

Mobilising identities: the shape and reality of middle and junior managers' working lives – a qualitative study

Janet Harvey,¹ Ellen Annandale,^{2*} John Loan-Clarke,³ Olga Suhomlinova⁴ and Nina Teasdale¹

¹Department of Sociology, University of Leicester, Leicester, UK

²Department of Sociology, University of York, York, UK

³School of Business and Economics, University of Loughborough, Loughborough, UK

⁴School of Management, University of Leicester, Leicester, UK

*Corresponding author

Declared competing interests of authors: none

Published May 2014

DOI: 10.3310/hsdr02110

Scientific summary

The shape and reality of middle and junior managers' working lives

Health Services and Delivery Research 2014; Vol. 2: No. 11

DOI: 10.3310/hsdr02110

NIHR Journals Library www.journalslibrary.nihr.ac.uk

Scientific summary

Background

Social scientists generally concur that employees' social identities are associated with how they interpret their roles and how they carry out their work. Arguably, therefore, comprehending health-care managers' identities can assist in the understanding of how they conduct their work and how effective they are. Yet little consideration has been given to the identity of managers within the NHS generally or in hospitals specifically, and even less to how this may influence the conduct of their work. This especially has been the case at ranks below the top management or executive team level and particularly at the level of junior or 'front-line' managers.

Aims

The research aims were:

1. to chart the work of middle and junior clinical and non-clinical NHS managers, including identity work and to produce an ethnography of their lived experience
2. to explore the identities of managers (goals, values, motivations, beliefs and interaction styles) and how these are constructed, and further, how the performance of managers' roles is shaped by these identities
3. to capture how they leverage their identities to create success, establish trust and broker alliances to exert influence in different and various spheres and to determine how they interpret and take forward their 'project' to achieve organisational, group and personal goals
4. to determine the influence of managerial identities on organisational processes and outcomes.

Methods

Two large hospital trusts in the same region with similar organisational structures (at the start of the fieldwork) were selected for in-depth ethnographic study. The main data source was one-to-one, semistructured interviews with four primary categories of managers [junior clinical (JC), junior non-clinical (JNC), middle clinical (MC) and middle non-clinical (MNC)] in each trust ($n = 91$). We also divided respondents into more finely grained 'work groups' for some aspects of the analysis.

Interviews were audio-recorded and transcribed in full. They were supplemented by the shadowing of a subsample of respondents and observation of meetings. An initial coding frame was developed while fieldwork was in progress. To promote reliability and validity, research team meetings were held to develop initial codes, check and re-check them against the interview data and to generate a coding frame. The interviews were then coded using NVivo7 and NVivo9 (QSR International, Southport, UK). Shadowing and observation field notes were examined by hand. Data were analysed using qualitative (the constant comparative method) and quantitative (the method of 'quantising') methods.

Results

The research confirmed that managers' role performance is influenced by their social identities. It also revealed how managers seek to mobilise (or leverage) facets of their identity for effectiveness and thereby how managerial identities can influence organisational processes and outcomes. Specific findings included:

1. The professional identities of respondents as managers were not particularly strong. Our findings paint a more nuanced portrait of a 'reluctant manager' than conveyed to date and indicate that this is a more widely spread phenomenon than hitherto reported, restricted neither to middle management nor to managers with clinical backgrounds. Those with higher education qualifications in management were more likely to define themselves as managers, as were those who previously had worked outside the NHS. Those who defined themselves as managers were more likely to identify with individuals or a work team than with a peer group.
2. The picture of 'what managers do' was complex and multifaceted. Across the sample, many managers reflected on the unpredictability of their working days, reporting frequent interruptions and having to juggle their responsibilities in the context of staff shortages and heavy workloads. There were some marked differences between middle and junior managers along expected lines, such as middle managers were far more likely to be involved in strategy formation than junior managers and tended to spend more time in meetings. There was also the obvious difference that clinical managers split their time between management and clinical work and non-clinical managers did not. But on some dimensions, such as 'span of responsibility', 'span of control' and cross-site working, internal variations by 'work group' meant that comparisons between the four primary groups were not particularly meaningful. This variety was added to by internal diversity even within a 'work group'. Hence the overall conclusion is that variation exists not only across the four primary categories and the finer-grained 'work groups', but also within them.
3. The analysis of self-reported effectiveness revealed that 'hard', demonstrable measures of performance, which we call 'transactional effectiveness', were important to all four primary categories of manager. However, many were also concerned with 'softer' indicators of their personal effectiveness, involving activities such as enabling others, supporting and developing a team, which we call 'processual effectiveness'. Although many felt that 'processual effectiveness' contributed to 'transactional effectiveness', for some, it was also a form of effectiveness in its own right that could be compromised by undue attention to 'transactional effectiveness'. Being a skilled or competent communicator was deemed a key contributor to general effectiveness. Although personal feedback was a gauge of effectiveness for most, many reported that feedback from their own line managers was lacking and/or only of a negative kind. In terms of organisational processes, effectiveness could be challenged by the sheer size and complexity of the hospital as a social structure. Effectiveness in one area could be compromised by 'knock-on' or 'ripple-effects' from another. Finally, many managers appreciated that the objective of combining clinical work and management is so that they positively reinforce each other thereby increasing overall effectiveness. However, lack of time and volume of work often made this a potential more than a reality.
4. Respondents mobilised both their managerial identities and their 'other' professional identities (e.g. nurse, doctor, accountant, scientist). In comparison with the mobilisation capacities of 'other' identities, which were fairly explicit, *managerial* identity often appeared 'in disguise'. Thus, many managers referred to their experience, or tenure, within the organisation as a resource to influence others and often cited their ability to communicate with others as their personality trait. Yet experience actually implies skilled knowledge of the organisational context. And, identifying, for example, as a 'people person' encompasses a raft of management skills such as the ability to translate specific demands placed on their subordinates by the organisation in terms that are clear and meaningful. The research also revealed that the 'mobilising capacities' of the 'facets of identity' of the various 'work groups' were subject to identity constraints arising from those they sought to mobilise for effectiveness, 'above', 'below' and 'laterally', as well as from the wider organisation (such as culture, resources) and from their workload. For clinical managers, it was also constricted by the need to juggle clinical and non-clinical work within time constraints.

Conclusions

1. Our finding that managers distanced themselves from an identity as 'a manager' is potentially problematic because a strong identity is associated with uncertainty reduction and employee strengthening (i.e. helping to deal with stress and facing new challenges).
2. Although there are differences between the 'content' and 'form' of clinical and non-clinical managers' work and that of junior and middle managers, the boundaries between them are nonetheless blurred (i.e. there is also variation within and similarities across categories of manager).
3. Although managers generally identified themselves as able communicators and as being supportive of those they manage, their *own* capacity to be effective is challenged by what they perceive as poor-quality feedback from above. Effectiveness is also affected by the complex, hard to navigate organisational environments they work in.
4. 'Mobilising capacities' derive from various facets of identity including, the 'content of identity' (i.e. values, goals and beliefs, stereotypic traits, knowledge and skills). We interpret these as managerial skills built up from tenure and from experience in managing and acquiring specific tacit organisational knowledge, but the managers tended to present them as personal qualities that were 'given' to them. Thus they underestimate their work-related skills and the capacity to develop them further to enable effectiveness.
5. Managers often felt that their mobilising capacity was inhibited by other 'work groups' (upwards, downwards and laterally in the organisation).

Further research is proposed as follows:

1. Given the variation found in this exploratory study not only across but also within the four primary categories and the finer-grained 'work groups', it would be valuable to extend the research with larger numbers of respondents.
2. There is scope to explore each of the 'work groups' in greater detail than has been possible here. This particularly applies to hitherto under-researched groups, such as scientist managers and Allied Health Professional (AHP) managers.
3. Many respondents were struggling with their identities as managers. Given that a strong identity is associated with uncertainty reduction and employee strengthening, more research is called for on how positive managerial identities can be enabled. This applies not only to managers' self-identities but also to identities conferred on them by others, such as colleagues, other NHS staff groups and the public.
4. Given that respondents generally felt that their mobilising capacity was inhibited by other 'work groups' (upwards, downwards and laterally in the organisation) there is scope to explore the perceptions that staff groups (including non-managers) have of the work of other staff groups and, if inaccuracies exist, to consider how they might be overcome to enable more effective working.

Funding

The National Institute for Health Research Health Services and Delivery Research programme.

Health Services and Delivery Research

ISSN 2050-4349 (Print)

ISSN 2050-4357 (Online)

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: nihredit@southampton.ac.uk

The full HS&DR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr. Print-on-demand copies can be purchased from the report pages of the NIHR Journals Library website: www.journalslibrary.nihr.ac.uk

Criteria for inclusion in the *Health Services and Delivery Research* journal

Reports are published in *Health Services and Delivery Research* (HS&DR) if (1) they have resulted from work for the HS&DR programme or programmes which preceded the HS&DR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

HS&DR programme

The Health Services and Delivery Research (HS&DR) programme, part of the National Institute for Health Research (NIHR), was established to fund a broad range of research. It combines the strengths and contributions of two previous NIHR research programmes: the Health Services Research (HSR) programme and the Service Delivery and Organisation (SDO) programme, which were merged in January 2012.

The HS&DR programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services including costs and outcomes, as well as research on implementation. The programme will enhance the strategic focus on research that matters to the NHS and is keen to support ambitious evaluative research to improve health services.

For more information about the HS&DR programme please visit the website: www.netscc.ac.uk/hsdr/

This report

The research reported in this issue of the journal was funded by the HS&DR programme or one of its preceding programmes as project number 08/1808/239. The contractual start date was in June 2009. The final report began editorial review in January 2013 and was accepted for publication in August 2013. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HS&DR editors and production house have tried to ensure the accuracy of the authors' report and would like to thank the reviewers for their constructive comments on the final report document. However, they do not accept liability for damages or losses arising from material published in this report.

This report presents independent research funded by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health. If there are verbatim quotations included in this publication the views and opinions expressed by the interviewees are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, NETSCC, the HS&DR programme or the Department of Health.

© Queen's Printer and Controller of HMSO 2014. This work was produced by Harvey *et al.* under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full report) may be included in professional journals provided that suitable acknowledgement is made and the reproduction is not associated with any form of advertising. Applications for commercial reproduction should be addressed to: NIHR Journals Library, National Institute for Health Research, Evaluation, Trials and Studies Coordinating Centre, Alpha House, University of Southampton Science Park, Southampton SO16 7NS, UK.

Published by the NIHR Journals Library (www.journalslibrary.nihr.ac.uk), produced by Prepress Projects Ltd, Perth, Scotland (www.prepress-projects.co.uk).

Health Services and Delivery Research Editor-in-Chief

Professor Ray Fitzpatrick Professor of Public Health and Primary Care, University of Oxford, UK

NIHR Journals Library Editor-in-Chief

Professor Tom Walley Director, NIHR Evaluation, Trials and Studies and Director of the HTA Programme, UK

NIHR Journals Library Editors

Professor Ken Stein Chair of HTA Editorial Board and Professor of Public Health, University of Exeter Medical School, UK

Professor Andree Le May Chair of NIHR Journals Library Editorial Group (EME, HS&DR, PGfAR, PHR journals)

Dr Martin Ashton-Key Consultant in Public Health Medicine/Consultant Advisor, NETSCC, UK

Professor Matthias Beck Chair in Public Sector Management and Subject Leader (Management Group), Queen's University Management School, Queen's University Belfast, UK

Professor Aileen Clarke Professor of Public Health and Health Services Research, Warwick Medical School, University of Warwick, UK

Dr Tessa Crilly Director, Crystal Blue Consulting Ltd, UK

Dr Peter Davidson Director of NETSCC, HTA, UK

Ms Tara Lamont Scientific Advisor, NETSCC, UK

Professor Elaine McColl Director, Newcastle Clinical Trials Unit, Institute of Health and Society, Newcastle University, UK

Professor William McGuire Professor of Child Health, Hull York Medical School, University of York, UK

Professor Geoffrey Meads Professor of Health Sciences Research, Faculty of Education, University of Winchester, UK

Professor Jane Norman Professor of Maternal and Fetal Health, University of Edinburgh, UK

Professor John Powell Consultant Clinical Adviser, National Institute for Health and Care Excellence (NICE), UK

Professor James Raftery Professor of Health Technology Assessment, Wessex Institute, Faculty of Medicine, University of Southampton, UK

Dr Rob Riemsma Reviews Manager, Kleijnen Systematic Reviews Ltd, UK

Professor Helen Roberts Professorial Research Associate, University College London, UK

Professor Helen Snooks Professor of Health Services Research, Institute of Life Science, College of Medicine, Swansea University, UK

Please visit the website for a list of members of the NIHR Journals Library Board:
www.journalslibrary.nihr.ac.uk/about/editors

Editorial contact: nihredit@southampton.ac.uk