Cranfield University
School of Management and Cranfield Health

NHS National Institute for Health Research
Service Delivery and Organisation Research Programme

How do they manage?

a study of the realities of middle and front line management work in healthcare

three years, starting January 2009

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**Scientific summary**

Managers constitute 3 per cent of the NHS workforce. That figure underestimates the impact of management practice on clinical outcomes, quality of patient care, and organizational performance. The NHS has concentrated on senior leadership, and less is known about the experience and attitudes of middle and front line managers in acute care, who are the focus of this project. Exploring the realities of management work, their role in change, and links between practice and performance, this study has four aims.

The first is to contribute to the *practice and theory of healthcare management* in order to improve patient care and organizational performance.

The second is to provide *evidence-based guidance* for management development, strengthening the impact of management practices on hospital performance, streamlining the implementation of changes following adverse events in the interests of patient safety.

These first two aims will be achieved with new perspectives, approaches, frameworks, diagnostics, methods, tools, and processes based on new evidence. We will identify the organizational features that support managers in contributing to clinical and corporate performance, building an ‘enabling environment’.

Our third aim is to *engage stakeholders* as co-researchers through our collaborative research design. In addition to respondent validation, this approach will develop ‘high impact’ channels for communicating the implications of findings.

Our final aim is to develop *the theory of managing*, synthesizing current models, theories of distributed leadership, and processual-contextual perspectives on change.

Our collaborative research design involves six hospital trusts over six stages: (1) set up (research assistant, background information, literature review, ethical approval), (2) management focus groups, (3) management survey concentrating on the themes of realities, changes, and contributions, with 60 per cent of items common for all sites for comparison and 40 per cent based on local trust issues and priorities, (4) management briefings to check findings, explore implications, consider diffusion mechanisms, and identify cases for the next stage; (5) case studies of change following extreme or adverse incidents, and (6) publication and knowledge transfer. Research methods include document analysis, focus groups, self-report survey questionnaires, interviews, and case studies of ‘extreme change’. Analysis methods include context profiling, content analysis, statistical analysis, visual mapping, event sequence analysis, and ideas capture from briefing groups.

Outcomes can be measured in terms of service impact. For patients and service users, this concerns management practices that will improve quality of care and clinical outcomes, and rapid changes following ‘extreme’ events leading to improved patient safety. For middle and front line managers, this means a better understanding of how the role is evolving, competency requirements, methods for influencing clinical and organizational outcomes, and techniques for managing ‘extreme’ change. For senior managers, we will provide guidance on management development and support needs, and advice on developing an ‘enabling context’ for the management impact on clinical, organizational, and change-related outcomes. For policy makers, this research will deliver a model of management work, explaining the demands and pressures, the new competencies required, the contributions to change and performance outcomes, and the implications of extending clinical engagement in management.
Lay summary

How do hospital managers handle the pressures and demands of a constantly changing health service? And what effect do managers have on the quality of patient care and the outcomes of treatment? We know surprisingly little about the work experience and attitudes of hospital managers, but when things go wrong, this is the group which usually takes the blame. A key management responsibility is changing hospital services for the better. Patient safety is a national priority, and we want to find out in particular how changes to working practices are managed after serious incidents. This seems to be a problem, as the advice of enquiries, in health and other areas, can often sit on the shelf. This study will build on what we already know about management work, and organizational change and change leadership, relating this to current trends and to change in ‘extreme’ circumstances. We will collect the information we need using briefing groups, interviews, a survey questionnaire, and case studies of ‘extreme events’ and their aftermath. We will ask the middle and front line managers involved in this study to help us with the design of the survey, and with choosing interesting examples of ‘extreme events’. As they are one of the main consumers of the findings from this project, we will ask them to check our understanding of the data, and to help us develop novel ways to communicate the implications, so that this work does have an effect on management practice. Finally, this project aims to improve patient safety by developing guidelines for change after adverse events. It will deliver advice on management development based on a better understanding of how middle and front line managers work, and how they can improve the quality and results of patient care, as well as overall hospital performance.
Details of research proposal

**Introduction, aims and objectives**

This project will address three related sets of questions:

1. **Realities**: What are the new pressures and demands facing middle and front line managers in healthcare? What are the implications of these trends? How do managers cope with shifting priorities and expectations?

2. **Changes**: What roles do middle and front line managers play in implementing changes? How are changes arising from adverse events implemented, and how can this process be improved?

3. **Contributions**: How does management practice affect clinical and organizational outcomes? What factors influence the management contribution to performance? How can the components of an ‘enabling environment’ for the management contribution be assembled and sustained?

**What we don’t know**

The service has invested in senior management (Department of Health, 2002). We know less about the working lives of middle and front line managers; the motives and rewards, the challenges and tensions, how the job is changing, new capabilities required. But when things go wrong, here is the group which often attracts most of the criticism.

**Managing realities**: we don’t know whether or how today’s novel pressures and demands are affecting the realities of middle and front line management work in acute settings, or the nature of the attributes and competencies required in these roles. But we do seem to understand the main components of traditional general management roles (Mintzberg, 1994).

**Managing change**: we don’t know why, following ‘extreme’ or adverse events, inquiry recommendations sit on a shelf, but are sometimes adopted rapidly. But implementing change is a key aspect of middle and front line management work, and we do seem to understand many aspects of ‘normal’ change in healthcare (Locock, 2001).

**Managing contribution**: we don’t know how middle and front line managers influence organizational and clinical outcomes, through change implementation and other dimensions of the role, or what would reinforce that contribution. But we assume that management practice is fundamental (Christian and Anderson, 2007).

We will thus follow ‘the chain of evidence’ from management realities, through change, to outcomes, focusing on middle and front line managers in acute care. ‘Middle and front line’ refers to management posts below trust board level, including career managers, clinical staff in ‘hybrid’ managerial roles, and medical staff who perform management and leadership functions (Department of Health, 2008). This embraces ward sisters, consultants, general managers, and clinical directors. While management in primary care is important, this is not a major theme in this project. PCT managers now focus on commissioning rather than delivering care, and SDO is funding separate research into commissioning. However, we are considering a PCT case study, proposed by a participating acute trust, focusing on changes in the primary care management role, implications for inter-organizational relationships, and the impact on management in acute settings.
Our overarching objective is to make a difference, contributing to the practice and theory of healthcare management to improve patient care and organizational performance. Our first aim is to generate fresh evidence, concerning managing realities, changes, and contributions. Our second aim is to develop a range of evidence-based guidance (tools, perspectives, frameworks, diagnostics, methods, approaches, processes), informing management development, identifying contingent factors jeopardizing and facilitating change, and enhancing the links from management practice to organizational and clinical outcomes. Our third aim is to engage stakeholders in the development of actionable knowledge, through our collaborative research design, disseminating implications widely by using our advisory board structure and participants to develop innovative communication modes and channels. Our fourth aim is to contribute to the theory of managing, by synthesizing and building on current thinking with regard to models of the management role, theories of distributed leadership and change agency, and processual-contextual perspectives on organizational change and service improvement.

Managing realities

Middle and front line managers face new pressures and demands; what are the implications? Managers, the textbook says, keep things running as they are, while leaders drive change; administrators versus innovators. Managers at all levels in the NHS may be excused a cynical response to this distinction, having implemented a series of major changes affecting all aspects of the service - culture, structures, priorities, governance, working practices - and more. The *NHS Operating Framework* for 2008/09 and the *Next Stage Review* continue the theme of transformation (Department of Health 2007; 2008). Following *Next Stage*, medical training will include management and leadership skills as a matter of routine. How do healthcare managers - professional and clinical - cope with a broad, diverse, and shifting agenda of competing priorities and expectations, and serial change generating ‘reform fatigue’ (Leatherman and Sutherland, 2008)? How do middle and front line managers cope with this challenging and sometimes contradictory context?

Managing changes

There is a perception that healthcare is ‘different’, and that the management of change is problematic (Øvretveit and Aslaksen, 1999). This has led to a renewed emphasis on medical engagement in leadership and change (NHS Institute, 2008; Hamilton et al., 2008). Nevertheless, many of the goals of *The NHS Plan* have been achieved, switching priorities away from finance and waiting times to quality of care, access, patient and public involvement, and patient safety (Department of Health, 2007). Recent studies show that many radical changes are implemented, not by small groups of senior managers and doctors, but by middle managers and other staff. With the emphasis on patient safety (a core standard; Healthcare Commission, 2007), we will explore the processes of change which follow extreme, adverse, or ‘sentinel’ events, such as accidents, misconduct, and other serious untoward incidents. Considerable efforts are often expended to learn the lessons from such incidents, but those lessons are not always implemented (Donaldson, 2000; Healthcare Commission, 2008). These issues have rarely been investigated from a change management perspective. We will remedy this oversight, linked to a separate cross-sectoral Cranfield project in this area. This is an area in which improved understanding will significantly benefit practice and patients (Shortell et al., 2007).
Managing contributions

How does management practice influence clinical and organizational outcomes? Managerial effectiveness is a slippery concept, stakeholders have competing views (Micheli and Neely, 2006), and assessing the impact of single practices on specific results is problematic. Nevertheless, research suggests a systemic link to outcomes (West et al., 2002; Boyne et al., 2006). While management competencies and practices are key, organizational context is also crucial, in determining receptiveness (Pettigrew et al., 1992), setting priorities and incentives, focusing attention and energy, and establishing an environment that either enables or stifles service improvement. What does an ‘enabling environment’ look like, and how can the components of this environment be assembled and sustained?

Relevance to SDO call for proposals

Our project focuses on the ‘realities of management’ theme (iii); ‘work life, roles and behaviours’, addressing priorities identified by Christian and Anderson (2007, p.19) who concluded that, ‘Management issues were seen as a fundamental determinant of organizational performance: in particular the importance of different management practices; the competency of managers to fulfil their roles; the ability to link in with front-line staff; and involving key figures in proposed changes’. We will explore related themes, such as clinical-managerial relationships, decision making, and knowledge utilization (Rousseau, Manning and Denyer, 2008; two members of our team, Micheli and Denyer, are members of the American evidence-based management collaborative established by Denise Rousseau). But a better understanding of managing realities, changes, and contributions are where this research will have the most significant impact on organizational performance, and quality and outcomes of patient care.

A second intent of this call for proposals is to promote exchange between academic and practitioner communities. Our project engages participating managers throughout the research process, from developing this proposal, through advising on the collection and interpretation of data, to developing implications for practice, and disseminating findings.

Background; NHS context and relevant literature

Of the 1.3 million employees in the NHS in England, there are approximately 36,500 managers, less than 3 per cent of the total (The Information Centre, 2007). That probably underestimates the number of staff who as part of their role perform management functions. And that percentage understates the significance of management contributions to performance. The desire to engage medical staff in management and leadership dates from the 1980s, and has achieved new urgency in current proposals, such as the ‘medical leadership competency framework’ approved by the Academy of Medical Royal Colleges (NHS Institute, 2008; Hamilton et al., 2008). In the context of the theoretical underpinning explained shortly, it is interesting to note that John Clark (Clark et al., 2008, p.33), director of the Enhancing Engagement in Medical Leadership project observes that, ‘Enhanced clinical engagement should work towards a model of diffused leadership, where influence is exercised across a complex set of relationships, systems and cultures. It is a set of behaviours that should apply to all rather than a few’.

Although the Next Stage Review promises ‘no new targets’, the change agenda is sustained. Lord Darzi focuses management attention on accelerating the pace of change with regard to quality of care (linked to funding), patient choice, personalized budgets and care plans, and integrated care, complemented by clinical and board leadership programmes (Department of Cranfield University
School of Management and Cranfield Health
Health, 2008). The *Operating Framework for 2008/09*, noting that finance and waiting times are no longer major concerns, declares an ‘ambitious new chapter’ in the transformation of the NHS, focusing on patient safety, access, better health and reduced inequalities, improving the patient experience and staff satisfaction, and enhanced emergency preparedness; not a recipe for stability (Department of Health, 2007). These aspirations will be achieved by empowering local management and staff to deliver with less central direction.

The *Operating Framework* also makes clear (p.32) that the status of Foundation Trust is no longer an aspiration, but an expectation for all. The governance arrangements of Foundation Trusts, particularly with service line reporting, mean that trusts, and their clinical services, run like businesses. Plans and decisions are now commonly couched in commercial discourse; business units, customers, competitors, marketing (‘promotion of services’), cost allocations, profitability, portfolio analysis, mergers and acquisitions, business development (e.g., Shepherd, 2008). This reflects values different from those that have inspired a publicly-funded healthcare system for the past 60 years. Our anecdotal evidence indicates that managers generally welcome these developments, but that many clinical staff remain sceptical. There is evidence to suggest that these changes are creating new tensions (Sambrook, 2005). It is in this dynamic context of the ongoing - accelerating - transformation of healthcare that this study is positioned.

**Realities**

Broadly, we think we understand what managers do; roles (Mintzberg, 1973; 1994), realities (Stewart, 1997), rewards and pains (Watson, 1994), how they spend their time (Kotter, 1999). But is that knowledge relevant to healthcare management today? Previous research into management roles is mainly ethnographic, using observational methods. Hales (1999) criticizes work which describes management without a theory of managing. Our aim is to understand the links between the realities and the contributions of management work. This will take the form of a multilevel perspective synthesizing three theoretical lenses (Watson, 1997). First, *frameworks* such as Mintzberg (1994) are a useful starting point, highlighting the interaction between values, competencies and style, role purpose, managing information, people and action, and the wider context. This model assumes a manager responsible for a single unit, a situation that does not always apply in the collaborative, process-driven, network organizational forms common in healthcare, where managing *across* internal and external boundaries is increasingly important. This model is silent concerning the links from management practices to outcomes; the ‘well rounded’ manager is presumably effective. Second, theories of *distributed leadership* (Gronn, 2002) draw attention to the fluid contributions to change at all levels (Bailey and Burr, 2005; Buchanan et al., 2007a). Third, *process explanations* consider how factors at different levels of analysis interact over time to shape outcomes (Langley, 2009). This perspective views ‘context’ not as a neutral stage on which action unfolds, but as shaping conditions, events, interactions, and outcomes by enabling, constraining, and predisposing (Fitzgerald et al., 2002).

**Changes**

Recent studies undermine the distinction between leaders who drive change and managers who maintain order, portraying middle management roles in strategy, and in change ‘by stealth’ and ‘under the radar’ (Floyd and Wooldridge, 1996; Huy, 2002; Badaracco, 2002). The development of distributed change leadership, based on the spontaneous concertive action of staff at all levels, is evident in healthcare (Brooks, 1996; Lüscher and Lewis, 2008). From a recent SDO project, Buchanan et al. (2007b) describe a distributed approach to service improvement in the treatment of prostate cancer involving large numbers of staff across the cancer network organizations. Contradictory anecdotal evidence suggests that middle managers follow directions, and have little input into the design of change, focusing on the immediate and the tactical, but there is no robust evidence concerning middle and front line
management experience and perceptions. Implementing change following extreme, adverse or ‘sentinel’ events, such as accidents, misconduct, and other serious incidents, is often problematic. We don’t know why this is so, although this affects patient safety. Consequently, we will focus on these events, rather than develop yet another ‘n-step guide’ to ‘normal’ change (Collins, 1998). Donaldson (2000) recognized the gap between passive learning (establishing the lessons) and active learning (embedding new practices). But in a recent report, he observes that ‘the pace of change has been too slow’ and that ‘we need to redouble our efforts to implement systems and interventions that actively and continuously reduce risk to patients’ (Department of Health, 2006, p.4). When extreme events occur, the focus tends to lie with establishing cause, attributing blame, and remedy. Once the enquiry’s recommendations are published, attention fades. Research has mirrored this profile of concern. There are studies of the ‘incubation phase’, (Turner and Pidgeon, 1997), the causes of ‘normal accidents’ (Perrow, 1999; Vaughan, 1999), the ‘critical period’ (Stein, 2004), sensemaking in crises (Weick, 1993), crisis management (Lagadec, 1997; Lalonde, 2007), ‘high reliability organizations’ (Weick and Roberts, 2003), and the role of public inquiries (Brown, 2000; 2003). The implementation phase has attracted less attention, and studies of extreme events from a change management perspective are lacking (although much can be learned from outliers; Pettigrew, 1990). Research on avoiding wrong site surgery is instructive, Rogers et al. (2004) noting that guidelines are inconsistently implemented because of the failure to account for the complex operating theatre environment. Linked to a separately-funded cross-sectoral study with overlapping project team membership, we will explore the conditions that respectively block and promote ‘active learning’ and change in such contexts.

Contributions

Building on the concept of the ‘receptive context’ for change (Pettigrew et al., 2002), we will identify the clusters of factors that respectively stifle and strengthen the contributions of middle and front line managers to clinical and organizational outcomes. We will identify the features of an ‘enabling environment’, and explore how these differ within and across acute care settings. Identifying the impact of management practices and changes on organizational performance is problematic (Iles and Sutherland, 2001). This is due to the systemic nature of the links between actions and outcomes (West et al., 2002), to the multiplicity of stakeholders, and to the socially constructed nature of ‘effectiveness’. Understanding these links requires a process perspective, in contrast with traditional variance explanations (Mohr, 1982; Langley 1999 and 2009; Van de Ven and Poole, 2002; Buchanan and Dawson, 2007). Process explanations demonstrate how antecedents lead, in particular contexts, to outcomes over time. The concept of ‘conjunctural causality’ involves identifying the clusters, combinations, or configurations of factors that explain the consequences of interest (Armenakis and Bedeian, 1999; Goldstone, 2003; Walker et al., 2007; Fitzgerald and Buchanan, 2007). A recent review of research concerning contributions to service improvement through medical engagement in management revealed little positive impact, but demonstrated how lack of such engagement is problematic (Ham and Dickinson, 2007).
Plan of investigation

**research design**

Collaborative research designs, although not without problems, have been shown to be effective in translating research into practice in healthcare (Denis and Lomas, 2003), and allow for local tailoring of data collection. User engagement contributes to the development and dissemination of findings, and to building research capacity among those involved. This design combines quantitative and rich idiographic data, enabling within-organization, cross-organization, cross-occupation and other comparisons. Outputs will be generated at each stage, not just at the end of the project. This is a six-stage multi-methods collaborative design involving six hospitals; Cambridge University Hospitals (Addenbrooke’s), Bedford Hospital, Gloucestershire Hospitals, Northampton General Hospital, North Bristol Hospital (Southmead), and Whipps Cross University Hospital. These sites display geographical spread, including Foundation and non-Foundation Trusts. We have links with four (Bedford, Gloucestershire, Northampton and Whipps Cross) through Cranfield Health (postgraduate medical school). We may add trusts with wider variance in financial challenge, population characteristics, and local competition, for the survey described in the methods section.

**project management**

We require a sounding board involving concerned and passionate individuals who will learn with us while contributing their ideas and insights. So, we will establish a two-tier advisory group. Tier one includes four healthcare managers and two independent academics, meeting quarterly. Tier two is a virtual group, with 20 managers and clinical staff drawn from our national, regional, and local networks, and with whom contact will be maintained by telephone, email, WebEx, and our project website. These two groups will advise on project methods and focus, access to stakeholder networks, interpretation of findings, applications, and dissemination. The combination of Operating Framework priorities, SHA visions, Local Area Agreements, Next Stage Review, and other national initiatives implies that management structures and roles in place as this research unfolds may differ from configurations at the proposal stage. Management practice in healthcare is a moving target, and our sounding board will ensure that this study sits at the cutting edge of practice and theory.

**research methods**

This is a multi-methods collaborative project using local participation, focus groups, surveys, documentation, performance data, case exemplars based on documentation and interviews, and management briefings. We will engage participants as co-researchers, in survey questionnaire design, case selection, data analysis and interpretation, exploring implications for management practice, and developing innovative methods for disseminating findings.

**Stage 1 (6 months) Set-up**

The first six months of this project will involve:

i. the collection of background information on our research sites through informal meetings and internet downloads;

ii. recruiting, orienting, and equipping our research assistant;

iii. conducting a systematic review of the literature on middle and front line healthcare management, the management of ‘extreme’ change in healthcare, and models of management contributions to healthcare organization outcomes;
iv. obtaining multi-centre, local, and trust ethical approvals - we will obtain approval for the study as a whole, then submit the questionnaire design as a subsequent amendment, rather than delay these approvals until that instrument is complete;

v. designing and establishing the project website;

vi. (under consideration) setting up the primary care trust case study, identifying up to five key informants, collecting background documentation, arranging site visits (four to six over two years), linking with other SDO research teams in this domain.

Stage 2 (6 months) Management focus groups

We will run three or four focus groups at each of the six sites, thus inviting around 100 management volunteers to help us to develop the survey instrument, with regard to new and emerging themes, pressures, trends and developments, affecting middle and front line management in general, and in particular with regard to local management needs, issues, and priorities. The findings from these groups, at each site, in aggregate, and considering cross-site comparisons, will inform survey design, and will constitute data in their own right, on the changing nature of middle and front line management work.

Stage 3 (9 months) The 60-40 Survey

This survey questionnaire will generate evidence on the nature of new and emerging management pressures and demands, and the implications for management practice, for management development and support, and for a theory of managing. Capturing experiences and attitudes, we will survey the middle and front line management populations (around 1,500 total) in our participating organizations. We will use a ‘60-40’ design, in which approximately 60 per cent of survey items will be common to all sites, for comparison and benchmarking purposes, and 40 per cent will be tailored to local priorities following the advice of the management focus groups. As well as the content, the percentages of common and tailored items are likely to vary between sites, and these variations will in turn provide further useful insights. The time allocated to this stage of the project reflects the workload involved in administering the survey, and then collecting, coding, and analysing the data. Subject to participant input and local tailoring, indicative themes are likely to include:

**biodata**

- survey responses will be anonymous and the data confidential
- standard biodata to permit a range of within-sample comparisons
- background; healthcare, other public sector, commercial, clinical, armed forces
- and current role; managerial, hybrid, clinical with management duties

**managing realities**

- values, attitudes, motives, priorities
- new pressures, demands, patterns of activity, and fresh emphases shaping the work
- changing personal attributes and competency requirements
- the management support and development implications of current trends

**managing changes**

- effect of professional barriers and multidisciplinary teams on service improvement
- management attitudes to innovation, growth, and risk
- what factors block effective implementation of service improvement
- change issues arising in implementing the lessons from extreme events
managing contributions

- is there a medical-managerial divide over what constitutes ‘performance’
- which practices, methods, perspectives make a difference
- what barriers must be removed to strengthen the impact of management practices
- does an ‘audit and compliance’ context stifle innovation

These themes will be elaborated through participant collaboration in focus groups, to ensure that the survey addresses local needs and priorities as well as the overall research objectives.

Stage 4 (3 months) Management briefings

It is important that research participants have an early opportunity to assess the findings and their implications. At this stage, findings will be presented to volunteer management focus groups at each site, with five objectives. First, for respondent validation. Second, to check interpretations. Third, to develop practical implications. Fourth, to explore innovative modes of dissemination. Fifth, to identify exemplars case studies for stage 5.

Stage 5 (6 months) Managing extreme events

These case examples will improve our understanding of change processes following adverse or ‘extreme’ incidents, and help develop practical diagnostics and frameworks. We will ask briefing groups to identify six incidents, focusing first on how these events are defined - opportunities for learning and/or for change. Through interviews and documentation, we will identify factors contributing to the outcomes. Although a small sample, we will develop *moderatum* generalizations (Williams, 2000), and contribute to theory through analytical refinement (Tsoukas, 2009). Recognizing the sensitivities and emotions surrounding such events, discussions with potential study sites suggest that research in this area is less problematic than might appear, for several reasons. First, information is often in the public domain. Second, our focus lies with the management of change, not with conducting fresh investigations. Third, the desire for individual and organizational learning is often strong and unmet. Fourth, those who have been involved often welcome an opportunity anonymously to share their thoughts and experiences. Fifth, we will include successful examples of change following extreme incidents, as equally valuable learning opportunities. Finally, events may have occurred in the past, allowing emotions and sensitivities to subside.

Stage 6 (6 months) publication and knowledge transfer

We will engage our advisory groups and the management participants in this project - the end users of the results - in a series of informal exchanges and where possible face to face meetings, to help develop innovative modes of dissemination (beyond professional journals and academic articles). We recognize the need to develop high impact, readily accessible modes of communication, which retain the integrity, and where appropriate the complexity, of the issues at stake and the implications for practice.

The main analytical approaches and techniques that we will deploy at each stage, what we will be looking for, and the anticipated contributions to each of the project’s three main themes - realities, changes, and contributions - are summarized in Table 1. In addition to this structured approach, we will be looking for the surprising, the unexpected, the ‘outliers’ in these data streams, and we will be considering what fresh insights - practical and theoretical - these are likely to reveal.
Benefits to the NHS

For patients and service users, although not involved directly in project fieldwork, this research will deliver:

- management practices and organizational features that have been demonstrated to contribute to improved quality of care and clinical outcomes;
- rapid changes to working practices following ‘extreme’ events, thus leading to improved patient safety.

For middle and front line managers, this research will deliver:

- knowledge of how middle and front line management work is evolving, and why;
- new competency requirements, and how these are acquired and can be best supported;
- new practices, tools, diagnostics, and frameworks for influencing clinical outcomes, care quality, and organizational performance;
- approaches and techniques for managing both ‘extreme’ and ‘normal’ organizational change.

For senior managers, this research will deliver new information on management development priorities and support needs, and a practical guide to the construction and maintenance of an ‘enabling context’ for maximizing the impact of management practices on clinical, care-related, organizational, and change-related outcomes.

For policy makers, this research will deliver a model of healthcare management work, explaining the demands and pressures which these roles generate, the competencies required, the contributions of management practices to change and performance outcomes, and the implications for extending clinical engagement in management and leadership roles.

This project will thus deliver fresh evidence about the realities of middle and front line management work, new perspectives on the implementation of change in atypical circumstances, and a better understanding of the effects of management practices. While evidence, perspectives, and understanding are intangible outcomes, they are nevertheless valuable to the extent that they redirect attention and energy, shape our understanding of problems and the settings in which they arise, and help to guide practical action.

The involvement of stakeholders

Our research design has the advantage of involving significant numbers of individuals with experience of and commitment to the service. Stakeholders will have multiple opportunities to contribute insights and to challenge. This project has several national, regional, and local stakeholders including policy makers, managers, clinical staff, and patients. These groups are not remote entities to be considered when the study is over. On the contrary, one role of our virtual advisory group is to help us to capture the views of those groups from the start.

Cranfield’s mission is to improve management practice through research that generates ‘near to market’ actionable knowledge. Our collaborative design, advisory groups, the involvement of management participants, focus and briefing groups, and dissemination mechanisms, are...
intended to ensure continuing stakeholder involvement, particularly in the co-production of implications for practice, and innovative ideas for dissemination.

**Dissemination plans**

*Researcher*: ‘In what form would you like to see our findings presented?’ *Chief executive*: ‘Not another report.’ Our staged and collaborative research design means that outputs will develop throughout the project, and data streams will be ultimately combined into a series of publications, including academic journals and a book. Our final report will be complemented by briefs summarizing practical guidance, and we will publish in practitioner journals. We will also use Cranfield open and customized programmes, and our Public Sector Performance Roundtable. The project will feature on our School website, and WebEx will be used as an interactive dissemination tool. We will also contribute to practitioner workshops and conferences. But those are all relatively conventional outcomes. We are sensitive to the need to develop ‘high impact’ communication and dissemination media and channels for this project. To help us to develop more innovative methods for disseminating findings, propelling the research-into-practice process, we will be driven by ideas from our project advisory and focus groups. We will be seeking their ideas in this respect throughout the project, and not just towards the end.

**Project timetable**

This project will run over 36 months, from 1 January 2009 to 31 December 2011:

Stage 1 Set-up: January to June 2009

Stage 2 Management focus groups: July to December 2009

Stage 3 The 60-40 survey: January to September 2010

Stage 4 Management briefings: October to December 2010

Stage 5 Managing extreme events: January to June 2011

Stage 6 Publication and dissemination: July to December 2011

**Interim reports**

We will submit interim reports during the first month following the completion of each stage of the project - in July 2009, January 2010, October 2010, January 2011, and July 2011. These reports will summarize progress, key findings, theoretical developments, practical implications, problems arising and how these will be addressed, and will highlight any unusual, unanticipated, and particularly significant issues and outcomes.
<table>
<thead>
<tr>
<th>stage</th>
<th>link to themes</th>
<th>analysis</th>
<th>what will this tell us</th>
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<tbody>
<tr>
<td>1. set-up</td>
<td>managing realities</td>
<td>context profiling, of participating trusts based on background documentation, key organizational and environmental factors</td>
<td>outcomes: identify local priorities, dimensions of within- and cross-site variations, factors potentially shaping management realities</td>
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<td></td>
<td>primary care case*</td>
<td>thematic case report documenting two-year period</td>
<td>outcomes: changes in management role in primary care, implications for inter-organizational relationships, impact on acute management</td>
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<td>2. focus groups</td>
<td>managing realities</td>
<td>content analysis, of discussion and key themes</td>
<td>outcomes: identify recurring patterns of emerging themes, pressures, trends, emphases, and developments affecting middle and front line management; deeper understanding of local needs and priorities, identify idiosyncratic, unexpected, ‘outlier’ themes</td>
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<td>managing change</td>
<td>statistical analysis, frequency distributions and crosstabs (ordinal and nominal data); coding and content analysis of open responses</td>
<td>outcomes: sample characteristics, motives and values, incidence and experience of new challenges and trends, factors and practices impacting effectiveness, components of ‘enabling’ and ‘disabling’ environments for management work, changing patterns of management activity, comparisons of attitudes and experience controlling for age, experience, gender, current role, background, service area and/or function, cross-site comparisons, cross-occupational (e.g., medical-managerial) perceptions and relationships, site-specific findings, unexpected ‘outlier’ results</td>
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<tr>
<td>4. briefing groups</td>
<td>managing contribution</td>
<td>content analysis, of discussion and key themes</td>
<td>outcomes: respondent validation, practitioner check on analysis and interpretations, explore management implications, capture dissemination ideas, identify case exemplars for next stage</td>
</tr>
<tr>
<td>5. extreme events</td>
<td>managing change</td>
<td>visual mapping and event sequence analysis, of incident narratives</td>
<td>outcomes: identify recurring success and problem patterns in extreme change processes, development of conjunctural explanations, contingency management framework based on cross-case comparisons of incidents and following contexts</td>
</tr>
<tr>
<td>6. knowledge transfer</td>
<td>managing contribution</td>
<td>ideas capture</td>
<td>outcomes: clarify and strengthen implications for management practice, develop high impact communications methods, range of publications, briefing seminars and documents, management development and support programmes</td>
</tr>
</tbody>
</table>

* under consideration
References


Cranfield University
School of Management and Cranfield Health


