Introduction

Not enough people are managing health care. And that is not because there are not excellent people running health care organizations. It is because that is what they are doing, concentrating on running their organizations. As a result there is a lot of measuring and monitoring, a lot of 'performance management' and, ironically, a lot of health care professionals (HCPs)[1] feeling *over*-managed. It's time for the focus to shift to managing health care itself, and this is a book for people who want to improve services, to regain the goodwill of HCPs and to help them deliver the kind of care we can all be proud of.

Why, when health care is such an important issue for so many people, do we not pay enough attention to management at the level that matters? Why do people called managers manage not health care but something else? In part it is because the job we are currently asking them to do is the wrong one, in part it is because they are tempted to concentrate on the wrong things and in part it is because we want to believe in magic. Let's look at these in turn.

First, the wrong job? Instead of defining the role of the health care manager by considering the health care task and what management can add to it, there has been an emphasis on translating the management role from other settings. Modifying it certainly, to take into account some of the differences between health care organizations and others, but *not* going as far as *defining* it using the distinctiveness of the health care task as the starting point. When we do this, when we aim to *add* to the contribution of those providing health care, and see it as essential to try to avoid wasting their time and good will, we see that the role we need is different, and requires particular skills, behaviours and attitudes of the people fulfilling it.

Second, the wrong things? Joe Batten, in his book *Tough Minded Leadership*,[2] draws a distinction between the 'simple hard' and the 'complicated easy'. The former could be something as simple, and as hard, as being trustworthy; the latter, drawing up complicated plans or redesigning organizational structures. Today's health care managers are concentrating on the complicated easy at the expense of the simple hard. This is understandable. The increasing specialization of health care has led to a culture in which there is an unspoken assumption that if we could just find an expert with a definitive answer, we would be able to solve any problem. While this belief may be well founded for many clinical problems where the constituent elements are cells and organs, in management problems those constituent parts are people and the richness of personality ensures that there is no definitive solution,

however complicated. Whenever we interact with other people, we cannot succeed unless we heed the simple hard.

Much of the complicated easy is, of course, necessary. Without it, managers – even *real managers* – do not have the tools with which to manage. However, without the simple hard the complicated easy does not work. Worse, it can actually impede the individuals and organizations it is supposed to be rendering more effective, and be perceived as unnecessary bureaucracy and constraint.

Third, magic? There has been a tendency over the past few years to identify 'leadership' as different from (and rather superior to) 'management'. But, surely, this is a false dichotomy, on both the practical and theoretical levels. The territories now claimed for leadership and management are not dissimilar from those linked previously to management and administration, respectively, and this suggests that in a little while the term 'leadership' too will have become demoted. This is because people are seeking something that can't exist; what they are looking for is the ability to win hearts and minds, to persuade people to do something they don't want to do, to take on groups who are being difficult and persuade them to work together for the greater good. Heroes and heroines who can do all that may exist in fairy tales and undemanding novels but not in real life. At least not in the quantities we seem to require! It is time to reinvigorate the neglected term 'management'.

What I offer here, then, is an argument that seeks to enrich, extend and indeed challenge current understandings of the word 'management'. In this book I outline a style of management I call *real* management. It is a style built up from tools, behaviours and attitudes I have observed that people working in health care find genuinely useful, find can help them to offer better services, find can help them to help others to work more effectively. Real management straddles the divide drawn between management and leadership, it takes account of the special circumstances of the health care task, it errs on the side of the simple hard, but it draws attention, too, to areas where it is important that the complicated easy is undertaken with rigour and discipline. Because it highlights the simple hard it will be dismissed by some, since the aspects that are simple and hard are indeed conceptually simple, so simple that in practice they often fail to receive the attention they warrant. For some people (particularly those whose intellect is only tickled by the complicated easy) it will prove irritating, simplistic and misguided. I very much hope that others will find it useful, practical, challenging and even transforming.

Is it evidence based? Well, it depends on what is meant by evidence, and I have discussed this in some detail elsewhere.[3] It is rooted in reflection, theory, action and experience – my own and that of others. Above all, it has been tested out by generations of HCPs taking on management roles; I have worked with these people on university courses, training programmes and in their own organizations. For all that, it is a subjective and personal account of the kind of

management I believe is needed, so it is perhaps necessary that you know a little of where I am coming from.

For the first fifteen years of my working life I worked as a pharmacist, in the bowels of health care organizations of all sorts, experiencing the dynamics of working within a large complex organization of interdependent professions and departments. After completing an MBA at the London Business School, I moved into management roles just at the time when general management was being established and the old district management teams of district medical and nursing officers with district administrator were being disbanded. In 1990 I moved to City University to establish the Health Management Group there and led the masters degree in health management for nearly nine years. And for the past five years I have worked with a number of different universities and NHS organizations, individuals and teams on all levels, exploring different management challenges and ways of addressing them.

All my observations lead me to conclude that it is vital that the people who directly manage front-line services are allowed and encouraged to flourish, and that organizations where that is the case are those offering the best health care, yet this is the tier of management receiving the least support and development. This book is written for them, for those first line managers (most of whom will be clinicians), for the people who manage them and for those who in turn manage them. In other words, this is a book that assumes that the task of senior managers is to support the clinical front line and the people directly managing that. It is also for a group of people I have had the pleasure of working with recently: non-executive directors in health care organizations. These passionate, able people are often inhibited from making a more valuable contribution because of their lack of understanding of the dynamics of health care. I hope this book will give insight that will help them bring fresh energy to the management task. And it is for a group of people who are becoming increasingly important, people in so-called 'hybrid roles': those clinicians who take on formal organizational management roles in addition to their clinical management ones.

It is always difficult to know where to start in a text about management. I have chosen to start with aspects of managing people, because this is where most anxiety is expressed, and most troubles begin. In Chapter 1 we look at how to work through other people, in Chapter 2 at working *with* other people, and here we look closely at what happens when those other people are members of different professions. In Chapter 3 we consider working for other people, how to work effectively in large organizations and how to decide whether your organization is the right one for you. Chapters 4 and 5 could easily have been presented in reverse order. In Chapter 4 we think about how to make the most of the resources available to a service, while Chapter 5 explores ways of managing change. Chapter 6 is more personal, and is about how to manage yourself, your time and your stress levels. You may be tempted

to read this first but I think you will find it more valuable having read some of the others first. Chapter 7 is about managing organizations or, more accurately, about the role of the manager in health care organizations, and while it refers more to large organizations than small the principles are similar. Next, we come to the case studies. In the first edition readers seemed to enjoy these. Their purpose is to explore how some of the principles can be put into practice while also seeing the world from the perspectives of people in different health care settings. One has been updated from the first edition and two new ones have been added. As you will see, they are not prescriptive, but look more at *how* than *what* must or can be done, and they are set in circumstances that I hope feel real to you, although they are compilations of incidents and people rather than an account of an actual scenario. The concluding thoughts are just that, a résumé of what I see as the most important points, and I hope you will want not only to read them but also to let me know your own thoughts. Every end is a beginning, as the saying goes, and I hope you will want to take what's written here as the start of your own role as a real manager. If you do, then I have included a selection of further reading that I think you will find useful.

If you do, or if you don't, I would welcome your views on what has been said here, so do please write or contact me via the Really Learning website at www.reallylearning.com.

Notes

1 I use the term 'health care professional', abbreviated to HCP, throughout the book. It is used to refer to members of all the clinical and clinical support professions.

2 Batten, J. (1991) *Tough Minded Leadership* (New York: Amacom). In this book, Batten contrasts the complex easy with the simple tough and draws a further distinction between tough and hard – the former resilient, the latter brittle. However, for a British audience, the terms 'hard' and 'complicated' more accurately convey the sense he intends.

3 See Iles, V. and Sutherland, (2001) *Managing Change in the NHS: Organisational Change* (London: NCC SDO).

9 Concluding thoughts

Real management is about what you *do*

This book has been about how to become a real manager, someone who really manages health care. It has been about how to *behave* in such a way that you become a master of the 'art of getting things done'. It hasn't focused on attributes or qualities, or even competences; in the main it has described ways of approaching situations that you can start to use straight away. And this is an important point: real management is essentially about action, about *you, acting*. Often, when I ask people what they are going to do in a particular set of circumstances they describe information they will gather, analyses they will undertake, papers they will write and presentations they will make – and sometimes some or all of these may be necessary. Just as often, however, they are a means of delaying, or of trying to avoid, the one conversation that could resolve the issue without the need for any of them. The complicated easy is so much more tempting than the simple hard.

As you begin to act as a real manager, you will inevitably become more skilful in what you are doing. Take the three rules described in Chapter 1, for example. When you start to use them you will do so in the ways described there. As you acquire more experience, you will become more accomplished in the skills of active listening, giving developmental feedback, perceptive questioning, active reflection and creative, collaborative problem-solving. And when you have more experience still, you will often feel very relaxed about allowing goals and solutions to emerge without any preformed ideas on your part.

It is this increasing skill, and the change in attitude that is likely to accompany it, that is reflected in the thought that management is as much about what we become as what we achieve.[1]

You start to be a real manager by doing things, the kind of things described in this book; and as you do them, you may become someone slightly different, you may acquire attributes and skills, but it is that way round.

Real management is fundamentally different

I want to emphasize the point that real management in an organization is not about doing existing management roles better. It is about seeing the management role in a different way. Just imagine if real management became established throughout an organization: clinicians of all kinds would be taking responsibility for their own behaviours, for improving systems, for delivering care as good as they want it to be within constraints they can see as reasonable. Managers would be supporting this activity and attitude by providing information, prompting strategic thinking, encouraging these constructive behaviours and discouraging any that weren't; above all by making sure that the three rules were implemented throughout the organization and by behaving with generosity and discipline themselves. Here, there is a completely different set of dynamics: proactive HCPs being prompted, supported and challenged by organizational managers, as co-owners of the organization and of its problems and potential. Really managing health care *means* everyone focusing on health care. Apart from anything else, this avoids the charge that clinicians and managers have two different sets of values. Everyone will be concerned with service performance (activity, outcomes, expenditure) and the organization becomes the means of doing this, rather than the HCPs focusing on service activity and outcomes, and managers on expenditure and the needs of the organization.

Responsibilities, too, will be held in rather different places from where they currently sit. Take rationing, for instance. At the moment, if two patients need to be admitted to a mental health ward and there is only one bed, the responsibility for deciding who receives the treatment they need, and who doesn't, rests with the clinician. But the clinical decision is that they both need treating. If only one can receive that treatment, then that is not a clinical but a rationing decision. Which is the profession that deals with reconciling different interests? Politics. But politicians will not accept responsibility for decisions they deem to be unnecessary because the shortage of capacity arises because resources are being wasted. So we need clinicians and organizational managers with real management skills to work together to ensure that resources are being used to their very best effect, and to demonstrate that this is the case. Then any rationing decisions that are necessary can go back to where they properly belong.

Similarly, the responsibility for drawing up an organizational structure will shift. Instead of being the prerogative of the chief executive alone (with much restructuring inevitably accompanying any change of incumbancy), this will be jointly held by all those focusing on how the organization can support the effective delivery of good health care.

It can be difficult to perceive the radical change that real management

would lead to because we are so trapped in the existing paradigm. Think, for example, of the term 'clinical engagement', much in vogue as I write. It sounds as though it shares many sentiments with real management. In practice, though, it has come to mean that 'lead clinicians' are sought for cross-boundary strategy groups, e.g. *older people* or *sexual health*, and a space is held on every organizational committee from locality groups to IM&T[2] committees. So it turns out to be an exercise in finding clinicians who will engage in an organizational perspective and not the other way round. It didn't have to turn out this way, but the existing mindset has taken a good concept and turned it into a degenerate form.

You may be irritated at my description of a really managed organization and accuse me of wanting to wave a magic wand. You may also want to ask me how I propose to get from where we are to that utopian ideal. But that is to operate again from within that paradigm. It isn't up to me or anyone else to impose it, it is up to us to describe it and try to live it, and leave it to others to decide whether to do the same. If we want to see it happening on more than a local scale, then we need to devise systems[3] that enable and reward real management behaviours, and discourage and penalize the kind of behaviours that managers have learned, by being rewarded for them, over many years.[4] And then we need to get out of the way. We need to adopt the same kind of non-doing that I described on a personal level in Chapter 6. This is important. At the moment I am constantly struck by how, in the UK, at every level of the organizational hierarchy, managers complain bitterly: often about the way people in positions more senior to their own are 'imposing' strategies, processes and targets upon them. It becomes quickly apparent, however, that the freedom they seek is the freedom to impose their own strategies, processes and targets on those they in turn 'manage'. At every level, people need to see their role, instead, as challenging and supporting people nearer the front line to make their own decisions, build their own strategies and become co-owners of the organization. The way to do this is to ensure that the three rules are enacted at every level, and in a spirit of generosity and discipline.[5] Anything else will inevitably lead to degeneration of ideas and approaches that are sound in themselves but not in the application.

Perhaps the most persuasive action we can take is to help people to reflect on the fact that the management models we have at the moment just aren't working. We are pouring more and more money into health care and seeing very little extra return for it. And because this is happening in so many places, in so many countries too, we can see that it isn't the people who are incompetent, it is the model.

Real management engages with the wider system

There are discussions about the nature of health care policy taking place in many countries and we need to find inventive solutions to the many dilemmas we currently face. Can we find ways to:

- improve health care for all and not just for the wealthy, while at the same time allowing people who are prepared to pay more for their care to do so;
- offer people choices[6] in areas where they want them, while not eroding those values and principles of the public sector that are worth cherishing;
- make essential services (like health care) accountable to the public?

If so, then we need HCPs to take an informed, proactive, outward-looking interest and to come up with ideas about health and social policy that they are happy then to debate, defend, amend and eventually champion.

In doing so, we will almost certainly need to shoot some sacred cows. Hatred of markets, for instance, and support for central planning. In the UK, we have for years set a few clever people the task of deciding for us how many doctors, nurses, physiotherapists, and so on we will need in 10–20 years' time. As a result, we consistently have a problem of capacity not matching demand and we go and recruit qualified staff from other countries, some of which can ill afford to lose them. We could go on doing this, or we could leave it to enterprising 18-year-olds to vote with their feet and decide for themselves what they think the market for different roles and skills will be by the time they qualify and beyond. From what we know about the 'wisdom of crowds',[7] we can be fairly sure that the 18-year-olds collectively will come up with much better answers than the experts. Here, introducing a market may allow us to behave *more* ethically rather than less. There will be many other examples where thinking afresh could lead to the diversity of ideas we need.

More than this, though, if we care about the health of all (and not just health care) we need HCPs to take an interest in macro issues: the nature of society, of our economy, of the global economy. We need them (you, us) to take an intelligent interest in policy debates about, for example:

- how to introduce checks on corporate power without stifling the ability of corporations to continue to contribute to society the massive benefits they have done;
- the pros and cons of globalizing professions;
- GATT talks and the nature of a governance at a global level.

We need able and committed people (you, us) to take an intelligent interest rather than indulge in knee-jerk reactions to misleading and undemanding arguments presented under the lazy headings of 'right' or 'left-wing'. These are complicated issues that need attention and care, and we mustn't leave this debate to others. Our care for our patients and populations surely needs to extend to some of these wider issues.

Really managing – anywhere, any time

When we looked at the three rules in Chapter 1 we saw that you can implement them whether or not you have any formal authority. You can use them if you are a member of a team, or when interacting with someone who is formally managing *you*. The same applies to nearly everything in this book. I know that there is a terrible disempowering force within large, particularly public sector, organizations. Indeed, many of the current performance and risk management processes actively enhance this disempowerment. There is a prevailing spirit of 'they haven't done this', 'they won't let me do that', 'nobody's told me to do X, only Y', and a reliance on having formal authority given to you before you can start taking responsibility. But real management isn't like that. You start with just yourself and your immediate working relationships. No one has to sanction it, no one can stop you doing it, you just start. You don't have to announce it, or tell anyone at all; there's no need to get any egg on your face, and you don't even need to find a lot of extra time because it will quickly save you so much.

Of course, as we are talking about the simple hard a lot of it won't work immediately (that is why it is termed hard). And in your efforts to change your behaviour in one direction you will often stray too far and need to shift direction again when you realize it. Susan Jeffers[8] refers to aeroplanes and autopilots when she says that at any given moment while in the air a plane is never on the right course – it is moving too much in one direction and will have to be corrected back to another as shown in Fig 9.1. So even the best real managers will constantly be getting some things wrong and there is no need to berate ourselves for doing the same. So we can not only start at any time, we can start again when we need to.

You may have noticed that nowhere in this book have I advocated emotional intelligence, and there is a reason for that: emotional intelligence is just so difficult. Many of the approaches described here are what might be considered part of an 'emotional intelligence toolkit', and will help us to behave in a more mature fashion. However, 'if you do find you are becoming angry or hostile or moving into the negative ego states described in Chapter 6, then I suggest you don't beat yourself up for your lack of emotional intelligence and instead use that negative energy to achieve something productive.[9]

For clinicians, perhaps the greatest incentive of all for starting to behave as a real manager is that the quality of your clinical care is likely to increase. (I illustrate how this might happen in Appendix 2.) But, for *all* of us, real management is important, and it doesn't require heroism, just quiet determination, and the preparedness to apply gradually some of the tools described here. Real management is important – to patients, to communities, to HCPs alike. If you are in a service or department that doesn't seem to have any, if you are surrounded by people who are concentrating on the complicated easy, as who are not generous and disciplined, then it will have to be introduced by someone. If no one else is prepared to do it, I guess it will be up to you. And as you don't need any special attributes or competences you could start right away, now, with your next decision.

Notes

1 Expressed by an interesting management development centre called Waverley, whose work is informed by a spiritual dimension. You can find them on www.waverley.uk.com
2 Information management and technology.
3 Eventually we might even be able to let them evolve.
4 Regrettably, some competent people are so trapped in the existing model that, although they appear to be superior performers within this system, they would probably need to make way for others if real management was to take hold system-wide.
5 One manifestation of fury at imposition is the huge resentment at the time of writing (May 2005) about the targets imposed by central government in England. I believe the fury is misplaced and that the problem lies not with the target but with the ways in which the 3 rules have been applied. As far as rule number 1 is concerned, it would be better if performance targets could be agreed rather than imposed, but in this I believe the government is much closer to what the public expects than are the HCPs. So it has a right to insist. The government then also needs to observe Rule 2, by ensuring that resources are adequate, and that there are skills within the system to achieve the targets. Outline where it has done this. It then needs to stand back and confine its role to giving feedback, rather than insisting on prescribing particular ways in which the targets should be reached. Most importantly, it also needs to ensure that civil servants are not being prescriptive either.
6 One of the things I have noticed in every organizational aspect of my life (work, community, voluntary, family) is that whenever decisions are taken on behalf of someone else they are almost never the same as they would have taken for themselves.
7 Surowiecki, J. (2005) *The Wisdom of Crowds* (London: Abacus). The author

argues, with some supporting evidence, that the average of the individual decisions taken by members of a crowd is, subject to certain attributes of the crowd, always were accurate than that of even the most expert individual.

8 In *Feel the Fear and Do It Anyway*; see Chapter 6, note 4.

9 As John Hunt, Professor of Organisational Behaviour at the London Business School, wrote in a review in the *Financial Times* (March 2001) of Daniel Goleman's (1998) book *Working with Emotional Intelligence* (New York: Bantam Doubleday): 'Maturity is admirable but organisations also demand innovation and creativity. Neither innovation nor creativity flourishes when emotions become sanitised.' He described emotional intelligence as a 'process for social control; an emotional form of bureaucracy; a clinic for consenting adults'.