



## **Managing People and Teams**

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This forms the text of Chapter 23 of Healthcare Management, 2<sup>nd</sup> edition, Sept 2011, Open University Press, edited by Kieran Walshe and Judith Smith, which can be ordered at: [http://www.amazon.co.uk/Healthcare-Management-Kieran-Walshe/dp/0335243819/ref=sr\\_1\\_sc\\_1?ie=UTF8&qid=1329918782&sr=8-1-spell](http://www.amazon.co.uk/Healthcare-Management-Kieran-Walshe/dp/0335243819/ref=sr_1_sc_1?ie=UTF8&qid=1329918782&sr=8-1-spell)

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## Managing people and teams

### ***This chapter***

Managing people is where healthcare management goes right or wrong. Whatever the nature of the healthcare system, and however much one applies the concepts described in the other chapters, if a manager is not able to work with and through other people they will not be successful in delivering the kind of health care to which they aspire.

Managing people is a very personally engaging matter. It is not something a manager can do from behind a closed office door, it involves getting to know the people you are managing and finding ways of helping them to flourish in their health care role. At heart it is about helping people to use their talents in pursuit of things both you and they, and the organisation in which you are working, believe are valuable. In general, for people to choose to use their talent and energy in this way they have to *want* to (or at least see the need to), and they also need to feel *able* to do this.

More than this, they need to keep refreshing and renewing their sense of purpose, so that they can continue to be creative, reflective, enthusiastic and ambitious in pursuit of that purpose, and do not become complacent in their thinking and practice.

Managing people is not therefore a science, it is more of an art, and it requires judgement as much as evidence, and practical wisdom as much as theory. The style of this chapter reflects that difference, for it too is active, personal, and based on experience and observation as much as theory and evidence. It will give you ideas and encouragement and leave the rest to you. The practical ideas presented here are the result of nearly 30 years of development work carried out by the author with individuals and organisations in health care, and drawing on theory from a broad range of sources.

### ***Helping people to flourish involves enabling and challenging***

As humans we are a complex mix of complacency and striving, of altruism and self interest. So if we are to flourish we all need to be supported and enabled in our altruistic creativity and endeavour, while also being challenged out of our self-interested behaviours and complacent attitudes. So when we are managing others we need to support and enable them and also to challenge them. This is a point worth stressing: with few exceptions, if you are not supporting, enabling and challenging then you are not managing. Similarly if you are not being supported, enabled and challenged you are not realising your potential. So this chapter is about supporting, enabling and challenging the people you are likely to be managing in health care.

### ***Three basic rules for managing people***

Whenever you are managing people, or indeed whenever you are relying on them, whether you manage them or not, there are three rules to keep in mind:

1. Agree with them what it is they are expected to achieve.
2. Ensure you are both confident they have the skills and resources to be able to do it.

3. Give them ongoing feedback about whether they are achieving it.

Simple to articulate they are nevertheless hard to implement. In part this is because they must be tailored to the individual and the setting. Thus when dealing with someone who likes a lot of detail and is perhaps in a well defined role you could implement the first rule in the course of several rich and detailed conversations and probably reach agreement on a number of specific outcomes. Where the field is new and the individual involved is a 'big picture' thinker the conversations you would have would again be rich but they would be exploratory and the outcomes you agree might include a degree of fuzziness that would be inappropriate elsewhere. Similarly you would observe the three rules differently with someone carrying out a job as a cleaner or gardener than with a chief executive of a large organisation. The time horizons, the degree of detail, and the ways in which you ascertained how well they were performing – all would be different, although the principles would be the same.

Ensuring that people have the skills and resources to achieve what is expected of them is not as easy as asking them or looking at their references. You will need to observe them in action and observe the results of their work. Where they themselves are managing people as part of their role those results will include how much their staff are being supported, enabled and challenged, and how they are flourishing. This is not the sort of thing that can be ascertained by sitting behind a desk, it requires active engagement with people and processes and practices in ways that have to be devised according to the setting.

The third rule, giving feedback, is again something that needs to be done face to face and on an ongoing basis. The feedback must be genuine (i.e. you must mean it) and include enough detail for the other person to believe it is genuine. So, for example, it would not be enough to say something like 'you seem to be settling in well' or 'you are a good member of the team'. To be credible, it needs to give examples of specific incidents: 'the report you wrote on ..... was very helpful', 'I particularly liked the point you made about .....'; or 'I thought you handled Mrs J's concerns very sensitively'.

Where you have criticisms of your colleague's work and you want them to make changes to the way they are doing something<sup>1</sup> it is often helpful to give some positive feedback along with the negative, and at the same level of detail - preferably with about twice as much positive as negative content to the conversation. There are many reasons for this, for not only does it help you keep things in perspective, but it also makes it much easier for the recipient to hear the criticisms you are raising or exploring. Giving negative feedback needs careful preparation on your part if it is to be effective. You will want to prepare what it is you are going to say, and it will also be important to prepare yourself emotionally for the conversation. It is often helpful to remember that what you are aiming for is that the other person leaves the conversation feeling that they *want* to make changes and that they feel confident in their *ability* to do so.

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<sup>1</sup> Please note that the kind of feedback I am discussing here is that undertaken in the course of everyday management. Once there are concerns about performance that require more specific attention specialist advice should be sought from an HR department or other source.

*An Example of Giving Feedback:*

'I thought what you said at the team meeting on Monday was very helpful. The points you made about X, Y and Z helped us all to see the situation rather differently and we made a better decision as a result of them. Thank you.

When Jane gave you some feedback from the patient experience surveys at the Clinical Governance meeting yesterday I felt you brushed it away rather than listening to it and taking it on board. I was disappointed because I thought it was important and I know you care very much about your service. Could you have another look at it? And perhaps think about whether you were a bit off-hand in the meeting?

You've demonstrated many times, not least in the meeting on Monday, that you really want to ensure the patients feel warmly welcomed so I'm sure you will want to.'

***Simple purposeful conversations***

Observing the three rules set out above is an ongoing process that can start at any time. They are very valuable when someone is new in post, and are equally appropriate if you have been working together for some time. Using the rules is most effective when it takes the form of frequent conversations in a variety of settings: in the corridor, the coffee room, informally at a work station or more formally at a pre-arranged time and place. While appraisal systems are important they are not a substitute for this day to day exchange of information and regard.

Over time the conversations should include three viewpoints: the enthusiasms, concerns, interests and ambitions of both of you, and the needs and constraints of the organisation in which you are working. As the manager you will have ambitions for the service and you have the right to express those ambitions. The person you manage will also have interests, enthusiasms and ambitions for the service or for parts of it, and a discussion between you that encompasses both sets of views will be motivating and creative. The organisational setting in which you are working may present constraints or additional requirements and it is important that these receive enough attention, yet do not become the *focus* of every discussion, merely a context.

*An example of a three viewpoint conversation:*

'Sharon I noticed when I was on the ward yesterday that it took a long time for the patient alarm bell to be switched off - are you and your team having any problems responding to these?'

'Yesterday! We were so busy yesterday morning, everyone was completely involved in something else: drug round, stripping and changing the beds (it's really important we get that done by mid morning or we're trying to catch up with ourselves all day), we just can't be everywhere at once. We did get to them as quickly as we could.'

'I can see all those things are important and it's good to know you are really on top of things like changing the beds, and I know how important that is for you. What's most important for me is that patients have confidence in us and in their care here, and the orderliness of the ward certainly contributes to that. If they ring the call bell and no-one comes it jeopardises that so badly, so that's the reason I think it's so important to answer those very promptly- whatever else is going on. How can we meet both of our agendas do you think? After all we both care about both of them, they are both important.'

'Another health care assistant in the mornings would make all the difference.'

'If that isn't in the budget then that just isn't possible. And actually when I last looked at the figures the staffing levels here were pretty compatible with those of similar wards in other hospitals. Don't you find that when you talk to your colleagues? Ward G have found that it works well if they nominate one of the team to respond to all the all buttons, leaving the others to carry on with what they were doing and helping out when they aren't needed by patients. How about trying that out here?'

'Well Ward G is very different from ours but I suppose we could try it out. Or I heard someone talking about a system called something like 'hourly rounding' where every patient on the ward is visited by a nurse every hour. They said it worked really well (I'm not sure I believe it but we could try it out). Apparently it led to much calmer wards and almost no use of the call buttons.'

'Well either of those sound like a good way forward, how will you get started? If it helps I could do a web search of this hourly rounding and email you some links – perhaps in time for your team meeting on Thursday? Can we agree that you'll make this a priority and that we'll talk about it again in a couple of weeks when you've had a chance to try out the nominated person idea, and to find out more about the other?'

The person with whom you are conversing will, naturally, have a different personality from your own and you will find the dialogue more productive if you choose your words and arguments so they are most likely to be able to hear them and not reject them. There are a number of ways of clustering personalities into different types and of describing the kinds of arguments and of behaviours the different types prefer, and many of these are useful. Some of the most common ones are the Myers

Briggs Type Indicator, 16 PF, or simpler ones such as Belbin's team roles, or Honey and Mumford's Learning styles. Whichever you choose, it is worth using the personality analysis tool to think ahead about how you yourself are going to behave and talk and what you are going to say. You can use the tool and its explanatory notes again once the meeting is over to reflect on how effective your approach was and what you might do differently another time.

An example:

If you used a Belbin team roles analysis with your own team, once the members know who has preferences for taking on the roles of shaper, implementer, monitor/evaluator, etc., then when they behave to that type you can reflect this back to them: 'That's the shaper in you again, pushing for a solution before we've considered how people are going to feel about this! Shall we ask our 'team worker' to comment on that?'

Or 'Don't worry Sam, that's just Mo being a Monitor Evaluator again – subjecting the idea to criticism before he commits. You know he'll support you all the way once he's convinced.'

It needs to be handled lightly and with care, but can be very valuable in preventing things said in meetings from being taken personally.

### ***Simple hard versus complicated easy.***

We have considered three rules and three perspectives and the need to use these frequently and in a range of settings, taking into account the personality of the people involved. That sounds simple, and indeed it is simple - simple but hard. Hard because it will require you to be: thoughtful in your discussion of what it is they are to achieve; perceptive and empathetic in your observation of how they are approaching things; and courageous when you have to give them feedback they may not enjoy hearing. We are all easily tempted to move from these 'simple hard' ways of managing into the 'complicated easy'.

The 'complicated easy' are activities that require us to use our brains but not much else. They include things like writing plans or strategies, and undertaking analyses. For people who are intellectually able, the lure of the 'complicated easy' is very great. On the other hand, the 'simple hard' will sound dull (no intellectually satisfying 'aha' moments) and will call upon other aspects such as our integrity, wisdom and courage. So it will feel hard and can also feel unsatisfying for we will not really feel we are getting it 'right', only that we are doing it better than we used to. However keeping focused on the 'simple hard' will keep energy within a system, whereas the complicated easy often drains it away.

Imagine, for a moment, that you were banned from using the words communication, communicating, communicate, and yet you wanted to discuss how you would implement a particular new policy. You would have to think about things such as:

- Who needs to hear what, from whom?
- Who needs to say what to whom?
- Who needs to ask what, of whom?
- Who needs to discuss what, with whom?

These are all 'simple hard' activities. Can you see that the actions themselves and the energy around them feel quite different from that of 'developing and implementing a communication strategy', which is the complicated easy way of approaching it? You will probably want to jot down these 'simple hard' actions (who you are going to ask what, what you need to find out from whom, who you need to tell that something is happening etc.). You can then call this your communication strategy, but it will look and feel different from the paper you would have produced if you had tackled the task the other way round.

### ***What do we mean by care?***

When we are managing people involved in health care it is helpful to be clear about what we mean by care, and it is not discussed in management courses as often as might be expected.

In the Road Less Travelled, M Scott Peck<sup>2</sup> defined love as 'the will to extend one's self for the purpose of nurturing one's own or another's [personal<sup>3</sup>] growth'.<sup>4</sup> Furthermore he suggested that 'If an act is not one of work or of courage than it is not an act of love. There are no exceptions'. One way of thinking about care is as a 'thinner', or a more widely disseminated form of love, and in that case we could use a similar definition for care: care is the will to engage in acts of work and/or courage in order to nurture personal growth.

David Seedhouse, a philosopher who has observed and considered issues of health and health care for many years suggests, in his book Liberating Medicine (1991, p48) that 'any genuine theory of health will be concerned to identify one or more human potentials which might develop, but which are presently or likely to be blocked. Health work, however it is defined will seek first to discover and then prevent or remove obstacles to the achievement of human potential.' This suggests that we could see 'personal growth' and 'health' in the same terms - progress towards the achievement of potentials, and thus that care is about the overcoming obstacles to the achievement of those potentials.

Thus combining these definitions we could say that health care involves acts of work and/or courage undertaken with the intention of enabling the potential of patients. Using an Aristotelian concept we could also frame this as acts of work and courage that enable or promote flourishing.

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<sup>2</sup> Peck M S, The Road Less Travelled. Arrow Books 1990

<sup>3</sup> He actually used the word spiritual but in a sense that is conveyed well by 'personal' as long as we think of personal in its widest sense – a flourishing sense!

<sup>4</sup> Page 81

These definitions are valuable when you want to enquire of yourself or of the people you are managing: 'are we caring?' or 'are we caring enough?' You can think of particular patients and ask yourself or others 'were we courageous enough?', 'did we put in enough work?', 'were we focused on helping them to flourish?'

In just the same way that the three rules for managing people apply everywhere but need to be tailored to the setting, so these definitions of care need to be discussed, interpreted and articulated differently depending on the care setting. Occasions to do so include the simple purposeful conversations described above.

If our health care professionals are to be able to engage in acts of courage on behalf of patients, then they themselves need to feel they are cared about and encouraged to flourish. One of the most important aspects of managing people is therefore caring about them - engaging in acts of work and courage that enable them to flourish in the service of others. Just as we can ask questions about whether we cared enough for a particular patient, so we can ask whether we cared enough for a particular member of staff. We can ask ourselves: 'was I courageous enough to challenge them about that area where they really need to develop?' and 'did I put enough work into observing how they..... to form a view about how what help they may need or what opportunity they might value?'

### ***Managing teams***

In healthcare, many of the people we manage work in teams. Sometimes we manage the team as a whole, sometimes not. What is it that makes a group of people a team?

Usually, when people are asked this question they will answer 'a shared goal' or 'shared values', but in many healthcare teams it is difficult to define a goal that is genuinely important to all the members – unless we resort to such a high level of abstraction (e.g. 'good patient care' or 'putting the patient at the centre of care') that it is akin to what we often refer to as 'motherhood and apple pie'. Similarly, values that are shared can often only be described at such a generic level that they do not drive behaviour on a day-to-day basis.

Teams we work with and manage in healthcare tend to be characterised by interdependency - I can only achieve my goals if you achieve yours, and the way I achieve my goals must not conflict with the way in which you achieve yours. Thus when you are working with teams, and want to improve their performance, it is often more productive to discuss what these interdependencies are than to try and articulate team vision and values – at least to start with. Once you have got people discussing with each other what each truly cares about, you may find that they volunteer views on values and vision. If however you start with values and vision, you can easily end up with a list of platitudes and a feeling that time has been wasted.

Since you are relying on the team and the members are relying on each other, the three rules need to be observed here too:

- Agree with the team (as a whole) what it is they are expected to achieve.



- Ensure that both you and they (as a team) are confident they have the skills and resources to be able to achieve it
- Be sure that they receive feedback (as a team) on whether they are doing so. You will also need to ensure that team members are relying on each other do the same.

The different personalities you find within any team are almost bound to cause friction from time to time, so another of your roles when managing a team may be to defuse or avoid tensions by educating team members about personality types and the kind of behaviours and preferences associated with them, in the same way as discussed above. This can give a team a vocabulary for dealing with points of tension and helps individuals to take disputes less personally.

### **Designing roles and teams**

It was Frederick Herzberg who said 'If you want people motivated to do a good job, give them a good job to do'<sup>5</sup> and this is an important point to bear in mind when we are designing the roles we ask people to undertake. It is just as important when we are designing the teams within which people work.

There are a lot of unhealthy (less than whole) roles and teams around. The symptoms of this lack of wholeness include:

- People don't get a sense of meaning and purpose from their work.
- People having to change their sense of who they are when they come to work
- People not believing in the organisation's goals.
- People feeling that their physical health is affected by work.

This kind of 'un-whole' work is detrimental for everyone involved: the patients; staff; management; and others. Finding ways of making work whole and healthy in large organisations that have significant amounts of complexity and specialisation is far from easy, especially given the need to account for performance.

If that is 'un-whole' work, what is its opposite? It is called whole work<sup>6</sup>. Whole work can be described as 'people working together in a multi-skilled, human-scale teams, responsible for something significant and purposeful, owning the whole set of tasks related to achieving that and empowered to plan that work, deliver it, and to 'evaluate' how they are performing it. This is a rich description and each of its terms deserves more attention than can be given here. Let us however illuminate the term 'evaluating'. This can be defined as 'bringing to full value that which was conceived', so in this context it includes an element of reviewing where we are now in relation to the idea or plan we started with, and what needs to be done to remedy any gap. We might also think of this as 'learning to do it better next time'.

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<sup>5</sup>In Herzberg, Frederick (1959), *The Motivation to Work*, New York: John Wiley and Sons

<sup>6</sup>The idea of whole work stems from 'whole systems' thinking, including the writings and work of Christian Schumacher (*To Live and Work*, MARC Europe, 1987).

The principles of whole work organisation design involve<sup>7</sup>:

- Mapping the primary work flow, which might be a flow that is informational, physical, mental, social or emotional – or in reality a mixture of all of these. In health organisations this is often a whole person view of the patient pathway.
- Identifying the purposeful, transformational, significant events around which to base the different teams. – these events usually involves a transformation in the patient’s (perceived) state. For example, in health care these might be based around prevention, diagnosis, treatment or recovery.
- For each team in turn, identify all the tasks that are closely associated with achieving their transformational significant event, and ensure they have the skills and support they need to these
- Make sure each team is of a ‘human scale’ so that team members can identify and relate to each other.
- Empower the team to plan its work, deliver it and ‘evaluate’ it.
- Ensure that the team has appropriate leadership, pulling it together and linking it with the wider organisation.
- Set them appropriate, simple performance measures that relate closely to achieving the significant event.

It has been found within healthcare organisations, with now numerous case studies, that by following these simple principles, whole work can be designed for teams that is motivating, empowering and healthy. This is good for everyone concerned. If a large, complex organisation can be built up from a network of these whole work teams, the organisation is found to have a clear and purposeful structure that makes sense to people, delivers better outcomes for patients and in which people enjoy their work more.

*Mini case studies:*

Maternity services: A whole system review of maternity services in a district in New Zealand began with the simple (but hard!) questioning of what were the relevant significant events. This led local clinical leaders to realise that they had insufficiently recognised the importance of post-natal care - the core transformational significant event is from ‘new mother [and father] with a new baby’ to ‘coping parent(s)’ – and to value the key role healthcare assistants were actually playing in supporting new mothers. They also realised that creating a true ‘whole work team’ for elective and emergency caesarean sections gave an opportunity for the much more productive deployment of theatre staff.

Older people’s health and social care services: On a much larger scale, the application of thinking around significant events has been used to develop a person-centred health and social care pathway model for older people’s care in England. This has been used to map current resources across councils and NHS services in Essex, and supported by a best practice review, has enabled a coordinated and aligned

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<sup>7</sup> For more background on how to apply this approach in health and social care see [www.tricordant.com](http://www.tricordant.com).

improvement programme to be developed across councils and health commissioners, and to be embedded in local NHS efficiency plans.

**Urology Ward:** A series of apparently very competent ward managers struggled to manage a busy 35-bedded urology ward – things always felt chaotic and patient experiences were sometimes compromised whilst the budgets were not controlled. The decision was taken to change the ward manager (again) but this time triggered by some minor building work, the ward was split into two smaller wards, each with their own leader and team. Much to the surprise of the local management, the two new mini-wards were both much calmer and more effective, and costs even fell overall. Serendipitously the changes created two whole work teams of a much more appropriate human scale to the large and effectively unmanageable 35-bedded single ward team.

### ***Managing high status professionals***

We established at the beginning of this chapter that managing people involves supporting, enabling and challenging them. In health care we run into a specific difficulty: the status in which different groups of health care professionals are held by society. Supporting, enabling and challenging high status individuals and groups can be problematic. We next consider how status is awarded, and how one can ensure it is used wisely and well.

### ***The nature of status***

Status is valuable, for otherwise it would not have evolved and persisted. It is accorded by society and allows people with status to be able, in the interests of society, to withstand pressure from people of lower status to do things in ways they deem not to benefit society. In other words, it confers a degree of professional autonomy. We can see it in action whenever newspapers support views of doctors over those of managers, or lawyers over those of administrators. When used wisely, status can be an important safeguard, enabling us to draw on professional wisdom and expertise. It can however be misused and then it may skew decisions so that they are not taken in the interests of all but only those of a few.

Status used wisely has two characteristics: it draws on the experience, expertise, and specialist knowledge base that is the reason the status has been awarded; and it is used in the service of society or its members. So when a consultant surgeon argues for a particular practice in theatre, having thought clearly and deeply about alternatives, consulted others involved and decided that this is the way the best outcomes will be achieved for patients, then we are wise to listen to her or him carefully, and perhaps defer to their judgement. When the same surgeon argues for a particular car parking scheme and especially if it is a scheme that makes life easier for him or her at the expense of others, then we should make sure that view is heard no more loudly than the views of everyone else involved. When engaging with people of high status (or when engaging *as* a person of high status) being clear about

when it is wise to defer and when to insist is important for it not only makes for better decisions but happier professionals and service users.

It is worth knowing which groups are accorded higher status than others, and this is the field of sociologists. There are many theories about status but the one that seems to have most explanatory and predictive value (i.e. you can use it to work out in advance who, in a group of different health care professionals in a room will have higher and lower status) is that of Jamous and Pelouille (1970). They suggest that it depends on what they call the 'technicality indeterminacy ratio'. They say that if the knowledge base of your profession or specialty is highly technical and definitive and you can give clear answers to questions (e.g. yes /no/3.95%) then you are likely to hold higher status than a profession or specialty that gives more contingent answers (e.g. it depends, it could be this or that, let's try it and see). However, if your knowledge base is too technical you could be replaced by a computer protocol or an algorithm, so your status will be protected if your knowledge needs to be interpreted differently in each of the cases you consider.

This is unlikely to be the final word on the nature of status and there will be other ways of thinking about it, but testing it out should help the manager to think ahead about what the behavioural dynamics are likely to be within a particular group, and hence how they are going to deal with them. For example, what are the kind of issues on which you are likely to defer to professional judgement, and when you will politely reframe a statement made by a high status individual into an indication of preference that will sit alongside other preferences?

### ***Status and Productivity***

When we are thinking about managing, enabling and challenging others, we have to recognise that it is not enough for them to be working on goals that are agreed between you, but that they are working towards them in ways that do not incur waste – of time or other resources. In other words, we are concerned about their 'productivity', and we are all under pressure to increase the productivity of healthcare, for the benefit of all.

In other industries four ways of increasing productivity are typically brought into play:

1. **Cuts** –unnecessary expenditure is cut out and in some cases customers that cannot be served profitably are discarded.
2. **Rationalisation** - production from several facilities is rationalised into a single site, realising all possible synergy . In health care this is usually called reconfiguration.
3. **Redesign** – individuals and teams work together to redesign service flows and processes so that they are as efficient and customer-focused as possible.
4. **Reflection** – individuals and teams reflect on their own performance on an ongoing basis to see how it can be improved.

In other industries all four ways of increasing productivity can be (and are) used because staff can be incentivised and required to engage in all four, in other words they are part of a *connected* hierarchy. In

health care, because of the status issues and professional autonomy described above, we face instead what Henry Mintzberg describes as a *disconnected* hierarchy.

It is a feature of a disconnected hierarchy that staff cannot be *required* to engage in attempts to increase productivity and *incentivising* them to do so may prove difficult since nearly all of the incentives (the things professionals care enough about to affect their performance) are not in the gift of managers. The regard of professional peers for example, publications and citations in peer-reviewed journals, and the respect of and gratitude from patients will typically matter more to clinicians than approval from managers. Thus in a disconnected hierarchy, productivity is usually pursued by means of only the top two options (cuts and rationalisation). This is a great disadvantage because on their own, these will produce only one-off savings – for ongoing productivity improvements the other two forms are necessary.

For example, if health service managers respond to the current international financial crisis by imposing cuts and reconfigurations, this will result a system of inefficient and rationed services. To ensure that health funds are used optimally managers should, instead, focus on finding ways of engaging clinicians in the redesign of services and in reflecting on the nature of care they themselves and their teams are providing.

### ***Encouraging high status groups to reflect on the wider impact of their individual practice***

While it is difficult to require professionals to reflect on their own practice and the shape of the service of which they are a part, they can be encouraged to do so in a number of ways, of which the following are only a few. Indeed, we can imagine that while one or two of these methods are helpful, if they became embedded in ‘the way we do things round here’ their impact would be very much greater.

#### ***1. Information***

Information about how their practice and their service compares with that of others, or with their own practice/service over time, allows practitioners to reach their own decisions about what aspects of their practice they could usefully change. The information needs to be credible (based on robust and relevant data) and presented in a way that is meaningful to those concerned (analysed in terms of activity clusters at the right level of detail/aggregation). It is however important not to wait until data are perfect before they are presented – as long as they are ‘good enough’, the more the data are presented and discussed the better they will get.

#### ***2. Peer example***

While *pressure* from peers can be resisted, opportunities to discover that the practice of peers and the design of their services are different: and exploring the implications of those differences, can lead to very constructive reflections on both of these. Engaging in this process of discovery is likely, however, to be resisted unless one of the two following features explored in 3 and 4 below is present:

#### ***3. Managers who are genuinely concerned about the care that is being offered and who want to help clinicians improve that care.***

When managers are concerned first and foremost about care and only secondly about their organisations (as the best means of offering good care), and demonstrate that commitment by their interest in and creative and timely response to suggestions about service improvements, then their credibility will allow them to draw attention to some of the opportunities described above.

This enthusiasm for care should not deter them from stating clearly financial and other realities, and they must demonstrate their competence at dealing with managerial processes. However, they must be driven first by concern for effective care, and definitely not by a primary concern for balancing books which allows services to suffer in order to achieve it.

*4. Thought leaders who are from a high status group who do not impose their own prescriptions for action but hold high expectations of the performance of others.*

Similarly the credibility of these individuals allows them to provide the challenges that encourage mature reflection rather than defensive resistance. Imposing a prescription for action is a sign of low expectations of those required to enact it. Expressing a genuine belief that others will choose to behave in a particular (professional) way is very different.

*5. Organisational stewardship.*

Where high status clinicians are allowed and encouraged to form some kind of 'clinical senate' whose brief is to shape the organisation's strategy, ensure the consultant body understands the internal and external pressures that make it the best way forward, and challenge behaviours and practices that are not consistent with that direction, then results can be impressive.

*6. First hand stories from patients and from other health care professionals*

While second- or third-hand stories and written complaints can be dismissed and the motives of their authors impugned, first-hand stories are a different matter. These can reflect the experiences of patients or those of other health care professionals. It is often one of the most valuable outcomes of discussions about care pathways, as long as the highest status people are in the room to hear the stories, and as long as the discussions are well facilitated so they consist of personal narratives (this is what I experienced) rather than accusation and blame (this is what you did). Methods for eliciting such views and experiences are explored in more detail in chapter xx (user and public involvement).

*7. Purposeful Conversation*

Performance and behaviour are shaped on a day by day basis, by the response of others around us to what we do and how we do it. If we want to influence these on the part of our clinicians then we have to shape it on that day by day basis by talking with them, by noticing what they are doing and encouraging some actions and discouraging others. This ongoing shaping is called management. It tends to go out of the window when we introduce something called performance management - which requires 'tough' conversations by people who are 'hard' enough to instigate them. Management requires, instead, conversations that are purposeful which can be undertaken by people who possess ordinary levels of niceness.

Another way of thinking about this is that good management aims to increase the capacity of the organisation to care, that is for acts of work and courage. On the other hand, performance management tends to reduce this for it requires acts of work from people, expecting them to look upwards for direction rather than downwards for inspiration and guidance (from the actual experiences of users). Instead of encouraging acts of work and courage focused on patients and frontline staff, performance management requires reports to be written and meetings attended and humiliating ‘telling offs’ to be endured. The observation of this author is that this leads to the overall capacity for care at the front line being reduced.

***Engaging with what matters to people***

Whenever we are managing others we do well to remember the human desire to be contributing to something significant. Thus we need to manage people in a way that speaks to their whole nature (some selfish-interests, also altruism, and the desire to make a significant contribution). If we assume healthcare is simply a set of auditable transactions in a market place and manage accordingly, we will get the kind of dynamics listed in the left hand column of the table below.

If however we allow that care often also involves elements of a gift economy where there is a relationship between the giver and recipient of care that could be described as a ‘covenant’, then we will manage differently. In that case, we will still aim for care that encompasses the transactional (left hand column) but also for more, namely care that also has the dynamics listed in the right hand column below.

**Table xx: two different ways of envisaging and delivering care**

<b>Transactional care</b> <i>Health care in the market economy – patient as consumer, professional as provider</i>	<b>Covenantal care</b> <i>Health care with elements of the gift economy – patient and professional are in covenantal relationship</i>
Patient is cared for	Patient is cared about as well as for
Professionals are seen as givers (or suppliers) of services	Professionals recognise that in their encounters with patients they give <i>and</i> receive
Focus on calculation and counting – this can be seen as objective	Focus on thoughtful, purposeful judgement – this is necessarily subjective but incorporates objective measures and evidence
Predetermined protocols	Emergent creativity which can include the use of protocols
Discourse and hyperactivity	Wisdom and silence in addition to discourse and action
Explicit knowledge	Tacit knowledge as well as explicit knowledge

Reflection on facts and figures	Reflection on feelings and ethics as well
Focus on efficiency and effectiveness	Focus on the quality of the moment as well
Dealing with the presenting problem	Keeping in mind the meaning of the encounter –for both parties while addressing the presenting problem
Competence is what is called for on the part of the professional	The humanity of the professional is also called upon
Individuals have a relationship with the state and with the market	Individuals have a relationship with the community and with wider society
Good policy ideas MUST degenerate as they are translated at every level of the system into a series of measurable, performance manageable actions and objectives. The focus here is on being able to demonstrate the policy has been implemented.	Policy ideas can stay rich and be added to creatively, so that solutions are responsive, humane, practical, flexible, and adaptable.  Here the focus is on solving problems.

It is important not to see the care described in the left hand column as bad and that on the right as good, nor to see the left hand as efficient and the right hand as wasteful. Rather, we can think of the factors in the left hand column as the cherries and the care of the right hand column as the cherry cake. Thus good transactional care will often be all that is needed and covenantal care always encompasses good transactional care but also includes more – a different attitude. It will not (often) require more time or financial resource, but it will call for more professionalism, and for more of the whole person who is offering that care, thus adding more meaning to the encounter.

There are a number of pervasive forces that encourage us all to make choices that lead to the behaviours of the left hand column. They include:

- the anxiety experienced by patients, professionals, managers and policy makers;
- the culture of audit now firmly established across the Western World;
- the dominance of a particular kind of management - the technocratic analyst rather than the practical humanist;
- the change in the role of politics from reconciling different interests in society for the good of all, to the rational administration of the market; and
- the digital revolution that has supported and accelerated the last three.

These forces have had many positive outcomes and we are unlikely to be able to challenge their existence. However, if we are aware of them and of the dangers they can pose in respect of pulling us towards the transactional care of the left hand column instead of ensuring we aim also for the covenantal care of the right hand column, then we can choose to respond in different ways. We can choose to give proper regard to transactional aspects of care while also engaging in the covenantal aspects when these are wanted or needed.



We have to caution against getting swept up in a culture of audit where we focus only on targets (whether process or outcome) and where there is a great danger that we lose sight of those other aspects of care. The elements in the left hand column are essential, and we must deliver those (if we care about someone we will also care for them), but we must do so in ways that allow us (managers, professionals, patients) to be whole people.

***Conclusion: Caring about the people you manage***

Managing people engages you as a whole person - it is active and personal. It is also about directing your energy, your thoughtfulness, and your courage towards that which you care about, –and because of that you cannot manage well unless you do care. In other words, you need to care about what you are trying to achieve and about the people you are managing.

Care, as we saw above, can be defined as ‘acts of work and courage in pursuit of human flourishing’. Since you will care about your service, your staff and yourself you will be engaging in acts of work and courage to enable all of you to flourish.

Managing people (helping staff and their patients to flourish) is at once simple and hard. That means it will call upon your integrity, your empathy, your courage, and your judgement. In other words, it calls upon YOU. In managing others, you need to bring all of yourself to work, and not put on a mask as you enter the door, or leave parts of you (the softer nicer parts) at home. As you develop your skills in dealing with the ‘simple hard’ you will find ways of saying hard things in gentle ways, and you will be able to help people to hear the things that will challenge them into realising their full potential. As you do, you will find that you yourself are expanding your awareness and abilities and coming much closer to realising your own potential,

**In summary, properly managing people in the service of patients and society, should enable you to realise your potential. This will be simple, hard, exciting, frustrating and worthwhile. That is why this chapter matters!**

**Self Test Questions**

1. When you think of the people you are managing, would you say you are supporting, enabling and challenging them? *How* are you doing so?
2. Are you yourself being supported , enabled and challenged? Where can you find support and challenge if you do not find it from your line manager?
3. Think of one person you manage – or someone you rely on – and think about whether you are observing the ‘three rules’. Have you had a face to face conversation with them to agree what it is they are expected to achieve? Are you noticing and finding out whether they have the skills

and resources to be able to do that? Are you giving them frequent face to face feedback on how they are doing?

4. Do you know what their enthusiasms and interests and concerns are? What are their ambitions for the service they are offering? Do they know yours? Are both of you clear about the needs and constraints of your organisation?
5. Have you ever used questionnaires to discover the Belbin's team roles or Honey and Mumford's learning styles or Myers Briggs Type Indicator preferences of yourself and the people you manage? If so, do you use the insights gained from them on a daily basis? If not, who in your organisation would be able to help you with those?
6. Notice how often during a day you use or hear the word 'communication'. For a day, whenever you do, try asking yourself (or others) 'who needs to know what? Who needs to say what? Who needs to ask what? Notice whether that changes the level of energy that is focused on the problem.
7. If you are managing (or are part of) a team: does everyone in it know who relies on them and their work, and how? Do they use the three rules (agreeing expectations etc) with each other so that team members are confident in the value of each other's performance and the team works effectively as a team?

If you are managing the team do you observe the three rules, and give them feedback as a team?

Is the team one in which everyone is contributing to a significant or transformational event? Is it small enough for members to know each other and recognise they are all part of the same team? Are the members taking part in planning, and evaluating the work the team as a whole is undertaking?

8. When you are about to take part in a discussion with individuals or groups who hold high societal status (which is different from organisational status) do you think in advance about how you will challenge them if they try to use their status inappropriately?

Do you ensure that in meetings that include professionals of different status the views of the lower status groups are properly heard?

9. When you are thinking about how to make care resources go further, do you focus on cuts and mergers or on service redesign and individual reflection?
10. How many of the methods described for encouraging high status groups to reflect on their practice are you using and encouraging?

How are you encouraging your clinical and managerial professionals to care about *both* good transactional and covenantal care? Do you need to demonstrate your interest in covenantal care for them to take more seriously initiatives to improve the transactions of care?

11. And most importantly of all: how are you caring about those you manage? What acts of work and courage are you engaging in today that will help them to flourish in the service of others? How does their ability to flourish support yours?

### Key points

- Management is a highly personal activity that involves rich interactions with other people. It requires energy and courage as much as intellect. It takes place largely through frequent ongoing conversations. It is simple and hard even though there is pressure to focus on the complicated and easy.
- There are three rules for managing people, three perspectives to take into account, and *defining* care allows us to ensure that both clinicians and managers are able to care.
- Designing work teams on the principles of whole work enables care to be more productive as well as more satisfying.
- Recognising when status is being used wisely and when inappropriately allows managers to defer or challenge accordingly.
- Ongoing improvements in productivity arise through redesign and reflection. Cuts and mergers yield only one-off savings. There are many effective ways of encouraging clinicians to reflect and redesign.
- Only if managers demonstrate their concern for the covenant of care will clinicians give sufficient attention to improving the transactions of care.
- Managing others involves acts of work and courage with the aim of enabling them to flourish in the service of others.

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