personnel argued, *'because of the problem of getting managers to realise they've got development needs'.*

He went on to describe Locality Managers as *'blinkered',* because they did not recognise the need for management development. The reason little management development had been done in the tmst, he implied, lay in its history and cuhure:

'This has been a community unit, built into the community trust, without a history of doing it that way. People have moved up and learnt the job by doing it, ... the good old Health Service tradition. You become a nurse manager and you 've been a district nurse before.'

As in the case of recmitment and selection below (section 7.2.2 b), responsibility for management development was imposed in a document statement - a written one-page management development policy. In this the role of the Personnel fimction was described as follows: 'Training and development are line management responsibilities, which will be co-ordinated, facilitated and supported by the Personnel Department.' However, given the resistance middle managers had towards management development, described by the Personnel Director himself, there remains a question mark over whether they would show the necessary commitment towards initiating management development, as set out in the policy statement.

Further, the competence-based approach used in the recmitment, described below, of Locality Managers had not been extended into their development. Therefore, it appeared that human resource policy and practices did not appear to be intemally integrated within the human resource strategic subsystem itself, never mind with other features of intemal and external context. On one hand, the recmitment and selection process was overhauled so that it was competence-based. Locality Managers were the first group of employees to be selected using this process. On the other hand, competence-based job specifications used for selection were not extended for use in identifying and meeting the development needs of those Locality Managers appointed. Instead, immediately following appointment, Locality Managers had been expected to deal with a large number of long-standing operational issues, yet little thought had been given to their development needs so that they had the capacity to solve those problems:

'I think it [the management development] didn't happen because it was such a Big Bang approach to introduce Locality Management that Locality Managers, no sooner had they set up their desks, they were hit by the day-to-day realities of the job, and the staff were now bringing up all the old chestnuts that had been around for years which the staff now expected the new management structure to sort out for them ...In reality, they should have taken a step backwards and said, 'Right, they've been around for years, we can't do anything about them at this point in time, let's kick off [with] the quality ones and leave some space to do that personal developmenf [Director of Finance].

As a result of a lack of emphasis upon management development, budgeted funding for such activity was relatively low. When pressed on the size of the management development budget, the Chief Executive replied,' *You 'll have to ask Bob [Director of Personnel]. Last time I knew it was about £20,000'.* 'When the £20,000 is broken down however, one Assistant Director consumes a quarter of this through his participation in an MBA programme and a further eighth is consumed by a Locality Manager's Diploma in Management. Thus, whether it is *'well-resourced',* as claimed beyond some high profile funding for certain individuals is arguable.

There were a number of factors militating against the extension of management development within the tmst. Short-term pressure on costs was the main constraint:

'It goes against your management costs, so, if, at the end of the day you are told [by the Government] that you 've got to reduce management costs by £40,000 and you 've got £20,000 committed to management development, then that's the thing that will go before you lose a post' [Director of Operations].

Assistant Directors, in commenting upon management development, talked of its contribution towards enhancing the middle managers role to include them in stiategic change. One Assistant Director [AD2] said management development needed to be seen against the background of a changing role for Locality Managers: *'the vision we had for a Locality Manager 3 years ago, there's a different vision we've got to be*

having for the next 5 years.' This would involve being more proactive in working with other agencies and taking a broader conception of what 'health' was. The role of the Personnel Department was to interpret the organisation's requirements [AD2]:

'Personnel should set out the direction the organization is going, these are the skills and competencies we need to get there, how do we work backwards to ensure that we have got the right skills for the organization, to get us where we want to go?'

Where there were gaps, another Assistant Director [AD3] asserted, was in succession planning and in developing a more strategic frame of mind.

`I know they [LocalityManagers] aren't strategists, but I think they perhaps need to understand, or be given the opportunity, to have a knowledge of the wider world. I think we've given them the how to do your budgets, how to recruit, how to take on your review and development, but I'm not sure that we've considered what we need to provide them with from a broader perspective, to enable them to carry on their jobs.'

7.2.2 (b) *Middle Management Narrative*

As far as the Locality Managers were concemed, they were quite blunt: *'I would say Personnel haven't produced anything'* [LM1]. Some development work had been undertaken from within the Operations Directorate. The main event was a team-building exercise held in Wales. The Locality Manager [LMl] was sceptical about its effects:

'At the end of it I actually said to my then Assistant Director ... 'I'm not sure whether I even said the truth or whether I said what was expected of me'. Because I'd played the game so many times I knew what outcomes they were looking for, so I wasn't sure for those of us who've played the game several times, how valuable it was.'

A second Locality Manager [LM2] described his own experiences of management development as *'very much me-led'. A* week-long, in-house managers course he dismissed as very superficial, and after that he felt that he had very much organized his own development himself, with little support from the organization:

'I applied to do a Certificate [of Management Studies] and got minimal support I got the day off, basically, and they paid the course fees and I paid for them through my wages, so they gave me an interest-free loan. They wouldn 't support me onto the MBA third-year course because it wasn't part of my job ... but I didn't want to do it anyway.'

A third Locality Manager [LM3] described her lack of preparation for her new post:

' We were pitched in the deep end and it took me six months to start swimming. We all were just chucked in, and as most of the Locality Managers had been managers before, they had got all the nuts and bolts before they started. I arrived here, kicked the health centre manager out of her office and took it over, and then spent six months hoping I was getting it right, and at the end of the six months nobody seemed to have died and I didn't seem to have had any complaints, so I decided I must be doing reasonably well!'

Further any courses that encouraged strategic thinking rather then delivering operations had to be identified by the Locality Managers themselves. Some were more able to do this than others. The process of the self-identification of needs was illustrated by one of the Locality Managers [LM2]. She felt that there were no mechanisms that encourage development:

'I've always got a lot out of courses when I go on them, and I've a different mindset towards that now, but that was a problem to start with and it was a while before I started saying, 'I need to go on this, that's joint Health/Social Services national development, and [to] see who else is there' - and to appreciate that that was a networking that was vital. But I drove that myself It might have been helpful if somebody had said earlier on, 'We expect ... X, Y andZ.'

In summary, the importance of management development as a contributor to an enhanced role for middle managers went unrecognised by the Personnel Director. The Locality Managers expected Personnel to take a lead role in identifying and providing suitable development opportunities and this added further fuel to the Locality Managers perception that Personnel did not solve their operational problems. This, combined with negative perceptions of local pay and the role of Personnel in its implementation, was reflected in Locality Manager resistance towards the attempts by Persormel to drive change around other issues, such as recmitment and selection and skill mix. In both these cases Locality Managers resisted the implementation of a deliberate strategy based around competence-based frameworks for jobs.

7.2.3 Recruitment and Selection

7.2.3 (a) *Executive Management Narrative*

Recmitment was an area in which the Personnel function - the Persormel Director in particular - was clear in the role it saw for itself At present, he implied, there was little in the way of a systematic approach to recmitment in the NHS:

'Posts come up, an interview panel are set up, an advert goes out and someone is appointed. Sometimes it's the right person and sometimes it isn 't. You normally know the appointment's all right because you know the candidate anyway.'

The Director of Personnel decided what systematic approach should be adopted by the idea that:

'[we should] move away from that [old system] to actually start applying what you might call industry-wide standards, and actually starting to analyse how the recruitment process worked, to remove some of the real dire problems you get from bad recruitment practices'.

The role of the Personnel fimction was thus to take responsibility for the underlying philosophy rather than the day-to-day operation of the policy. He thought that if approached in the right way, managers would accept that poor selection was at the root of many of their problems with staff, and that they would see the benefits in change. In intention at least, the Personnel Director sought middle manager input into the details of the framework. However, this intention was not realised. As is evident in 7.2.3(b), Locality Managers felt that competence-based recmitment and selection had been imposed upon them.

It seemed to be more important to the Personnel Director that some principles were in place, rather than what those principles actually were. Competence-based recmitment, he said, ' *is maybe jargon, and maybe contrary to some of these principles, but it's moving into a vacuum '.*

For another member of the Personnel Department [Professional Training Manager] competence-based recmitment was linked to the organisation becoming a NVQ assessment centre. This would provide a *'kitemark of excellence'* for the Persormel function. Again, the emphasis appeared to be upon influencing extemal perceptions so that the CCHT was seen as 'progressive'. Competence-based recmitment, she said, *'has provided a route for being very specific in the definition of what the competences are that we require'.*

One problem was that competence-based recmitment was applied across the tmst to all posts, rather than being applied selectively where it fitted operational context. When asked about competence-based recmitment in the tmst, the Medical Director agreed that it could certainly be applied to managerial roles but not necessarily clinical ones:

'*If you 've been through management training you know what these things are and you can play the game. What I find it's limitations are, however, is when I've been involved with clinical appointments, that the people coming don't understand where it's based, and therefore get confused and put off by what that system is, and I don 't think that's fair. There's a danger of its being applied too rigidly. So someone who comes for a Director role will be asked this; someone coming in for Clinical Assistant will be asked the same questions.'*

Besides this, other problems mentioned by executive management were that middle managers were not involved in its development and that the discretion promised for Locality Managers was subsequently clawed back by Personnel. The views of the Personnel Advisors, who provided a link between the corporate centre and operations, illuminate the exclusion of middle managers from influence in the strategic change process. They illustrate that middle managers concems were marginalised in comparison to the strategic direction determined by the corporate centre:

' *They [Locality Managers] moan about competence-based recruitment and selection. Our job is to make sure they implement it in the way intended [by the corporate centre]*' [PA2].

At the level of the Locality Managers, such issues are viewed even more acutely to give a much less positive picture of competence-based recmitment.

7.2.3 (b) *Middle Management Narrative*

One particularly important issue in the eyes of the Locality Managers was that the discretion they were given was at a mundane administiative level and that there remained a large element of control following this by Personnel. This was aimed at ensuring the prescribed competence-based approach was followed. Their first exposure to this competence-based approach had been in the selection process for their jobs, which they held currently. They were very scathing of this, since they felt it had not fitted the job:

'Personnel came up with these wonderful models of skill required to do the job, and whichever one you want to choose, there was this lovely, rosy-eyed picture of what somebody should be able to do' [LM2].

At the same time, he argued, their general models failed to take account of the sector in which they were operating:

'The other thing is they don 't understand the people they're personnel-ing, they don 't understand the Health Service.People like me have been [20] years in the Health Service, I understand the Health Service, where it is and where it's coming from, and they don't. So they start applying all these lovely models they 've got, and you can see what they 're doing. Single pay ... how do you apply a model like that to a culture that doesn 't sit like that?'

Although in theory, general management was in place, said another Locality Manager [LM3], in practice it was on the manager's professional expertise that the organisation often relied. She explained how her own background as a nurse was often exploited when certain issues arose but this was not officially acknowledged:

' There is an unofficial culture in the organization, there always is, isn't there? The official culture is that we have general management, blah, blah, blah; the unofficial culture is, 'This is the way we keep the show on the road'. It's only when they find out that you 're keeping the show on the road and it doesn 't fit the model, that they then start questioning what you 're doing. And then you get into this debate around what is the best way to manage it and you find that you 're more competent than they are because you understand what the problem is. They don't understand what the problem is.'

That Locality Managers' knowledge was cmcial in deciding appropriate changes and then implementing them, was illustrated by a Locality Manager's description of a review of the role of caretakers in the tmst. The Locality Managers had favoured combining the role with that of handyman but Personnel *`got involved'* and said that what was needed was a generic cleaner/caretaker. This, said a Locality Manager [LM2], failed completely to take account of the realities of the situation:

'They 've looked at the fact that we 've got loads of caretakers on part-time hours, and if you stick them all together you could have 4 instead of 9, and that would make more sense. It makes sense on paper, but how do 4 people open up nine health centres at 7.30? So then they start questioning whether they all need opening up at 7.30, and we get into this thing about them telling us when we open the health centres. So you then turn around and say, 'Well, I don 't need to be a Locality Manager, Personnel can decide ... they don 't think these things through, they just look at this nice little boxed model. So at the moment we end up having to fight all the time, and having to produce evidence, and all the time having to explain to people that it doesn 't work like that.'

That Persormel exerted a great deal of control over recmitment and selection was a source of finstration for the Locality Managers. *' We have the budgets,'* said a Locality Manager [LM3], *'so why can't we decide what we want to pay people?'* Locality Managers contrasted the strategic role chosen and executed by Personnel against their own exclusion from strategic change:

'[The Personnel Department] have stepped out of the way of recruitment and selection. I think they see themselves as having an overview, a role in looking at employment law, rights, policies, etc. I don't think they see themselves doing the nuts

and bolts of it I think they think that's operational. There's this wonderful phrase within the trust, `Oh, that's Operations'.

Perceptions more generally of the appropriate role for a corporate function in relation to Locality Managers were reflected in a Locality Manager's comments about the recmitment and selection framework and process and the role of the Persormel function within this. Personnel were intent on maintaining a quite direct form of control:

'But the minute you do anything wrong, like send a form in with the wrong code on it, they 'll slap your wrists. And you say, 'Hang on a minute, one minute you empower us and the next minute you police us,' They police you now, and so you end up with a sub-culture that says, `Don't tell them.' So we don't tell the any more, so we do our own thing; then they find out and say, 'You can't do that,' and we say, 'Well, we got fed up of asking for permission, so we 're doing it now' [LM2].

Further, there was still a standard Personnel format to follow:

'There's the disk with all the letters on ... and then we customise them ... and Personnel still placed the advert, and checking with them before you offer the salary as well, they want to be involved and make sure that we 're offering the right point on the scale.'

Finally, another Locality Manager [LM5] commented: *'my vision was that people would be coming out to be based with us, and they 're not.'* Their ideal role, she said, would be:

'to support and advise, very much supportive and advisory and consultative and coming out here, finding out what the issues are .. but we don't see them unless we 've done something wrong outside our [Locality Managers] meetings with them once a month.'

In summary, Persormel adopted a similar top-down approach to the development and implementation of competence-based recmitment and selection as it did with local pay. Its claims that the competence-based framework allowed for discretion in decision-making for Locality Managers are questionable. Further, Locality Managers were able to resist the top-down implementation of competence-based recmitment and selection, but only in some cases. Successful resistance was more likely where human resource interventions were ill-fitted to operational contexts in which health care was delivered and where there were some important clinical considerations. This allowed the Locality Managers, through their detailed knowledge of operations and associated clinical issues, to sidestep control by Persormel. Yet, in other cases, where such knowledge was less cmcial in non-clinical areas, such as the organisation of caretakers, they are still subject to its imposition.

Regarding influence beyond resisting or modifying the implementation of deliberate strategy, that this was available to Locality Managers was not greatly, if at all, evidenced. If anything the competence-based framework militates against an enhanced role for Locality Managers because it provides a straitjacket for any attempt to go beyond the implementation of deliberate strategy. In addition, that the competence framework used was one imported from the private sector, through the use of extemal consultants, excluded the Locality Managers from shaping the framework in the first place, and further excluded them from influencing upwards.

The next issue - skill mix - is also one which the competence-based framework, underpins. In relation to this issue, given the even greater importance of professional

knowledge in contributing to skill mix decisions, we might expect a more influential role for Locality Managers beyond mere implementation of deliberate strategy.

7.2.4 Skill Mix

7.2.4 (a) *Executive Management Narrative*

The Persormel Director said that the competence-based framework developed by Persormel for recmitment and selection, allied with its cormection to a NVQ framework[50], had created the means by which certain types of skill mix could be achieved. Drawing the distinction between vertical and horizontal skill mix, he said the creation of NVQs, *'which we drove',* allowed the former to be introduced. *'We got that in early,'* he said, *'because it's a threat to a lot of professional groups'.* Again, as in the case of competence-based recmitment and selection, the Personnel Advisors ensured that the corporate line was adhered to:

'When the issue of skill mix comes up in any meeting [with Locality Managers], we direct them towards NVQs as a way of doing this ... in fact, the only way of doing it sometimes' [PA2].

The Persormel Director admitted that one of the reasons for a focus upon skill mix was the increasingly tight financial constraint. He regarded skill mix changes, alongside local pay, as helping the Locality Managers with the resultant operational problems caused by financial constraints.

[50] NVQs are based upon occupational standards developed by employer-led Industry Lead Bodies for each sector. They are expressed in terms of occupational competences, which are defined as, 'the ability to perform satisfactorily in an occupation or range of occupational tasks' (Winterton and Winterton, 1999: 3).

A big issue in community health tmsts was that Enrolled Nurses were disappearing as part of district nursing teams, and this raised the question of the role that could be played by less-skilled staff such as healthcare assistants:

'So that process [NVQ] and the local pay structures that can support the development, and the willingness of healthcare assistants to move into that role, is a major step towards [vertical] skill mix' [Persormel Director].

Horizontal skill mix raised different questions for the Persormel function. The Persormel Director regarded it as the more difficult issue because *'professional tribalism'* impacted upon making any decision about skill mix. Therefore, the Personnel function allowed most of it to be *'carried out by Locality Managers as an ongoing process.'*

That financial considerations were cmcial in any human resource initiative was apparent when examining the Finance Directorate's view of skill mix. Their view was that skill mix could and did allow a combination of cost saving and service improvement. The Finance Director said:

' We increase skill mix as much as possible, but we're looking to make savings as well. And we 're quite up front about that because we see that it should be possible to achieve savings. The trust has to make savings anyway, year on year, and as just over 70 per cent of our spend is on pay, we have to make savings in pay each year. The obvious route for that is skill mix - well, skill mix which improves services as well. It's not simply to make savings; it's not simply to provide a low quality service; it's got to be a true efficiency saving.'

The Finance Director described progress on skill mix as inconsistent on the basis of differentiation between professions: *'/ think some professions are further ahead than others.'* District nursing, for example, he saw as well ahead of health visiting.

'There's certainly a lot more scope, I think,' he said, *'for generic workers who can work across professions at a help level.'* In trying to explain the differences he argued that the pressures on district nurses were greater, because they were a large staff group and therefore consumed a great deal of resource, than those on health visitors, who were a much smaller group. Health Visitors tended to be isolated members of Primary Care Teams (for example, there may be only one health visitor in each Primary Care Team) and the Finance Director felt that, *'they tend to retreat within their professional boundaries much more than district nurses.'* In addition, *'they were difficult to recruif* [ADl] and this gave them some power to resist initiatives. In contrast district nurses were much more amenable to managerial initiatives specifically and general management generally. This was evident in the composition of the Locality Manager group, most of whom were of a district nursing background, but not one of whom was a health visitor. This led to a situation whereby the management of health visitors was also much less *'enlightened'* [Finance Director] than that of district nurses.

The Operations Director felt that skill mix increasingly was being approached in a sensible and systematic way. She played up the concept of *'clienf* need, something that was increasingly being emphasised in the NHS (for example, see the NHS Human Resources Strategy, 1998). She argued that it was something that Locality Managers would be receptive towards, if expressed in the language of 'patient' rather than 'chent' need:

'I think a few years ago there was a big, big push in skill mix. I think there is less of push to skill mix as a concept, but the move now is towards looking at the needs of the people using the service: what are their needs or the needs of the locality, and how do we best meet those needs?'

However, one of the hurdles to overcome was the view of professional bodies that skill mix would dilute professional skills:

'I think when it was first introduced, skill mix, to everybody, meant unqualified staff coming in to do what was perceived as their role' (Director of Operations).

7.2.4 (b) *Middle Management Narrative*

The Locality Managers were given a more influential role in skill mix than had been ascribed to them around the other issues. However, that financial considerations were paramount was emphasised. This was an emphasis that may not be shared by Locality Managers, but one to which they could contribute nevertheless. The decision to skill mix would be made not by the Operations Director, she herself said, but by the Locality Manager or appropriate nursing or therapy staff. Any such decisions were:

'driven by having to keep in budget. So if somebody leaves who is top G-grade nurse, for example ... the thing is that you try and recruit at the bottom of the grid.'

According to Locality Managers, the most important problem with the idea of skill mix was that at the operating level it broke down in the face of professional rivahies. Self-managed teams were being developed which included both district nurses and health visitors:

You 've got to sit down on a table and agree what the priority for next year is, and if the priority is, say, less health visiting and more district nursing, and a vacancy in health visiting comes up, the team would then obviously sit down and, through pure objectivity, would decide that they required less health visiting; so the vacancy would be given to district nursing because that's what the locality needs. When it gets down to that level, it all goes out the window ... People say, 'There 'll be less health visitors,

so the profession is threatened, we can 't have that'. So people then come up with other reasons why it shouldn 't happen ... Because you 've got to remember that health visiting and district nurses had professional rivalry ten years ago ... and health visitors have always seen themselves as better, more academic.'

Yet, at least at the level of vertical skill mix, there was change implemented in relation to health visitors and nursery nurses took on some of their work. However, there was inconsistency across the tmst in such skill mix changes. On one hand, because the tmst had a poor record in evaluating pilot schemes, a thorough system of evaluation had been built in to an initiative in one Locality Manager's [LM3] area. The idea was that once the pilot had been shown to work, it would be handed over to the Operations Directorate for more general use. What happened, however, was that a number of other localities had begun to follow the model in an ad hoc way, and this had detracted from the impact the pilot might have had. The role of Persormel, she said, in skill mix was one where they sought to frame skill mix initiatives via an NVQ framework, which the Persormel Director had already successfully implemented in his previous post at another community tmst:

'I put four nursing auxiliary packs together, and those packs were put together as a result of a need within the service, within district nursing. All of a sudden, they 've got to be hijacked and turned into NVQ-competency-accredited. Because that's what Personnel decided, so they're a right bastard when it comes to things like that ' [LM2].

She described the kind of situation that could occur:

'We did an NVQ assessment for a job and there were about four NVQs, and she did two of these, one of these and one of these, so she ended up with six or seven units, but they didn 't fit to one NVQ, they fitted to four or five. So the poor lass would have ended up with bits of jigsaw pieces that didn 't belong to the same jigsaw.'

The Persormel fimction seemed impervious to these complaints, maintained the Locality Manager, concentrating instead on influencing extemal perceptions of their activities. Again, Personnel aspired to obtain a 'kitemark' of what was seen as best practice by the Personnel community more generally - in this case 'Investors in People' (IIP). Stmctured frameworks, such as that provided by the NVQ framework, were a necessary component of such accreditation. Yet NVQs did not necessarily fit with operational delivery of health care and there was a danger of NVQs driving the job rather than the other way round:

' When staff say, 'I'm doing an NVQ and I need to go and work in this section for four hours to get this competency,' you just say, 'Well, that's not part of your job' — `But then I won't get my NVQ' — 'Well, hard cheddar.' And then other managers say, 'Oh, go on, it won't do any harm, let her work on reception for a couple of hours ...To get my NVQ I need to do this,' -I say, 'To get your wages, this is the job you need to do.' The two don 't fit.'

In summary, Persormel did not lay claim to expertise in this area, particularly around horizontal skill mixing. However, the Personnel fimction, driven by a need for efficiency gains, wanted to manage any skill mix change by ensuring it fitted with the NVQ framework. Such a generic framework did not fit with operational need. Further it is imposed in a top-down way upon Locality Managers. This was despite an admission, even by Personnel themselves, that the Locality Managers were best placed to formulate change in this area. Therefore, potentially in this area, they could enjoy an enhanced role in skill mix that contributed towards more efficient and effective delivery of health care, yet this opportunity was not fiilly reahsed.

7.3 Discussion

Firstly, the main concem of this thesis, that of whether an enhanced role for middle managers in strategic change has been realised, will be discussed in relation to the case. In the case there appear to be two contextual characteristics in particular, which impact upon the potential for an enhanced role for middle managers - centie-periphery relations and supportive conditions within inner context, such as organisation stmcture and organisation and management development. Each of these will be discussed in tum. In the case of centre-periphery relations, the focus is upon the relationship between the executive management and middle management at tmst level.

7.3.1 An Enhanced Role for Middle Managers

The main role illustiated for middle managers in CCHT was the implementation of deliberate stiategy (Floyd and Wooldridge, 1992, 1994, 1997). Even withim this role their influence was limited since, in the cases of local pay, competence-based recmitment and selection and vertical skill mix and both ends and means to realise stiategic change were tightly prescribed by executive management. In most cases, while middle managers argued against initiatives on the basis that they were insensitive to operational context, largely they exhibited compliance with the requirements of human resource strategy. For example, middle managers expressed strong reservations about the NVQ framework adopted by Personnel as the basis for vertical skill mix. Similarly, they claimed the implementation of local pay did not solve the operational problems they faced. However, in this latter case and to a certain extent in

the case of vertical skill mix, they worked to the generic frameworks that the Personnel fimction adopted as the basis for strategic change, despite their reservations. Only in some cases did knowledge of the clinical and operational context give the middle managers power to resist or modify deliberate strategic change in some cases. For example, they resisted competence-based recmitment and selection and ignored it or modified it in the recmitment for those jobs, such as nurses, for which they felt it was ill-suited and were able to do this without Personnel knowing.

Further, only in the case of horizontal skill mix, were middle managers able to take on an enhanced role where they were able to shape the aspirations of the Personnel function. Their intimate knowledge of clinical and operational issues that influenced the realisation of skill mix change enabled them to initiate and implement horizontal skill mix change. It was one of the few areas in which the Personnel function recognised the important contribution that middle managers could make. As was apparent in section 7.2.2 and 7.2.3, the perception that middle managers should not be included in strategic change had remained since middle managers were initially selected for their posts.

Around the issue of horizontal skill mix middle managers took on an enhanced role but it was still one that remained mainly within the role of implementing deliberate strategy (Floyd and Wooldridge, 1992, 1994, 1997). Personnel aspired as one of their strategic themes to realise a more flexible workforce as an end but were unsure how ro realise that end. Therefore, middle managers were given some discretion to decide the means to that end. However, the Personnel function still attempted to contiol any

emergent strategic change by an all-encompassing NVQ framework. On one hand this allowed the Persormel function to move towards obtaining an extemal kitemark of excellence, such as that provided by IIP and to present itself and the tiiist as progressive to the local health authority. On the other the contextual knowledge that middle managers could bring to bear upon the formulation and implementation of stiategic change was not fully utilised so that strategic change would solve operational problems.

An interesting question is why the Personnel function should allow an enhanced role for middle managers in relation to horizontal skill mix. In other areas, besides skill mix, where the clinical and operational knowledge of middle managers may also prove important, the Personnel function adopted a top-down approach in which both ends and means were tightly prescribed by them. It may be that the discretion allowed to middle managers around this issue is no more than Personnel abdicating responsibility for matters of skill mix in the face of an unreceptive context for them to drive change or that they lacked expertise in this area.

Certainly, around other human resource issues the Persormel fimction in CCHT still did not fully appear to recognise the enhanced contribution that middle managers could make towards the realisation of strategic change. The strategic change literature outlined in chapter 2 argues such a limited role for middle managers illustrated in CCHT leads to poorer organisational performance. Therefore, why CCHT executive management should have such a limited conception of the middle manager role is an interesting question, which can be illuminated by considering the characteristics of outer and inner context in which the middle manager role was positioned.

7.3.2 Centre-Periphery Relations

The relationship between the government and tmsts influenced the role of the middle managers in strategic change at tmst level. For example, in the area of local pay, although prevarication around the issue of local pay by central government was problematic the tmst decided to push ahead anyway because of another aspect of central government policy - rationalisation of health services. This caused a relatively small tmst (in budget terms), such as CCHT, to fear for its survival, and seek to present itself as a progressive tmst to the health authority, by adopting local pay. This is an illustration generally that executive management in CCHT paid attention to stakeholders outside, rather than inside, the organisation. A result of this was that there was no emphasis upon negotiating change with middle managers and including them in strategic change nor was there much attempt to influence their perceptions of context.

The relationship between executive management and middle management was a more important aspect of centre-periphery relations than the central government-trust one, at least in this case. The weaknesses of a top-down planning approach to strategic change and the separation of formulation and implementation can be seen in the approach adopted to strategic change taken by Personnel. Such weaknesses were reinforced because the Personnel function tightly prescribed ends and means in those areas in which it chose to take on a stiategic role. Further the means prescribed to realise strategic change were often transferred from the private sector - for example, competence-based recmitment and selection. The lack of inclusion of middle managers in strategic change is highlighted as a significant weakness in this approach.

The Director of Personnel in the case study held an assumption that the Personnel fimction can adopt a stiategic role (Storey, 1992). As he admitted, this was influenced by the success he experienced in a previous community tinst in taking up a strategic role. As discussed above, this choice was reinforced by business objectives to present the CCHT as a progressive tmst to extemal stakeholders to ward off threats of take-over.

Further, in relation to local pay, central government encouraged this, even though the emphasis upon this was rather inconsistent (see section 7.1.2). Also, given the efficiency gains called for at national level year-on-year by the DoH (see chapter 2), the outcomes of stiategic change had to be cost-neutral at best and preferably result in decreased costs. Hence, in moving towards local pay, CCHT was constiained in the extent to which they can offer higher pay rates. Therefore, the advantage claimed for local pay that it would solve recmitment shortages was unlikely to be reahsed. If there was any increase in the wages bill because of local pay then this would need to be offset by changes in skill mix.

While the Personnel Director paid attention to features of outer context, the same could not be said in relation to intemal context and potential constiaints within this. Cmcially, the influence of middle manager resistance upon the realisation of the aspirations of Persormel went unrecognised. Any attempt at influencing stakeholders within the tmst by the Director of Personnel appeared directed towards fellow executive directors, most notably the Chief Executive. Thus, the process of necessary negotiation with intemal stakeholders, such as middle managers, of a role for Personnel (Bamett et al, 1996) was not evident in this case. That, *'we did not consult middle managers much'* [Director of Personnel], reflected a lack of awareness, by the Director of Personnel,

that middle managers can significantly influence the realisation of the aspirations of the Personnel function. Only with local pay did Personnel recognise the influence of stakeholders further down the organisation and engage in persuasive argumentation (by allowing employees to opt back to Whitley should they wish). What was evident was that the Persormel function aspired to take on a stiategic role in many instances but that reahsation of its aspirations around all HR issues proved difficult in the face of middle manager influence. In the next case (chapter 8) that the Personnel function used 'influencing techniques' to negotiate a role for itself with intemal stakeholders, such as middle managers, is more evident.

In CCHT, one mechanism by which middle managers could be included in strategic change was through their relationship with the Personnel Advisors, who were located in the Personnel Department. The Locality Managers themselves expressed a desire that someone from Persormel come out from the centre and works alongside them to provide support and advice. Yet the Persormel Advisors remained wedded to the corporate centre and to the vision and philosophy of the Personnel Director. A consequence of this is that instead of being 'out there' in operations, they worked in the physically remote (from operations) corporate centre.

Finally, CCHT did not employ any medics. The strongest professional group employed was dentists and the Medical Director was recmited from their ranks. The interaction of middle managers with the medical group was through contracts with GPs. However they were small in number. As a result middle managers potentially could enjoy a greater influence on strategic change than in Florence Hospital. The realisation of this was most notable, as discussed above in the area of skill mix, where

middle managers developed and implemented different models of service provision. While nursing also represented a strong professional group, that Locality Managers had nursing backgrounds meant nursing concems were linked with managerial initiatives so that resistance from this group was mediated. However, while medical group influence may not come directly through employees of the tmst, it may come indirectly through the ability of GPs to define service provision offered. This was an area that went unexplored in the CCHT case and therefore, may be profitably explored further.

7.3.3 Organisation Structure and Organisation and Management Development

Cmcially, there was a lack of emphasis upon management development. This was cmcial because the most important competency for a Persormel fimction is that it should develop the capacity to change in an organisation (Ulrich, 1997). That there was a lack of investment in maangement development may be due to calls for cuts in management costs by the centie at national level. Again the influence of central intervention and inconsistencies in this (since general management had been emphasised and elaborated prior to this as is evident in chapter 2) appeared a significant constraint upon stiategic change. That Personnel put little effort into developing middle managers had an adverse impact upon the reahsation of human resource strategy, as illustrated in the cases of local pay, recmitment and selection and skill mix above. The 'sophistication', for want of a better description, of the middle managers was insufficiently developed so that they were not proactive in bringing in the Persormel function, beyond its role in industrial relations issues, to solve operational problems. Middle managers appeared to lack a broader perspective that

would allow them to take on a more strategic frame of mind. What management development there was focused on equipping the Locality Managers with technical competences, such as negotiating skills, to help them deliver operations, rather than raise their awareness of and contribution to strategic change.

As a result, middle managers were less able to realise a role beyond implementing deliberate strategy and within this, constrained by the approach adopted by the Persormel function, their role was limited since they had little discretion to determine means. The Floyd and Wooldridge typology (Floyd and Wooldridge, 1992, 1994, 1997) suggests that realising strategic change through an enhanced role for middle managers may be beneficial for organisational performance. However, in this case an enhanced role was not realised. On the one hand, middle managers lacked the skills and knowledge to initiate Personnel involvement in solving their operational problems. On the other, they also appeared unable to influence Persormel's perception of operational problems through 'synthesising information' (Floyd and Wooldridge, *ibid.).* If management development had been forthcoming they may have been more able to take up a role such as 'synthesising information', so that they could then take up a 'championing alternatives' role. In such a way, strategic change was more likely to match the operational context in which middle managers worked. Altematively, they may have influenced strategic change so that it diverged from the corporate vision in a role of 'facilitating adaptability' (Floyd and Wooldridge, *ibid.).* Any such potential for an enhanced, middle manager role may have been lost because of a lack of investment in their development.

There may have been a good reason for de-emphasising management education in the short-term at least. Resources were limited since efficiency gains had been called for in management costs. As a result the Personnel Director was adopting a view that a politically more acceptable altemative to further job losses for middle managers (only around half of the District Nurse Team Leaders obtained Locality Manager posts in the re-stmcturing) was to cut the management development budget. Therefore management development bore the bmnt of efficiency gains in management costs.[51]

Unsurprisingly, in the face of a limited resource to promote the development of managers, he de-emphasised the Personnel role in this area. Further there was little expertise in the Persormel fimction in this area. Instead, the Persormel Director claimed that responsibility for the identification of development needs and providing solutions to perceived needs lay with the Operations Directorate. His view appeared to be that the management development arena represented an unreceptive context for Personnel to make an impact (Pettigrew et al, 1992) and that, therefore they were not going to attempt to drive strategic change in this area. The examples that Locality Managers gave of the limited management development provision, were mainly courses funded and developed by the Operations Directorate.

Organisational stmcture also inhibited inclusion of middle managers in strategic change in CCHT. Locality Managers concentrated on delivering health care in their geographical 'patch', perhaps influenced by their previous role of a District Nurse Team Leader. Such delivery took place from health centres, each health centre being physically distant from the others (for example, five miles). Very rarely did Locality

[51] The budget held centrally for management development was 'small' (£20,000), which for instance could fund four part-time MBAs of six Diplomas in Management at the local universities).

Managers meet with each other on a formal basis and share best practice. In addition, their boundary-spanning with other functions tended to be through advisors dedicated to their geographical patch - for example, Personnel Advisors or Finance Managers. However, as discussed above, Personnel Advisors were closely aligned with the corporate centre rather than with the operational periphery. The interaction between middle managers and Personnel Advisors was mainly through the formal monthly meetings between the Locality Managers' group and the Persormel function. Even more rarely did middle managers span the boundary between the organisation and environment. Probably the only time they did this was in the 'loose' relationship they had with GPs in their area, particularly those based in the health centres in which the Locality Managers had their offices. In this relationship, however, they were probably sub-ordinate since the medical group may regard itself as above the concems of general managers.

Other aspects of organisational stmcture did not support the intended strategic change (also see section 7.3.2). Those who formerly headed up District Nurse teams were those who subsequently became Locality Managers (albeit there were fewer Locality Manager posts than District Nurse Team Leader posts). One of the main changes for them, in moving into Locality Manager positions, was that they had to manage beyond the district nursing boundary. This was a role they were stmggling with, which meant that some lacked confidence to initiate change that impacted across professional boundaries, such as horizontal skill mix changes (although it should also be noted that this was a significant area of influence for some other Locality Managers (see section 7.3.1).

7.4 Summary of CCHT Case

In this case middle managers were excluded from the formation of strategic change. This was a result of characteristics of inner context inhibiting their inclusion. Firstly, a top-down plarming approach, in which transfer of generic practice was embedded, was taken to strategic change. As part of this formulation and implementation of stiategic change was separated with middle managers being confined to the latter. The issue of centre-periphery relations was related to this. In CCHT, the Persormel function 'chose' to take on the role of strategic change-maker (Storey, 1992) in local pay and to an extent around other issues, such as recmitment and selection. In these the Personnel function formulated strategy in isolation. It did not seek to involve other stakeholders in this, most notably middle managers. Cmcially, the influence of middle manager resistance, upon the reahsation of the aspirations of Personnel, went unrecognised.

When 'choosing' what human resource policies and practices to adopt, the Personnel Director, influenced by previous success at another community tmst (claim in interview by Director of Personnel), tried to implement generic models of best practice from the field of personnel management generally, such as a single pay spine, competence-based recmitment and selection and NVQs. To the middle managers, such generic frameworks represented a straitjacket and were not suitable, as they stood, to the NHS context. Yet their views were not sought as to how they should be modified at the formulation stage. Thus, where they could, particularly in the cases of recmitinent and selection and skill mix, middle managers either ignored the generic frameworks or modified them.

That attention should be paid by the centre, at the organisational level, to negotiating stiategic change with middle managers (Bamett etal, 1996), rather than it being a matter of choice, was illustiated in CCHT, where the middle managers had a significant influence upon the realisation of the intent of the Personnel function. Knowledge of the clinical and operational context gave the middle managers in the case a particularly significant influence upon realisation of the change in the area of human resources and impacted upon the role that the Personnel function could adopt in relation to issues. In addition, most notably in the area of skill mix, there were suggestions that the middle managers can take on a more influential role regarding the realisation of strategic change, beyond resisting the implementation of deliberate strategy. However, even within this role middle managers' influence was limited due to an approach to strategic change by the Personnel fimction that tightly prescribed both ends and means.

In CCHT the conditions to allow for an enhanced role for middle managers in the realisation of strategic change were absent. Firstly, there was a lack of emphasis upon management development. As a result, middle managers appeared to lack a broader perspective that would allow them to take on a more stiategic frame of mind. Secondly, stmctures in the organisation did not necessarily support the intended strategic change because there was a lack of boundary-spanning opportunities for middle managers. Instead, Locality Managers, influenced by their previous role as a District Nurse Team Leader, concentrated on delivering health care in their geographical 'patch', while Personnel Advisors tended to work within the corporate centre rather than with operations.

These issues raised in the case of of CCHT will be considered in comparison to the outcomes of the next case - Edwards Hospital - at the end of chapter 8 (see section 8.4). Before this cross-case analysis, the thesis discusses a within-case analysis of the role of middle managers in Edwards Hospital in the realisation of human resource strategy.

Chapter 8

The Role of Middle Managers in Human Resource Strategy at Edwards Hospital

8.1 Introduction

This chapter examines the case of human resource strategy at Edwards Hospital. It enjoys the benefit of understanding gained from previous cases, particularly that of human resource strategy at CCHT. It elaborates upon the themes that emerged from the case of CCHT represented in chapter 7. In the last case, human resource strategy at CCHT, there was a strong element of top-down rational planning in evidence. This militated against any middle manager role beyond the implementation of deliberate strategy in which their influence was limited because executive management set the ends and means of strategic change. The case of human resource strategy at Edwards Hospital is different. Even early in, during negotiation of access at Edwards Hospital, the case of human resource strategy here appeared to offer the opportunity to illustiate an enhanced role for middle managers and to identify the necessary conditions for this. It is these issues that this chapter concentrates upon.

The sensitising framework for analysis is outlined in section 7.1, an elaborated version of which can be read in chapter 3. The literature that investigates the research question of the role of the Personnel function in strategic change generally and specifically in the NHS is outlined in section 7.1.1. Rather than go through this again,

the reader is reminded that the following theme was emphasised here - that the Personnel fimction is subject to influence from other stakeholders, most notably middle managers. In addition the role of being strategic is not a matter of choice for the Persormel function, but is further compromised by extemal constraints, such as government intervention (Guest and Peccei, 1992, 1994; Bach, 1994). This heightens the importance of the relationship between the Persormel function and middle managers and has been highlighted in the human resource management literature (Poole, 1990; Sisson, 1990; Storey, 1992). The impact of the extemal constraints may be overcome by Personnel realising its intent through negotiating its role with middle managers (Bamett et al, 1996) and managing through middle managers (Ulrich, 1997).

This chapter culls data from 4 human resource interventions. These were - Investors in People (IIP), organisation and management development, skill mix, and sickness and absence policy. Given the pre-understanding by the researcher brought to bear upon this final case through a process of successive cases (Eisenhardt, 1989), themes were clearly identified a priori, which the researcher investigated. Therefore, rather than deal with data under headings that reflect the substantive human resource issues, it is brought together under themes of - the role of middle managers in strategic change, the influence of centre-periphery relations upon this role, the influence of inner context. Given this slightly different stmcture, rather than have a discussion and summary of the case as in chapter 7, following the representation of data, there will be a summary of the Edwards Hospital case and then a cross-case comparison with CCHT towards the end of this chapter.

8.1.1 Edwards Hospital and its Personnel Department

Edwards Hospital is an acute hospital. fts budget at the time of the research (1997/98) was £114 million. It employs around 5000 staff. The stmcture of the hospital is slightly unorthodox when compared to other similar hospitals. For example, in comparison to the Florence Hospital (chapters 5 and 6), which was structured around 6 clinical directorates, Edwards Hospital is stmctured around 32 clinical directorates and 5 non-clinical directorates. As a result the organisation is 'flatter' but there is a relatively large middle management group (57 'middle managers').

That those who constitute the middle management group varies between organisations is illustrated here. In contrast to the Florence Hospital, where the 6 Clinical Directors were positioned as part of an executive management group, in the face of the large number of directorates, Clinical Directors in Edwards Hospital are considered to be part of the middle manager group. The 32 Clinical Directors are positioned as linking pins to an executive management group, which they are connected to via a Medical Director. Representatives of the Personnel function emphasised this and the Clinical Directors also agreed that they were middle managers. Besides the 32 Clinical Directors, in addition 13 Specialty Managers and 12 Nurse Managers were also considered to be middle managers by the researcher, by the Human Resource Department and by the managers themselves. The Clinical Directors, Specialty Managers and Nurse Managers came together in a tripartite arrangement to manage the clinical directorates in a managerial arrangement, in which it was claimed by the Director of Human Resources, that none of the three was subservient to the other. The reader might have noted that this reflects the consensus management arrangements

prior to the implementation of general management through the Griffiths Report (DHSS, 1983).

Middle managers were interviewed in three directorates of the hospital. Two of the directorates were clinical - Theatres and Oncology - while one was non-clinical - Operational Services.

Theatres dealt with out-patients and in-patients 5 days per week based upon a 9am-5pm working day. Besides the medical group, the two main groups of employees here were nurses and theatre practitioners (called Operating Department Assistants in Edwards Hospital). The latter essentially carried out a similar job as nurses but were subject to different pay and conditions. A major intervention in this area was the Theatres Project[52]. This involved amalgamation of the nursing and theatre practitioner groups and harmonisation of terms and conditions. This was achieved by implementing competence-based job descriptions and a local pay scheme associated with this.

Oncology was an area of cancer care and rehabilitation. There were two main groups of workers here. One group was that employed in Medical Physics. They were responsible for radiotherapy. This group was highly qualified. At the technician level, many were qualified to degree level. Beyond the technician level employees tended to have postgraduate degrees. The other main group of workers was a group of specialist nurses, who tended to be placed towards the top of the nursing scales, although there was a significant number lower down the scale who could not progress because of low

tumover of those further up the pay scale. In addition, there were others, who supported the specialist nurse work, who had been trained via a competence-based route to a lower level of nursing competence.

The non-clinical area of Operational Services managed employee groups cormected with laundry, porters, domestics and sterile services. Although this area was heavily unionised, in most areas, it was not professionalised.

The Persormel fimction was called 'The Department of Human Resources' (henceforth referred to as the HR Department) and was headed up by a Director of Human Resources. His career had always been in the Health Service in some capacity. He had a place on the Board alongside five other Executive Directors and the Chief Executive. He did not have voting rights at Board meetings although *'it rarely came to this'* (Director of Human Resources). The Board was supported by five non-executive directors, one of whom took up responsibility for Persormel matters. A working group concemed with Persormel matters provided advice to the Board. Both the Director of Human Resources and the non-executive director with responsibility for Personnel matters were prominent members of this working group, which also included middle managers. The Director of Human Resources concemed himself, in the main, with building and maintaining influence with his fellow Board members, the medical group and extemal stakeholders, including the Personnel community in the NHS - for example, through a significant role in the Association of Healthcare Human Resource Managers (AHHRM). Much of the responsibility for day-to-day Personnel matters in the operational directorates and the relationship between the

[52]The Theatres Project sought to bring 2 work groups together- nurses and theatre practitioners- into a single work group. This would make rostering easier and facilitate flexible working. The 2 groups were brought onto a single pay spine, outside the

Personnel function and middle managers lay with the Personnel Manager, who reported into the Director of Human Resources and deputised for him when necessary.

The Personnel Manager, prior to coming into the NHS three years ago, had been a Personnel Manager for the National Coal Board. Into the Personnel Manager reported three Persormel Advisors, who were attached to 'patches' within the hospital. In contrast to the Persormel Advisors in CCHT, they spent much of their time out in the directorates to which they were attached, working alongside middle managers.[53] There were a number of other posts, specialist (such as the Medical Staffing Manager and the Manpower Information Officer) and administrative/secretarial. Of particular interest, given the lack of emphasis upon organisation development and management development in CCHT, is that there was a specialist post of Organisation and Management Development Manager, who reported directly into the Director of Human Resources. An Organisation and Management Development Advisor reported into her. Stmcturally at least there appeared to be more emphasis upon organisation development and management development in Edwards Hospital.

Current Human Resource Strategy was set out in a document - 'Human Resource Stiategy 1998-2003'. This document had been preceded by various others, which related to specific policy areas, such as the 'Stiategy for Management Development, Organisation Development and Training' produced in 1992 and 'Sickness and Absence Policy' produced in 1996.

Whitley framework, for this purpose.

8.2 The Findings

In Edwards Hospital, middle managers were included to a much greater extent in strategic change than was illustrated in the cases of the Florence Hospital and CCHT. In contrast to the previous cases, in the main, the views of middle managers were congment with those of the executive management in the corporate centre. Data is organised, as was explained earlier, under the following themes - the role of middle managers, the impact of centre-periphery relations upon the role of middle managers, the influence of characteristics of irmer context upon the role of middle managers.

In the first theme, the discussion of the role of middle managers is framed by the Floyd and Wooldridge typology (Floyd and Wooldridge, 1992, 1994, 1997), as outlined in section 2.3.1. Secondly, the theme of centre-periphery relations focuses upon two levels at which relationships are important in relation to the role of middle managers - govemment-tmst relations and executive management-middle management relations. Embedded in discussion of these issues, the characteristics of strategic change that facilitate an enhanced role for middle managers are also considered. When discussing the third theme the operational problems that middle managers face have a bearing upon their role in strategic change. Should a strategic change initiative be ill-matched to operational context in the middle managers' eyes then they were more likely to resist its implementation. Further, in this section, the existence of two broad supporting mechanisms for enhancing the middle manager role

[53]This difference may have due to to the geographical dispersion of services provided by CCHT compared to services provided in Edwards Hospital, which were mainly provided on the same site. As a result, in Edwards Hospital, it was relatively easy for

was evident in Edwards Hospital. Firstly, despite financial constraints, significant effort and resources were committed to developing organisational and individual capacity to change, particularly when it is compared to CCHT (see chapter 7). Secondly, organisational stmctures facilitated an enhanced role for the middle manager. Both of these supporting mechanisms are discussed in detail.

8.2.1 The Role of Middle Managers in Strategic Change

ft could be argued that the role of middle managers in Edwards Hospital remained mainly that of implementing deliberate stiategy, since they worked to themes set out in stiategy documentation. However, it was evident that in many cases their role was enhanced beyond the implementation of deliberate strategy illustrated in the CCHT case because in Edwards Hospital middle managers were allowed discretion to set means by which broad ends were realised. This was particularly well illustrated in the skill mix but also the sickness and absence initiative and the local pay initiative, particularly the Theatres Project.

The Theatres Project illustrated how middle managers can be included in strategic change in a way that enhanced their role. At least initially, the HR Department, in a drive to ensure consistency across the hospital, wanted directorates to implement a generic framework. However, in Theatres, as well as other areas, middle managers were able to resist the generic pay and conditions frameworks, on the basis that they didn't fit operational context. Middle managers in this area stressed that:

Personnel advisors to meet face-to-face with middle manager as required.

'What we needed in Theatres did not run with what Human Resources wanted to run. They kept saying, 'it was for the whole hospital' and we said, 'well, it won't work for us. We 'll have to be an exception on this one.' So there was an argument around that because I think there was a feeling that they had designed it for the whole hospital and they didn't want us to come in and change it all so it then was useless for the rest of the hospital. But equally it wasn 't any use to us in the state it was in, a lot of if [Clinical Director: Theatres].

Eventually, in the face of middle manager resistance, and against the backdrop of local pay no longer being emphasised by the Government, the HR Department allowed the middle managers significant influence over local pay and conditions developed for the area. Middle managers in Theatres developed a single pay spine for Theatre Nurses, Theatre practitioners [ODAs] and ancilliary staff in their area:

'We decided there would be several bands, gave them numbers and fitted 170 staff into it. The majority of our trained nurses fit into band 6, which is the old nursing grades of D and E. Our direct entry ODAs come in here [demonstrated on chart as five], which is a massive jump when they are qualified. Porters, auxilliaries and clerks fit into band 2. We haven 't got charge hands, the old A&C [Administrative and Clerical] 3 grades who might go into band 3 and we don't use 4 at all' [Nurse Manager: Theatres].

As well as contributing towards the content of local pay and conditions, they also contributed towards development of the processes by which implementation of local would be managed.

' We [Specialty Manager and Nurse Manager] made up the appeals mechanism for those who didn't agree with their new pay and conditions' [Specialty Manager: Theatres].

However, the need for middle managers to have a close relationship with the HR Department because of the many on-going issues about which they needed advice or support, meant that the HR Department could play a significant role in shaping local pay and conditions frameworks from the inside:

'On one hand they only provided advice when we wanted it, but both Simon [Personnel Manager] and Pete [Personnel Advisor 1] did much more than that They helped me think through the different points on the spine and what we should expect from nurses placed here' [Nurse Manager: Theatres].

In addition, their close involvement with the Theatres Project allowed the HR Department to take lessons teamed from the Theaties Project across the hospital, thus fulfilling a boundary-spanning role:

'We've got some plans to move into another four or five areas and use the corporate framework and to use the Theatres success to evaluate it and see how we can move local pay forward in these other areas' [Personnel Manager].

Connected to the Theatres area was a newly built Patients Hotel. An enhanced role for middle managers in this area is illustrated. One of the reasons for this was that the '*greenfield site'* [Nurse Manager: Outpatients] represented a receptive area in which they could make an impact since antecedent policies and practices that constrained any initiative were absent:

'The Patients Hotel was a great opportunity for me as a manager. We could do what we wanted. There was none of this, 'we've always done it this way around here [Nurse Manager: Outpatients].

As a result, when Personnel asked for areas to volunteer to be pilot sites for IIP, middle managers in the Patents Hotel put themselves forward. :

'We had done most of the things required for IIP, such as having the systems and records in place relating to training and that we were constantly evaluating our practice, equal opportunities, all that sort of thing ... I suppose where it helped was that it brought everything together that we [local management] had developed' [Nurse Manager: Outpatients].

In relation to skill mix, the Human Resources Strategy (1998-2003) set out a key theme of 'encourag[ing] more flexible working practices aimed at the delivery of quality patient care' within which the main objective was to 'create new roles and review boundaries between jobs on the basis of service needs and effective delivery of care to patients'. The middle managers enjoyed an enhanced role in two ways in relation to this strategic theme. Firstly they had been included in the development of these strategic themes, as discussed in section 8.2.2(b) 8.2.3(c). Secondly they elaborated upon these broad themes so that they fitted operational context and developed the means by which such ends were realised. That skill mix was initiated by middle managers was apparent in both non-clinical and clinical areas. In the former it seemed fairly straightforward:

'There's one or two various pockets where we're [middle managers] breaking down traditional boundaries that usually surrounded jobs. We've now implemented an integrated distribution team in Laundry. Between Maternity and the canteen, we've implemented a fiexible working arrangement, where we've got people who wash plates or waitress trained to cover portering jobs when it's needed' [Operational Services Manager].

It was also common in clinical areas, where it had to be done by those with the relevant clinical knowledge since it's a matter of clinical protocols, *'about which the HR Department has scant knowledge'* [Oncology Manager]:

'The Nurse manager at Charles House, she wanted to change the emphasis from a nursing-led environment to a rehabilitation-led environment, which meant a quite radical change of role for a number of staff The initiative came from the manager. She had a vision of the future and asked me, 'this is what I want to do. Can it be done?" [Personnel Advisor 2].

In another example - Outpatients - the Nurse Manager introduced a new role, 'Outpatients Assistant', whose position is dependent upon acquisition of an NVQ

Level 2 qualification but who could progress to NVQ Level 3. This new role replaced and enhanced the role of the old Nursing Auxiliary grade. Alongside this highly tiained staff were reduced in number and Senior Sisters were asked to apply for their own jobs which were reduced in number. The role of the HR Department was limited to one where they handled the industrial relations fallout.

In yet another area, Cancer Services, the need to consider changing skill mix was due to acute overspending. Here the middle manager made the decision to re-profile the workforce so that it was fewer in number but more highly skilled. This decision was made with advice from the relevant professional body, the College of Radiotherapy, who provided benchmarking information. In many other areas professional bodies also have an influence upon the skill mix process. For example, the Sterile Services Manager and the Radiotherapy Manager described their main source of advice regarding skill mix, as being their professional bodies. However they conceded that the HR department brought information to their attention about what was happening in other areas of the hospital.

An enhanced role for middle managers was also illustrated in the development and implementation of the sickness and absence policy since the means by which sickness and absence were reduced was left to the discretion of middle managers. There was a drive to reduce sickness and absence initiated by executive management, following collation of statistics about the issue that showed relatively high sickness and absence particularly in some areas. The executive management set a sickness and absence figure of 3.5 per cent (the same as in Florence Hospital) towards which directorates had to aim, but within which middle managers were free to respond differently. The

result was a range of interventions, initiated by middle managers, which varied across directorates, and through which emergent strategic change was realised. For example, teamworking[54] emerged in Operational Services as a mechanism for reducing absenteeism:

'The reason we've encouraged teamworking is that within one of our areas, Estates, their sickness absence has dropped considerably. One of the factors the Estates Manager felt had helped was the fact that his staff now work in teams within a directorate. I think this has helped them attend work more regularly because they can see the results of what they do and if they're absent their colleagues will moan that they had to pick up their work' [Operational Services Manager].

In another area the Bradford Index[55] is adopted to highhght cases in which the local middle manager should intervene. The adoption of this was a result of the Persormel Advisor bringing it to local management's attention:

'Pete [Personnel Advisor 1] had done a lot of work using the Bradford Index to record sickness and absence but I've tended to use the corporate formula. What we do in the areas I cover is pull a print of people who have had four or more spells of absence in the past six months and focus upon them' [Persormel Advisor 2].

In another example:

' We 've come up with our own sickness and absence management system. We do a number of different things. We want to change the culture from one of blame. We don 't question whether the sickness was genuine but are concerned with causes and patterns. Is there any stress in the workplace that's contributing to this? We look at it in a supportive way rather than an antagonistic way' [Nurse Manager: Oncology].

While there are many illustrations of an enhanced role for middle managers, middle managers influence in resisting any deliberate strategy should not be overiooked.

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[54] Teamworking in this case reflected the definition of teamworking described by Buchanan and McCalman (1989) and Mueller and Purcell (1992), the main charcateristic of which was that the team is self-managing, self-organising and self-regulating.

[55] The Bradford Index is a statistical software package, which highlights cases of absence that should be followed up by middle managers.

Even where middle managers worked within broad indicators, which set ends only, they exhibited resistance where they felt that ends were ill-matched to context. On one hand they supported the national drive for reduction in absence rates, which had been taken up by the tmst. On the other hand they criticised its cmde application. They regarded the absence targets set as something broadly to aim for but felt that they were rather over-optimistic. What irked the middle managers in particular was when they were criticised for high absence figures that they could do little about. They claimed that a relatively high absence figure for their area was due to genuine long-term absence, for instance, or that they had a high workforce age profile or a small workforce. Such contextual differences need to be recognised. For example, one middle manager commented that:

'*Sickness and absence percentages are unfair on departments which only have 2 or 3 staff rather than 200 or 300 hundred staff ... also we've had people in a small team long-term sick for the full 12 months. That can make your sickness and absence look bad '* [Sterile Services Manager],

In addition performance indicators regarding absence which managers are subject to should not be examined in isolation:

'/ don't think the crude target of five person days per quarter is very helpful. I have said this before particularly because of the way it's presented at the Board, in isolation to other indicators. What's the purpose of it? To show morale in the organisation? In which case it's only one indicator. Also, we've found managers coding wrongly, sometimes deliberately so that absence is less' [Director of Corporate Services].

8.2.2 Centre-Periphery Relations

8.2.2 (a) *Government, Region and District*

The Director of Human Resources emphasised that there was an, *'ongoing tension between centralism and devolution'.* This was best illustrated in the move towards local pay arrangements. Initially such a move was high on the national agenda for change in the NHS. As a result of this the HR Department, in line with the corporate objective that NCH be seen as a high profile progressive tmst, led the move at tmst level towards local pay arrangements. To begin with this was a top-down initiative, *'driven by HR'* [Director of Human Resources]. And this was a stance which felt *'lonely'* [Personnel Advisor 2] at times. Middle managers recognised that the HR agenda in this area was a result of the national climate but remained unhappy that there was little discretion for them:

'You have to think of the operating climate at the time. When this was coming out it was still early in the brave new world of competition. It was a chance for the trust to make its mark nationally and be at the cutting edge. It was something for HR to really grab headlines over and they pushed it But one of the things that very quickly started to go wrong was the extent of centralist intervention versus local freedom. The actual freedom the government gave you was about 0.5%' [Director of Operational Services].

Some executives and middle managers felt that, following the election of a new government, national policy had changed and local pay was no longer emphasised. Currently it appears unclear what the new government wants to do with NHS pay arrangements[56]:

[56]The current government is proposing that core conditions, pay spines and job evaluation will all be set on a UK-wide basis. But local employers will be responsible for job design, have the freedom to set pay bands, and to make decisions about pay progression which would replace automatic increments (reported in Health Service Journal, 23 September 1999 pp.10-11).

'It's not fully clear what the position at national level is. There seems to be different ways of saying 'yes' to local pay but on the other hand, there's the view that national bargaining arrangements should remain' [Chief Executive].

In addition, as discussed in the previous empirical cases (chapters 5-7) and in chapter 3, which set the policy context for the NHS, the policy backdrop was one of financial constraint and central government requests for year-on-year efficiency gains. The HR Department highlighted the impact of financial constraint upon strategic change:

'It's all about the bottom line today and not necessarily investing in the future. I believe in the longer-term, over five or six years, we could save thousands of pounds by introducing harmonised pay and conditions into nursing by reducing turnover, vacancies, induction but it isn't real money this year. That's the over-riding priority — cost not benefit' [Persormel Manager].

As an illustration of a 'bottom line' emphasis, the impact of financial constraint was most obvious around the implementation of local pay:

'If we were to go further with a single pay spine then the cost of doing that in the short-term has to be balanced against long-term benefits. We have to be sure we can afford it in the short-term. If it proves highly beneficial in Theatres we 'll roll it out but it's very expensive then we won't unless we were being pushed nationally' [Chief Executive].

On one hand, such tight prescription regarding finance may lead to a middle manager role of merely implementing deliberate strategy as illustrated in previous cases (chapters 5-7). On the other hand, in the case of Edwards Hospital, financial constraints gave middle managers some additional influence within this role, to argue against local pay because they were more able to work out the financial implications within their operational areas. For instance in Operational Services the HR Department *'pushed hard on it [local pay]'* [Operational Services Manager] in the

early days of tmsts being encouraged to go down that route but middle managers were able to resist this on the basis that they felt it was not affordable:

'We were highlighted, following the downsizing of Laundry, to be an area that should look at local pay. As a manager I felt pressurised into implementing it but I had too many concerns, particularly that we couldn't afford it. There was a very acrimonious meeting where they [HR] were push, push, push and I was saying that local pay was pushing me even further adrift of my budgef [Operational Services Manager].

As a result of the financial constraints facing the tmst, any local pay initiative *'had to make sound business sense'* [Director of Human Resources]. Therefore middle managers were more likely to be included in the formulation of strategic change in the area of local pay because *'middle managers input was required at an early stage so that a business case could be made'* (Director of Human Resources]. In addition government policy towards local pay remained uncertain and there was no centrally driven prescription in the area. Ironically, this appeared to encourage middle managers, rather than discourage them, to consider local pay as a solution to their problems in a more proactive way. As a result, both the direction and detail of local pay, in contrast to earlier days when it was driven by Persormel, was driven by middle managers:

'We decided what we wanted to do. We mapped people's salaries. We had meetings with our staff in which Human Resources were involved. We wrote forms and letters. This is the package. This is your offer [Theatres Manager].

'*So we went to the Board with the Theatres project fully costed - £30,000 best case, £60,000 worst case etc - and worked closely with Theatres management to ensure we met these figures. They [Theatres management] had to be involved right at the start because there was so much nitty gritty work to be done'* [Director of Human Resources].

The realisation of local pay was fiirther hampered by past policy, which instituted complex, national pay stmctures. This meant implementing change was difficult even where there was a will from the Personnel fimction to do so:

'The whole system nationally [Whitley structures] is Byzantine and it will take years to unravel this and to do anything' [Director of Human Resources].

In addition, further down the NHS stmcture, the District Health Authority, which was the organisation in which the Edwards Hospital had been placed before it became a tmst, had left working practices, which were now considered unsuitable:

'You have to remember that, although the organisation has been around for much longer, as a trust it has only been in existence for six years. So lots of employment policies, procedures etc were Health Authority ones that didn't fit what we were trying to do as an organisation. We must have done about 16 different HR policies and procedures over the last two and a half years I've been here' [Persormel Manager].

The effect of antecedent policies and practices was that the formulation and implementation of local pay systems went hand-in-hand so that any difficulties could be worked through. Since middle managers were those closest to the *'messy arrangements'* [Director of Human Resources], this was another reason to include them at an early stage of the development of local pay.

8.2.2 (b) *The Relationship between Executive Management and Middle Management*

At the organisation level there was also the issue of the relationship between the corporate centre - in this case, the HR Department - and the periphery - the Clinical and operational directorates and their middle managers. Both the HR Department, and

the middle managers in the directorates, attributed a dual role to the HR Department. Firstly, the HR Department was regarded as having an advisory role. Secondly, The HR Department was ascribed a role to ensure consistency across the tmst in the area of human resources.

Regarding their advisory role, the HR Department advises middle managers on what they *'can and can 't do'* [Theatre Manager]. In particular, advice is called for where there may be legal implications, such as in the case of disciplinary proceedings or redundancies:

' What happened in our laundry was that as a result of going to market we lost contracts. So we had to downsize and make people redundant. So I was almost parachuted in to handle this but I made sure Human Resources were alongside me so we didn't find ourselves before an Industrial Tribunal' [Operational Services Manager].

As one middle manager commented, *'to do things properly might involve the HR Department*'.

As well as an advisory role, the HR Department itself emphasised that it provides an umbrella strategy. This represents the corporate line to which operational managers must adhere in solving problems but one that is broad enough to allow for local discretion:

'Sometimes we have to tell the operational managers that the corporate line is 'x' and that is the 'umbrella' that we have to work around. We need to have some corporate line so that there is consistency in the trusf [Director of Human Resources].

The main fabric for such a role is the setting up of policy and procedures into which corporate and legal requirements are built:

'In recent times we've had a secondment policy, volunteers policy, equal opportunities policy that are all human resource strategy. All of these things have been discussed at executive level before, not necessarily before they've been known about by the whole hospital because there's often a two way approach to it - a top down and bottom up. If you like, policies are put into effect by directorates, but with the assistance of Human Resources' [Chief Executive].

It was also important that each human resource initiative was not seen in isolation to others. Middle managers suggested that one human resource intervention may be complemented by or lead on to another. For example, in Oncology:

'At the moment we are looking at a competency progression scheme for staff to address some of the recruitment and retention problems and training and development issues and we've [the Nurse Manager and Personnel Advisor] developed a draft framework but in order for that framework to be totally successful and be fully implemented then it will have to, at some point, be linked to local pay since the Whitley framework is too constraining' [Nurse Manager: Oncology].

Integrating actions and decisions made in the clinical directorates was seen as cmcial, as was the need to address some operational issues more broadly:

'I think it's a function of the devolved nature of management in the organisation, where we've actually devolved the responsibility for recruitment and retention and the budgets down to individual clinical directors and there are 32 of those. And I think we have resisted, in the past, having strategies that pull some of that back' [Director of Finance].

In addition, problems, such as the recmitment of staff, were common to many areas and may lend themselves to a common approach led by the centre:

'I keep hearing, everywhere I go, that managers can't get staff to do the job. That comes up every single time, so it's an organisation-wide issue that needs to be addressed' [Director of Finance].

This view was also shared by middle managers. Despite the contention that the HR Department is at the beck and call of the middle managers, middle managers also felt that the HR Department has an important role to play in ensuring consistency of approach across the disparate directorates by giving directorates *'a light to aim for':*

'The Human Resources Strategy is like the Finance Strategy. They've got to fit the corporate direction. And as the Finance people initiate the Finance Strategy, I think it's right that the Human Resources people initiate the Human Resources Strategy' [Operational Services Manager].

One of the main ways in which central functions such as the HR Department influence strategic change through middle managers is via strategy documents, such as the Edwards Hospital Human Resources Strategy 1998-2003, of which the researcher was provided with a copy. The strategy reflects the characteristics of an umbrella strategy, as laid out by Mintzberg and Waters (1985). Key themes were identified such as a flexible workforce, continuous development, employability, collaborative team working, integrated workforce planning, family friendly employment, open and supportive management, partnership, a healthy workforce and strategy implementation. There then follows some more specific objectives relating to these themes. These relate to ends rather than means. A statement within the strategy document outlines the role of the corporate centre and emphasises that middle management contribution is cmcial to its realisation:

'A strategy should describe a method of achieving certain aims and objectives as well as describing those aims and objectives. The implementation of the strategy is the responsibility of numerous managers within the Tmst who have responsibilities for human resources. There are certain aims that will only be achieved if corporate action is taken and the role of the Human Resources Department will be to ensure that action is taken when necessary and to give the appropriate support and advice to managers to enable the strategy to be implemented' (Human Resources Strategy 1998-2003: 3).

This statement did not preclude middle managers from taking up a role beyond implementation of deliberate stiategy. The broadness of the strategy framework allowed middle managers significant discretion to influence strategic change, albeit providing it was consistent with corporate stiategy (into which middle managers also had an input). A particularly significant feature of the Strategy for Human Resources, which was connected to this, was that it very clearly reflected the emphasis of the National Human Resources Stiategy (DoH, 1998). As with many other strategic subsystems, strategic change within the human resources area, was constrained within a national framework.

However, despite extemal constiaints, it was emphasised by executive management that a top-down approach to strategic change that emphasises the more formal elements of strategy and deliberateness, was likely to be unsuccessful:

'In the early days of local pay we drove it from the top but it didn 't address their [middle managers] needs and their objectives and therefore they felt that they couldn't support it and take it forward. We did set it up as a very corporate project because it was driven nationally. We did all the classic structural hierarchy things. In retrospect we would have done it differently' [Personnel Manager].

In order to alleviate the impact of extemal constraints, which might have forced a top-down approach from the HR Department, there were three main mechanisms for realising the Human Resource Strategy. Firstly, there was a close relationship between the Persormel Advisors and the middle managers. Secondly, there were Working Groups (for example, in relation to equal opportunities) on to which middle managers were co-opted. Thirdly, there was the Strategic Management Group and Hospital Executive Committee, which fed up to the Board (see section 8.2.3(c)).

8.2.2 (c) Middle Manager: Medical Group Interface

While the middle managers in Edwards Hospital appear to enjoy the most influence of all the middle managers across the three case studies, as in the case of Florence Hospital, their influence was also subject to limit because of medical group power. The Clinical Director of Oncology provided some illustrations of the interface between middle managers and the medical group that show, on the one hand that that the medical group remain dominant but on the other, show some scope for middle managers to influence change, particularly as it relates to their own professional group but also contributes to service re-profiling generally. Firstly, the issue of clinical freedom and the power it bestowed upon clinicians remained strong:

'It's still quite difficult to manage this business of the new NHS. It really imposes quite a lot of restrictions on what we used to call clinical freedom. It's quite difficult to encourage one's consultant colleagues, who feel traditionally that they are quite independent to tow the party line. "We can't afford to do that Can you stop doing those tests? An 't you use a different drug because the drug budget is overspent?'" [Clinical Director: Oncology].

Despite retaining clinical freedom to a large extent the medical group appeared willing to concede aspects of their job that required less expertise to other professional groups. This gave some scope for middle managers to influence service provision in areas previously reserved for decision-making by the medical group:

'We were one of the hospitals around the country to move to getting nurses to give intravenous chemotherapy rather than doctors. We were the first in the country to delegate a Therapy Radiographer to have a full-time job providing patients with information rather than doctors. As a management team, myself the Senior Nurse Manager and the Specialty Manager worked the new way of doing things ouf [Clinical Director: Oncology].

Even more scope for influencing strategic change remained in the professional areas other than medicine. In areas such as nursing, for example, medical group interference was limited to the power of veto:

'Ella, who manages the nurses, keeps a close eye on her skill mix and has tended to move to having slightly fewer but more highly trained staff I'm hands-off there. They are her staff and that part of the budget is allocated to her. If she keeps it in balance fine but if she runs into trouble I want to know' [Clinical Director: Oncology].

8.2.3 Characteristics of Inner Context

Strategic change was most likely to be realised where it fitted with operational context so that initiatives would help solve the operational problems that middle managers faced. This is taken as a first theme in this section. As a second theme, the influence of organisation and management development upon an enhanced role for middle managers is discussed. Finally, a third theme discussed is that of the influence of organisation stmcture upon the role of middle managers.

8.2.3 (a) *Solving Operational Problems*

Strategic change in directorates around human resource issues was not just dependent upon finance but was influenced by operational context generally. That operational context was cmcial to the realisation of changes was succinctly put by Personnel in relation to local pay:

'But there are still opportunities [for local pay] despite central government doubt In practice we 've come to appreciate that we should implement it on a local basis where there's good reason for it and where local managers will allow you to' [Personnel Advisor 2].

In terms of downward influence, when resisting the implementation of deliberate stiategy, most middle managers could lay claim to a uniqueness of service that others, outside the area, were unlikely to understand and meant that actions taken needed to contextually sensitive. Transfer of generic frameworks, for example regarding competences that were commonly linked to pay and reward systems, was argued against on the basis that frameworks did not fit operational context:

'I see the usefulness of competence as not so much in the knowledge areas but in the more managerial and supervisory duties. From our point of view, as far as the scientific and technical knowledge and duties are concerned, we feel it's quite clear what the issues are and what staff are able to carry out what duties. So rather than use a competence framework we have documentation in which there is a matrix of duties against staff, so it's quite clear who can do whaf [Radiophysics Manager].

Even within the same directorate, claims to uniqueness could be made which meant that there were differences in whether human resource initiatives were appropriate or not. In Oncology, for example, some argued [in the Radiophysics area] that local pay was inappropriate on the basis of its affordability in an area that has acute budgetary problems. However, others, for example in the nursing area of Oncology, argued that it may be appropriate because of recmitment and retention problems and the changing needs of service:

'I think there is a lot to gain [from local pay] not only in terms of remuneration, but also terms and conditions and being more flexible. We need that flexibility because of changes in the chemical mix of patients and also because where additional nurses might come from. They may be working mothers, single parents and need to be more flexible, part-time, work different hours' [Nurse Manager: Oncology].

In this latter case the inflexibility of the Whitley framework is seen as contributing towards problems rather than helping solve them. As a result of this a competence-based framework is being developed for nursing in the area. While local pay is not yet a feature of the area the Nurse Manager suggested it may be appropriate in the fiiture in conjunction with competences. Thus, despite a de-emphasising of local pay at national level, the intention is to push ahead with local pay in the area as it relates to the nursing group. This was being led by the Nurse Manager in Oncology with the Personnel Advisor working alongside her.

In Theatres the HR Department provided the initial impetus regarding local pay, encouraged by national policy, but it wouldn't have happened unless there were specific operational problems which local managers wanted to solve; for example, a need for flexibility. Any Government or Board policies were viewed as subservient to this, although convergence between corporate objectives and directorate operational problems helped:

'The motivation was that management in Theatres wanted to do something with the organisation of Theatres for a very long time. In the last few years a corporate structure project, led by Roy [Director of Personnel], was set up to look at what might be a feasible set of terms and conditions - lots of work over 2 years to provide a corporate model. So then, with the motivation being there from managers, and with a corporate model, that allowed us an opportunity then to move that forward' [Persormel Advisor 1].

Further, Theatre managers 'insisted' that local pay be implemented despite it being put on the backbumer nationally:

'A long time ago we wanted to do something about it and we were told, 'wait for local pay'. And we sat back and we waited. Nothing progressed. Eventually I think HR got tired of waiting as well and asked for pilot sites. So we said, 'can we be the pilot for

local pay?' because we really need to sort this problem of Whitley anomalies' [Theatres Manager].

In order to encourage teamworking, *'we would need to produce a rota that would work for both groups [nurses and theatre practitioners] of staff* [Theatres Manager] and pay and conditions would need to be harmonised. The results were:

'It has enabled us to be much more flexible with working. Because you can ask people to do extra hours without worrying about what their conditions are' [Clinical Director: Theatres].

However, despite a joint desire from both operational Theatres management and the HR Department that local pay be implemented in Theatres, the Persormel Advisor [1] described the implementation of local pay in this area as difficult in the area. There has been a long history of *'fudges'* [Personnel Advisor 1] created by the previous system and implementation took place within a context of considerable professional power and differentiated '*cultures*' [Persormel Advisor 1] of the theatre practitioners and nurses:

'What you don't realise until you get into it is all the fudges that have been made in the past, all the quick flxes, and eventually they all build up and are pushed under the carpet and then suddenly you lift the carpet and they 're all there ... local management need to be involved to sort these out because we couldn't '[Persormel Advisor 1].

8.2.3 (b) Developing Organisational and Individual Capacity to Change

The area of management and organisation development is seen as a specialist activity within the HR Department although many of the general human resource interventions are also complemented by an organisation development or management development element - for example, in the Theatres Project an organisation

development activity concentiated upon clarifying roles and responsibilities. The overall philosophy was described thus:

'The overall culture is that we want to empower managers to do as much HR as possible but because managers are all at different levels, we have to give them different support at different times' [Personnel Advisor 1].

Any organisation or management development activity took place framed by a policy document. An important document, which influenced much of current, as well as past, organisation and development activity, was developed back in 1992 - 'A Strategy for Management Development, Organisation Development and Training'. The document was produced by the then new 'Organisation Development' function and was a response to DoH requirements that required every hospital to adopt an approved management development strategy. As with the 'Human Resource Strategy (1998-2003)', produced by the Human Resource Department in Edwards Hospital, the framework was one of aims, objectives and values, which outlined broad ends, rather than any tightly prescribed means. Middle managers were given discretion to a large extent for the latter.

In the Edwards Hospital document, 'Stiategy for Management Development, Organisation Development and Training (1992)', it was evident that the Personnel fimction should manage through middle managers, while retaining some degree of control:

'This integration of development activity with normal managerial processes requires the adoption of a decentralised approach ... However, this approach inevitably involves the loss of central control and creates problems of co-ordination and duplication. In order to minimise these problems it will be necessary for the [Development] Unit to be clear about aims and priorities and to actively promote

them, as well as developing systems which foster the sharing of resources and information' (Strategy for Management Development, Organisation Development and Training, 1992: 5).

Further it stressed that development activity is, 'long term, forward looking and an essential part of normal management processes' (Strategy for Management Development, Organisation Development and Training, 1992: 2). While some readers may question the relevance of strategies developed in 1992, the researcher, in contrast argues that, such an emphasis is coming to fruition in the existence of a 'sophisticated' middle management group in Edwards Hospital, who are proactive regarding strategic change in the area of human resources. That earlier efforts in building individual capability had come to fruition was evident in claims that:

'Perhaps because I've been around for a while, I've been developed and I've worked closely with the Human Resources people, I know what they can provide. I involve them as early as possible' [Speciality Manager: Surgery].

Yet it was also recognised that efforts to build individual capabihties should continue:

'Although everything on paper is marvellous I think, in reality, because you 've got the old people in a new organisational structure there's probably still some learning that needs to be done' [Persormel Advisor 2].

Currently, IIP also provided an umbrella for integrating human resource initiatives that promote development:

'Part of IIP will be expanded in the training and development strategy - the continuous learning, continuous development theme with its emphasis upon individual responsibility as well as trust responsibility. This is a result of having some concerns about how we develop them in a flatter structure' [Director of Personnel].

Co-ordination of development took place through the Training and Development Steering Group, whose members included Executive Directors and middle managers, as well as representatives from the HR Department. In this way, development activity was integrated with corporate strategy, as well as being linked to the concems of operations, the middle managers being ideally placed to comment on the latter. To further improve co-ordination the intention of the Organisation Development Unit within the HR Department was to establish networks of staff involved in similar areas of work, so that '*collaborative learning could take place'* [Organisation Development Manager]. In addition, some development was discharged centrally - for example, certificated programmes such as the part-time Health Service MBA. In this example, Edwards Hospital along with a neighbouring hospital set up a Health Service MBA with two local universities. This was a significant investment when one considers course fees for an MBA (currently around £6000 per student) and that eight managers were sent from the Edwards Hospital as part of the first cohort of students. This initial cohort graduated around 1995. Since the MBA has started Edwards Hospital has continued to send its middle managers on the programme at a rate of around two per year.

Currently, a management development 'menu' exists from which local managers can select the appropriate interventions. The competence approach dominates the menu, following best practice as identified by the Institute of Personnel and Development (IPD). However, in contrast to Florence Hospital, generic models for management competences accredited by the Management Charter Initiative (MCI) are eschewed in some areas in favour of competence-based frameworks developed in a bottom-up way that are sensitive to individual directorate context.

There also existed a number of action teaming sets which managers can join. These had been set up to foster teaming at little cost beyond the managers own time:

' We ran some development centres and they actually enjoyed being together and they got a lot of support from each other. They wanted to continue meeting and we offered to facilitate it. Through these action learning sets we help them with whatever work issues they are dealing with and through using action learning principles helped them work through problems' [Organisation and Management Manager].

Ad hoc teaming, at little cost, also took place through the interaction of Personnel with the middle managers:

'We enable managers to take actions themselves. We've put a lot of time into individual managers and individual situations where we 've taken managers through a particularly difficult programme and spent a lot of time reviewing things afterwards so that they take on board the lessons for the future' [Personnel Advisor 2].

The Organisation and Management Development Manager also involved herself on an ad hoc basis with middle managers:

'There were some problems in Theatres about people not taking up their responsibilities and not knowing what was expected of them. For example, the Nurse Manager was only used to managing nurses. So we did some work on that with the managers, asking them what their expectations were and putting it on post-its, sticking them on a board, all that sort of thing' [Organisation and Management Development Manager].

Therefore, despite financial constraints, there was still a relatively large amount (compared to CCHT) of organisation and management development going on out in the directorates. For example, in the Hotel Services area of the Operational Services Directorate:

'There's a fair amount [of management development] available, both informally and formally. For example, we 've got managers doing MBAs. We 've got one on Managing Hotel Services, which is a Postgraduate Certificate. I've got two doing a general management NVQ4 qualification in-house' [Operational Services Manager].

It should also be noted that the HR Department was responsive to the impact of broader changes across the organisation. Currently, for example:

'I think, in terms of developing staff, as a consequence of having flatter management structures within the trust now, there are not the promotional opportunities that existed historically, for instance being a deputy. So we 're developing, for example, some sort of secondment policy, which enables people to gain experience in a different way' [Personnel Advisor 2].

8.2.3 (c) Supporting Organisational Structures

As well as effort and resources aimed at organisation development and management development, supportive organisational stmctures were put in place to facilitate an enhanced middle manager role:

'One of the things we 've got on the go at the moment is an organisation structure and process review. We 're looking at how we organise the hospital and whether the roles contained within that, whether they serve the purpose well or not. This is the third time we 've done such a review. We 're particularly concerned with whether the people within the structure, within the organisation, feel the organisation is working well for them or nof [Organisation and Management Development Manager].

One of the issues, recognised by middle managers that was fed into the review process, about the current organisational stmcture was that it made boundary-sparming difficult:

'The difficulty with the devolved structure, I feel, is that you don 't know what other managers are doing for their staff what terms and conditions they might be using for their staff and how it's working' [Radiotherapy Manager].

However there were other aspects of organisation stmcture, which did promote boundary-spanning. For example, in contrast to the situation at CCHT (see chapter 7), Personnel Advisors were positioned closely to the middle managers in the directorates. Middle managers saw this as one of the cmcial aspects of the influence of the HR Department:

'He's [Personnel Advisor] there whenever needed. There is also a formal monthly meeting and the Personnel Advisor is a permanent member of that meeting. I also have a one-to-one meeting in my diary with him to go through issues that are coming on board, as a two way process' [Specialty Manager: Surgery].

A particularly important role which Personnel Advisors fulfilled was that they brought to the attention of middle managers any initiatives taking place in other parts of the tmst thus providing a degree of lateral networking which the fragmentation of directorates mitigated against:

'They tell us, 'Theatres are doing this' and network across directorates so that each directorate doesn't re-invent the wheel but instead shares good practice' (Nurse Manager: Oncology].

'Our Personnel Advisor has been feeding back to us the different approaches to managing sickness and absence from other areas of the hospital' [Operational Services Manager].

Another role of the Personnel Advisor was to brief middle managers on environmental changes that they may have to be proactive towards:

'Our one to one meeting is an ideal time [for the Personnel Advisor] to brief me upon changes in policies at a national or European level It would be an ideal time to talk through European directives - what are they, is it going to affect us, what might we do to prepare?' [Specialty Manager: Surgery].

However, it should be noted that this relationship has taken some time to develop:

'There's still a fair amount of distance between the HR Department and managers out in the directorates. I think it could be closer and that's happening. They [Personnel Advisors] are changing their role a bit. They 're seeing you on a regular basis so you can go through anything you feel. Rather than being reactive you can be proactive' [Sterile Services Manager].

Apart from the forging of close relationships between middle managers and Persormel Advisors, the HR Department involved middle managers in the realisation of human resource strategy through membership of working groups, who passed comment upon draft policy. These provided boundary-sparming opportunities for middle managers:

'I have recently been on a working group - it's a cross-section of the hospital - that's looked at the Human Resources Strategy that will take us forward from 1998 forfive years, looking at corporate direction and objectives and how we need to develop the workforce to try to achieve that strategic direction. We looked at various drafts of the document and put our comments forward. We weren't actually writing from scratch' [Operational Services Manager].

In another example, a working group was set up specifically to consider local pay:

'HR showed us a model from Sheffield, which they thought was quite good and asked our opinion. From our comments that it wouldn't work because of this and that, they then went and modified if (Outpatients Manager].

In some directorates, project groups had been set up by middle managers to discuss issues that impacted across directorates. These also facilitated boundary-spanning:

'I've set up a Strategy Project Group with senior nurses in Oncology and we meet once a month. I see these people influencing the future direction of nursing within this directorate. And then I can take that to our bigger directorate meeting ' [Nurse Manager: Oncology].

'/ identified the key people who could help me [with skill mix], who knew what the processes were and obviously during that phase it wasn't necessarily important to have a Human Resources representative there but they [Personnel Advisor] were in the background giving advice when asked. So I had what you might call a process-re-engineering group and then when we had worked out the issues she [Personnel Advisor] was invited along to get involved in the nitty-gritty' [Radiotherapy Manager].

In addition the presence of professional bodies, rather than hindering strategic change, was positive because they provided boundary-sparming opportunities for middle managers:

'/ have strong links with the College of Radiographers. Because I was doing something [skill mix] that I thought was quite radical. I was looking to have four highly skilled radiographers working on one treatment machine over an extended day whereas others are looking at five or six. So I sought out support through the College [of Radiographers] to find out what's happening elsewhere and it gave me confidence that some others were thinking along the same lines'

And even where professional bodies might not exist, for example in non-clinical areas, middle managers formed their own networks to facilitate boundary-spanning:

'/ attend meetings of Operational Services Managers from other hospitals. We meet up once a quarter and talk about professional issues. And sickness and absence is always one of the things on the agenda because everybody struggles with it. And I do know some have picked up on ideas discussed and tried it in their own hospitaf (Operational Services Manager].

8.3 Summary of Edwards Hospital Case

8.3.1 Role of Middle Managers in Strategic Change

The role of middle managers in the realisation of human resource strategy was found to be an influential one. Middle managers, on one hand, resisted attempts at top-down change. On the other hand, they also contributed towards emergent human resource strategy in the face of operational problems by identifying where they wanted to go and how they would like to do it.

The influence of middle managers, beyond the implementation of deliberate strategy, as in CCHT (see chapter 7) was most evident in the area of skill mix (see section 8.4 for cross-case comparison). The clinical knowledge of middle managers allowed them discretion in this area and 'relegated' the role of the HR Department to that of providing advice around employment law issues. In combating sickness and absence, while ends were set in the form of percentage indicators, as we saw at the Florence Hospital (see chapter 5), middle managers adopted different means to attack the problem in different areas. They did not concem themselves too much with meeting the sickness and absence performance indicator set. For example, in some cases it was claimed to insensitive to context on the basis that an area had a unique workforce make-up. Instead the basis for their concem with sickness and absence was that there were significant amounts of 'casual' sickness and absence that should be eradicated so that health care delivery was better. Beyond this, middle managers were not concemed to bring sickness and absence down for the sake of meeting a performance indicator set by the corporate centre.

The most notable example of where strategic change was realised because middle managers felt a human resource initiative might solve operational problems, was the Theatres Project. The Theatres Project was illustrative of the inclusion of middle managers more generally in strategic change. In the Theatres Project, importantly, middle managers were allowed influence in the formulation as well as the implementation of the pay and reward system and the necessary re-profiling of the workforce. The role of the HR Department was one of initially providing a broad philosophy and framework around which middle manager discretion would determine the details. Even in this, middle managers from all areas of the hospital were involved as Working Group members. Then, subsequently in its implementation, Personnel Advisors assisted middle managers with employment law and other employee relations matters. However, it was middle managers who developed a single pay spine for the area and developed appeals mechanisms for staff

8.3.2 Characteristics of Strategic Change

Rather than go through the impact of centre-periphery relations upon the role of middle managers, it is more useful to emphasise charateristics of strategic change that were embedded in discussion of centre-periphery relations (sections 8.2.2(a) and 8.2.2(b)), which are relevant to the concems of this thesis. It should be emphasised that, at least in this case, such characteristics of strategic change, not only facilitated an enhanced role for middle managers, but also that strategic change was realised where such characteristics were present.

The area of local pay provided an interesting illustration of the inclusion of middle managers in strategic change beyond merely implementing strategic change. When local pay was driven in a top-down way by executive management, following government prescription in this area, middle managers' role was one of implementing deliberate strategy. However, they were able to resist deliberate strategy because they were closest to operations and could therefore present a case that showed it be financially unviable. Ironically the emphasis upon cost was also a result of government policy and this acted against the realisation of strategic change in local pay. When the government was less prescriptive about local pay but remained prescriptive about financial constiaint, there remained a need for any implementation of local pay to be cost neutral but there was no great impetus to implement local pay for executive management. In this case, local pay arrangements were often initiated at the request of middle managers, because they faced operational problems which local pay might solve - for example, in Theatres. Then having initiated it, middle managers had to work through the details of it with Personnel Advisors alongside them, so that a business case could be made. Further, antecedent pay and conditions arrangements required middle managers' knowledge so that they could be worked around.

In this way where the formulation and implementation of strategic change were intertwined and where strategic change was emergent as well as deliberate, strategic change was realised because it was sensitive to operational context. The latter was a resuh of middle managers being included in strategic change at an earlier stage than implementation and bringing their distinctive professional and operational knowledge to bear. Developing strategic change based upon operational concems, rather than

imposing best practice from the Personnel field that may take no account of context, appeared to more successfully realise strategic change.

More generally, the Personnel function has produced an 'umbrella strategy' (Mintzberg and Waters, 1985), which sets out a corporate line but whose themes are broad enough to allow for middle manager discretion in strategic change beyond the implementation of deliberate stiategy. The main aim of the umbrella strategy is to ensure consistency in the emergence of stiategic change throughout the tmst and to ensure that this is convergent with the corporate vision.

The broad themes to which middle managers must work were set out through strategy documents, such as the Human Resources Strategy Document 1998-2003 and policy documents, such as that relating to Equal Opportunities. The views of middle managers were also included in the development of such documentation through, for example, their inclusion in Working Groups, which drew up the policies. Even those who were not members of the relevant Working Groups may have found their views considered through Persormel Advisors, who continually fed back operational concems to the Persormel Manager and Director of Persormel.

Another example, of the way in which an umbrella strategy can work was provided by the call by Personnel for Investors in People (IIP) pilots. For the middle managers within whose remit lay responsibility for the Patients Hotel, IIP provided a coherent framework for strategic change in their area and one to which they could work in fiirther developing strategic change.

There are lessons for for the corporate centre to draw out in these illustrations. The approach described above meets concems raised in the HRM literature that the Personnel fimction should negotiate change with middle managers (Bamett et al, 1996) and seek to manage change through middle managers (Ulrich, 1997), rather than choose to take on a strategic role (Storey, 1992) without considering relationships with other stakeholders. An umbrella strategy approach provides a framework within which this process can take place but also one which ensures government directives are taken into account. Such lessons for executive management will be fiirther discussed in the final chapter.

8.3.3 Inner Context

8.3.3(a) *Operational Context*

Operational context was cmcial to the realisation of strategic change in the human resource sub-system. Whether deliberate strategic change was likely to be realised and the emergence of stiategic change influenced by middle managers in the directorates, intended or not by the Persormel function, was dependent upon it fitting with middle managers' perceptions of operational problems. As Pettigrew et al (1992) noted those perceptions can be influenced and context mobilised by the Persormel function to promote the legitimacy of their intentions in a process of persuasive argumentation. What seems more evident, rather than any explicit persuasive argumentation, was that the HR Department in Edwards Hospital was sufficiently aware, through the Personnel Advisors, of what were likely to be receptive contexts for change. On this basis it was able to promote initiatives accordingly.

By the same token, because the Personnel Advisors were close to operations, the HR Department was able to avoid putting effort into promoting initiatives where context was unreceptive. Only, for example, in the early days of local pay, did the HR Department 'push' initiatives in the face of unreceptive contexts such as that evident in Operational Services. That it attempted to do this was influenced by an extemal policy context that encouraged a 'big bang' approach to the implementation of local pay where it was implemented across the whole organisation in a top-down way. However, here, as might have been expected, middle managers were able to mobilise context to resist the implementation of local pay, drawing on both the extemal factor of government inconsistency towards local pay and the intemal one of budget deficit. Thus the 'big bang' approach to strategic change in the area of pay and reward was doomed to failure in many cases.[57] Therefore, the best way forward for the HR Department to realise strategic change in its area was to work through middle managers and to allow them influence in strategic change beyond the implementation of deliberate strategy.

8.3.3(b) *Supporting Mechanisms for Enhanced Middle Manager Role*

Apart from certain characteristics of strategic change being in place, such as that reflected by an umbrella strategy (Mintzberg and Waters, 1985), there were other conditions within Edwards Hospital that facilitated an enhanced role for middle managers. Most notably these were an emphasis upon organisation development and management development and appropriate organisational stmctures.

[57]This was a lesson that Edwards Hospital executive management were also to learn from the implementation of the Hospital Information Support System (HISS) - see Brown (1994, 1997) - since when they have adopted a more bottom-up approach that

In order to facilitate middle manager inclusion in strategic change in the human resource strategic sub-system, considerable effort and resources were devoted to organisation and management development. Most evidently, the HR Department appointed a specialist manager in the area of Organisation and Management Development and into her a specialist Organisation Development Advisor reported.

On one hand, some of the organisation and management development activity was formalised. The broad framework within it took place was set out by policy and there existed a menu of formal management development initiatives, in-house and extemal, to develop the individual capacity of middle managers. On the other hand, there was also a great deal of informal more emergent development going on. This ranged from ad-hoc teaming for middle managers in their interactions with Persormel Advisors to more obvious reactive interventions, such as when the Organisation Development Manager was brought in to work with Theatres managers in clarifying and developing roles, to emergent practices, such as the development of action learning sets.

In addition, there were organisational stmctures that supported an enhanced middle manager role. A notable necessary feature for an influential middle manager role is that there be boundary-spanning opportunities for middle managers (Floyd and Wooldridge, 1994, 1997). Such boundary-spanning was facilitated in the human resources area by the close working relationship between middle manager and Persormel Advisors.[58] As Personnel Advisors were able to tune into operational

has proved more successful - see Chartered Institute of Management Accountants project on this issue, based at Edwards Hospital, by Currie et al (1999).

[58] This was also a feature of other areas, such as Finance, where there was a Financial Advisor.

concems, so middle managers were able to tune into corporate concems and what was happening across the hospital, via their relationship with Personnel Advisors.

It was also likely in the Personnel Advisor-middle manager relationship that operational concems were fed back to the corporate centre and that these concems helped shape formal strategy. As well as membership of Working Groups described previously, middle managers in some directorates had been proactive to the extent that they set up their own Project Groups to shape strategic change in their area. Finally, middle managers enjoyed boundary-spanning opportunities through membership of outside professional bodies and even through more informal non-professional networks.

8.4 Cross-Case Comparison of CCHT and Edwards Hospital

The main role for middle managers in CCHT was the implementation of deliberate strategy, which was driven from the top in a way where ends and means were tightly prescribed. In Edwards Hospital, only during early attempts to implement local pay did the Personnel fimction attempt to drive local pay through in a top-down way. In CCHT and Edwards Hospital middle managers resisted such attempts at top down change. For example, in CCHT, they modified or ignored deliberate strategy in the area of competence-based recmitment and selection and vertical skill mix. In Edwards Hospital, they argued that local pay led to budget deficits in order to resist its implementation. In both tmsts features of operational context, with which middle managers were intimately familiar, allowed them influence in resisting top-down change.

To mediate any such resistance where the context is unreceptive, the Personnel function could engage in persuasive argumentation that the necessary intervention made operational sense. They can do this by tuning into the directorate management agenda. The stmcture of the Personnel function in Edwards Hospital facilitated this. By working alongside middle managers in the directorates, even where 'only' providing advice, Persormel Advisors in conjunction with the Personnel Manager were well placed to recognise receptive or unreceptive contexts, to engage in any necessary persuasive argumentation, and to shape strategic change in the area of human resources. Only in the case of local pay, where employees were offered the opportunity to retum to Whitley at any time, was such persuasive argumentation evident in CCHT.

In the interventions illustrated in Edwards Hospital, apart from the early attempts to implement local pay, the Personnel function worked through middle managers (Ulrich, 1997) to realise strategic change in which the formulation and implementation of strategy was intertwined. Such strategic change took account of operational context because middle managers knowledge was brought to bear in the formulation and implementation of strategic change. For example, instead of having pay spines imposed upon them that were difficult to use, as middle managers found in CCHT, in Edwards Hospital, Persormel negotiated change in the area of local pay with middle managers (Bamett et al, 1996) by including them in the process of formulation and implementation. In Edwards Hospital, middle managers 'synthesised information' (Floyd and Wooldridge, 1992, 1994, 1997) and worked alongside Personnel to develop local pay scales.

More generally, while implementing deliberate strategy remained their main role, the discretion allowed for middle managers within this meant their influence was much greater in strategic change than that at CCHT because the deliberate stiategy expressed broad themes only. Further middle managers were included in the formulation of these broad themes.

The role of the HR Department in Edwards Hospital, besides that of broadly being an advisor, was to ensure consistency and coherence to what emerged in strategic change in the human resources strategic subsystem. The positioning of the Persormel Advisors also facilitated the role of the HR Department here. Also, cmcially, to help ensure consistency and coherence of strategic change in the human resources area, the HR Department provided frameworks within which any emergent change took place. An 'umbrella [human resource] strategy' (Mintzberg and Waters, 1985) represented the most effective way by which the HR Department carried out its role effectively. Within the tmst itself strategies were broad enough to allow local interpretation whilst ensuring that the vision of the Board and the requirements of Government policy were adhered to. This was a fine balance to achieve but one in which the HR Department at Edwards Hospital appeared relatively successful.

While the Director of Personnel may claim that local pay was a success in CCHT because over 80 per cent of employees were subject to local pay and conditions, it is questionable whether the implementation of local pay was successful. On the basis of middle managers' comments about local pay, it not only caused them difficulties because it was ill-fitted to context, but the promises made by the Personnel Director

that it would solve recmitment problems and increase flexibility were not reahsed. In contrast, in Edwards Hospital, local pay only partially covered the workforce (around 20 per cent were covered). Yet success could be claimed because it contributed towards solving operational problems - for example, in Theatres.

In CCHT, only in the area of horizontal skill mix did middle managers have an enhanced role beyond that of implementing detailed deliberate strategy driven from the top. In this area, the Director of Personnel recognised the distinctive operational and clinical knowledge of middle managers that would help realise strategic change in this area and largely left responsibility to them. In Edwards Hospital, not only in the area of local pay, but in the areas of skill mix, IIP and sickness and absence, middle managers had a role beyond that of implementing deliberate strategy. For example, they 'synthesised information' (Floyd and Wooldridge, 1992, 1994, 1997) so that competence-based progression fitted with grades and responsibilities previously defined by Whitley, worked within the existing workforce profile and integrated with local pay scales.

It should be noted that while there was emergent strategic change that emanated from middle managers in Edwards Hospital, such middle manager influence was more likely where it was consistent with the corporate vision. There appear to be much fewer, if any, illustrations of divergent role of 'facilitating adaptability' or 'championing alternatives' (Floyd and Wooldridge, 1992, 1994, 1997). For example, even though middle managers initiate the implementation of local pay in their areas or skill mix, in both cases it is consistent with corporate direction. Similariy, with sickness and absence, while middle managers may be innovative in the mechanisms

they use to manage it, their efforts are consistent with the corporate drive to reduce casual absenteeism.

However, there appears to be significant differences between middle manager influence at CCHT and Edwards Hospital in their main role of implementing deliberate strategy, which the constmct of implementing deliberate strategy does not distinguish between. In CCHT both ends and means of strategic change were imposed upon middle managers and this limited their influence within the role of implementing deliberate strategy. However, in the case of Edwards Hospital middle managers enjoyed considerable influence in determining the means to realise broad ends set by executive management.

Why CCHT and Edwards Hospital should adopt different approaches, which have a contrasting impact upon the potential for middle management influence in the strategic change process, is an interesting question. The answer to this question illustrates the impact of central government in inhibiting or facilitating the inclusion of middle managers in stiategic change. On one hand it could be argued that CCHT and Edwards Hospital were exposed to similar central government interventions - for example, inconsistent prescription around local pay and continual calls for efficiency gains. On the other hand, one particular feature of the CCHT outer context was that there was a threat of merger with a neighbouring tmst. CCHT were more likely, as a result of this, to adopt govenunent prescription such as local pay with more enthusiasm and then drive it a top-down way. They also adopted best practice from the Persormel field - for example, competence-based recmitment and selection - and again imposed it in a top-down way. It was this top-down characteristic of strategic

change, which to a large extent came from pressures in the outer context of the tmst, which militated against the inclusion of middle managers in strategic change.

Features of irmer context are also relevant to discussion of the different approaches taken by CCHT and Edwards Hospital. In Edwards Hospital, in order to facilitate middle manager inclusion in strategic change in the human resource strategic sub-system, considerable effort and resources were devoted to organisation and management development. The result of this was the development of a relatively sophisticated and proactive group of middle managers, who are able to contribute towards strategic change because attention was paid to developing organisational and individual capacity to change (Ulrich, 1997). This was in contrast to CCHT where organisation and management development was cut in the face of a Cential Government directive that management costs should be reduced. This further reinforced the exclusion of middle managers from stiategic change.

The influence of the medical group may also be a powerful constraint upon influential role for middle managers in a hospital setting. Arguably this may not be so in a community setting, where the absence of the medical group as employees may allow middle managers an enhanced role. However, it should be noted that, while this was not apparent in CCHT because the case was one of human resource strategy and was mainly concemed with intemal matters, that GPs may exert a significant influence upon service provision and so limit middle managers' strategic role.

Another feature of inner context that impacts upon the role of middle manager is that of organisational stmctures. A notable feature of organisational stmcture in Edwards

Hospital for an influential middle manager role was that there existed boundary-sparming opportunities for middle managers (Floyd and Wooldridge, 1992, 1994, 1997). These were provided mainly through the interactions of middle managers with Persormel Advisors, but also through other mechanisms such as membership of Working Groups and through middle manager participation in action teaming sets. In contiast, in CCHT, middle managers were isolated and lacked boundary-sparming opportunities and Persormel Advisors worked closely with executive management rather than with middle managers.

Chapter 9

Conclusion

9.1 Introduction

This thesis has investigated the influence of middle managers upon strategic change in the mid-to late-1990s within the context of the NHS. Its aim is to generalise theoretically (Yin, 1994). The findings of this study centre on the role of the middle manager in strategic change, utilising a typology of involvement developed by Floyd and Wooldridge (1992, 1994, 1997), and how features of inner and outer context of middle managers' work organisations impact upon the possibility of an enhanced role.

This concluding chapter will illustrate issues raised in the literature reviewed in the first three chapters with data gathered from five case studies (four of which have been fully represented here) within the NHS. The themes highlighted in the literature, which this thesis has sought to illuminate through case study illustrations, are as follows:

(1) Middle manager's roles in the NHS context: using the typology set out by Floyd and Wooldridge (1992, 1994, 1997) this chapter will provide a summary of the cases illustrating the roles taken on by middle managers and a commentary about any changes (or not) in their role following policy reforms, aimed at encouraging a general management ethos, initiated by the Griffiths Report (DHSS, 1983). In particular this concluding chapter will address the question of whether middle

managers' influence extends beyond the operational or administrative domain to that of strategy.

(2) The influence of medical group upon the role of middle managers in the NHS: in particular, does the power exerted by the medical group limit middle managers' influence to the administrative domain only.

(3) The influence of central government upon the role of middle managers in the NHS: in particular, to what extent top-down central government intervention limits middle managers' influence to that of implementing deliberate strategy

(4) Characteristics of strategic change that facilitate or inhibit an enhanced role for middle managers in the NHS: for example, the balance between deliberate and emergent strategic change, the extent to which strategic change is separated into a formulation and implementation stage, the balance between top-down rational plarming and a political element of strategic change and discussion of the generic transfer of organisational and managerial practices from private to public sector and the response of middle managers to this.

(5) The existence of supporting mechanisms for an enhanced role for middle managers: in particular, in the cases how did organisation stmcture and investment in organisation and management development support a more influential role for middle managers.

This concluding chapter will take each of the research questions (1 to 5) above as themes and summarise the evidence. This final chapter will then consider whether the same conclusions can be applied to other settings outside the NHS. Following this, areas for fiiture research will be highlighted. Finally, the contribution of the thesis will be highlighted.

9.2 The Literature Themes Illustrated

9.2.1 *The Role of Middle Managers*

Based upon the definition of strategic change in section 4.2.1 (b) as something that occurs through actions and decisions taken at the subsystem level as well as at the corporate strategy level and that it involves actors beyond the executive management group, firstly the influence of middle managers upon strategic change in each of the cases - business plarming and marketing at Florence Hospital and human resource management at CCHT and Edwards Hospital - will be discussed together in relation to the typology of Floyd and Wooldridge (1992, 1994, 1997).

In summary the description by Floyd and Wooldridge (1992, 1994, 1997) of the different enhanced roles that middle managers take up appear rather optimistic in the case of the UK NHS. Their role remains that of implementing deliberate strategy rather than any of the other three roles - championing altematives, facilitating adaptability, synthesising information - which Floyd and Wooldridge *{ibid.)* suggest they might take on. As such their influence upon strategic change may be limited particularly in the light of constraints imposed by medical group power and central government intervention (see section 9.2).

For example, middle managers did not appear to propose innovative, entrepreneurial initiatives in a role of 'championing altematives'. There was no evidence that they were change agents who fostered organisational teaming within a role of 'facilitating

adaptability'. However, in one case, that of marketing at Florence Hospital, the role of 'facilitating adaptability' was illustrated, In this case, for example, they undertook marketing activity to develop business in the areas of surgery, pain management and therapy services, outside the purview of executive management. This represented influence by middle managers upon business unit strategy (Johnson and Scholes, 1997), which responded to the new competitive environment created by the intemal market reforms so that new services were offered to meet customer needs.

However, allowing middle managers influence at the strategic subsystem level is not without problems because each subsystem has its own timing and sequencing (Quirm, 1980). Discretion allowed to middle managers in developing business, which lay outside executive management control, necessitated subsequent executive management intervention in Surgical Services when GP fimdholders ran out of money to fund surgery half way through the year. Such discretion for middle managers may therefore be inappropriate. The suggestion by Floyd and Wooldridge (1994) that middle managers should be allowed room to experiment in the role of facilitating adapability may be inappropriate under conditions such as those experienced by the NHS. Instead, some control by executive management over emergent stiategic change emanating from middle managers is necessary. This is particularly necessary to ensure that any strategic change emerging from actions and decisions taken by middle managers lower down the organisation converges with corporate stiategy so that environmental demands are matched, which in many cases is necessarily based upon central government policy (see section 9.2.2(b)).

There was some evidence of middle managers realising a role of 'synthesising information'. For example, they synthesised information in the realisation of human resource strategy at Edwards Hospital in the Theatres Project so that resources in the organisation were stretched (Hamel and Prahalad, 1994). Taking into account the corporate strategy that local pay be introduced they worked out the impact of local pay upon budgets to make a business case for its introduction. They also worked out implications for individual's pay and managed problems associated with this. Influence such as this, upon the strategic architecture (Scholes and Johnson, 1997) of the organisation, which was integrative with corporate strategy, appeared more appropriate on the basis that it did not alter the overall direction of the organisation but was concemed to leverage resources within the organisation. While it might not represent influence upon broad corporate stiategy it represents influence upon the strategic subsystem level of Edwards Hospital. The way in which theatre practitioner and nurse performance was incentivised through pay, the stretching of resources, and that it matched demands from customers for patient-focused care, unbroken by professional boundaries, gave Edwards Hospital theatre services some advantage over services offered by neighbouring hospitals to the extent that it was recognised as a case of innovative practice in a national awards scheme for Persormel practice[59].

Similarly, in the the early days of business plarming at Florence Hospital and in the development of competence-based progression in Oncology at Edwards Hospital, middle managers' influence in a synthesising information role was consistent with the strategy set out by executive management. However, some divergent influence for middle managers may be realised, even where this role falls short of championing alternatives, in synthesising information because middle managers may focus

[59] In order to preserve anonymity of case the details of this must remain vague.

executive management's attention on certain strategic issues, which otherwise may be ignored (Floyd and Wooldridge, 1992). For example, in the Theatres Project in the last paragraph, the problem that theatre services were under-utilised because of different pay and conditions for work groups who have to be rostered together in order to provide theatre services was drawn to the attention of executive management. As a result the workforce in theatre services was re-profiled through combining local pay and competence-based progression. In this way, middle managers had some upward influence upon strategic change.

In Oncology at Edwards Hospital, the Nurse Manager and Specialty Manager identified a problem of lack of progression for nurses in their area that caused high tumover or meant a lack of motivation for nurses so that performance was impaired and this combined with a more complex patient profile to cause difficulties in providing a high quality service. As a result of this, in conjunction with their nominated Persormel Advisor, they developed a competence-based progression scheme onto which nurses, previously bound by Whitley grades, were placed. Competence-based profiling for jobs was something that the HR Department was keen to encourage, as was apparent in the HR strategy document. Further, the middle managers in Oncology saw local pay as a natural extension of the competence-based scheme they introduced and intend to develop this in response to staff requests for local pay progression. Again at the strategic subsystem level of the organisation we see that the process of strategic change is shaped by powerful intemal characteristics of the organisation (Pettigrew and Whipp, 1991), which middle managers are well placed to identify.

However, the empirical cases illustrate that the main role in which middle managers make a contribution to strategic change is in the role of implementing deliberate strategy (Floyd and Wooldridge, 1992, 1994, 1997) because of their knowledge of context (Bower, 1970) rather than the other roles identified by Floyd and Wooldridge (1992, 1994, 1997). That their main contribution remains that of implementing deliberate strategy, however, does not necessarily mean that the role of middle managers is of little consequence in the NHS since implementing deliberate strategy is a key strategic role (Nutt, 1987; Schendel and Hofer, 1979).

There is considerable variation in the influence that middle managers can exert in this role. Such variation is something that the typology of Floyd and Wooldridge (1992, 1994, 1997) does not distinguish between. Floyd and Wooldridge *{ibid.)* view any enhancement of the middle manager role as being through them taking up an upward influencing role, such as championing altematives (also a divergent role) or synthesising information, or a role that is divergent from corporate strategy, such as facilitating adaptability, rather than through enhanced influence within an implementing deliberate strategy role.

On the one hand, the influence of middle managers within the role of implementing deliberate strategy may be limited. In some cases, they may merely be able to resist strategies imposed upon them. This was the case in the management education programme at Florence Hospital, competence-based recmitment and selection and vertical skill mix at CCHT and the early attempts to implement local pay at Edwards Hospital.

In other cases middle managers may not have the power to even resist deliberate strategy. For example, in CCHT, local pay was imposed upon operational areas and middle managers were expected to manage its consequences. They appeared unable to influence its course through any actions that they took. A lack of power to resist executive management prescription was commonly a result of executive management adopting a prescriptive stance towards strategy as a resuh of tight central government prescription. Under these conditions middle managers may not be able to ignore or modify deliberate strategy. For example, the template for business planning imposed by executive management upon middle managers at Florence Hospital was the result of central government prescribing performance indicators. In this case, middle managers complied with the demands of deliberate strategy because the tmst's survival may be determined by their performance against such indicators (see section 9.2.2(b)).

On the other hand, middle managers may enjoy enhanced influence in the strategic change process through implementing deliberate strategy beyond mere resistance to prescription by executive management. In the role of implementing deliberate strategy middle managers may implement a series of on-going actions that aligns organisational action with deliberate strategy (Quinn, 1978). In cases of strategic change where ends are set, which are broad themes, and where middle managers are allowed discretion regarding the means to meet those ends, then middle managers will enjoy an enhanced role. In this situation they translate broad strategic objectives into shorter-term operational foci of behaviour (Hrebiniak and Joyce, 1984) and mediate between operational 'reality' and executive managements' vision (Nonaka and Takeuchi, 1995). Such was the case in the marketing strategy at Florence Hospital

and human resource stiategy at Edwards Hospital. For example, in the realisation of human resource strategy at Edwards Hospital middle managers identified operational problems as described earlier in this section and then proposed courses of action, which fitted with broad strategic direction, set out in the HR Strategy document. Such was the case with local pay and skill mix in particular at Edwards Hospital. In these cases strategic change was characterised by an 'umbrella strategy' (Mintzberg and Waters, 1985) (see section 9.2.3).

In summary, there is some question about the extent to which middle managers can take up an enhanced role so that they contribute significantly towards strategic change by, for example, altering services offered by the tmsts. On the one hand, on the basis of the illustrations above in 9.2.1, it could be argued that any influence for middle managers lay within the operational rather than stiategic domain. For example, middle managers in Edwards Hospital highlighted as one of their main areas of contribution as being that of developing ways to manage sickness and absence, which was an operational concem. At Florence, the business plarming process became mainly one that was used by executive management to control middle managers' performance. As resource constraints became more acute in the NHS the opportunities for middle managers to influence service development were minimal. Similarly, in CCHT middle managers roles was that of operationalising frameworks for local pay or competence-based recmitment rather than contributing to strategic change in formulating those frameworks.

On the other hand, there were some illustrations that middle managers also contributed to strategic concems beyond merely implementing deliberate stiategy or

that within implementing deliberate strategy they enjoyed enhanced influence. For example, in Edwards Hospital, middle managers re-profiled Theatre Services through developing a single pay spine so that there was more flexible working practices. In another illustration of a strategic input a middle manager changed the emphasis in their area of oncology from a nursing-led environment to a rehabilitation environment. Again, service profile was altered. In another ward-based area of oncology, workforce profile was changed so that there were fewer, more highly skilled nurses. Another middle manager, this time in Outpatients, developed a new job in their area of Outpatients Assistant. More generally at Edwards Hospital middle managers contributed towards the formulation of strategic frameworks through membership of Working Groups. In CCHT middle managers implemented horizontal skill mixing between health visitors and district nurses so that service was both more effective and more efficient. In Florence, pain management and therapy services were developed and a greater customer orientation in Accident and Emergency was realised largely through the efforts of a new General Manager in this area, who 'championed' the need for a better intemal and extemal profile for the department.

However, at least within the context of the NHS opportunities for an enhanced role are significantly constrained. Therefore the assertions of an enhanced middle manager role suggested by Floyd and Wooldridge (1992, 1994, 1997), Frohman and Johnson (1993) and Smith (1997) appear rather optimistic in the face of the constraints of outer context imposed by medical group power and cential government intervention in particular. It is to these we now tum.

9.2.2 The **Influence of Outer Context upon Middle Manager Influence**

In section 9.2.1 that the influence of middle managers is subject to considerable constraint is evident. The second section of the conclusion considers some of the limiting influences upon the role of middle managers. Firstly, there appears little evidence that middle managers extended their jurisdiction into the medical domain without the support of the medical group. Secondly, central government policy may mean that middle managers could not modify, resist or ignore changes imposed upon them by executive management.

9.2.2 (a) *The Middle Manager-Medical **Group** Relationship*

On the one hand in the cases, Mintzberg's (Mintzberg, 1979, 1995), claim that in professional bureaucracies, the professional operating core, in this case the medical group, are likely to be able to resist any control by middle managers, is upheld to a large extent. On the basis of the illustrations provided in the case studies, individual clinicians make strategy in hospitals by decisions about whom to treat and how to treat them (Hardy et al, 1984; Mintzberg, 1979) without needing to be take up formally-defined administrative roles (Harrison et al, 1992). This was particularly illustrated in the cases of business plarming (chapter 5) and marketing (chapter 6) at Florence Hospital where vascular surgery, orthopaedics, sports injuries and hand unit services were offered that reflected the consultant expertise in the hospital, even where, in the case of vascular surgery, it did not make commercial sense.

Even where they take up managerial roles, for example the role of Clinical Director or Medical Director, medics may allow middle managers decision-making power but influence or resist managerial choices through a political, negotiated process in which they exert significant power (Bums, 1981; Strauss et al, 1963). For example, the SBU initiative at Florence Hospital was put on hold because the medical group was not behind it. The medical group also retained the power of veto. For example, in Edwards Hospital, the Clinical Director in Oncology described how he conceded decision-making power to the general manager and only intervened in exceptional circumstances.

As a result any strategic change is likely to incremental (Harrison et al, 1989a). The power of managers appears limited in the face of medical group power, through clinical freedom, to define and control service development (Ackroyd, 1996; Ham, 1981; Haywood and Alaszewski, 1980; Hunter, 1979). Therefore, it could be argued that middle managers are no further forward than their pre-Griffiths position, where they were merely diplomats (Harrison et al, 1989a) and their influence was limited to a narrow administrative domain rather than, for example, service development.

On the other hand, the need to ration health care in the face of resource constraints (Harrison et al, 1992; McKee et al, 1999) and intemal market arrangements (Dent, 1993; Whittington et al, 1994) may offer some opportunity for managers to enhance their power beyond a narrow administiative domain. The impact of resource constraints was evident in the case of business planning at Florence, where medical group demands for expensive 'kit' or an expensive surgical intervention were

questioned. More generally at Florence Hospital, executive and middle management talked of giving a commercial flavour to consultant decisions.

To take advantage of any influencing opportunity, for example regarding service development, it appears necessary for middle managers to pay attention to persuasion and negotiation with the medical group (Langley, 1988). In Florence Hospital, in Surgical Services, for example, the general manager talked of the need to 'lobby' the medical group rather than address them head-on. An altemative source of influence for middle managers may be to educate doctors by involving them in decisions or exposing them to relevant information (Langley, 1989). For example, the General Manager in Surgical Services in Florence Hospital used waiting list referral pattems to influence service development.

There was some limited evidence of an enhanced role for middle managers, despite medical group power, across the case studies. For example, middle managers at Edwards Hospital blurred boundaries between the medical group and other professional groups in delivering care, albeit with medical group agreement. As illustrations of this, nurses gave intravenous injections in Oncology and Therapy Radiographers gave information to patients, both tasks being formerly carried out by doctors. In certain circumstances, in certain areas, middle managers may be able to significantly influence services offered extemally, as well as intemal arrangements by which they were delivered. In Florence, through the business planning process, pain management and therapy services were developed by the General Manager and Service Manager. This was an area in which the medical group had less representation than, for example, in general surgery. Marketing was a prominent feature of

managerial activity in Accident and Emergency in Florence, an area that might be considered to less amenable to marketing than many. Here the threat of merger meant that extemal presentation of what was considered the 'flagship' of the hospital was important. In the re-profiling of services in Pathology, consultants worked closely with General Managers. This area was under threat from competition from other hospitals and private pathology concems that went beyond the local geographical area. More generally, as commented upon by the former Chief Executive at Florence, managerial influence over the medical group was less likely in a teaching hospital and more likely where a hospital faced crisis, such as that of being tumed for tmst status, a position the Florence Hospital faced in the early-1990s. In the case of CCHT the absence of a medical group might have allowed a more influential role for middle managers in strategic change. However, the top-down approach taken by the Personnel fimction in the case meant any evidence of this was limited to illustrations of resistance. Also, medical group power in a community tmst situation may come from the power of GPs, who are not employed by tmsts, to define service provision.

However, even in this more optimistic scenario for middle managers, it should be noted that managers have not necessarily gained power at the expense of the medical group. It is more likely that members of the medical group may become involved in the management process and may work alongside general managers in more collaborative managerial arrangements (Ferlie et al, 1996; Fitzgerald, 1996; Whittington et al, 1994) and that this may allow the more politically astute middle manager some influence over strategic change. For example, in the area of Pathology at Florence, which was sensitive to market forces, General Managers and Consultants worked alongside each other to re-profile services. Further, at Florence, General

Managers participated alongside Executive Directors and Clinical Directors in Board 'awaydays'. At Edwards, middle managers worked alongside executive management and the medical group in the formulation and implementation of strategic change through membership of Project or Working Groups. More generally, at Edwards, the managerial arrangement was one where the Specialty Manager and Nurse Manager worked alongside the Clinical Director.

9.2.2(b) ***Central Government Constraints***

Central government intervention also represents a significant constraint upon the influence of other stakeholders in the NHS (Harrison et al. 1992). This is very evident in the case of middle managers. Any middle manager influence beyond the implementation of deliberate strategy is militated against by the impact of the central government intervention. Central government prescription meant the realisation of a role for middle managers that diverged from strategic change set out by executive management was unlikely. Discretion for the more divergent influence of middle managers is likely only where central government prescription is relatively limited - for example, in the case of marketing at Florence Hospital (see chapter 6) - where a role of 'facilitating adaptability' for middle managers was illustrated.

That central government intervention represents a constraint upon middle manager influence is most obviously illustrated in the case of business planning at Florence Hospital (see chapter 5). Here performance indicators set out by cential government were embedded in the business plarming process. Any tmst that did not work towards these may have put its survival at risk. Therefore middle managers influence was

necessarily convergent with tmst strategy, which in tum was focused upon meeting the centrally set indicators and directives. Further, financial constraints, where the Government asked for efficiency gains every year, impacted adversely upon any enhanced role for middle managers in business planning at the Florence Hospital because there was little funding for service development proposed by middle managers.

Even in the case of human resource strategy at Edwards Hospital the influence that middle managers enjoyed was framed by central government policy, for example in the introduction of local pay in Theatie Services, that encouraged tmsts to adopt local pay as part of a more business-like approach to health care provision but required that change be cost-neutral as part of a drive for efficiency gains.

Requests for efficiency gains were also illustrated in central government calls for a reduction in middle manager numbers (see section 3.4.4). That such requests existed alongside an emphasis upon a general management ethos that might be expected to enhance the role of middle managers reflects the contradictory forces at work that affect the role of middle managers (Newell and Dopson, 1995; Daudi et al. 1997; Smith, 1997). This was particularly illustrated in Florence Hospital and CCHT.

In Florence Hospital, for example, three of the managers on the competence-based management education programme were made redundant during the early stages of delivery of the programme. Other participants on the programme viewed this as an attack upon their role and questioned whether they had a future. This reflects the more pessimistic view (for example, Peters, 1992, in the USA and Wheatley, 1992 in the

UK), reported in chapter 1 (see section 1.3) that middle managers' jobs may be on the verge of extinction. However, of the three managers made redundant, two were immediately re-employed under the nursing rather than management budget and carried out a similar role to that they were employed in before. This might suggest that the 'redundancies' were merely a matter of re-allocating costs to meet with government requirements rather than a diminution of the role of middle managers.

In CCHT, there was a restmcturing of the middle manager group that involved District Nursing Team Leaders being replaced by a lesser number of Locality Managers. However, in intention at least, executive management saw the new role of Locality Manager as being one of a broader remit than the operational management of a narrow professional group. Hence holders of Locality Manager posts required a broader set of generic competences. These changes may reflect a more optimistic view (for example, Frohman and Johnson, 1993 in USA and Dopson and Stewart, 1990), reported in chapter 1 (see section 1.4) in UK of the role of middle managers in which the remaining smaller number of middle managers might enjoy an enhanced role. Further at CCHT there was some debate about whether Assistant Directors, into whom Locality Managers reported, were necessary. If the organisation was to be further re-stmctured and Assistant Directors' posts removed, then management costs would be reduced in line with the government's call for efficiency gains but Locality Managers may exert more influence through being closer to executive directors.

9.2.3 The Influence of Inner Context upon Middle Manager Influence

The conclusion now considers features of inner context impact upon the role of middle managers in strategic change. Firstly, it considers how characteristics of strategic change - for example, the balance between deliberate and emergent aspects of strategy, top-down rational planning and political elements of strategic change, and generic tiansfer - impact upon the role of middle managers. In some cases, they inhibited involvement of middle managers in strategic change. In others they facilitated middle manager involvement. Secondly, it considers how aspects of organisational structure and attempts to build individual capacity inhibited the influence of middle managers in some cases but facilitated influence in others.

9.2.3(a) *Emergent and Deliberate Strategic Change*

As discussed in the last section, middle manager influence within the role of implementing deliberate strategy will vary with the extent to which strategy is deliberate. The common perception is that middle managers resist change in the implementation of deliberate strategy. This appeared to be most evident where the degree of deliberateness in strategic change is greatest. Where the ends and means of strategic change are tightly prescribed middle managers are more likely to resist strategic change. For example, in the case of management education at Florence both content and process of the programme was imposed upon participants. Middle managers were able to resist the content of the programme on the basis that the generic competences, which underpinned the programme, were insensitive to the context of the NHS. Their resistance manifested itself in a drop out rate that meant

only 2 of the original 35 participants completed the programme. Similarly, in CCHT middle managers ignored or modified the competence-based recmitment and selection framework imposed upon them because it was unsuitable when selecting for the professions, such as nursing.

However, in cases where strategic change is not tightly prescribed by executive management, middle managers may have an influence upon strategic change that goes beyond mere resistance. For example, in Florence Hospital, in the case of marketing, middle managers realised an enhanced role. There were two conditions that allowed this to happen. There was a lack of Government prescription regarding marketing activity. In addition, there was also a lack of Tmst Board prescription for marketing activity. This allowed middle managers, albeit taking account of the whether the medical group expertise was available and the willingness of the relevant medics to provide those services, to market and develop services offered. Middle managers took on the role of 'part-time marketers' (McNulty et al, 1994; Whittington et al, 1994) and undertook boundary-spanning roles (Floyd and Wooldridge, 1997) between the extemal and intemal environments of Florence Hospital to develop services in the Surgical Services and Therapy Services areas. While some executive directors expressed concem about the chaos that might be created through allowing middle managers discretion in this area, the corporate centre only intervened retrospectively when, for example, GP fimdholders ran out of money in Surgical Services or when the local health authority expressed concem that business was being taken from other tmsts.

Conceiving strategy as a broad vision (Ferhe et al, 1996; Pettigrew et al, 1992) also facilitated an enhanced role for middle managers in strategic change in the case of human resource strategy in Edwards Hospital. In Edwards Hospital, an 'umbrella strategy' (Mintzberg and Waters, 1985) for the management of human resources gave some significant discretion to middle managers to develop the means to meet very broadly defined ends. These broad ends were set out in the Human Resource Strategy Document 1998-2003. For example, there were themes of developing a flexible workforce and collaborative team working to which middle managers responded in the Theatres and Oncology areas. In Theatres middle managers proposed and introduced harmonisation of pay and conditions for two separate groups of workers while, in Oncology, middle managers proposed and introduced a competence-based progression scheme for nurses.

In summary, the findings suggest that where strategic change is deliberate then formulation and implementation are likely to be separated. This may have the effect of limiting the role of middle managers to that of implementing deliberate stiategy (Floyd and Wooldridge, 1992, 1994, 1997). Further, middle managers are likely to have a very limited influence upon stiategic change within this role. Where strategic change allows for emergent change as well as deliberate change then middle managers are likely to be included in strategic change to a greater extent because formulation and implementation are likely to be intertwined. Under these conditions, including middle managers in strategic change may address the problem of an implementation gap (Hamson eLal, 1992; Feriie et al, 1996). For example, human resource strategy in Edwards Hospital was more successfiilly realised than in CCHT

because in Edwards Hospital strategic change was relatively emergent and formulation and implementation were relatively intertwined.

9.2.3(b) *Top-down Rational Planning and Political Elements of Strategic Change*

The balance between top-down rational plarming and a political element of strategic change is an important influence upon strategic change. The political element of stiategic change that was highlighted in disjointed incrementalism (Lindblom, 1959, 1968, 1979) and was evident in logical incrementalism (Quinn, 1978, 1980, 1982) and the work of Pettigrew et al, (1992) appears to be a necessary part of strategic change in the NHS. An important part of the political element of strategic change is that the NHS be seen as a pluralist organisation in which there are competing interests. Therefore there is likely to be a process of partisan mutual adjustment in the realisation of strategic change (Lindblom, 1959, 1968, 1979). This was most obviously seen in the realisation of human resource strategy in Edwards Hospital where the Personnel fimction realised strategic change through negotiation with middle managers (Bamett et al, 1996; Ulrich, 1997). This took place in Edwards Hospital by involving middle managers in Working Groups and through the relationship between Personnel Advisors and middle managers.

Conversely where strategic change was imposed rather than negotiated, deliberate strategic change may be resisted. For example, the management education programme failed in Florence Hospital and some aspects of human resource strategy, such as competence-based recmitment and selection and vertical skill mix through NVQs were not wholly realised in CCHT because the content of these interventions had not

been negotiated with middle managers. In these cases we see that the resistance of middle managers in their role of implementing deliberate strategy (Floyd and Wooldridge, 1992, 1994, 1997) is a significant influence upon the realisation of stiategic change.

This is further evident in the success of middle managers in mobilising context to create legitimacy for their resistance (Pettigrew et al, 1992) - for example, in the cases of the management education programme at Florence Hospital, competence-based recmitment and selection at CCHT and even in Edwards Hospital, where the middle managers resisted local pay in the area of Operational Services.

Some of the conflict between executive management and middle management in these areas was linked to the issue of generic transfer of management ideas from private to public sectors (Ackroyd et al, 1989, Hood, 1991; Pollitt, 1990; Stewart and Ranson, 1988; Stewart and Walsh, 1992). As Bennett et al (1992) note, in the pubhc sector the consideration of the meanings and assumptions about what counts as good management in the context of an organisation's own value system, should be encouraged. The history and professional elaboration of groups in the health service means that the value system of a hospital is unique compared to other types of organisations. In which case, interventions such as management education in the NHS represent a pluralistic meeting point in which conflicting purposes and values comes together (Burgoyne and Jackson 1997). In this situation creating legitimacy for change attempts may be a significant aspect of a political element of strategic change to ensure the realisation of deliberate stiategy (Pettigrew etal, 1992). In establishing legitimacy for change, executive management might take note of Pettigrew et al's

{ibid.) conception of context as something, which can be mobilised to legitimise views and actions taken by various stakeholders in the strategic change process.

In all cases the importance of this is evident. However, in Florence Hospital and CCHT, it is the middle managers rather than executive management, who mobilise context successfully. In the case of management education at Florence, for example, facilitators stiessed the generic nature of management and drew upon private sector cases to illustrate managerial cases and almost totally ignored the context in which the participants on the programme worked. The Business Development Manager was accused of being 'marketing mad' by the Director of Business Development because he promoted marketing frameworks derived from private sector practice, which were insensitive to NHS practice. Similarly, at CCHT the Personnel Department imposed a competence-based recmitment and selection framework upon middle managers without concem for its applicability to professional groups. Even in Edwards Hospital the Personnel Department attempted to impose local pay frameworks upon areas for which it was unsuitable. Yet in all these cases there appeared little attempt to persuade middle managers that the interventions addressed problems. In response, middle managers drew upon the very features of inner context to demonstrate that such interventions were unsuitable. For example, in the latter case of local pay at Edwards Hospital, the Operational Services Manager argued that local pay would result in budget overspend. In the cases of marketing and management education at Florence, middle managers' resistance was predicated on an argument that such interventions were cmde and that they missed out on the caring aspects of the NHS or the public service ethos that was held by staff.

This is not to downplay the importance of top-down rational planning, which Pettigrew eLal (1992) note. On the one hand, within the NHS there is some concem expressed that there is too much rather than too little control, mainly as a result of central government intervention, over the influence of middle managers in strategic change (Wall, 1999). On the other, a political element of strategic change, which allows for emergent strategic change, may need to be complemented by a planning framework that controls the emergence of strategic change (Mintzberg, 1987, 1991), as evidenced when middle managers were allowed discretion to develop business through marketing efforts, which was discussed earlier.

9.2.3(c) ***Supporting*** *Mechanisms*

The case of human resource strategy at Edwards Hospital illustrates the greatest amount of middle manager influence upon strategic change. One of the main reasons for this may be that features of inner context - in particular, the existence of boundary-spanning opportunities for middle managers and the development of organisational and individual capacity for change - supported an enhanced middle manager role. Each of these features of inner context will be discussed in tum:

9.2.3(c)(i) *Organisation Structure*

A number of academic commentators advocate that the inclusion of middle managers in strategic change is facilitated by developing horizontal organisation stmctures that allow middle managers to span intra-organisational boundaries (Floyd and

Wooldridge, 1994; Frohman and Johnson, 1993; Kanter, 1993). The impact of organisational stmcture upon the role of middle managers is illustrated across the cases. For example, in CCHT a lack of boundary-spanning opportunities for middle managers, so that they can take on an enhanced role, was in contrast to the presence of boundary-spanning mechanisms that sought to include middle managers in strategic change in Edwards Hospital. In CCHT Locality Managers managed distinct geographical 'patches' or localities that were remote from the corporate centre. In the case of human resource strategy, the Locality Managers interacted with the Personnel function through Persormel Advisors attendance at locality meetings. While, their concems may have noted by Persormel Advisors in these meetings and fed into the formal strategy, deliberate human resource strategy appeared to be formulated at the centre without including those concems. Instead human resource strategy appeared to be based upon 'successes' that the Persormel Director enjoyed in his previous job at another health tmst and the strategic interventions reflected what the Personnel community at large might regard as best practice - for example, flexibility offered by local pay, competence-based recmitment and skill mix. Following its formulation that strategy was then imposed upon Locality Managers through a formal document and its realisation at the local level was monitored through the interaction of Personnel Advisors with Locality Managers. Largely as a result of a lack of boundary spanning opportunities the influence of Locality Managers upon strategic change was limited to resisting its imposition in the cases of competence-based recmitment and selection and skill mix via NVQs.

In Florence Hospital the situation regarding boundary-spanning opportunities was mixed. On the one hand, middle managers spanned boundaries between inner and

extemal contexts in the reahsation of the marketing strategy. On the other hand, they were excluded from contributing towards any change that lay outside the narrow confines of their directorate. This was evident in the development of business plans, where each directorate developed business plans in isolation from others and the executive management group mediated any inconsistencies.

In contrast, in Edwards Hospital, there appeared greater scope for middle managers to boundary span outside their directorates. Firstly, in Edwards Hospital, middle managers were included in strategic change at the level of corporate strategy through their involvement in Working Groups at Edwards Hospital. These groups were consulted on policy - for example, the Equal Opportunities Working Group - and shaped strategic change through, not only interpreting broad corporate aims in relation to operational context, but also in influencing broad corporate aims themselves

Secondly, middle managers developed Project Groups to examine operational problems at the level of business strategy that may be of common concem to a number of middle managers and boundary-span across different operational areas.

Thirdly and most importantly in Edwards Hospital, Personnel Advisors worked alongside middle managers in Edwards Hospital. This provided a contrast with the relationship between the Personnel fimction and the operational periphery in CCHT. In CCHT, while the Personnel Advisors are allocated geographical areas of responsibility, they spend most of their time at corporate headquarters, which is physically distant from operations. Alongside this, they tend to take their cue from the Director of Personnel. In contrast, at Edwards Hospital, the Personnel Advisors split

their time between the corporate centre and operations and took their cues from the Director of Personnel and middle managers. While, this might lead to problems should the objectives and actions of middle managers in operations conflict, in many cases the link was invaluable. The close relationship between Personnel Advisors and middle managers meant that the former were aware of middle managers' concems and could link this to initiatives, which the corporate centre was promoting. Such was the case with the Theatre Services project of which local pay was a feature and the introduction of a competence-based progression scheme in Oncology. Personnel Advisors were also able to bring the attention of middle managers to the vision of the centre and thus provide an 'umbrella strategy' (Mintzberg and Waters, 1985) within which decisions and actions of middle managers should take place. That the Persormel fimction should discharge its responsibilities in this way fits with the assertions in the human resource literature, that the Personnel fimction should negotiate its role and establish legitimacy for its actions with stakeholders intemal to the organisation (Bamett et al, 1996), and that it should manage through line managers (Ulrich, 1997).

9.2.3(c)(i) *Developing Capacity to Change*

At Florence Hospital, the efforts of the corporate centie to promote change through management education are laudable in the light of Ulrich's emphasis upon developing organisational and individual capacity for change (Ulrich, 1997). However, in this case the success of the management education programme, was compromised by the approach adopted. The approach adopted suffered from two main weaknesses. Firstly, it was a top-down rational planning approach. Secondly, it represented generic tiansfer of management education practice from the private sector to the public sector

through its assumption that managerial competences and behaviours are similar in all organisations.

There was some limited success at Florence Hospital in developing capacity for change. This was due to the efforts of the Business Development Manager and marketing consultant rather than the Organisation Development Manager, and lay narrowly with the development of a marketing orientation rather than more generally developing a proactive middle management group, which was the intention of the competence-based programme. One of the features of development here was that a great deal more discussion was allowed for in considering the utility of marketing frameworks drawn from the private sector. However, interaction with individual, more receptive managers, such as the General Manager: Surgical Services, appeared more effective than workshops that addressed the general management group as a whole.

In CCHT, that management development was cut in the face of Government calls for efficiency gains, may have proved a false economy in relation to the realisation of strategic change, since the result was that, rather than exhibiting the necessary proactivity to shape strategic change, middle managers felt they lacked influence to shape any change and limited their role to resisting deliberate stiategy in cases such as competence-based recmitment and selection and NVQ based skill mix. Instead of shaping strategic change through contributing their knowledge of contextual circumstances at CCHT, Locality Managers acted as many commentators might expect middle managers to behave, by resisting the implementation of deliberate strategy and acting as blockers to change.

In contrast in Edwards Hospital, considerable budget and other resources, much of it at little cost, was devoted to developing individual and organisational capacity to change. On one hand, there was a formal menu of management education. On the other, much of it was informal. Firstly, action teaming sets were set up. Secondly, the Organisation Development Manager worked closely with middle managers - for example, in the case of the Theatres Project. Thirdly, Personnel Advisors, in their interactions with middle managers, sought to develop the contribution of middle managers to strategic change. In these conditions, strategic change was successfully realised, in a way that also met the intentions of the corporate centre. The author of this thesis suggests that this was due, in some part, to the efforts and resource devoted to the development of organisational and individual capacity so that middle managers could take up an enhanced role.

9.3 Are Findings Case Specific?

This section will briefly consider how applicable findings from the case studies in this thesis relate to other settings. Firstly, cross-case comparison has shown some variation in NHS case contexts. As a result the question of applicability of the findings to other cases in the NHS beyond those represented in this thesis is considered. More broadly, beyond the NHS, there is a question whether the findings from this research, that middle managers can enjoy an enhanced role under certain conditions, are applicable to other sectors. This is best taken in two stages. Firstly, the question needs to be asked of the applicability of the findings to other public sector contexts. Secondly, do the findings apply more generally to the private sector.

9.3.1 The NHS

On the one hand, there may be features of outer context that similarly apply to all tinsts. A constant feature, in hospital tmsts at least (the influence of GP fimdholders in community health tmsts was not investigated), is the power of the medical group to constrain the influence of middle managers. The impact of central government intervention is also likely to constrain the possibility of any enhanced influence for middle managers upon strategic change given that all tmsts are similarly subject to govemment policies.

On the other hand, there appear to be some significant variation across NHS contexts that suggest the illustrations represented from the cases at Florence Hospital, CCHT and Edwards Hospital may be case specific. The influence of middle managers may vary within NHS contexts because NHS tmsts vary along a number of dimensions that impact upon middle manager role and influence, as illustrated in the case studies. Most evident in the case studies is that they vary in relation, firstly, to their stmctures and the boundary-sparming opportunities for middle managers, which are a result of this. Secondly the case studies vary in their emphasis upon developing capacity for change. For example, in Florence Hospital there were 7 directorates, while in Edwards Hospital there were 37 directorates. In the latter, complementing the large number of directorates were the existence of Working Groups concemed with areas of strategic change and Personnel Advisors who were close to operations. These stmctures in Edwards Hospital allowed middle managers to have a greater influence upon strategic change than in the case of Florence Hospital or CCHT. In addition, an

enhanced role for middle managers in Edwards Hospital was facilitated by resources devoted to the development of organisational and management development. This was in marked contrast to CCHT, in which middle manager's influence was limited to the implementation of deliberate strategy. Here, organisation and management development budget had been severely cut in the face of a need to make managerial efficiency gains.

Further, the role of middle managers in strategic change is affected by the ways in which strategic change is conceived. This may vary, even within the same organisation. For example, in Florence Hospital, in the cases of business planning and management education the emphasis was upon deliberateness and rational planning, while in the marketing case, strategic change was much more emergent, promoted by an emphasis upon cultural change. In the latter case, the role of the middle manager was enhanced.

There may also be some features of outer context that may vary between tmsts, which impact upon the role and influence of middle managers. For example the threat of merger may have an adverse impact upon any enhanced role for middle managers. For example in the case of Florence Hospital and CCHT strategic change was increasingly top-down driven by executive management in their quest to be viewed as a 'progressive' tmst and avoid being merged with a neighbouring health tmsts.

In summary, ceratin features of context that impact upon the role of middle managers in the NHS are likely to remain constant across NHS trsusts, most notably central govemment intervention and medical group power. Other features, particulariy those

of inner context, such as the characteristics of strategic change, are likely to vary. Therefore, more empirical work may usefully be carried out to ascertain the applicability of the findings from the case studies to other NHS settings and the variation between features of context and their influence upon the role of middle managers in the NHS.

9.3.2 The Public Sector

Outside the NHS, that there are similar themes in strategic change across the public sector is evident in the grouping of such changes under a generic heading - New Public Management (for example, see Ferlie et al, 1996). Literature in the field of education management and local govemment suggests that findings are not limited to the NHS.

On one hand, this literature describes a growth in management hierarchy, numbers of managers and an enhancement of the role of middle managers (McVicar, 1996). In education, middle managers in schools and colleges enjoy more 'freedom to manage' and a new and challenging managerial role (McVicar, *ibid.).* Change in local govenunent also reflects changes in the NHS and education. There is an introduction of more business-like management (Elcock, 1996) that has enhanced the role of middle managers, which in tum has contributed to improved organisational performance (Leach et al, 1994). In local govemment, as was the case in the NHS, one of the necessary conditions for an enhanced middle manager role is that there should be opportunity for them to span boundaries within and outside the organisation (Leach et al, 1994; Local Govemment Training Board, 1987).

On the other hand the literature reports a more limited role for middle managers in other public sector areas and in some cases, attacks upon middle managers, similar to those in the NHS. For example a study of middle managers in education, who participated in a competence-based management development programme, showed their role to be limited to that of resisting deliberate change (Cave and Wilkinson, 1992; Jagger, 1992). In local govemment Keen and Vickerstaffe (1997) identified a number of influences that constrain rather than enhance the role of middle managers. These are similar to those in the NHS, such as central govemment and executive management prescription. In her study of human resource policies and practices, Keen (1994/95) was not optimistic for any enhanced middle manager role beyond a limited influence in the implementation of deliberate strategy on the basis that there were increasing tendencies within the local authority organisation studied towards recentralisation that led to a diminution of autonomy for middle managers. As a result of increasing central govemment intervention across the public sector, it is questionable whether there is greater opportunity for middle managers to adapt organisational policies and activities to local circumstances and needs and therefore enjoy an enhanced role (Famham and Horton, 1996).

Therefore, it appears that the competing tendencies, which impact upon the role of the middle manager in the NHS, are also apparent in other public sector arenas. On one hand there is an elaboration of general management through which an enhanced role for middle managers may be realised. On the other hand, there is a diminution of the role of middle managers to that of limited influence within the implementation of deliberate strategy prescribed by executive management in the face of central

govemment intervention. The latter tendency is reflective of a view that middle managers do not add value to public services.

Given that the changes in other public sector arenas, which impact upon the role of middle managers, mirror those in the NHS, there may be scope for taking themes raised in this thesis forward to those other arenas. Again, more empirical work may usefully be carried out to ascertain the applicability of the findings from the case studies to other public sector settings outside the NHS.

9.3.3 Private Sector Organisations

The public and private sectors appear distinctive in relation to the research question in this thesis because of the significance of the impact of central govemment intervention and the power of professional groups - the medical group in the case of the NHS - upon the role of middle managers in the public sector. More generally, in the private sector, while shareholders may represent an important stakeholder who needs to be satisfied the govemment does not directly intervene in the affairs of the private sector to nearly the same extent as the public sector. Therefore middle managers in the private sector might enjoy a greater degree of discretion in the absence of tight govenunent prescription that provides a framework for their activity. Similarly, while there may be professional groups in the private sector - for example, engineers in manufacturing settings - their power is likely to be less than that of the medical group. If middle managers can enjoy an enhanced role in significantly constrained situations, such as the NHS, arguably they can do so more in private sector contexts.

In summary, the call for more empirical research in this area still remains, as identified by Dopson and Stewart (1990). In terms of methodology, it may be useful to gain some statistical generalisation, as well as theoretical generalisation, via surveys across sectors based on constmcts developed from themes identified in the case of the NHS. It is to the area of future research that the conclusion now tums.

9.4 Future Research

Some areas for future research have been highlighted in section 9.3. These relate to the applicability of findings to settings beyond those of the case studies in this thesis. There are other themes around which research could usefully be carried out.

9.4.1 Other Stakeholder Perspectives

This thesis focused mainly upon middle managers as informants. Other stakeholders may usefully illuminate the question. Executive management were interviewed and added to an understanding of the middle manager's role in strategic change. However, it may have been useful to gather data from decision-making arenas, such as board meetings to determine to what extent the concems of middle managers were taken into account into the formulation of strategic change. This may have illustiated more fiilly the role of middle managers in 'synthesising information' (Floyd and Wooldridge, 1992, 1994, 1997). Another important group of stakeholders within the NHS is the medical group. While executive and middle managers interviewed threw light upon the ways in which the medical group inhibited an influential role for middle managers in strategic change, fiirther interviews with medics, beyond the

limited number undertaken, may have further illuminated the interaction of middle manager with the medical group. There has been substantial academic commentary upon the power of the medical group regarding the impact of the reforms (see section 3.4.5) but in relation to the research question in this thesis, there appears to be little consideration of the way in which middle managers might impact upon or be inhibited by medical group power.

9.4.2 Typology of Floyd and Wooldridge

In this thesis the typology of Floyd and Wooldridge (1992, 1994, 1997) has been utilised to sensitise the author to the way in which the middle manager may exert influence beyond the implementation of deliberate stiategy. This has proved useful to illustrate whether middle managers enjoy (or not) an enhanced role in strategic change in the NHS, beyond that commonly conceived in the practitioner and academic literature. However, at times, it has proved difficult to distinguish the influence of middle managers in relation to the Floyd and Wooldridge *{ibid.)* typology. Their typologies of influence are very broad but at the same time are also discrete, apart from their assertion that a synthesising information role can lead on to a role whereby middle managers can champion altematives. A significant weakness of the typology of the middle manager role developed by Floyd and Wooldridge *{ibid.)* is that it does not recognise the variation in discretion that is available to middle managers in their role of 'implementing deliberate strategy' (Floyd and Wooldridge, *ibid.).*

For example, where middle managers develop means to realise broad ends set out in an umbrella strategy (Mintzberg and Waters, 1985) they may enjoy a more influential

role. Conversely where both ends and means are tightly set they have a more limited role. In the NHS, where this limited role is a result of govemment prescription, middle managers' scope for resisting the implementation of deliberate strategy and influencing the realisation of strategic change through this, may be further limited because they have to comply with govemment requirements.

Therefore, further constmcts may be usefully developed to 'measure' middle manager influence and describe their roles more accurately, particularly in relation to implementing deliberate strategy. This may necessitate, in order to establish statistical as well as theoretical generalisation, that a more quantitative-based approach to methodology be adopted, as noted in section 9.3.3. In addition, the link between organisational performance and an enhanced role for middle managers may also be of concem to some researchers.

In conjunction with the above, and of concem to practitioners involved in strategic change, as well as academics, is the question of the necessary conditions for an enhanced middle manager role. There are some specific conditions that should be highlighted as worthy of fiirther research.

9.4.3 Inner Context

Firstly, that the characteristics of strategic change significantly influence the role of middle managers has been highlighted in the thesis. This begs the question that asks what the model for strategic change should be for the NHS. There was some limited discussion of the relevance of various models of strategic change for the NHS in

chapter 2. It may be useful to investigate this in more detail. For example, the data gathered for the purposes of this thesis could usefully be interrogated to ascertain the descriptive accuracy and prescriptive validity of models of strategic change. In particular, given that the vahdity of logical incrementahsm (Quinn, 1978, 1980, 1982), commonly considered to be the dominant model for strategic change in the public sector, has been questioned by Pettigrew et al (1992), its descriptive accuracy and prescriptive validity may be worthy of further research and discussion. In addition, fiirther research may be required to separate out the effects of generic tiansfer from effects of top-down implementation that contribute towards the resistance exhibited by middle managers.

Secondly, the problems of centre-periphery relations are well documented in the academic literature and have been explored in the thesis. While, there may be little that those practitioners involved with strategic change can do, at ti^st level, about the way in which govemment sets and implements policy, the latter cases of human resource strategy in CCHT and Edwards Hospital provide lessons for the role of functions at the corporate centre, over which those practitioners do have some control. Thus, further research may be usefully carried out to assess the ways in which corporate functions, such as Personnel, negotiate their role within an organisation with various stakeholders and in doing so, alleviate extemal constraints such as Govemment intervention. Certainly, the view of this thesis is that middle managers are important, but so to may other relationships Personnel have. For example, within an NHS tmst, the relationship between the Personnel Director and other executives may be important, as may the relationship between the Personnel and Finance functions more generally.

Thirdly, the development of both individual and organisational capacity to change, as a condition for enhanced middle manager influence in strategic change, is worthy of more detailed investigation. In particular, those concemed with organisation development and management development, in the face of having to justify the worth of their activity, may be interested in further research that examines the link between developing individual capacity to change and those individual's subsequent contribution to the realisation of strategic change. In addition, while the nature and impact of boundary-sparming mechanisms upon the role of middle managers has been illustrated in this thesis, this could also be investigated further.

9.4.4 Future Government Agenda

Finally, within the NHS the environment appears to be changing again, following the White Paper, *The New NHS: Modern, Dependable* (DoH, 1997). A major feature of recent policy changes, following the election of the Labour Govemment, is that a new NHS stmcture is to be established. This maintains the separation between planning and provision but reduces the number of organisations on each side of this divide. For example, on the purchasing side, new organisations are being created across the country called Primary Care Groups (PCGs). They will commission health care and increasingly take on the responsibilities of the Health Authority for planning health care over time, eventually developing into Primary Care Tmsts (PCTs).

So far, given that we are in the eariy days of the Labour Govemment reforms aimed at the NHS, there has been little empirical analysis of the new arrangements from

academics in the management field, perhaps reflecting that these new arrangements are still emergent. There has been some 'armchair theorising' which argues that the intemal market has been de-emphasised and that, instead there is a shift towards more collaborative relationships between purchasers and providers (Kirkpatrick, 1999; Rhodes, 1997), which constitutes a 'third way' between markets and hierarchies (Hunter, 1998).

This may well have implications for the role of middle managers since there may lie a greater emphasis upon 'networks'. These may represent boundary-spanning mechanisms that can enhance the middle manager's role, providing they are in a position to take advantage of this - for example, that their capacity to do so has been developed. Ferlie and Pettigrew (1998: 209), for instance, note that, 'particularly at middle management level ... the pace and complexity of work had been upped' as a result of the networking phenomenon in the NHS and that middle managers feh under threat from networking. In addition, while the growth of the networking phenomenon has paradoxically been the result of central govemment intervention (Ferlie and Pettigrew, 1998), an enhanced middle manager role in the new network arrangements may require that central govemment intervene less than has been evident during the realisation of general management and intemal market reforms. Whether the current Labour Govemment is less likely than the previous Conservative Administration to intervene is questionable. As Klein (1999) notes, 'Labour's new NHS represents a reversion to a command and control model' (Klein, 1999: 9), Further the Labour Govemment is committed to budget austerity and greater visibility for the performance of the NHS. This may militate against an enhanced role for middle managers.

9.5 Summary - The Contribution of the Thesis

Finally it is necessary to highlight how the findings of this research contribute to academic literature about the influence of middle managers upon stiategic change and their role within the management of health services. In chapter 1 an empirical gap was noted in discussion about the possibility of an enhanced role for middle managers (Dopson and Stewart, 1990, 1993; Smith, 1997). In chapter 2, that the typology of involvement of middle managers in strategic change developed by Floyd and Wooldridge (1992, 1994, 1997) may be a useful theoretical lens to view middle managers influence upon stiategic change, was noted. This chapter also suggested features of inner and outer context of the organisation in which middle manager is situated may impact upon the possibility of an enhanced role. Chapter 3 developed this further within the specific context of the NHS and highlighted that, despite the promotion of a general management ethos, that central govemment intervention and medical group power may represent considerable constraints upon an enhanced role for middle managers.

The contribution of this study is firstly to provide an empirical basis to assertions, positive or negative, about the role of middle managers in organisations (Dopson and Stewart, 1990, 1993; Smith, 1997). ft does this by investigating the role of middle managers within a public sector organisation. This sector is one that is under-researched by management academics, much of whose research takes place in private sector organisations. For example, even Quinn's work (Quinn, 1978, 1980, 1982)

takes place in a private sector context yet this is a framework for strategic change commonly seen as useful for public sector organisations (Pettigrew et al, 1992).

Secondly, the thesis has brought generic management literature to bear upon the public sector by considering the utility of the theoretical framework developed by Floyd and Wooldridge (1992, 1994, 1997) in analysing the role of middle managers in the NHS.

Thirdly, in a contribution to the health services management literature, the study considers the limiting features within the context of the NHS to any enhanced influence for middle managers and how features of irmer context might facilitate an enhanced role for middle managers.

Finally, the thesis makes a methodological contribution in operationalising the successive case studies approach (Eisenhardt, 1989). In situating the researcher in the production of the data in chapter 4, the thesis highlights some of the issues that other researchers might consider in more inductive case study approaches.

The empirical findings illustrate that both pessimistic and optimistic commentaries about the future of middle managers may have substance, at least in the case of the NHS. The case for pessimism is supported by the restmcturing of the case study organisations, particularly Florence Hospital and CCHT, so that there is a smaller number of middle managers, and by the presence of significant constraints upon middle managers influence, notably the power of a professional group, such as medics, and the impact of central govemment intervention in the NHS. A more

optimistic reading of the role of middle managers is supported by the emphasis in the cases upon a general management ethos in the face of resource constraints and the development of an intemal market. As a consequence, middle managers may enjoy an enhanced role, although this is likely to remain within the role of implementing deliberate strategy, rather than that they take up a 'facilitating adaptability', 'synthesising information' or 'championing altematives' role (Floyd and Wooldridge, 1992, 1994, 1997).

While the typology of middle managers involvement in strategic change developed by Floyd and Wooldridge (1992, 1994, 1997) provides a useful lens through which to view the influence of middle managers upon strategic change, as noted above it appears a rather optimistic reading of an enhanced middle manager role, at least within the context of the NHS. Further, given that the empirical findings in this study suggest any enhancement of role to lie mainly within that of the role of implementing deliberate strategy, as noted in the section on further research (9.4.2) Floyd and Wooldridge *{ibid.)* do not recognise the variation in discretion that is available to middle managers in this role. The case studies illustrate that middle managers may enjoy an enhanced role in strategic change within the role of implementing deliberate strategy where features of an umbrella strategy (Mintzberg and Waters, 1985) are present as opposed to situations in which strategic change is imposed upon middle managers and where both means and ends are tightly set.

The main limiting factors to middle managers influence upon stiategic change lie within the outer context of the organisation. These are significant and add weight to a more pessimistic scenario of the fiiture of middle managers in the NHS. Medical

group power remains a force that commonly may limit middle managers' influence to that of the administrative domain. In addition, central govemment intervention may increasingly mean that strategy is formulated by executive management and that both ends and means of this are tightly set by them in response to government policy. This limits any discretion allowed for middle manager influence upon strateguc change. However, to an extent, limiting factors may be overcome and a more optimistic argument about the role of middle managers may be supported by the case study evidence. The case studies illustrate that where characteristics of strategic change allow for emergence, as noted above, where organisational stmctures allow for boundary spanning on the part of middle managers and where resources are devoted to the development of the middle manager group, that middle managers can enjoy an enhanced influence upon strategic change within the constraints imposed by the medical group and central govemment policy.

References

Ackroyd, S. (1996), 'Organization Contra Organizations: Professions and Organizational Change in the United Kingdom', *Organization Studies,* 17(4), pp. 599-621.

Ackroyd, S., J. Hughes and K. Soothill (1989) 'Public Sector Services and Their Management', *Journal of Management Studies,* 26(6), pp 603-619.

Albert, M. and M. Silverman (1984a) 'Making Management Philosophy a Cultural Reality: Part 1', *Personnel,* 61(1), pp 12-21.

Albert, M. and M. Silverman (1984b) 'Making Management Philosophy a Cultural Reahty: Part 2', *Personnel,* 61(2), pp 28-35.

Allen, D. (1996) *The Shape of General Hospital Nursing: The Division of Labour at Work.* Unpublished PhD Thesis, University of Nottingham.

Allsop, J. (1995) *Health Policy and the NHS.* Hariow: Longman.

Ansoff, H. I. (1965) *Corporate Strategy: An Analytical Approach to Business Policy for Growth and Expansion.* New York: McGraw Hill.

Arkin, A. (1990) 'Cutting Out the Middle Manager', *Personnel Management Plus,* 1(3), pp 16-17.

Ashbumer, L. (1996), 'The Role of Clinicians in the Management of the NHS', In (Eds. J. Leopold, I. Glover, M. Hughes), *Beyond Reason: The National Health Service and the Limits of Management,* Aldershot: Avebury.

Ashbumer, L. and L. Fitzgerald (1994), 'Boards of Directors in Healthcare and Strategy Formulation Processes', *British Academy of Management Conference,* Lancaster, September.

Ashbumer, L. and K. Birch (1999), 'Professional Control Issues between Medicine and Nursing in Primary Care" In (Eds. A. L. Mark and S. Dopson), *Organisational Behaviour in Health Care: The Research Agenda',* Basingstoke: MacMillan.

Ashbumer, L., E. Ferlie, and L. Fitzgerald (1994) *Organisational Transformation and Top Down Change: The Case of the NHS.* University of Warwick: Centre for Corporate Strategy and Change.

Astley, W. and P. Sachdeva (1984) 'Stmctural Sources of Intraorganisational Power: A Theoretical Synthesis', *Academy of Management Review,* 9, pp 104-113.

Bach, S. (1994) 'Restmcturing the Personnel Function: The Case of NHS Tmsts', *Human Resource Management Journal,* 5(2), pp 99-115.

Baggott, R. (1997) 'Evaluating Health Care Reform: The Case of the NHS Intemal Market', *Public Administration,* 75(2), pp 283-306.

Bamard, K., K. Lee, A. Mills and J. Reynolds (1979), *Towards a New Rationality: A Study of Planning in the NHS.* Leeds: University of Leeds, Nuffield Centre for Health Services Studies.

Bamett, S., D. Buchanan, M. Patrickson, and J. Maddem (1996) 'Negotiating the Evolution of the HR Function: Practical Advice from the Health Care Sector', *Human Resource Management Journal,* 6(4), pp 18-37.

Bechhofer, F. (1974) 'Current Approaches to Empirical Research', in J. Rex (ed.), *Approaches to Sociology: An Introduction to Major Trends in British Sociology.* London: Routledge and Kegan-Paul.

Beer, M., P. Lawrence, Q. Mills, and R. Walton (1984) *Managing Human Assets.* New York: Free Press.

Bendix, R. (1956) *Work and Authority in Industry: Ideologies of Management in the Course of Industrialization.* Berkeley and Los Angeles: University of California Press.

Bennett, N., M. Crawford & C. Riches (1992) *Managing Change in Education: Individual and Organisational Perspectives.* London: OU Press and Paul Chapman Publishing.

Berger, P. and T. Luckmann (1967) *The Social Construction of Reality.* London: Unwin.

Best, G. (1987) *The Future of General Management - Where Next?* London: Kings Fund.

Bloor, M. (1997) 'Techniques of Validation in Qualitative Research: A Critical Commentary', in G. Miller and R. Dingwall, (eds.), *Context and Method in Qualitative Research.* London: Sage.

Bogdan, R. and S. K. Biklen (1982) *Qualitative Research for Education.* Boston: AUyn and Bacon.

Bomcki, C. and P. Byosiere (1991) 'Toward Global Business Leadership: Emerging Middle Managerial Roles in Five American MNCs', *12th Annual International Conference of the Strategic Management Society,* London, June.

Bomcki, C, P.H.R. Byosier and S. Dopson (1992) 'Changes in the Role of the Middle Manager: A European View', *Third Conference on International Personnel and Human Resource Management,* Ashridge Management College, July.

Bower, J.L. (1970) *Managing the Resource Allocation Process.* Cambridge MA: Harvard University Press.

Bowling, A. (1996), 'Health Care Rationing: The Public's Debate', *British Medical Journal,* **312,** pp. 670-674.

Boyd, K. M. (1979) *The Ethics of Resource Allocation in Health Care.* Edinburgh: University of Edinburgh Press.

Bozeman, B. and J. Straussmann (1990) *Public Management Strategies.* Oxford; Jossey Bass.

Brass, D. (1984) 'Being in the Right Place: A Structural Analysis of Individual Influence in an Organisation', *Administrative Science Quarterly,* 29(4), pp 518-539.

Brockner, J. S., T.R. Tyler, & R. Cooper-Schneider (1992) 'The Influence of Prior Commitment to an Institution on Reactions to Perceived Unfaimess: The Higher they are, the Harder they Fall', *Administrative Science Quarterly,* 37, pp 241-261.

Brown, A. (1995a) *Organisational Culture.* London: Pitman.

Brown, S. (1995b) *Postmodern Marketing.* London: Routledge.

Bryman, A. (1988) *Quantity and Quality in Social Research.* London: Unwin Hyman.

Bryman, A. and R. G. Burgess (1993) *Analysing Qualitative Data.* London: Routledge.

Bryson, J. M. (1988) *Strategic Planning for Public and Non-Profit Organization.* San Francisco: Jossey-Bass.

Buchanan, D. and J. McCalman (1988) 'Confidence, Visibility and Pressure: The Effects of Shared Information in Computer Aided Hotel Management', *New Technology Work and Employment,* 3, pp 38-46.

Buchanan, D. and J. McCalman (1989) *High Performing Work Systems: The Digital Experience.* London: Routledge.

Buchanan, D., S. Jordane, D. Preston and A. Smith (1998), 'Doctor in the Process: Engaging Clinical Directors in Hospital Management', *Leicester Business School Occasional Paper 40,* Leicester: De Montford University.

Burgelman, R.A. (1983a) 'A Model of the Interaction of Strategic Behaviour, Corporate Context, and the Concept of Strategy', *Academy of Management Review,* **8**(1), pp 61-70.

Burgelman, R.A. (1983b) 'A Process Model of Intemal Corporate Venturing in a Diversified Major Firm', *Administrative Science Quarterly,* 28, pp 223-244.

Burgelman, R.A. (1983c) 'Corporate Entrepreneurship and Strategic Management: Insights from a Process Study', *Management Science,* 29, pp 1349-1364.

Burgelman, R. A. (1991) 'Intraorganizational Ecology of Strategy-making and Organizational Adaption - Theory and Field Research', *Organization Science, 2,* pp 239-262.

Burgelman, R. A. (1994) 'Fading Memories - A Process of Strategic Business exit in Dynamic Environments', *Administrative Science Quarterly,* 39, pp 24-27.

Burgess, R. (1984) *In the Field: An Introduction to Field Research.* London: Allen and Unwin.

Burgoyne, J, and B. Jackson (1997) 'The Arena Thesis: Management Development as a Pluralistic Meeting point', In (Eds. J. Burgoyne and M. Reynolds) *Management Learning: Integrating Perspectives in Theory and Practice.* London: Sage.

Burrell, G. (1996) 'Hard Times for the Salatariat', In (Ed. H. Scarborough), *The Management of Expertise.* London: Macmillan.

Burrell, G. and G. Morgan (1979) *Sociological Paradigms and Organisational Analysis.* London: Heinemann.

Burris, D. (1994) *Technotrends.* New York, NY: HarperCollins.

Caines, E. (1990) Time to Grow Up: Message from the Top for NHS Personnel Managers', *Personnel Management,* August 12th, p 12.

Cameron, K.S., S. J. Freeman and A. K. Mishra (1991) 'Best Practices in White Collar Downsizing: Managing Contradictions', *Academy of Management Executive,* 5(3), pp 57-73.

Carr-Saunders, A. M. and P. A. Wilson (1933) *The Professions.* Oxford: Oxford University Press.

Cascio, W.F. (1993) 'Downsizing: What Do We Know? What Have We Learned?', *Academy of Management Executive,* 7(1), pp 95-104.

Cassell, C. and G. Symon (1994) *Qualitative Methods in Organisational Research.* London: Sage.

Castle, B. (1980) *The Castle Diaries 1974-76.* London: Weidenfeld and Nicolson.

Caulkin, S. (1995) 'Take Your Partners', *Management Today,* Febmary, pp 29-30.

Cave, E. & C. Wilkinson (1992), 'Developing Managerial Capabilities in Education', In (Eds. N. Bennett, M. Crawford & C. Riches) *Managing Change in Education.* London: OU Press and Paul Chapman Publishing.

Chandler, A. (1962) *Strategy and Structure.* Cambridge,MA: MIT Press.

Chandler, A. (1977) *The Visible Hand: The Managerial Revolution in American Business.* Cambridge MA: Harvard University Press/Belknap Press.

Child, J., M. Fores, I. Glover, and P. Lawrence (1983), 'A Price to Pay? Professionalism and Work Organisation in Britain and West Germany', *Sociology,* 17, pp. 63-77.

Christopher, M., A. Payne and D. Ballantyne (1991) *Relationship Marketing.* Oxford: Butterworth-Heinemarm.

Clark, P. and K. Starkey (1988) *Organisation Transitions and Innovation.* London: Pinter.

Clarke, J. and J. Newman (1997) *The Managerial State.* London: Sage.

Compton, R. and G. Jones (1988) 'Researching White Collar Organisations: Why Sociologists Should Not Stop Doing Case Studies', In (Ed. A. Bryman), *Doing Research in Organisations.* London: Routledge.

Coopers and Lybrand (1993) *Introduction to Business Planning.* London: Coopers and Lybrand.

Corby, S. (1992) 'Industrial Relations Developments in NHS Tmsts', *Employee Relations,* 14(6), pp 46-59.

Corby, S. and D. Higham (1996) 'Decentrahsation of Pay in the NHS: Diagnosis and Prognosis', *Human Resource Management Journal,* 6(1), pp 42-62.

Crompton, R. (1990), 'Professions in the Current Context', *Work, Employment and Society,* May, Special Issue on The 1980s: A Decade of Change', pp 147-166.

Grossman, R. H. S. (1977) *The Diaries of a Cabinet Minister: Volume 3; Secretary of State for Social Services, 1968-70.* London: Hamish Hamilton and Jonathan Cape.

Currie, G. (1993) 'Influence of Organisation Structure upon Management Development for Clinicians', *Health Manpower Management,* 19(1), pp 4-7.

Currie, G. (1996) 'Contested Terrain: The Incomplete Closure of Management in the Health Service. *Personnel Review.* 25(5), pp 8-22.

Currie, G. (1999a) 'Resistance Around a Management Development Progranune: Negotiated Order in a Hospital Tmst', *Management Learning,* 30(1), pp 43-62.

Currie, G. (1999b) 'The Influence of Middle Managers in the Business Planning Process', *British Journal of Management,* 10(2), pp 141-156.

Currie, G. (1999c) 'The Role of Middle Managers in Strategic Change: The Emergence of a Marketing Strategy in a Hospital Tmst', In (Eds. A. Mark And S.

Dopson), *Organisational Behaviour in Health Care: The Future Research Agenda.* London: Macmillan.

Currie, G. (2000) 'The Role of Middle Managers in Strategic Change - The Case of Marketing in the NHS', *Public Money and Management,* Special edition on the pubhc manager in 2010, 20(1), pp. 17-21.

Daudi, P., L. Holden and I. Roberts (1997). 'European Managers: The Search for Identity in an Evolving Role: Challenges and Uncertainties', *Institute of Social Sciences Management Working Paper,* **No.5,** University of Kalmar.

Davies, C. (1983). 'Professionals in Bureaucracies: The Conflict Thesis Revisited', In (Eds. R. Dingwall and P. Lewis), *The Sociology of Professions.* London: MacMillan.

Davies, J. and Y. Deighan (1986) 'The Managerial Menopause', *Personnel Management,* March, pp 28-32.

Dawson, S., V. Mole, P. Winstanley, and J. Sherval (1992) 'Management Competition and Professional Practice', *Knowledge Workers in Contemporary Organisations Conference,* University of Lancaster, September.

Dean, A., Y. Cariisle, C. Baden-Fuller (1999 forthcoming) 'Punctuated and Continuous Change: The UK Water Industry', *British Journal of Management* (Special Edition from British Academy of Management Conference, 1998).

Dent, M. (1993), 'Professionahsm, Educated Labour and the State: Hospital Medicine and the New Managerialism', *The Sociological Review,* 41, pp. 244-273.

DHSS (1983) *NHS Management Inquiry (Griffiths Report).* London: HMSO.

DoH (1989a) Working for Patients (White Paper). London: HMSO.

DoH (1989b) Caring for People: Community Care in the Next Decade and Beyond. London: HMSO.

DoH (1990) *National Health Service and Community Care Act.* London: HMSO.

DoH (1997) *The New NHS: Modern and Dependable.* London: HMSO.

DoH (1998) *Working Together - Securing a Quality Workforce for the NHS.* London: HMSO.

Doherty, N., J. Bank & S. Vinnicombe (1995) *Managing Survivors: The Experience of Survivors in BT and the British Financial Sector.* Bedford: Cranfield University.

Dopson, S. (1993), 'Management: The One Disease Consuhants Did Not Think Existed', *Templeton College Management Research Papers,* MR94/2, Oxford: Templeton College, Oxford University.

Dopson, S. (1996), 'Doctors in Management: A Challenge to Established Debates', In (Eds. Leopold, J., I. Glover, M. Hughes), *Beyond Reason: The National Health Service and the Limits of Management.* Aldershot: Avebury.

Dopson, S. (1997). *Managing Ambiguity and Change.* Basingstoke: MacMillan.

Dopson, S. and R. Stewart (1990) 'What is Happening to Middle Management?', *British Journal of Management,* 1(3), pp 3-16.

Dopson, S., A. Risk and R. Stewart (1992) 'The Changing Role of Middle Managers in the United Kingdom', *International Studies of Management and Organisation*, **22**(1), pp 40-53.

Dopson, S and R. Stewart (1993) 'Information Technology, Organisational Restmcturing and the Future of Middle Management', *New Technology, Work and Employment,* 8(1), pp 10-20.

Dmcker, P. (1988) 'The Coming of the New Organisation', *Harvard Business Review,* 66(1), pp 45-53.

Dutton, J. and S. Ashford (1993) 'Selling Issues to Top Management', *Academy of Management Review,* 18(3), pp 397-428.

Dutton, J. and R. Duncan (1987) 'The Influence of the Strategic Planning Process on Strategic Change', *Strategic Management Journal,* 8, pp 103-116.

Dutton, J.E., and S.E. Jackson (1987) 'Categorising Strategic Issues: Links to Organisation Action', *Academy of Management Review,* 12, pp 76-90.

Eckstein, H. (1958). *English Health Service.* Cambridge Mass: Harvard University Press.

Eckstein, H. (1958). *English Health Service.* Cambridge Mass: Harvard University Press.

Eckstein, H. (1960). *Pressure Group of Politics.* London: Allen & Unwin.

Edwards, R. C. (1979) *Contested Terrain: The Transformation of the Workplace in the Twentieth Century.* London: Heinemann.

Eisenhardt, K.M. (1989) 'Building Theories from Case Study Research', *Academy of Management Review,* 14(4), pp 532-550.

Elcock, H. (1993) 'Strategic Management', In (Eds. D. Famham & S. Horton) *Managing the New Public Services.* Basingstoke: MacMillan.

Elcock, H. (1996) 'Local Government' In (Eds. D. Famham & S. Horton), *Managing the New Public Services.* Basingstoke: Macmillan.

Elcock, H. and S. Haywood (1980). *The Buck Stops Where? Accountability and Control in the National Health Service.* Hull: University of Hull, Institute for Health Studies.

Enthoven, A. (1985) *Refiections on the Management of the National Health Service,* Occcasional paper, 5; London: Nuffield Provincial Hospitals Tmst.

Etzioni, A. (1959), 'Authority Stmcture and Organisational Effectiveness', *Administrative Science Quarterly,* pp. 43-67.

Evans, P. (1992) 'Developing Leaders and Managing Development', *European Management Journal,* 10(1), pp 1-9.

Exworthy, M. and S. Halford (1999), 'Professionals and Managers in a Changing Public Sector: Conflict, Compromise and Collaboration' in (Eds. Exworthy, M. and S. Halford) *Professionals and the New Managerialism in the Public Sector.* Buckingham: OU Press.

Fairey, M.J., C. Condon, N. Darby, I. Donaldson, D. Kenny and I. Wickings (1975). *A Review of the Management of the Reorganised NHS.* London: Association of Chief Administrators of Health Authorities.

Famham, D. & S. Horton *{\996) Managing the New Public Services.* Basingstoke: Macmillan.

Ferhe, E. (1992) 'The Creation and Evolution of Quasi Markets in the Pubhc Sector: A Problem for Strategic Management', *Strategic Management Journal,* 13, pp 79-97.

Ferlie, E. and A. Pettigrew (1998) 'Managing Through Networks', In (Eds. C. Mabey and J. Storey), *Strategic Human Resource Management: A Reader.* London: Sage.

Ferlie, E., L. Caimcross and A. Pettigrew (1992) 'Understanding Intemal Markets in the NHS', In (Ed. I. Tilley), *Managing the International Markets.* London: Chapman and Hall.

Ferlie, E., L. Ashbumer, L. Fitzgerald, and A. Pettigrew (1996) *The New Public Management in Action.* Oxford: Oxford University Press.

Fitzgerald, L. (1996), 'Clinical Management: The Impact of Changing Context on a Changing Profession', In (Eds. Leopold, J., I. Glover, M. Hughes), *Beyond Reason: The National Health Service and the Limits of Management.* Aldershot: Avebury.

Floyd, S.W., and B. Wooldridge (1992) 'Middle Management Involvement in Strategy and its Association with Strategic Type: A Research Note', *Strategic Management Journal,* 13, pp 153-167.

Floyd, S.W. and B. Wooldridge (1994) 'Dinosaurs or Dynamos? Recognising Middle Management's Strategic Role', *Academy of Management Executive,* 8(4), pp 47-57.

Floyd, S.W. and B. Wooldridge (1997) 'Middle Management's Strategic Influence and Organisational Performance', *Journal of Management Studies,* 34(3), pp 465-485.

Forster, N. (1994) 'The Analysis of Company Documentation, in (Eds. C. Cassell and G. Symon), *Qualitative Methods in Organizational Research.* London: Sage.

Forsyth, G. (1966) *Doctors and State Medicine: A Study of the British hational Health Service.* London: Pitman Medical.

Frohman, A.L. and L.W. Johnson (1993) *The Middle Management Challenge: Moving from Crisis to Empowerment.* New York: McGraw-Hill.

Further Education Development Agency (1997) *Press Release.* July 1st

Geertz, C. (1973) *The Interpretation Of Cultures.* New York: Basic Books.

Giddens, A. (1990) *Consequences of Modernity.* Cambridge and Oxford: Polity and Blackwell.

Glover, I. and J. Leopold (1996), 'The Future: Reahsm and Diversity?' In (Eds. Leopold, J., I. Glover, M. Hughes), *Beyond Reason: The National Health Service and the Limits of Management.* Aldershot: Avebury.

Goffee, R. and R. Scase (1992) 'Organisational Change and the Corporate Career: The Restmcturing of Managers Job Aspirations', *Human Relations,* **45(4),** pp 363-385.

Guest, D. & R. Peccei (1992) 'Employee Involvement: Redundancy as a Critical Case', *Human Resource Management Journal,* 2(3), pp 34-59.

Guest, D.E. and R. Peccei (1994) 'The Nature and Causes of Effective Human Resource Management', *British Journal of Industrial Relations,* 32(2), pp 219-242.

Gurm, L. (1978) 'Why is Implementation so Difficuh?' *Management Services in Government,* 33, pp 10-19.

Ham, C. (1981), *Policy Making in the National Health Service.* London: MacMillan.

Ham, C. (1997) *Management and Competition in the NHS.* Oxford: Radchffe Press.

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in Practice.* London: Routledge.

Hancock, C, (1994) 'Managers Out For The Count', *Health Service Journal* **105**(5384), p 17.

Hardy, C, A. Langley, H. Mintzberg and J. Rose (1983), 'Strategy Formation in the University Setting', *Review of Higher Education,* 6(4), pp. 407-433.

Harrison, S. (1981) 'The Politics of Health Manpower' in (Eds. A. F. Long and G. Mercer) *Manpower Planning in the National Health Service.* Famborough: Gower Press.

Harrison, S. (1988) *Managing the National Health Service: Shifting the Frontier?* London: Chapman and Hall.

Harrison, S. (1999) 'Clinical Autonomy and Health Policy: Past and Futures', In (Eds. M. Exworthy and S. Halford) *Professionals and the New Managerialism in the Public Sector.* Buckingham: OU Press.

Harrison, S. and C. Pollitt (1994) *Controlling Health Professionals.* Buckingham: OU Press.

Harrison, J. and S. Nutley (1996), 'Professions and Management in the Public Sector: The Experience of Local Govemment and the NHS in Britain', In (Eds. J. Leopold, I. Glover & M. Hughes), *Beyond Reason: The National Health Service and the Limits of Management.* Aldershot: Avebury.

Harrison, S., S. Haywood and C. Fussell (1984), 'Problems and Solutions: The Perceptions of NHS Managers', *Hospital and Health Services Review,* 80(4).

Harrison, S., D. J. Hunter and C. Pollitt (1990) *The Dynamics of British Health Policy.* London: Unwin Hyman.

Harrison, S., D. J. Hunter, G. Mamoch and C. Pollitt (1992) *Just Managing: Power and Culture in the National Health Service.* Basingstoke: Macmillan.

Harrison, S., D. J. Hunter, G. Mamoch and C. Pollitt (1989a), *General Management in the NHS: Before and After the White Paper.* Leeds: Nuffield Institute.

Harrison, S., D. J. Hunter, G. Mamoch and C. Pollitt (1989b), 'General Management and Medical Autonomy in the National Health Service', *Health Services Management Research*, 2(1), pp. 38-46.

Harrison, S., D.J. Hunter, G. Mamoch and C. Pollitt (1989c) *The Impact of General Management in the Health Service.* Milton Keynes: Open University.

Hart, S. (1992) 'An Integrative Framework for Strategy-Making Processes', *Academy of Management Review,* 17, pp 327-351.

Hart, S. and C. Banbury (1994) 'How Strategy-making Processes can make a Difference', *Strategic Management Journal,* 15, pp 251-269.

Hartley, J.F. (1994) 'Case Studies in Organisational Research', In (Eds. C. Cassell and G. Symon), *Qualitative Methods in Organisational Research.* London: Sage.

Haywood, S. and A. Alaszewski (1980), *Crisis in the Health Service.* London: Croom Helm.

Health Service Journal (1994a) 'Experts Warn Against Lack of Leadership in the NHS', 104(5427), p 3.

Health Service Journal (1994b) 'The First Lesson for Margaret Beckett', 104(5427), p 15.

Heckscher, C. (1995) *White Collar Blues: Management Loyalties in an Age of Corporate Restructuring.* New York: Basic Books.

Heginbotham, C. (1993), 'Health care priority setting: a survey of doctors, managers and the general public', In (Ed. R. Smith) *Rationing in Action,* London: BMJ Publishing Group.

Hicks, R.L. (1971) 'Developing the Top Management Group in a Total Systems Organisation', *Personnel Journal,* 50(9), pp 675-693.

Hinings, C. R., D. J. Hickson, J. M. Pennings and R. E. Schneck (1971), 'Stmctured conditions of intraorganisational power', *Administrative Science Quarterly,* 16(2), June, pp. 147-159.

Hirst, P. and G. Thompson (1995) *Globalisation in Question.* London: Polity Press.

Hoggett, P. (1991). 'A New management in the Pubhc Sector?' *Policy and Politics,* 19(4), pp. 243-256.

Hoggett, P. (1994) 'The Politics of Modemisation of the UK Welfare State', In (Eds. R. Burrows and B. Loader) *Towards a Post-Fordist Welfare State?* London: Routledge.

Hood, C. (1991) 'A Public Management For All Seasons', *Public Administration,* 69(1), pp 3-19.

Hooley, G., J. Lynch and J. Shepherd (1990) 'The Marketing Concept: Putting the Theory into Practice', *European Journal of Marketing,* 24(9), pp 7-24.

Hoos, I.R. (1960) 'When the Computer Takes Over the Office', *Harvard Business Review,* 38(4), pp 102-112.

Houston, F. S. (1986) 'The Marketing Concept: What ft Is and What ft Is Not', *Journal of Marketing,* 50, pp 81-87.

Hrebiniak, L.G. and Joyce, W. F. (1984) *Implementing Strategy.* New York: Macmillan.

Hunt, J.W. (1982) 'Developing Middle Managers in Shrinking Organisations', *Journal of Management Development,* 1(2), pp 10-22.

Hunt, J.W. (1986) 'Ahenation Amongst Managers - The New Epidemic or the Social Scientists Invention', *Personnel Review,* 15(1), pp. 21-26.

Hunter, D. J. (1979), 'Coping With Uncertainty, Decisions and Resources Within Health Authorities', *Sociology of Health and Illness,* 1(1), pp. 41-67.

Hunter, D. J. (1980), *Coping with Uncertainty.* Chichester: Research Studies Press.

Hunter, D. (1998) 'Putting the National in the NHS', *Health Service Journal* **108**(5590), p 18.

Income Data Services (IDS) (1998) *IDS Report 754 (February).* London: IDS

Industrial Relations Services (1993) 'Local Bargaining in the NHS: A Survey of First and Second Wave Tmsts', *IRS Employment Trends,* 537, pp 7-16.

Industrial Relations Services (1997) *Health Service Report.* London: Industrial Relations Services.

Jackson, P.M. (1993a) 'Editorial: Public Sector Performance - The Unended Quest', *Public Money and Management,* 13(4), pp 3-4.

Jackson, P.M. (1993b) 'Pubhc Service Performance Evaluation: A Strategic Perspective', *Public Money and Management,* 13(4), pp 9-14.

Jacobs, R. and R. Bolton (1993) 'Career Analysis: The Missing Link in Managerial Assessment and Development', *Human Resource Management Journal,* 3(2), pp 55-62.

Jacoby, S. (1984) 'The Development of Intemal Labour Markets in American Manufacturing Firms', In (Ed. P. Osterman), *Internal Labour Markets.* Cambridge MA: MIT Press.

Jacques, E. (1976) *Health Services: Their Nature and Organisation.* London, Heinemarm.

Jagger, J. (1992) 'MCI and Educational Management', In (Eds. N. Bennett, M. Crawford & C. Riches), *Managing Change in Education.* London: OU Press and Paul Chapman Publishing.

Jemison, D. (1984) 'The Importance of Boundary Spanning Roles in Stiategic Decision-Making', *Journal of Management Studies,* 21(2), pp 131-152.

Johnson, G. (1988) 'Rethinking Incrementalism', *Strategic Management Journal,* 9, pp 75-91.

Johnson, L. and A. Frohman (1989) 'Identifying and Closing the Gap in the Middle in Organisations', *Academy of Management Executive,* 3(2), pp 107-114.

Kanter, R. (1982) 'The Middle Manager as Irmovator' *Harvard Business Review,* July-August, pp 95-105.

Kanter, R. (1983) *The Change Masters: Corporate Entrepreneurs at Work.* London: Routledge.

Kanter, R.M. (1989) *When Giants Learn to Dance.* New York: Simon and Schuster.

Kanter, R. M., B.A. Stenn and T.D. Jick (1992) *The Challenge of Organizational Change: How Companies Experience It and Leaders Guide It.* New York: Free Press.

Keen, L. (1994/95) 'Organisational Decentralisation and Budgetary Devolution in Local Govemment: A Case of Middle Management Autonomy?', *Human Resource Management Journal,* 5(2), pp 79-98.

Keen, L. & S. A. Vickerstaffe (1997) 'We're All Human Resource Managers Now: Local Govemment Middle Managers', *Public Money and Management,* 17(3), pp 41-46.

Kester, I. (1999), 'Strategic Management in the Public Services', In (Eds. S. Horton & D. Famham) *Public Management in Britain.* Basingstoke: MacMillan.

Kidder, T. (1981) *The Soul of a New Machine.* New York: Basic Books.

Kirkpatrick, I. (1999) 'The Worst of Both Worlds? Public Services Without Markets or Bureaucracies', *Public Money and Management,* special edition on 'Markets, Hierarchies and Networks', **19(4),** pp 7-14.

Klein, R. (1989) *The New Politics of the NHS.* 2nd Edition, Hariow: Longman.

Klein, R. (1995) *The New Politics of the NHS.* 3rd Edition, Harlow: Longman.

Klein, R. (1999) 'Grating Expectations', *The Guardian (Society),* 20th October, pp 8-9

Kotler, P. and S. J. Levy (1971) 'Demarketing Yes Demarketing', *Harvard Business Review,* **49(6),** pp 74-80.

Kvale, S. (1997) *Interviews: An Introduction to Qualitative Research Interviewing.* London: Sage.

Laing, A. and A. Galbraith (1995) 'Strategic Marketing in the NHS: Kwik-health NHS Tmst', *Journal of Management in Medicine,* 9(2), pp 6-14

Laing, A. and A. Galbraith (1996) 'Developing a Market Orientation in the Health Service: A Survey of Acute Tmsts in Scotland', *Journal of Management in Medicine,* **10(4), pp** 24-35.

Langley, A. (1986) *The Role of Formal Analysis in Organisations.* Unpubhshed PhD thesis, Ecole des Hautes Etudes Commerciales de Montreal.

Langley, A. (1988), 'The Roles of Formal Strategic Planning', *Long Range Planning,* 21(3), pp. 40-50.

Langley, A. (1989), 'In Search of Rationality: The Purposes Behind the Use of Formal Aanalysis in Organizations', *Administrative Science Quarterly,* 34, pp. 598-631.

Leach, S. (1996) *Mission Statements and Strategic Visions: Symbol or Substance?* London: LGMB.

Leach, S., J. Stewart & K. Walsh (1994) *The Changing Organisation and Management of Local Government.* Basingstoke: MacMillan.

Lebor, W. and Stofinan, J. (1988) 'Putting Management Back in the Middle', *Personnel Administrator,* September, pp 45-50.

Leifer, R. and A. Delbecq (1978) 'Organisational/Environmental Interchange: A Model of Boundary Spanning Activity', *Academy of Management Review,* 3, pp 40-50.

Lemieux, L. and F. Champagne (1998) 'Special Canadian Issue on Healthcare Organizational Performance', *Health Services Management Research,* **11**(1).

Lester, T. (1992) 'Metamorphosis of the Manager', *Management Today,* August, pp 72-75.

Likert , R. (1961) *New Patterns of Management.* New York: McGraw Hill.

Lindblom, C.E., (1959) 'The Science of Muddling Through', *Public Administration Review,* 19, pp 79-89.

Lindblom, C. E. (1968) *The Policy Making Process.* Englewood Cliffs NJ: Prentice Hall.

Lindblom, C.E. (1979) 'Still Muddling, Not Yet Through', *Public Administration Review,* 39(6), pp 517-526.

Llewellyn, S. (1997), 'Purchasing Power and Polarized Professionalism in British Medicine', paper presented at University of Nottingham Business School staff seminar, Febmary.

Local Govemment Training Board (1987) *Getting Closer to the Public.* Luton: Local Govemment Training Board.

Mark, A. and R.Brennan (1995) 'Demarketing - Managing Demand in the UK National Health Service', *Public Money and Management,* **15(3),** pp 17-22.

Martin, J. and P. Frost (1996) 'The Organisational Culture War Games: A Stmggle for Intellectual Dominance', In (Eds. C. Hardy & S. Clegg), *Handbook of Organisational Studies.* London: Sage.

Maynard, A. (1983) 'Privatising the National Health Service, *Lloyds Bank Review,* **148,** pp 28-41.

McKee, L., G. Mamoch and N. Dinnie (1999), 'Medical Managers: Puppetmasters or Puppets? Sources of Power and Influence in Clinical Directorates' In (Eds. A. L. Mark and S. Dopson), *Organisational Behaviour in Health Care: The Research Agenda.* Basingstoke: MacMillan.

McKevitt, D. (1992) 'Strategic Management in the Pubhc Services' in (Eds. L. Wilcocks and J. Harrow) *Rediscovering Public Services Management.* London: McGraw Hill.

McNulty, T., R. Whittington, R. Whipp and M. Kitchener (1994) 'Implementing Marketing in NHS Hospitals' *Public Money and Management,* 14(3), pp 51-57.

McTaggart, J. M. (1994) *The Value Imperative.* New York: Free Press.

McVicar, M. (1996) 'Education', In (Eds. D. Famham & S. Horton), *Managing the New Public Services.* Basingstoke: MacMillan.

Melia, K.M. (1997) 'Producing Plausible Stories: Interviewing Student Nurses', In (Eds. G. Miller & R. Dingwall), *Context and Method in Qualitative Research.* London: Sage.

Melman, S. (1983). *Profits Without Production.* New York: Alfred Knopf.

Miles, M.B. and A. M. Huberman (1984) *Analysing Qualitative Data: A Sourcebook for New Methods.* Beverley Hills CA: Sage.

Miles, R.E. and C.C. Snow (1986) 'Organizations: New Concepts for New Forms', *California Management Review,* 28(3), pp 62-73.

Millman, Z. and J. Hartwick (1987) 'The Impact of Automated Office Systems on Middle Managers and Their Work, *MIS Quarterly,* **11**, pp 479-492.

Ministry of Health and Scottish Home and Health Department (1966) *Report of the Committee on Senior Nursing Staff Structure* (Chairman: Brian Salmon). London: HMSO.

Mintzberg, H. (1973) *The Nature of Managerial Work.* New York: Harper Row.

Mintzberg, H. (1979) *The Structuring of Organisations,* Englewood Cliffs NJ: Prentice Hall.

Mintzberg, H., (1987) 'Crafting Strategy', Harvard Business Review, July-August, pp 65-75.

Mintzberg, H. (1990) 'The Design School : Reconsidering the Basic Premises of Strategic Management', *Strategic Management Journal,* 11, pp 171-195.

Mintzberg, H. (1991) 'Leaming 1 Planning 0: Reply to Igor Ansoff, Strategic Management Joumal, 12, pp 463-466.

Mintzberg, H. (1993) *The Rise and Fall of Strategic Planning,* Hemel Hempstead: Prentice Hall.

Mintzberg, H. (1995) 'The Professional Organisation', In (Eds. H. Mintzberg, J.B. Quinn & S. Ghosal), *The Strategy Process.* London: Prentice Hall.

Mintzberg, H. and J.A. Waters (1982) 'Tracking Strategy in an Entrepreneurial Firm', *Academy of Management Journal,* 25, pp 465-499.

Mintzberg, H. and J.A. Waters (1985) 'Of Strategies Deliberate and Emergent', *Strategic Management Journal,* 6, pp 257-272.

Mintzberg, H., B. Ahlstrand and J. Lampel (1998) *Strategy Safari: A Guided Tour Through the Wilds of Strategic Management.* Hemel Hempstead: Prentice Hall.

Mueller, F. and J. Purcell (1992) 'The Drive for Higher Productivity', *Personnel Management,* May, pp 28-33.

Newell, H. and S. Dopson (1995) 'Middle Management Careers: A Case Study of the Experience of Middle Managers in British Telecom', *Warwick Papers in Industrial Relations,* No.51, University of Warwick: Industrial Relations Unit.

Newell, H. & S. Dopson (1996) 'Muddle in the Middle: Organizational Restmctiming and Middle Management', *Personnel Review,* 25(4), pp 4-20.

NHSTA (1986) *Better Management, Better Health.* Bristol: National Health Service Training Authority.

NHSTD (1992) *A Management Development Strategy for the NHS: A Report on the Launch Conference.* London: NHS Training Directorate.

Noer, D. M. (1993). *Healing the Wounds: Overcoming the Trauma of Layoffs and Revitalizing Downsized Corporations.* San Francisco: Jossey Bass.

Nonaka, I. (1988) 'Towards Middle Up/Down Management: Accelerating Information Creation', *Sloan Management Review,* 29, Spring, pp 9-18.

Nonaka, I. (1991) 'The Knowledge-Creating Company', *Harvard Business Review,* November-December, pp 96-104.

Nonaka, I. (1994) 'A Dynamic Theory of Organizational Knowledge Creation', *Organization Science,* 5, pp 14-37.

Nonaka, I. and H. Takeuchi (1995) *The Knowledge Creating Company.* Oxford: Oxford University Press.

Nonaka, I., H. Amikura, T. Kanai and T. Kawamura (1992) 'Organizational Knowledge Creation and the Role of Middle Managers', *Academy of Management Conference*, Las Vegas, August.

Nutt, P.C. (1987) 'Identifying and Appraising How Managers Install Strategy'. *Strategic Management Journal,* 8, pp 1-14.

Gates, D. (1992) 'Too Much Round the Middle', *Accountancy,* September, pp 39-40.

Osterman, P. (1986) 'The Impact of Computers upon the Employment of Clerks and Managers', *Industrial Relations and Labour Relations Review,* 39(2), pp 175-186.

Peters, T. (1985) 'Why Smaller Staffs Do Better', *New York Times,* 21st April, pp 14-15.

Peters, T.J. (1987) *Thriving on Chaos.* New York: Harper and Row.

Peters, T.J. (1992) *Liberation Management.* New York: MacMillan.

Peters, T. and R. Waterman (1982) *In Search of Excellence.* New York: Harper and Row.

Pettigrew, A. M. (1985) *The Awakening Giant.* Oxford: Blackwell.

Pettigrew, A. and R. Whipp (1991). *Managing Change for Competitive Success.* Oxford: Blackwell.

Pettigrew, A.M., E. Ferhe and L, McKee (1992) *Shaping Strategic Change.* London: Sage.

Pettinger, N. (1998) 'Bureaucracy: Hit and Myth', *Health Service Journal,* 108(5592), pp 30-31.

Piercy, N. (1991) *Market-led Strategic Change.* London: Grafton.

Pinsonneault, A. and K. L. Kraemer (1993) 'The Impact of Information Technology on Middle Managers', *MIS Quarterly,* September, pp 271-292.

Polhtt, C. (1990) *Managerialism and the Public Services.* Oxford: Blackwell.

Pollitt, C, S. Harrison, D. Hunter and S. Mamoch (1991) 'General Management in the NHS: The Initial Impact 1983-1988', *Public Administration, 69,* pp 61-83.

Poole, M. (1990) 'Editorial: HRM in an International Perspective', *International Journal of Human Resource Management,* 1(1), pp 1-15.

Preston, D., A. Smith, D. Buchanan and S. Jordan (1996) 'Symbols of the NHS: Understanding the Culture and Communication Processes of a General Hospital', *Management Learning,* 27(3), pp 343-358.

Procter, S. and G. Currie (1999) 'Making Teamworking Work in the Inland Revenue', *3rd Annual Conference on Teamworking*, Royal Holloway, University of London, September.

Procter, S., G. Currie and H. Orme (1999) 'The Empowerment of Middle Managers in a Community Health Tmst', *Personnel Review,* 28(3), pp 242-257.

Pugh, D.S., D.J. Hickson, C.R. Hinings and C. Tumer (1968) 'Dimensions of Orgarizational Stmcture', *Administrative Science Quarterly,* 13, pp. 65-91.

Quirm, J.B. (1978) 'Strategic Change: Logical Incrementahsm', *Sloan Management Review,* 20, pp 7-21.

Quinn, J.B. (1980) *Strategies for Change: Logical Incrementalism.* Homewood ILL: Irwin.

Quinn, J.B. (1982) 'Managing Strategies Incrementally', *Omega,* 10(6), pp 613-627.

Raelin, J. A. (1995) *The Clash of Cultures: Managers Managing Professionals.* Boston, MA: Harvard Business School Press.

Ranade, W. (1995) 'The Theory and Practice of Managed Competition in the National Health Service', *Public Administration,* 73, pp 241-262.

Ranade, W. (1997) *A Future for the NHS? Health Care in the 1990s*. London: Longman.

Ranson, S. and J. Stewart (1994) *Management for the Public Domain: Enabling the Learning Society.* London: MacMillan.

Reader, W. J. (1996) *Professional men,* London: Weidenfeld and Nicholson.

Redman, T., A. Wilkinson and E. Snape (1997) 'Stuck in the Middle? Managers in Building Societies', *Work, Employment and Society,* 11(1), pp 101-114.

Reed, M. and P. Anthony (1992), 'Professionalising management and managing professionals: British management in the 1980s', *Journal of Management Studies,* 29(5), pp. 591-614.

Rhodes, R.A.W. (1997) 'From Marketization to Diplomacy: ft's the Mix that Matters', *Public Service Research Unit Annual Conference,* Cardiff, April.

Riordan, J. F. and J. Simpson (1995), 'Getting Started as a Medical Manager', In (Eds. J. Simpson and R. Smith) *Management for Doctors.* London: BMJ Publishing.

Robertson, R. (1992) *Globalization: Social Theory and Global Culture.* London: Sage.

Sayles, L. (1993) *The Working Leader.* New York: The Free Press.

Scase, R. and R. Goffee (1989) *Reluctant Managers.* London: Unwin Hyman.

Schatzman, L. and A. Strauss (1973) *Field Research: Strategies For Natural Sociology.* Englewood Chffs NJ: Prentice Hall.

Schendel, D.E., and C. W. Hofer (1979) *Strategic Management: A New View of Business Policy and Planning.* Boston MA: Little, Brown and Co.

Schilit, W.K. (1987) 'An Examination of the Influence of Middle Level Managers in Formulating and Implementing Stiategic Decisions', *Journal of Management Studies,* 24, pp 271-293.

Schiht, W. and F. Paine (1987) 'An Examination of the Underlying Dynamics of Sti-ategic Decisions Subject to Upward Influence Activity', *Journal of Management Studies*, *24{2),pp* 161-179.

Schuler, R.S. and D. Harris (1992) *Managing Quality: The Primer for Middle Managers.* New York: Addison Wesley.

Schulz, R.I. and S. Harrison (1983) *Teams and Top Managers in the NHS: A Survey and Strategy,* Paper No. 41, London: Kings Fund Project.

Scrivens, E. (1991) 'Is There a Role for Marketing in the Pubhc Sector?' *Public Money and Management,* **11(2), pp** 17-24.

Segal-Horn, S. (1998) *The Strategy Reader.* Milton Keynes: Open University.

Sheaff, R. (1991a) 'Marketing in the National Health Service: Prospects and Variants', *Public Money and Management,* **11(2),** pp 25-32.

Sheaff, R. (1991b) *Marketing for Health Services.* Milton Keynes: Open University Press.

Sherwood, J. (1988) 'Creating Work Culture with Competitive Advantage', *Organizational Dynamics,* **16(3), pp** 4-27.

Shorten, S. M., E. Morrison and B. Friedman (1990) *Strategic Choices for America's Hospitals: Managing Change in Turbulent Times.* San Francisco: Jossey Bass.

Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text, and Interaction.* London: Sage.

Simpson, J. (1995), 'Doctors and Management - Why Bother?' in (Eds. J. Simpson & R. Smith) *Management for Doctors.* London: BMJ Publishing.

Simon, H. (1960) 'The Corporation: Will it be Managed by Machines?' In (Eds. H. Leavitt and L. R. Pondy), *Readings in Managerial Psychology 1964.* Chicago: University of Chicago Press.

Sisson, K. (1990) 'Editorial: Introducing the Human Resource Management Journal', *Human Resource Management Journal,* 1(1), pp 1-11.

Sloan, A.P. (1963) *My Years with General Motors.* London: Sedgewick and Jackson.

Smith, V. (1997) *Managing in the Corporate Interest: Control and Resistance in an American Bank.* Berkeley CA: University of Califomia Press.

Snell, R. and J. Davies (1988) 'Tackling Organisational Disillusionment Through Management Development', *Journal of European Industrial Training,* 12(6), pp 5-11.

Staehle, W. and F. Schirmer (1992) 'Lower Level and Middle Level Managers as the Recipients and Actors of Human Resource Management', *International Studies of Management and Organisation,* 22(1), pp 67-89.

Stewart, R. and N. Fondas (1992) 'How managers Can Think Strategically About Their Jobs', *Journal of Management Development,* pp 10-17.

Stewart, J.D. and S. Ranson (1988) 'Management in the Public Domain', *Public Money and Management,* 8(2), pp 13-19.

Stewart, J. D. and K. Walsh (1992) 'Change in the Management of Pubhc Services', *Public Administration,* 70, pp 499-518.

Stewart, R., P. Smith, J. Blake and P. Wingate (1980) *The District Administrator in the National Health Service.* London: King Edward's Hospital Fund.

Stock, J., I. Secombe and P. Kettley (1994) *The Changing Role of the NHS Personnel Function.* Brighton: Institute of Manpower Studies.

Storey, J. (1992) *Developments in the Management of Human Resources.* Oxford: Blackwell.

Strauss, A. and J. Corbin (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park CA: Sage.

Strong, P., and J. Robinson (1988) *New Model Management: Griffiths and the NHS.* Nursing Policy Studies Centre: University of Warwick.

Taylor, S.J. and Bogdan, R. (1984) *Introduction to Qualitative Research: The Search for Meanings.* New York: Wiley.

Thomas, R. and D. Dunkerley (1997) 'Enriched or Enslaved? Middle Management in the Dela'yered Organisation', *The Strategic Direction of Human Resource Management Conference,* Nottingham Trent University, December.

Thomas, R. & D. Dunkeriey (1999) 'Middle Managers Experiences in the Downsized Organization', *British Journal of Management,* 10(2), pp 157-169.

Thompson, D. (1996) 'Business Planning in Hong Kong hospitals: The Emergence of a Seamless Health Care Management Process', *Health Services Management Research,* 9(3), pp 192-207.

Thomhill, A. & A. Gibbons (1995) 'The Positive Management of Redundancy Survivors: Issues and Lessons', *British Journal of Management,* 7(3), pp 5-12.

Thomhill, A. & M. Saunders (1997) 'Downsizing, Delayering - But Where's the Commitment?', *Personnel Review,* 26(2), pp 14-22.

Trice, H.M. and Beyer, J.M. (1993) *The Cultures of Work Organisations.* Englewood Cliffs NJ: Prentice Hall.

TumbuU, S. (1998) 'Corporate Ideology: An Iron Cage for the Middle Managers in a Large Corporation', *British Academy of Management,* Nottingham, September.

Tushman, M. and E. Romanelh (1983) 'Uncertainty, Social Location and Influence in Decision-Making', *Management Science,* 29(1), pp 12-23.

Ulrich, D. (1997) *Human Resource Champions.* Boston MA: Harvard Business School Press.

Van Maanen, J., J. Dabbs and R. Faulkner (1982) *Varieties of Qualitative Research.* Newbury Park CA: Sage.

Waddington, D. (1994) 'Participant Observation', In (Eds. Cassell, C. & G. Symon), *Qualitative Methods in Organisational Research.* London: Sage.

Wall, A. (1999) 'Courtin' the Middle', *Health Service Journal,* 109(5640), pp 22-25.

Walsh, K. (1991) 'Citizens and Consumers: Marketing and Public Sector Management', *Public Money and Management,* 11(2), pp 9-16.

Walton, R. and P. Lawrence (1985) *Human Resources Management: Trends and Challenges.* Boston: Harvard Business School Press.

Watson, T.J. (1994) *In Search of Management: Culture, Chaos and Control in Managerial Work.* London: Routledge.

Webster, C. (1988) *The Health Services Since the War, Volume 1.* London HMSO.

Westley, F.R. (1990) 'Middle Managers and Strategy: Microdynamics of Inclusion', *Strategic Management Journal,* 11, pp 337-351.

Wheatley, M. (1992) *The Future of Middle Management.* London: British Institute of Management.

Whipp, R. and P. Clark (1986) *Innovation in the Auto Industry: Product, Process and Work Organisation.* London: Pinter.

Whittington, R. (1993) *What is Strategy - and Does it Matter?* London: Intemational Thomson Business Press.

Whittington, R., T. McNulty, R. Whipp (1994) 'Market-Driven Change in Professional Services: Problems and Processes', *Public Administration,* 31(6), pp 829-845.

Williams, A., P. Dobson and M. Wahers (1993) *Changing Culture: New Organisational Approaches.* London: IPM.

Wood, J. (1990) 'How Organisations Survived Redundancy', *Personnel Management,* December, pp 38-41.

Wooldridge, B. and S. Floyd (1990) 'The Strategy Process, Middle Management Involvement, and Organisational Performance', *Strategic Management Journal,* 11, pp 231-241.

Yin, R. K. (1994) *Case Study Research.* Newbury Park CA: Sage.

Yorke, D. A. (1990) 'Developing an Interactive Approach to the Marketing of Professional Services', In (Ed. D. Ford), *Understanding Business Markets.* London: Academic Press.

APPENDIX A

Interview Schedule - First Phase of Interviews at Florence Hospital

(1) Background and current position of interviewee.

(2) How have you seen things change over period worked in NHS? (Break down into distinct time periods if necessary). Explore issues raised in more detail.

(3) Impact of changes upon NHS, organisation, individual. Have changes been imposed or does individual manager have some influence in change. What changes has there been in any managerial role undertaken by yourself over the period of the changes?

(4) Agreement or disagreement with changes & reasons for this. In particular, explore professional:managerial conflict.

(5) Professional:managerial conflict at an individual level eg. explore identity, role conflict.

(6) What are the implications of changes since 1983 for management education of middle managers?

(7) What management education have respondents received since 1983?

(8) Will competence-based programme meet development needs? Why/why not? Explore issues raised in more detail.

APPENDIX B

Interview Schedule - Second Phase of Interviews at Florence Hospital

(1) Personal background and current position?

(2) Describe what's happening regarding management education in tmst for middle managers.

(3) Who's driving the programme?

(4) What influence have middle managers had over content & process?

(5) Does it meet middle manager needs? In what ways?

(6) What problems are there with it? Elaborate - delivery/assumptions behind comp/imposition?

(7) Response to problems? Examples of resistance from middle managers.

(8) What middle managers need in management education terms?

(9) Perceptions of business planning - what is it, time frame, content?

(10) Feelings about introduction of business planning in NHS?

(11) What is middle managers role in this?

(12) What other parties are involved? How?

(13) Has content/process of business planning changed since introduction? Why?

(14) How (not) middle managers influence through business planning? Examples?

(15) Main constraints upon middle manager influence?

(16) Any other problems of business plarming in NHS?

(17) Any other comments about management education or business plarming?

APPENDIX C

Interview Schedule - Third Phase of Interviews at Florence Hospital

(1) Check personal background & current role?

(2) Elaborate upon how business planning changed over time since introduction. Pick up on influence of performance indicators imposed by govemment.

(3) Elaborate upon how individual directorate business plans are brought together at corporate level.

(4) Any examples of service development proposed by middle managers through business plarming that have been realised?

(5) What are the conditions that allowed this to happen?

(6) What is interaction of middle managers with medical group in business plarming? To what extent do medics constrain service development proposed by middle managers? Examples.

(7) Any other constraints upon middle manager influence through business plarming.

(8) What's happening re. Marketing in the tmst?

(9) How is it linked to business planning in tmst?

(10) What are your feelings about the introduction of marketing in the tmst?

(11) Who's driving its introduction? How?

(12) What is your perception of the marketing workshop?

(13) What involvement do middle managers have in the marketing process?

(14) Examples of marketing activity carried out by middle managers?

(15) Any constraints upon middle manager influence?

(16) Interaction with Medical group

(17) How 'helped' to carry out marketing?

(18) Any other comments re marketing & business plarming?

APPENDIX D

Interview Schedule at CCHT

(1) Personal background - career history & current position.

(2) What's your view of the current situation regarding local pay?

(3) Who are the main parties involved in its formulation & implementation? Role of Personnel/Finance? What arguments do they present in its favour?

(4) What's been your involvement? What constiaints upon your role?

(5) Has local pay been a success? Why/why not? Objections?

(6) What's your view of management development in the tmst for middle managers?

(7) Who is responsible for management development? Role of Personnel?

(8) Is management development meeting your needs? Why/why not?

(9) What's happening re. competence-based recmitment & selection in the tmst?

(10) What parties have been involved in its formulation & implementation?

(11) Role of Personnel? What arguments do they present in its favour?

(12) What is your involvement in formulation and implementation of this?

(13) Has it been imposed upon you? What is your response to this?

(14) What constraints upon your influence upon competence-based r&s?

(15) Has it been successful? Why/why not?

(16) How would you describe the current situation re skill mix?

(17) What parties have been involved in its formulation & implementation?

(18) Role of Personnel? What arguments do they present in its favour?

(19) What is your involvement in formulation and implementation of this?

(20) Has it been imposed upon you? What is your response to this?

(21) What constraints upon your role?

(22) Any other comments?

APPENDIX E

Interview Schedule at Edwards Hospital

(1) Personal background & current position.

(2) Elaborate upon current role & characteristics of directorate managed, if apphcable.

(3) What are the main HR issues faced in directorate/across tmst.

(4) Elaborate upon each of these - eg. local pay, competences, skill mix, management education, sickness and absence

(5) How is HR strategy formulated - by Personnel function? involving middle managers? What form does strategy take? (top-down, rational planning, emergent, umbrella?)

(6) Elaborate upon role of Personnel in realisation of strategic change - take each issue in tum - does Persormel formulate & impose HR solutions?.

(7) What is role of middle manager? Do middle managers identify problems & suggest HR solutions?

(8) Examples that illustrate influence of middle manager or not in each HR area identified.

(9) Any constraints upon realisation of HR strategy generally & contribution of middle managers specifically towards this? Medical group/govemment policy?

(10) Under what conditions is stiategic change in the area of HR realised? Characteristics of strategic change? Govemment policy? Medical group influence?

(11) Under what conditions are middle managers likely to enjoy influence upon strategic change in the HR area? Boundary-sparming opportunities ? Management education support?

(12) Any other comments?