

**SENSE-MAKING BY CLINICAL AND NON-CLINICAL
EXECUTIVE DIRECTORS
WITHIN NEW GOVERNANCE ARRANGEMENTS**

ABSTRACT

This paper explores the various ways in which clinical executive directors and non-clinical executive directors are interpreting and responding to the extensive reforms and restructuring in the UK health service. The key changes include devolved accountability, the introduction of some market mechanisms and incentives, some element of competition between healthcare provider organisations, more patient choice, a clearer provider-purchaser split, and increased competition from private sector and third sector providers. Changes to healthcare environments of this kind are occurring in many countries but such is the extent and intensity of these changes that the UK government sees this set of reforms leading to a peerless world class health service. The paper draws upon detailed research in two very large teaching hospital organizations in order to understand how actors crucial to the delivery of this vision are responding. We found the clinical and non-clinical directors of these organizations engaged in a process of active sense making which was leading to significant changes to the service and also changes to identity.

KEYWORDS: SENSEMAKING; HEALTHCARE GOVERNANCE; DEVOLVED
ACCOUNTABILITY; PROFIT CENTRES

INTRODUCTION

The purpose of this paper is to examine the way in which clinical executive directors and non-clinical executive directors are interpreting and responding to the new opportunities and threats presented by new governance arrangements and new quasi-market environments. The changes to healthcare environments of this kind are occurring in many countries, this particular study focuses on developments in the UK National Health Service (NHS). The paper draws upon very detailed and prolonged research work in two large public sector teaching hospital organizations in London each of which enjoyed an international reputation.

There are many important dimensions to the array of changes which we label as ‘governance’ in the public sector. At the core of the changes is the devolution of (some) authority and decision-making from the centre to a multitude of locally-based organizations. These organizations are in turn subject to an array of changes to the rules of the game within which they must operate. To survive at all (as individual leaders in senior posts and in the sense of organizational survival) senior managers and the organizations must simultaneously ‘compete’ in a new market-like environment; they must however also meet a wide number of centrally-dictated targets and show accord with standards stipulated and inspected by regulatory bodies; they must also show that they can cooperate and collaborate with other players in the healthcare system. In other words, the directors and senior managers of these devolved, semi-autonomous, public healthcare organizations are subject to a challenging tripartite regime of market, hierarchy and networks. The way in which the directors of these organizations make sense of these rules, regulations, prompts and possibilities is the subject of this paper.

There is a further dimension to the question. The Executive Boards of these organizations are composed of a mix of clinical executive directors and non-clinical executive directors. A further purpose of our analysis is to compare the ways in which clinicians interpret and responded to the opportunities and challenges and the way in which those directors without clinical qualifications and responsibilities make sense and respond. The general consensus from previous research on clinicians as managers has been that, in the main, these professionals have been equivocal and rather reluctant managerial practitioners (Dopson 1996). Further, it has been also suggested that they are not even receptive to the idea of devolved autonomy (Hoque 2004).

Our work suggests a more complicated picture. The assortment of changes and the way in which a number of them interlock and are reinforcing mean that the penalties for disengagement from this round of governance reforms are much higher than heretofore. The focus of our attention in this analysis is on the upper echelon. We do not seek here to assess how departmental heads and clinical leads of service lines are responding.

As we will describe below, both these sets of actors (clinical and non-clinical directors) are working within a complex environment with a plethora of governance changes, governance principles and governance mechanisms. There is undoubtedly lots of governance to attend to. There is scope for argument about how coherent or messy the arrangements are but such an evaluation is not our purpose here. As noted, our intent is to examine how these senior actors are making sense of the governance infrastructure. It is they who need to, and do, make calculations of which aspects to take seriously and which to play-down or even ignore. It is they who decide how to respond as a consequence. It is their story we seek to tell.

Our central question is, therefore, *what are the most significant of the governance changes and how are the actors responding to the new mix of principles and the new rules of the game?*

The paper is organised into five parts. The first part briefly reviews relevant literature on governance in public sector health services and the findings from previous studies on senior clinical responses to governance regimes; the second part describes our research methods; the third part summarises the main changes to governance in the UK national health service; and the fourth part reports on the findings from our research in two major teaching hospitals; the final part discusses the implications of the findings.

THE LITERATURE ON GOVERNANCE AND CLINICIANS

The role of clinicians as managers has been a topic of concern for many years. Work by Degeling et al (2006) compared the similarities and differences in the value stances of clinicians and hospital managers across a number of countries – most notably comparing China with a number of Commonwealth countries. Their results showed a marked division between clinicians and managers in the non-China countries about issues that affect clinical autonomy, whereas this was not the case in the Chinese hospitals (Degeling, Zhang et al. 2006).

Academic research reports in the 1990s generally tended to report the lack of commitment by doctors to managerial roles (for example: (Weightman 1996) (Dopson 1996). In their single case study of a ‘middle-range’ district general hospital, Hoque *et al* (2004) found little inclination to strive for autonomy either from the trust senior managers or from the consultants. Indeed Hoque

et al state that ‘there was no desire for autonomy’ (p373). One development has been the growth of what is known as ‘clinical governance’. This tends to denote some set of protocols to oversee clinical practice (Franks 2001) (Wallace, Spurgeon *et al.* 2001).

Since these reports there have been significant changes to governance in healthcare and in the public services more generally in the UK and elsewhere. Governance has been described as a ‘defining narrative’ in policy circles (Rhodes 1997). Indeed, the ‘governance turn’ has become so pervasive that it has even been suggested that ‘new public governance’ represents the latest paradigm shift displacing the much vaunted ‘New Public Management’ (Osborne 2006). In the NHS, ‘governance’ has been projected to an even more prominent position through a series of policy reforms and reorganisations which have attended to the idea and apparatus of governance in a very explicit way and at multiple levels and in diverse settings. The ideas, principles and mechanisms constituting governance in the NHS derive from an amalgam drawn from corporate governance, public governance and a variety of other sources. The resulting miscellany presents directors, managers and senior clinicians with a considerable sense-making challenge.

The machinery of governance may be established in order to steer, oversee or control the executive function. It has been suggested that the key function of corporate governance is to control and discipline management (Daily and Dalton 2003). This approach accords with agency theory, the main perspective that has been used in governance research and theorising. In the context of the NHS it can be extended to also include control over clinicians. From this perspective, governance represents a means to control ‘self-interested behaviour by agents’ (Jensen and Meckling 1976). In the case of the NHS, these ‘agents’ may be variously viewed as managers and clinicians. Depending on circumstances, the part of the controlling principals may

be played by directors or by regulators. The senior team acting as a corporate board of directors may enact governance and seek to ensure due diligence as part of its overall set of activities.

There can thus be a blurred line with ‘corporate strategy’ and with ‘leadership’. The assumption of the need to control for self-interested behaviour of agents by principals is not shared by all theories of governance. Stewardship theory which works from the assumptions that there can be alignment between intrinsic service motivations and organizational interests offers a significant alternative (Davis, Schoorman et al. 1997).

Policies and experiments in the realm of governance of the NHS have been described as representing a particular manifestation of a confluence of forces and ideas. In part they reflect a wider trend of the ‘hollowing out of the state’ (Rhodes 1997) across a number of service. In addition they reflect the influence of market ideology and the reform of public service provision. They additionally, reflect responses to widely publicised prompting for a greater willingness and desire to learn from others’ experiences (Benz 2007). Governments from each of the main political parties in the UK have honed a narrative about the NHS which suggests the need for a ‘movement from a “failed” bureaucratic model to a system of entrepreneurial governance that would help it to survive’ (Currie and Brown 2003 p.568).

As noted above, our focus was upon the ways in which executive directs – both clinical and non-clinical made sense of these governance arrangements and how they have responded in consequence.

RESEARCH METHODOLOGY

The research reported here is the outcome of the exploratory first stage of a large scale research project led by the authors and concerning the impact of new governance arrangements on the UK NHS. In the present study, we interviewed each member of the top team of executive directors in each of the two teaching hospitals. We selected these organisations on the basis that they were broadly similar but unconnected. Both were large and well established NHS organisations and had publicized themselves as trailblazers in their speed of adaptation to the new governance regime. We therefore identified them as valid sources of data on executive sense making. We chose to explore our theme of executive sense making with two organisations in parallel, not because we expected to find any particular contrasts, but because we wanted to control for any particular circumstances that might make any single case study especially unrepresentative. We do not of course claim that our two cases are representative, even of the population of “leading edge” large Trusts. The kind of validity we claim for our research design is that it provided an opportunity for studying executive sense making in some depth and so could lead us to some tentative conclusions and frameworks for thinking about this sense making, to explored further in other contexts in future research.

There were 17 interviews in total. In Trust A we spoke to five non-clinical executive directors – the part-time chairman, the chief executive, the deputy chief executive, the finance director, and the workforce (or HR) director. We also spoke to four clinician executives – three medical directors and the director of nursing. A number of the directors were interviewed twice. In Trust B, which had a slightly smaller Board, we again spoke to five non clinical directors – the part-time chairman, the chief executive, the finance director, the facilities director, and director of

strategic development – and three clinical directors, comprising two medical directors and the director of nursing. We used a semi-structured interview schedule, asking open questions about each executive’s background, role, and view of developments in NHS governance and how they and their colleagues had responded. One of the authors carried out all the interviews in Trust A and the other in Trust B, this facilitating development of an understanding of developments in each Trust. All interviews were recorded and transcribed. Both authors read all the transcripts, which led to the identification of key themes or categories for coding the interview data. The authors undertook some cross coding of each other’s interviews to ensure consistency in application of the codes, which led to modifications of some the themes. The final set of categories used for understanding executive thinking is set out in the Findings section.

Before coming to this, we review in more depth current developments in NHS governance that formed the context for our two cases.

CHANGES TO GOVERNANCE ARRANGEMENTS IN THE NHS

The shift from central government control to ‘governance’ is often seen as a key component of New Labour’s modernisation project. It relates to devolution and to strategic change.

Modernisation and governance can be seen as part of a related discourse embracing such ideas as a shift from producer interests to client interests, from uniform standardised services to a demand-led approach activated by the intelligent consumer.

Policy makers within the UK Department of Health (DH) are well aware of the linkages between governance and the modernisation agenda. In the publication 'Governing the NHS' (DH 2003) the connection is made quite explicitly:

“Good governance is an essential springboard for modernisation. Getting it right not only enables staff to do a good job. More critically, it leads to better patient care and enables boards to demonstrate proper accountability to local people for the safe running of the health service”.

This statement places board members and senior managers of local primary care and acute care organisations, known as “Trusts”, at the heart of the reforms. It means that accountability is of a higher order than heretofore. Part of the relatively unspoken agenda is the desire to wrest control from doctors, especially hospital consultants, who have long been able to resist the various initiatives such as those stemming from the Griffiths Report (DHSS 1983) which sought to curtail clinicians’ power. Backed by their Royal Colleges, individual doctors have largely succeeded in preserving professional autonomy. The notion of ‘management’ within the NHS therefore has been described as more akin to ‘diplomacy’ (Harrison 1999)p.52. The more recent changes to governance, with the admixture of plurality of acute healthcare providers, payment by results, clinical audit and clinical governance, greater commissioning powers granted to Primary Care Trusts (PCTs), and even further attempts to bolster the power of trust boards and chief executives, may however be cumulatively changing this long-standing state of affairs.

A whole series of organisational changes have been initiated across both primary and secondary care in England which is designed to facilitate the implementation of such principles and ideas. A crucial accompaniment to many of these has been a conscious attempt to build-in formal governance arrangements. These include for example, specifying the accountability of Foundation Trusts, the new and preferred model for organisations that provide acute hospital care. These organisations are accountable to their Boards and through them to their Governors and in turn to local citizens through Membership structures. Supplementing these are the elaborate arrangements for monitoring, regulation, standards and inspection. Such governance structures and processes cover not just corporate boards but also clinicians through parallel arrangements for oversight of clinical practice through clinical governance procedures.

In total, NHS staff including directors, managers and clinicians of all types, find themselves in the middle of a new array of structures, procedures, standards, and targets. They are variously expected to conform to given standards, to meet given targets, to act in business like ways by competing and making a surplus, to abide by professional codes, to cooperate and participate in networks. These cross-cutting regulatory systems combine elements of command and control, bureaucracy, and markets. The diverse demands can seem bewildering. They are in market-like competition for referrals from PCTs, but there is no real market; prices for example are fixed according to national tariffs and are not elastic. The Department of Health in effect sets what a Foundation Trust can charge a Primary Care Trust for treating a particular kind of referral.

Governance issues emerge in relation to numerous types of decision making. These may be major strategic decisions such as the core mission of a trust, its intended size and shape, its new service

configurations, mergers and acquisitions, hospital closure, or other significant matters of scale. Or they may be decisions about a clinical procedure or a special project, or about the routine cycle of operations and their monitoring and reporting. Public confidence issues, media attention, regulatory and judicial scrutiny all contribute to a continuing focus on accountability: who makes decisions, how they are made and how they are disclosed.

At Trust level, overall governance is effected through sets of arrangements based on models borrowed to a considerable extent from the corporate world. Trust Boards have been established, each comprising Non-Executive Directors, a Chair and a Chief Executive. Extensive guidelines detailing how these bodies should be structured and should behave in order to mimic 'effective boards' have been promulgated by the Appointments Commission in conjunction with an independent regulator, called Monitor, supported by Dr Foster Intelligence (DH 2006). The guides state the purpose of NHS boards: to set strategic direction, to oversee progress towards strategic goals and to monitor operational performance' (p1). Additionally, they define the principles which should guide how each of the organisations should operate, they stipulate the role of the boards, outline the precise information requirements needed in order for boards to discharge these responsibilities, they provide model board agendas and an annual cycle of board activities. In other words, there is very considerable guidance and thus scope for relatively uniform practice.

In addition to the guidance about procedures there are numerous external audits of performance outcomes. Of crucial importance here is the national Healthcare Commission which evaluates performance against a detailed list of 'standards'. But at the theoretical axial point to the whole

apparatus is the notion of ‘corporate governance’. This denotes the machinery and processes at Board level which are designed to allow supervision and policy direction of trust management in primary and secondary care. The intense concentration on Trust Boards in recent years including, for example, the focus on building ‘effective boards’ is indicative here.

The extent to which all these initiatives are delivering value for NHS trusts is an empirical question. Corporate governance is a phenomenon that sits above and oversees ‘management’. Its main manifestation is to be found embodied in the Board of Directors including Non-Executives as well as Executive Directors. Their joint role is to assume corporate responsibility, to undertake risk management and to ensure assume responsibility for the financial viability of the undertaking as well as its performance outcomes.

The way in which the top echelon directors of these trusts are making sense of this array of opportunities and threats is the subject of the next section.

FINDINGS

This section analyses the stances through which executive directors (clinical and non-clinical) in our two cases were making sense of the array of governance arrangements within which they now found themselves. Using our interview data we examine their interpretations as to what is involved in taking up their roles and the systems of thinking that inform these roles. We are particularly interested in understanding the range of stances adopted by executive directors with a clinical background versus those with a general management background. For each of these we seek to illuminate how far their stances reflect the strands of thinking that inform NHS policy –

such as entrepreneurialism, community and patient representation; aspects of more traditional professional or clinical values, such as the right of clinicians to decide treatment; and new and emergent modes of sense-making that do not fit easily within either of the previous categories.

Six conceptual categories emerged from the data. These were interpretations about the rationale for change; about the relationship between managerial and clinical priorities; about governance requirements stemming from demands of regulators; desirable principles for organising and managing clinical work; effectiveness of the wider health system organisation; and commitment to organizational success. Using these categories, the overall picture is revealed in the data display shown in Table 1.

[TABLE 1 ABOUT HERE]

We now examine each of these interpretations and stances in turn – first for the non-clinical directors and next for the directors who were clinicians.

NON -CLINICIAN DIRECTOR SENSE-MAKING

In each case, the non-clinical directors included the Chief Executive, the Chair of the Board, the Finance Director, deputy Chief Executive, Operations Director and similar business functions.

(i) Rationales for change

Non clinical executives in both cases spoke as if with one voice about their desire to achieve healthcare delivery more attuned to the needs of patients, seen as customers. As the chief executive of Trust B put it:

“The best of the service industry has moved on to being accessible, convenient, user-friendly, and has transferred the costs to itself, and away from the punter. Whereas, in healthcare, the costs – the travel, right down to trying to park on this site, waiting and so on – are still very much with the patient, and their relatives and carers.”

This aspiration was generally couched in contrast to what the strategic managers saw as the less desirable traditions of the NHS, a high handed, “take it or leave” it attitude as to what services should be delivered and how, held in different but self reinforcing ways by old style senior administrators and their senior medical colleagues. The chairman of Trust A saw his organization as developing along these lines not simply for social reasons, but above all for business reasons, importing a private sector stance that business viability is directly linked to customer service:

“...much more responsive, much less arrogant, much more externally focused on people rather than on institutions.... in terms of a, much more of a focus on customers, I suppose you’d call it customers rather than... our last patient survey shows us as being mediocre in far too many areas and that’s going to have to be an issue... This is not about political correctness it’s actually about being an organization that’s fit to do its job...the business is going to go elsewhere...”

Executives in each case were further driven by the need to avoid past serious failings that had come to light under previous managerial regimes. In Case A, there was a need to avoid the recurrence of significant financial losses, through much more rigorous management. In Case B, the organization had been taken to task for inadequate financial governance and safeguards, which had permitted illegal practices to remain undetected for a period. So there was a strong rationale for a more transparency and external scrutiny in the organization was run and governed.

(ii) Understandings of the relationship between clinical and managerial priorities

A common theme for non clinical managers in both Trusts was that the perspectives of strategic management were different from those of the majority of clinicians in the central emphasis given to financial viability. This could be brought together with the contrasting perspective of prioritising clinical care and outcomes, but the fit would always be full of tensions and require considerable work in negotiation. One of the organization A executives, who had come most recently from a private sector organisation outside of healthcare, drew parallels with his current perception of senior clinicians and his previous battles with a powerful sales function:

“...in the same way as someone who’s essentially a very, very good salesperson, may not always make the most sensible financial decision, someone who is ultimately a really dedicated clinician is never going to care quite enough about the finances to make that decision, so it’s actually to do with what level of financial support you can delegate out there as well....so if you can mature finance enough to say, okay, I’ve got a great clinician out there, I trust what he does because I know I’ve got a fantastic accountant riding side-saddle with him...”

His counterpart in Case B showed a similar sense of realism combined with a stance that this kind of negotiation and accommodation is all part of running a business:

“We fret about it a lot: we worry about clinical engagement all the time....But you shouldn't judge the fact that we worry about it, that we're not pretty good at it in many respects.”

Particularly in Case B, our respondents differentiated their priorities as strategic managers from those of their senior clinical colleagues in one further and significant sense. They emphasised their own role in identifying how the clinical and scientific capabilities of the organisation could be harnessed to bring in new streams of income:

“..diversifying our income and that's really about growing fund raising, and its also about developing [the Trust's] commercial services and R&D income...Pathology runs like a business – we're selling to district general hospitals, primary care, independent sector treatment centres..”

The implication is that non clinical managers are freer to think about new ways of using established professional expertise.

(iii) Views on external regulators

Executives in both organizations recognized the central need to satisfy the key regulatory agencies in what they were doing, particularly in the context where both organizations were attempting to show that they were well into recovery after encountering serious problems in the recent past. As the chief executive of Organization A put it:

Monitor can sack any of us, the Healthcare Commission can shut bits down if we breach certain standards. So they have different accountabilities but they're both critical to us"

In the words of his Chairman:

"If we don't deliver the recovery plan I get fired"

As we saw with clinicians, there was recognition of the value of the disciplines imposed. Executives in Case A felt that they had anticipated the kind of solutions to issues that the key agencies would expect them to follow, and had been able to craft versions, for example, of clinical profit centres that served them well. The chief executive of Organization B felt that the very specific templates for organizational governance set out by one Agency in particular had been exactly what his organization needed:

"It was a time when we needed a response which put in some mechanical structures. [The Trust] didn't have enough structure. And I think there is a relation between culture and

structure, and I think that helps to militate against the sort of society without government approach of professionalism.”

In both cases, there was however some resentment that the over prescriptive requirements of regulators had consumed unnecessary management energy. In particular, the Chair of Organization B felt that the demands of the main agencies for over-detailed conformance to governance requirements had held him and his organization back from entrepreneurial activity, engaging with the possibilities of generating new income streams.

(iv) Preferred principles for managing clinical work

Executives in both Organizations saw the future for the organization and management of clinical work in terms of “Clinical Divisions” or “Care Groups”, each with their own management structure, including a finance function. This can be characterized as a devolved view of organizational functioning and accountability, but distinct from established notions of professional autonomy in that devolved subunits are held accountable for financial as well as all aspects of clinical performance, and also expected to engage in their own strategic planning.

In both Organizations, steps were at an advanced stage for each clinical division to act as a profit centre, producing an annual plan for income and expenditure, and then being held accountable for achieving an agreed surplus. In the words of a Organization A executive:

“the profit centre approach is there to enable that to happen so that, what I’m trying to get to is a position whereby people are incentivized, first, to be profitable, that is, to do work

that generates a surplus, generates a margin of profit, and secondarily, to increase activity, particularly that activity which generates a profit, and to be aware of the activity they're doing that's making a loss and to either address that to make it profitable, or to stop doing it.”

Divisions were to be allowed to retain their surpluses for reinvestment.

Organization B executives preferred a slightly different flavor in an otherwise similar recipe. They emphasized the possibilities of using formal approaches to process analysis and redesign within all aspects of caring for and dealing with patients, and the need for new management accounting systems, involved activity-based costing, for understanding costs of existing practices, as a basis for making decisions on their viability and directions for improving them. This was intended to provide the basis for strategic planning within each division, as to which care procedures should be expanded, and which not. According to the Director of Strategic Development: “Everyone's coming out with annual plans at the moment and I'd like to performance manage them through the year against that, not just operationally...but against how they're developing their strategies, so we got into market analysis, we've got into providing them with effectively trading accounts”.

This director and his Organization B colleagues also emphasized their own role in complementary aspects of strategy – developing strategic alliances, and setting up projects by which clinicians from the Organization explored with colleagues from primary care organizations how some aspects of care traditionally associated with hospitals, including some medical and

surgical procedures, could be performed for mutual benefit outside of the hospital setting. This was to allow the Organization to employ its capacity more effectively and profitably. There was thus in this case perhaps a greater emphasis on the entrepreneurial lead of professional managers, in setting up and transforming care configurations for clinicians to work within.

In Organization A in particular, there was recognition that not all clinical areas would be able to rise to the challenge of working as profit centres, and that the corporate management regime would have to differentiate those capable of such responsible autonomy from those not so capable or willing. In the view of the Director of Finance:

“If they’re delivering then their management will be much freer and if they’re not delivering their management will be much more intense. So I think we’re moving towards a differential management model and there’ll be a much clearer transparency of managers that are delivering and managers that aren’t... Those people whose results are falling into metric two or one then they’ll be the subject to the fierce heat of recovery planning, reporting, delivery, daily reporting...”

(v) Views on the wider healthcare system

Executives in both organizations were critical of many aspects of the complex framework within which they had to operate. However, whilst embracing the new entrepreneurial possibilities of the Foundation Trust concept, they did not adopt a simplistic stance that the direction for the healthcare system was to move in the direction of more market elements. Rather, they were bemused at the apparent lack of strategic co-ordination of the various agencies in their region. As the Chairman of Organization A said:

“the fact that foundations have no connection to anything ...because you’ve got these big beasts wandering around the place...the idea that they are controlled by commissioning is a bit farfetched ... I mean if control is one issue the other issues is how do you make sure that the things they’re developing for the future are actually what the commissioners want. We’re talking about developing a big cancer centre, huge capital investment. Now there’s actually no chance of getting our commissioners to sign up to it, the risk is entirely ours. There isn’t the mechanism for making sure that what we want to do is consistent with what the service around wants and there’s no mechanism for making sure that someone else isn’t doing the same thing two miles down the road... it’s a problem in terms of whether or not foundations are going to be adequately responsive to their commissioners on a day-to-day basis...”

Further, Executives in both Organizations shared concerns that national standard prices for medical or surgical procedures were not geared up to recognize that patients going to specialist tertiary units contained with either Organization were inevitably more complex cases. They might require more medical time and more sophisticated equipment. The standard tariff meant the Organizations often had to cross-subsidise such tertiary care.

(vi) Commitment to organizational success

That non-clinical Organization executives professed great commitment to the survival and success of their organizations did not surprise us. This is what senior managers are paid to deliver on. However, it worth noting the degree of social commitment that respondents showed when

they talked about why their organization and its future were important. Several executives in each organization referred to the importance of their organization to the area as an employer and as service.

We can now compare and contrast these responses with those of the executive directors who were clinicians.

CLINICAL EXECUTIVE DIRECTORS SENSE-MAKING

Clinical executive directors were a new breed of medical director and nurse directors. In these large teaching hospitals covering multiple sites and with multiple constituent elements these top clinicians tended to hold full-time appointments for their directorial duties. As will be seen, they tended not to see themselves as mere ‘representatives’ of the doctors voice.

(i) Rationales for change

A first stance we encountered on the part of clinician directors in Organization A expresses dissatisfaction with earlier modes of governance and management within the NHS, seeing them as bureaucratic, unresponsive, and even stifling of clinical priorities and judgment. According to the director of nursing:

“It seems to be, in principle, like a very good idea to get people much more engaged because I think people have lost the will to live under the hierarchical and bureaucratic financial regimes that we’ve been struggling with and they bitterly resented the massive top slice, which has gone into...well, the Finance Director’s back pocket, I mean I’m sure he’s got a good place for it.”

In Organization B the analogous view was that the organization could not continue with what appeared to be an inadequate system of financial planning and control. Its future as a leading teaching hospital was in doubt, so a more rigorous regime of management control and external scrutiny was necessary. In both Organizations, thus, clinician directors were able to explain why new, more integrated approaches to management and governance were needed. There was no illusion that it was possible to perpetuate or return to a previous golden age of when clinicians were clinicians and managers were unimportant administrators. The old system had failed and needed to be replaced with something else.

(ii) Understandings of the relationship between clinical and managerial priorities

Medical and nursing executive directors in both cases each indicated that they had been on an eventful personal journey to discover how to make sense of their role and identity as clinician directors, and how it related to their earlier calling as medical practitioners. One kind of resolution was expressed by a Organization A medical director, who saw his managerial role as still concerned with dealing with patients:

“I have a lot of engagement with care, be it in neurology, obstetrics, cancer... a lot of human engagement with patients, but not as their doctor. So, if you said ‘what sort of core values do I have?’, the only answer would be those of a patient focused clinician, and I don’t suppose that’s going to change.”

According to this way of thinking, there was considerable continuity between the basic concerns of clinicians and clinical directors, that of the primacy of the interests of the patient and their

right to the best available treatment. So management was in a sense an alternative way of fulfilling a professional calling.

One of the Organization B medical directors took a different direction for understanding his own role and the relationship between clinical and managerial perspectives. He saw himself as still a practising clinician and research-active academic, as well as being an executive director of the Organization. He confessed to happily working a 70 hour week, in order to maintain a two-day-a-week workload as a specialist physician. This allowed him to maintain “street credibility” with his clinical colleagues, so that he could never be accused being unaware of the current pressures of clinical practice within the Organization. At the same time, he felt this arrangement gave him even greater credibility in representing the clinical perspective at Board meetings. He illustrated this by explaining how he had opposed managerial initiatives to reduce the floor area and bed numbers available to a department that had made improvements to its treatment times and so could logistically manage with fewer beds and less floor space. His reason had been that putting more patients in the same beds would inevitably increase the incidence of hospital-acquired infections – a priority not fully understood by the managerial “owner” of the bed reduction initiative.

This kind of recognition that there are important differences between managerial and clinical frames for thinking led several other clinician directors in both Organizations to see themselves in a mediating role:

“You could say in some ways it’s still a bridge function between career managers and clinicians and I can sit now very comfortably in the middle and hold hands with them on either side; very comfortably, and it wouldn’t be possible to go back.”

“... another important aspect of my role is to act as patient advocate. Now I noticed a trend to do that in any case but I do actually see it as my job also when I get round the executive board table because it’s very easy for patients to be completely lost sight of and for them never to be discussed at all and for the impact of the decisions on patients, particularly on pathways and what have you, not to be discussed.”

“I would say if three children died it would have far more significance than a £36 million deficit. And I think the issues of patient safety, quality, experience are the real challenge, and if you took a five year view and achieved high quality patient care, safety, experience, the organisation would flourish in any financial regime the Government put in place because patients would want to use it, and that would secure your future because we’re here to treat patients. The outcome of what you do is treating patients: if you treat them well...”

(iii) Views on external regulators

Rather like their non-clinician colleagues, we heard our respondents talking as though they had internalized a model of responsible autonomy represented to them by external regulatory agencies. They understood that the way for the Organization as a whole to achieve autonomy was to take on the mixture of clinical and financial measures required by their regulators. And

they saw devolved clinical units below them as needing to make similar sense of how to behave.

According to one of the Organization A medical directors:

“Well, it’s [the external regulator] for the trust, it’s the trust board for the executive board, it’s the executive board for the clinical board and it’s the clinical board for the divisions. If a division is so far out of kilter that I, in the clinical board, have not got a solution then it is possible the executive board will want to look more closely at that division, but if that division is doing well, executive board won’t be interested at all.”

There was little indication that any of these clinical executives saw this kind of external scrutiny as in principle an infringement of professional autonomy and restrictive of effective clinical decision-making. Rather, the weight of opinion was that external promptings were appropriate to make sure that clinicians within a Organization operated with due regard for costs of care, up-to-date evidence as to effective care procedures, and were also open to regular scrutiny to detect poor practice and understand any deterioration in clinical outcomes. As a medical director at Organization B put it:

“I’m absolutely not in doubt that legislation from the Department of Health and dictat from [Regulatory Body] have provided a framework and guidelines which make it clear what governance is, what the expectations are what the areas...needing to be considered under the governance umbrella. And I think all of that is a good thing... I think in terms of individual practice, clinicians assume they know what they’re doing and 99% of the time they do, but do they keep up with the guidelines? ..Do they recognize the increasing

requirement for multi-disciplinary care, working with nurses?...Do they recognize that they need to take responsibility for ...other consultant colleagues?...”

Within this basic framework of acceptance, like their general management colleagues, several clinician directors in both Organizations complained about the volume of competing and overlapping external guidelines and appraisals.

(iv) Preferred principles for managing clinical work

Medical and nursing directors in both Organizations expressed thoroughly positive views concerning the devolved models being implemented for the management of clinical sub-units. They saw the integration of clinical and financial decision-making at operating level as desirable. In Organization B, there was a more matter-of-fact acceptance that clinical decisions had to be brought together with consideration of costs, and that this could be done through the application of lean process thinking. The director of nursing was clear that the consideration of finance did not mean that financial considerations always took precedence. Indeed, she was keen to cite a case where after thorough discussion and investigation of costs in multi-disciplinary forum, the division concern had received backing from the Organization to cross subsidise, temporarily at least, an apparently uneconomic procedure.

“Now, clipping is quite inexpensive but has a fairly high mortality rate; coiling is very expensive but has a much better patient outcome. The trouble is that we don’t get enough money for coiling, we lose money by doing it. So, as a committee, we looked at that with the clinicians involved, and we felt that we couldn’t make the decision to go back to

clipping because of the poor outcomes. So we would acknowledge that we were losing money and seek to make savings elsewhere, but we would also lobby nationally in order to get the cost of coiling recognised, so that the tariff would be adjusted, which it was the subsequent year”

In Organization A, medical and nursing directors shared a more thoroughly entrepreneurial view of the role of clinicians in managing what care. This way of thinking builds links between, on the one hand, apparently traditional ethics of service to patients and notions of professional autonomy and accountability in decision-making, and, on the other hand, new opportunities for embracing financial accountability and benefiting from financial success within devolved clinical directorates or divisions. The following three quotes come from three different clinician executives in Organization A:

“...a lot of doctors though, doctors are very smart people and the people here are smarter than your norm, and the thing about medicine is that it’s always been associated with money and the making of it, so we’ll only be running this for a bit before someone will come up with notions that will make more money, because they’re very entrepreneurial as a staff...”

“If you start saying, if you’re going to leave the lights on that’s fine, you pay for your electricity bill, your element of it. If you want to have a big office that’s fine, you can pay for the space, you can rent a big office from the organization. On the other hand if you

want to use that money more efficiently, for your patients, have a small office and switch the lights off. It will change behaviours...”

“They all want to be part of a successful unit. Everybody wants to be part of a successful unit so if the trust is successful, that reflects on the staff, if the directorate is successful it reflects on the staff...we can do all these things we’ve wanted to do and haven’t had the money for, you know, you can buy things for patients or you can buy extra pumps or you can buy, you know, all the things that you can’t have because but you can go out and get them...”

(v) Views on the wider healthcare system

Clinician directors’ views of the wider healthcare system within which they operated in many respects reflected those of their non clinical executive colleagues. They complained about the system for setting for tariffs for tertiary procedures, and about the lack of a transparent system for planning tertiary capacity. They also showed considerable concern for the funding and support for the primary care system which refers work to them. They were concerned to think systemically about how healthcare is provided, beyond the remit of their own organization.

(vi) Commitment to organizational success

Of the six clinician executives interviewed across the two organizations – three in each case – all had worked at the organization, or an earlier incarnation of it, for at least ten years, and in some cases for over thirty. They all expressed deep identification with the success of the organization, and like their managerial colleagues, were proud of its role in the local community and economy.

The medical director of Organization B brought out a further dimension to this pride in his organization, which related it to his sense of professional pride. He explained that he was committed to safeguarding above all the “reputation” of the Organization, and that reputation meant more than merely how it was currently rated by various regulators. He felt that “reputation” for a hospital was multi-faceted, and meant, amongst other things avoiding negative attributions, for example avoiding high profile disasters, such as uncontrolled outbreaks of infection. But above all he was keen that others should focus on the what “reputation” meant for the organization

“How do we attract the very best consultants? There’s lots of consultants out there, but how do we get ‘class’ consultants? How do we get people to stay, but stay with enthusiasm? ... you know, every day I walk into this hospital through the front door. I don’t actually have to walk through the front door. I could easily walk through a side door. But I walk through the front door, and every day I say, ‘This is my hospital. What am I going to do today to make it a better hospital?’ Now the question is, how do you get everybody thinking like that? That is the issue. And if you do that, then you have reputation, because everybody contributes. So I worry a lot about reputation.”

It was evident overall that in both cases the clinical directors had travelled some considerable distance from the profession-first stance. They were identifying very strongly with the mission and success of their organizations. Indeed, they had come to a judgement that they had rather more of a sustained stewardship responsibility for the viability and success of their organization than most of the general managers who were more likely to come and go between organizations.

DISCUSSION AND CONCLUSIONS

The preceding accounts reveal various aspects of the actors' interpretations of the rules of the game – and indeed the nature of that game. Directors of trusts are working within a system or set of systems comprised of multiple principles and multiple drivers. Knowing how to play multiple games simultaneously is a skill in itself.

The various reforms to governance constitute an admix of rules, institutions and ideologies simultaneously involving central direction, local accountability and professional agency. The way in which the actors make sense of and navigate their way through the cross cutting principles and the layered reforms is a critical issue.

The kind of structural changes to governance described in this paper which involve, inter alia, devolution of accountability to semi-autonomous bodies, have been viewed as part of the “hollowing out” of regimes of state governance. This entails public sector actors having to make themselves more entrepreneurial and innovative while also being held accountable for what they do according to specific measures and by demonstrating that they have followed specific practices. One influential interpretation of this process is to cast these actors as ‘self-disciplining subjects’ (Rose and Miller 1992; Miller 1993). The basic idea here is that the practices and routines of governance carry with them systems of rationality which shape how people think as well as behave.

Our data from two Boards of Directors provides a rich understanding of the way this kind of process operates at executive level in acute healthcare organizations. Above all, it indicates the importance of active sense making as executives struggle to reconcile new demands on them, new ideologies of what public healthcare should be about, and relate these to their established notions of priorities and values.

We saw both clinical and non-clinical directors becoming willing participants in taking up their roles and making complex and potentially contradictory governance arrangements understandable and communicable to others. At the same time, both groups were aware of the potential downsides, the inconsistencies and the contradictions in the systems within which they had to operate. Hence, many of them also took up the challenges of seeking to influence the nature of this context at policy level. They were very much active agents, negotiating both their roles and the rules of the game, rather than mere receptacles of new management practices and modes of thinking about the management of healthcare.

This conclusion can be illustrated for both the clinical and non-clinical executives we interviewed. The clinical executives were open to the idea of experimenting with new approaches to governance and management because they had a range of dissatisfactions with the previous modes of strategic control of their organizations. They recognized that a more integrated approach to the financial and clinical governance was needed, in order to ensure that the limited resources available to their organization and the NHS in general could be put to best use. This led them to accept by-and-large the legitimacy of external monitoring of clinical governance within their organizations, and the idea that clinical divisions or directorates should

become accountable for financial performance. Some in particular had found ways of incorporating the focus on accountability for costs within their professed core ethic of service to patients. They made sense of their own role in these terms, and then made further sense of their role in mediating this kind of integrated understanding of clinical priorities to colleagues who did not have the time or inclination to understand it as fully themselves. They were aided in doing so by the discourse of professional accountability closely bound up with the notion of clinical governance. We saw how one medical director had begun to see “clinical governance” as encompassing the professional rhetoric of self regulation, of taking collective responsibility for the performance of one’s colleagues as well as oneself. They were further aided in communicating the concept of the “clinical division as profit centre” by the availability of tools and techniques needed to support integrated decision-making. These included process analysis and the application of “lean thinking” to process redesign, and management accounting techniques that allowed the costs of care processes and procedures to be represented and discussed.

This sense-making on the part of clinicians can be seen as counter-pointed by that undertaken by their non-clinical colleagues. Here we found little trace of what might be called “managerialism” - a view of the primacy of financial management and business rationality and the need to achieve the supremacy of this over established clinical or professional privilege. Whether non-clinical managers came from a public sector health service background, or whether they had recently been brought in from private sector industrial corporations, we found a consistent picture that these executives recognized a wide range of accountabilities, both social and financial. Like their clinician colleagues, they identified with the professional standing of their organizations as much

as with financial success. They recognized that the implementation of governance structures as prescribed by external regulators could benefit the coherence of the management and direction of their organization.

But they also saw the possibilities of picking and choosing between the prescribed elements and interpreting them in different ways. So, these non clinical executives too played an active role in shaping the response to the new array of governance requirements. In doing so, some of them called on their established practical understandings of the multiplicity of organizational goals, and the need to recognize that even senior figures in a complex organization are not perfectly aligned in what they are seeking to do. Thus, it was that one recent recruit to a Trust board from a private sector organization was able to see how he could accommodate the drive and enthusiasm of leading clinicians in much the same way as he had previously related to sales directors. He had recognized and lived with energetic but financially inconsistent salesmen in the private sector and saw a similar challenge with clinicians in his public sector role. This provides an example of how active sense making on the part of a non clinical manager, in terms not particularly implied by the new governance regime, has provided the necessary conditions for reciprocal and matching sense making on the part of senior clinicians.

These findings about Board members sense making need to be considered in relation to the wider context. The design of the new 'Foundation Trusts' gave them new status as separate 'businesses' with devolved accountability for profit and loss, income and expenditure, and ultimately responsible for their own survival. To varying degrees, the two sets of directors (both clinical and non-clinical) have been able to reconcile their patient-focused mission with a market-oriented

stance. They have sought to be entrepreneurial and to create and seize opportunities for ‘new business development’.

Devolved accountability to service line level reveals tensions. Under pressure from the regulator, Trust Boards have been encouraged and even required to ensure transparency and income and expenditure, profit and loss for each service line. At minimum this means service line reporting, but there is also additional pressure to develop this into service line ‘management’ (i.e. active devolved managerial accountability) and even the creation of ‘profit centres’ and business units at clinical directorate level. The behavioural responses by directors, managers and senior clinicians so far have been complex. Managers have been keen to promote transparency and indeed to devolve accountability, but they have also been circumspect about devolving too much power. The kind of accountability they carry makes them nervous about devolving decision making to lead clinicians.

This bolstering of the clinical directorate concept gives further impetus to the idea of using clinicians to manage other clinicians. In the past, however, such attempts have sometimes been seen as subverted by senior clinicians who took on such roles in order to ‘protect’ rather than change traditional practices. It was even suggested that under earlier versions clinical directors appropriated the language of ‘service quality’ in order to defend the status quo and to negotiate more resources (Whittington, McNulty et al. 1994). Whether this is a ploy which could be repeated under today’s more complex and inter-locking governance regime is an interesting question.

The meta-narrative of the policy reforms in the past few years has been of a shift from a centralist, producer-led service to a devolved patient-focused service. To enable such a change, shifts in governance were seen as necessary. Accountability, choice, challenge through multiple providers, regulatory compliance became the key watchwords and enabling devices. Some of these elements have been talked about, and to a degree launched as policy initiatives, before. In previous instances the changes have generally been judged as of limited success. But, as we have indicated, there are some signs that things may be different this time around.

There are a number of indications of such difference. The scale of the change and the multi-layered nature provides a set of mutually-reinforcing drivers. There is considerable professional expertise within the system. The regulatory bodies have recruited staff with high levels of talent and they produced tools which are persuading many management teams to adopt them. A national 'Appointments Commission' has taken steps to ensure that persons appointed to senior positions in trusts are of high calibre and are people who broadly share the values of the change programme. Some Medical Directors in the larger trusts had taken on full-time roles as director-managers and had relinquished their clinical practice, others were working part time as divisional clinical directors.

Of course despite the number who were committed to the role and who had the calibre to fulfil the role there were others within the organizations at the next tier down whose attitudes more closely reflected those found in previous studies – ambivalent, essentially committed to the clinical role, reluctant to manage other clinicians and so on (e.g. (Dopson 1996; Ferlie, Pettigrew et al. 1996; Hoque 2004) (Pollitt, Harrison et al. 1991)). However, this time around, there are a

number of key differences. One is that those trusts which are leading the change are taking steps to remove these less committed consultants from clinical director roles and they are only able to do this because they have located enough consultants who can and are willing to undertake the role in the fuller sense. It is true that there is no surfeit of these candidates but it is significant that there are beginning to be at least enough. Much hinges on how much influence they are truly allowed.

While many lead clinicians at lower tiers than those reported on in this paper remain sceptical about the extent of devolved autonomy, there were overall fewer signs of ambivalence about the desire to achieve it. This contrasts with previous studies which placed emphasis on the strong identification with their profession (Pollitt, Harrison et al. 1991);(Hoque 2004). There were, of course, still examples of the latter, but they were less in evidence in the lead trusts which had pushed ahead with the service line management concept. In these latter instances, the allure of spending a proportion of retained surpluses, and the exemplar of divisions and directorates which had invested in new ventures, brought-in new clinical teams and initiated new services, were powerful magnets.

Moreover, as noted above, some of the leading clinicians who were championing the drive to clinical directorate autonomy were in advance of their chief executives and operations director colleagues and were prepared to play the long game – they were aware that consultants were in post for decades whereas they had seen chief executives come and go. Moreover, unlike previous studies, these lead clinicians were not in thrall to their professions and Royal Colleges. In other

words, while few in number this new breed of medical director were marking out new and uncharted territory.

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TABLE 1: CLINICAL AND NON-CLINICAL DIRECTOR SENSEMAKING

	Trust A Executive Directors		Trust B Executive Directors	
	Clinicians	Non clinical Directors	Clinicians	Non Clinical Directors
i) Views of rationale or need for change	Dissatisfaction with previous unresponsive and stifling administrative regime	Need to eradicate entrenched professional & administrative “arrogance”, replace with humbler focus on patient as customer	Lack of effective financial control threatened future of the Trust as a high status teaching hospital	Need for customer responsiveness to ensure continued viability in a competitive environment; lack of financial mgt.
ii) Views of relationship between managerial & clinical priorities	Advocacy of and accountability to patients, with ethic of service; responsibility for resource control seen as extension of professional accountability in the interests of patients; recognition that “managerial” clinicians need to mediate this to others	Clinicians will always have different priorities from managers, and need to have financial managers working alongside them at all levels, to build an integrated understanding of performance and how to control it.	Viewpoints are different, so key role for clinical managers as mediators: clinicians will only respond to managers who are clinicians and still practising; and general managers need clinical managers to represent clinical viewpoint to them.	Acceptance of different viewpoints and priorities, so clinician engagement is sporadic and needs to be worked at; need for managers to take a lead in shaping a competitive mix of secondary and tertiary services & identifying new income streams
iii) Views of governance requirements of external regulators & inspectors	Trust autonomy can be retained by pre-emptively adopting the targets, measures and approaches favoured by external bodies	Strong recognition of accountability to and power of regulatory bodies, failure according to their standards can lead to termination of appointment.	External bodies have driven necessary internal focus on clinical governance, examining current practice and how to improve it and detect bad practice.	Provide necessary stimulus for building an accountability structure, with prominent non exec role; at the same time have delayed more entrepreneurial focus on increasing income and new business streams.
iv) Views of desirable principles for organising & managing clinical work	Responsible autonomy: clinical divisions expected to be accountable for patient outcomes, care processes, sound finances and use of resources; financial autonomy the reward for performing against targets.	Responsible autonomy: clinical divisions as profit centres with range of managerial specialisms, allowed to reinvest surpluses as long as generating a margin and increasing activity.	Emphasis on competence & teamworking between different care professions at all levels; use of management structure and comprehensive performance measurement for improvement in care processes	Clinical divisions expected to undertake indepth process analysis and lean redesign, supported by activity based costing and responsibility for profit and loss; need to rethink care processes across organisational boundaries
v) Views of effectiveness of wider health system organisation	Concerns that national system of standard prices for procedures does not recognise complexity of tertiary work; or specific demands on the Trust associated with geographical location	Concerns at: lack of integration between strategic plans of secondary and tertiary care organisations; contradictions between expectations of “high performance” and “community accountability”.	Concerns at lack of coherence; external targets on cost reduction contradict measures needed to reduce hospital acquired infection; weight of demands of overlapping regulators; fragmented clinical governance	Concerns that national standard pricing for tertiary work not geared to techniques with lowest mortality;
vi) Commitment to organisational success of Trust	High, and reinforced by experience of taking on senior management responsibility	High, reinforced by social commitment to local community and economy.	High, identification with maintaining multi-faceted reputation of the Trust	High, bound up with identification with local community and economy.

