



Settling for the best you can get' : creating a cross professional management team:

Introduction

This case is about creating a new management team across specialist professional disciplines, following a major re-structuring in a large acute health trust. The new directorate spans at least 8 different areas of medicine. The re-structuring which created it was key to the feelings among the partners. It seemed generally acknowledged that this process had not been well handled, leaving people resentful and with personal losses.



The restructuring was also seen to reduce management resources by creating more strategic management posts and so taking operational level posts away. The beginning of the new directorate management team was also hindered by the time it took to get all the people in post, especially all three operations managers. A year or so on, the general manager, members of the management team and managers who work to them can all see some progress.

[Alison, Clinical Director](#), Directorate of Specialist Medicine, a doctor

[Michael is the General Manager](#) of the new directorate

[Kumba is a Sister managing nurses in 4 outpatient departments](#) in the new directorate

[Hilary is an Administrative & Clerical Manager](#) within the Directorate of Specialist Medicine

[Marian, operations manager of one of the specialisms](#) in the new directorate, a nurse

Issues in these stories

Clinical Director

Alison, Clinical Director, Directorate of Specialist Medicine, a doctor

Alison relates how the re-structuring which produced the directorate was *a bad idea. Done*

for no reason and the wrong reasons. Michael and I went to a wine bar, drank some very nice wine and drew diagrams.

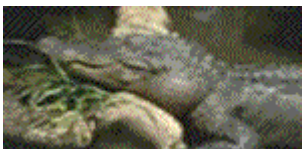
She adds that this is not what theyd have wanted but they had no guidance and it was typical that the process was done differently throughout the trust.

She goes on: Luckily we knew each other, we sat down and worked out what we could do, how many people doing what. Michael was clear what he wanted: a culture we believed in even if that meant going against what happened elsewhere in the trust. He wrote the mission statement the words mission statement are anathema to doctors anyway! I was happy with it but its not me. Our core values which we did were more me, things like dont re-invent the wheel. Then we appointed our team using interviews [this process didnt happen in all directorates] and we told them the plan, **that we didnt want dinosaurs.**

She describes how this process of assembling the team took longer than they wanted and some difficulties en route with one particular specialism were only resolved when they were allocated elsewhere, which made things easier. Assembling the various elements is only the first stage though, for Alison Im still not happy the team is forged yet. Were very disparate and our finance and personnel people also work for another directorate. Its also only been six months and there are still people in the various local teams who still resent the re-organisation.

Alison feels the **main thing which has helped** the partnership between specialties is the **focus on culture:**

mostly people feel well-supported. Someone recently told me they feel less intimidated by [a professorial colleague] as they feel they will be supported [by managers]. Its a friendly place. We are clear we dont like the dinosaur culture and we give out the positives.



She also thinks she and Michael get on well which helps, maybe too well.

The monthly meetings with all the heads of service who work to the management team are also key, cathartic and are supplemented by Michael having lots of 1 to 1s with managers, hes really skilled at that. And I do it with the doctors. [Clarke and Newman]

As to **what the partnership is achieving**, she feels it is too soon to say, although: Some common themes are coming through, which are not a surprise to Michael and me but perhaps are to our colleagues, such as the out-patient focus and the IT implications of that. For example I can now email results direct to patients. The issue is how to spread this and make

sure it happens across the directorate. We also need to develop the primary care focus all the teams should have a primary care project and look at our referrals and so on.

General Manager

Michael is the *General Manager* of the new directorate

Challenges to Michael as the leader in building this new team as a partnership turned out to be public, personal and apparently intractable.

The challenges included people strongly blocking any focus on inequalities, saying they hadn't encountered any prejudice and so did not believe it existed, and a key senior clinician who said about the new team: ' we have nothing in common, therefore there is no point in us all meeting together.'

Michael is working with the challenge about working on inequalities by shifting the focus to the needs of service users, rather than internally to employment practice, as 'slightly less threatening.' It also represents more of an innovation for his service areas to think about the different needs of different groups of service users - men and women, black and white people, older and young people, lesbians, gay men and heterosexuals, and so on.

His **approach to the senior clinician** was to work with his key ally, his own immediate boss. Together they : 'actually talked to him and asked him not to do it [ie publicly sabotage them in meetings]. And trying to get behind what some of his issues were in doing that. And that ... brought out a lot of things we hadn't realised.'

Procedures especially **had excluded this clinician** from some recruitment decisions in the re-structure, which produced a lot of resentment on his part. Michael comments on the importance of his own reflections in gaining more of an understanding of where this person 'was coming from and the pressures on him'.

Michael came to realise: 'coming from a sort of collegiate profession ... how difficult it was for him, and [I] probably appreciated more the amount that he did budge towards where I was - which wasn't quite as much as I'd have liked in the beginning... there really is a large degree of just settling for the best you can get out of situations like this.'

Importantly too several of the clinician's peers took up the new partnership positively, 'helpful in [me] not despairing of medics .. ' comments Michael. The clinician wasn't the only person unhappy with how things had turned out. Crucially Michael and his boss recognised this : 'those people could come to us and sound off. ...I think we would have real resistance to that new change [the next task of building new partnerships locally especially with

primary care organisations] if we hadn't dealt with the resentment and tensions that were underlying the formation of the partnership itself.'



Michael also describes how in developing his new management team: 'we were going to do things differently... work in partnership and sit down and listen - at the end .. I realised we'd set up another... committee, which was very top-down ... as

hierarchical as others'. But now he feels that has been taken on, with their weekly meetings occupied far less with the giving of information. He asks managers to work together and bring their improvement plans to the meeting 'to share best practice and for people to learn from each other.'

Equally the approach to building work with primary care reflects this shift :

'it's time to go round and get some voices ... we decided the going out there is important .. we go to a meeting where it is their [the local primary care team] agenda and where we might just be an item ... get a far stronger flavour for what was important to them.'

[Chambers on power in relationships - here a large acute trust is recognising the need to deal with the power it may be perceived to wield by people in primary care, to turn the usual process over and go to them; also low profile symbols of culture - where you meet]

The partnership is now turning its sights outwards from its start as an internal structure, and Michael is also planning to develop its focus on service users in the next phase of its life.

Nursing Sister

Kumba is a Sister managing nurses in 4 outpatient departments in the new directorate. She has been 3 years in post.

As a person experiencing the new management team and its work together, she comments:

'There've been lots of changes. I've been here 3 years and it was in bad shape then. Mine was a new post to manage nurses in 4 areas, which is a big job and pretty challenging from being a ward sister. There was not much support in place and it was quite isolating, being on 4 different floors and my office separate. I have had several managers. The original one retired - she knew a lot about the trust and was really able to help me with problems. But I was reporting to the Directorate manager and not to a nurse, so I couldn't take them my



clinical problems. Now there is a lot more [professional] support.'

There is a head of nursing as a result of the re-structuring; although the nursing is so diverse here that more specific support was needed. So the new [management] layer of clinical nurse managers and operational managers has really helped. The head of nursing brings us all together to meet and discuss issues. I find it really reassuring - the things I used to worry about, that I felt we were really 'rusty' on, I find others are the same! I can also network with the other sisters and have formed a real link with one especially, we talk a lot. I have also got into clinical supervision/(mentorship).

I feel the problems have been tackled [by the new management team], like resources. It's more organised, a consensus effort from senior managers to get us the resources we need. I feel the people who've been here for a very long time have been through hard times. It has got better, it's good.'

Administrative & Clerical Manager

Hilary is an Administrative & Clerical Manager within the Directorate of Specialist Medicine

As a person experiencing the new management team and its work together, Hilary comments:

'The management team is different. Till a year ago they were separate and you never saw them. Now they are more involved. I could get on with my work, but when I needed someone in authority or an answer there was never anyone available. They're more accessible now. Michael introduced himself to people and still intends to do it [with new staff]. My manager knows everybody. It's a vast improvement.

It was a 'them' and 'us' situation and they're trying to bridge it. I've been on one site for 10 years in admin and clerical sections and was isolated from the other site. Now there is centralised admin for out-patients which is working quite well and we're encouraged to work across sites.'

Operations Manager

Marian, operations manager of one of the specialisms in the new directorate, a nurse. **Her story of the new directorate begins** with the wholesale organisational restructuring of which it formed a part. She describes how 'most of the managers like me, clinical and operations managers were not happy, we were against it' She and colleagues could not see how such a major disruption to re-structure directorates could be worthwhile. Her view is

that 'it was single-handed' in that the Chief Executive really pushed it through, with one or two others at Board level,'despite doubts from all areas and our view that it would create unrest and disenfranchising'. So the new cross specialty team did not have a good start at all. What made it worse was the length of time the process took. For Marian this was compounded personally since she took up a secondment to operations management level on the encouragement of her managers, as a development move.

The restructuring meant she had to do both jobs, which was agreed with her for the planned 6 months. But it went on for 18 months rather than the planned 6 month secondment and was very difficult.'I had to juggle it somehow .. the solution always seemed to be just around the corner' During this period Marian and a colleague opposed the inclusion of their specialty in the new directorate: 'We were not happy with it. Why? Why move us? Leave us on our own or if they have to move us, then to a stand-alone position, we had the critical mass for that.' She explains they were open about their views and copied Michael, the new directorate's manager in on all their notes and comments. She also heard that he himself had experienced difficulties with the restructuring, as had almost everyone in management. But at the same time she comments 'we all tried very hard for the clinical service not to feel any of this .. the [ward] sisters knew, but were not really affected - this is how it is in the NHS.'

The **beginning of the new management team was hindered** by the time it took to get all the people in post, especially all three operations managers. The restructuring also took up management resources in creating more strategic management posts and taking operational level posts away:'it annoyed lots of people including me that the reorganisation took away some management resources and we didn't get more we were very concerned and I still am.' At the same time the pace of work and the amount of change kept up, so that: 'We were very task-oriented and not formed as a team. All of us including Michael were very task focused and stressed. Michael seemed especially stressed and it was hard to get to him, to contact him, and to get a response to emails or messages. He was not approachable then. I feel that if I need him, then it is a serious matter and I do need a response in a very reasonable time' What is more, Michael made a key decision to centralise clerical and administrative staff for the directorate as a whole. Marian disagreed with this approach and said so, 'as I am responsible for the service and I get the flack', but went along with it as a review was promised 'if it was not working'.



A year on she feels it is not working and a discussion is only now about to happen - importantly to first agree on how 'it working' might be defined. [assumptions] [see also] Marian comments on the importance to her of an open relationship with her manager, which she feels has developed: 'I value I can be open with him and he listens. There was a time when he couldn't hear me [about the clerical issue]and would roll his eyes up! That has changed, he's taken it on board, we've resolved that now.' Marian saw Michael as starting out with an 'idealistic' approach which was 'nice to hear but it was clear it couldn't work - it's not how the NHS works, there just aren't the time or resources.' The management

team had no links other than their weekly meeting, which is 'very task-y, information coming down, with only brief minutes for us to pass information up, very little time for that.' The 3 operations managers have recently discussed together what to change about these meetings and made proposals, agreed with Michael, to enable more time for discussion of their issues and for their process as a team.

A year or so into the new partnership across specialties Marian comments: 'it makes more sense now, I've revised my position - I still doubt whether the process [endured] was worth it, but I've moved on. The common link is our services are all out-patient focused. [link to commentary on purpose] The problems haven't stopped me working well with others and I've always tried new things. The process didn't help, what did help was the experience and reputation of Michael and the clinical director. Others reassured me Michael was 'sensible' and he is experienced, having worked up from the ranks. He understands the service. So I felt he was OK and I'd be OK. The clinical director has a similar reputation in the trust. Also one of the other operations managers had been my staff before so I knew her too.'

Regarding the next stages for the team, Marian is clear that: 'we need to focus on forming as a team, and not just [be] a conglomerate formed by the organisation.' She sees the change of a new head of nursing joining the team soon as perhaps an opportunity for this and feels Michael is listening and happy to take things on suggested by the 3 operations managers. This subgroup have only recently found the chance to talk more as a trio, partly through some 'protected space' offered by a trust-wide study day on 'leading for change' where two of them were able to really discuss these issues for the first time.

Issues in this story

This case raises several issues which are echoed in other cases.

On leadership, it shows the power of a direct approach to resistance and tackling 'bad behaviour' especially that displayed in public fora and this links strongly to the joint commissioner's approach in one of the other cases . This approach is in contrast to that in another case where one person did block progress and wasn't challenged. Michael's conclusion about just how far you can move people highlights the importance of recognising even small shifts and their cost to individuals. Partnership for him is about what you can achieve, short of outright support [[degrees of agreement continuum](#)].

This story emphasises **reputation and credibility in leaders**, being both visible, known and accessible. Also that these issues are noticed by staff. The story shows too how the leader



is always looking to the next thing, the next change, even in the middle of present changes - boundary scanning and keeping the innovation of the partnership moving.

Michael saw his role as both making the new structure work and tackling issues of discrimination and inequalities. He is doing this by a focus on the needs of service users, in order to resolve or at least move forward on matters of conflict regarding tackling inequalities. He is battling with the paradox of including these issues but also making it explicit they are being tackled, which produces strong reactions in his staff. [Helvig Square](#)

In common with other stories the trigger to set up the partnership was key here [Webb: reasons for partnership - mandate, altruism or exchange] The mandated 'forced marriage' from the start produced many of the problems that Michael had to deal with. This highlights recurring dilemmas about structures - their advantages and disadvantages, how long re-structuring can take, how partnership has to go beyond a structure to a 'forged' partnership. And how long it may take to see the benefits. Only now are members of the management team seeing any links across their specialisms, such as the commonality of out-patient services, which the leaders saw from the start. It isn't clear from the stories how far staff further down the hierarchy see the links, or if they do. [[Weil's cycle of change](#), how people will be at different places at different times]

The story emphasises issues of culture and relationships, openness in making this shift to a real team - and that lack of time to look at processes or surface assumptions and stress all get in the way. It also raises concepts of power : moving towards people to deal with complex issues, both to engage them for real as with the reluctant doctor; and also as a symbol of shifting power, as with the intention to 'go out' to primary care teams. [Chambers](#)]Here a large acute trust is recognising the need to deal with the power it may be perceived to wield by people in primary care, to turn the usual process over and go to them; They are recognising low profile symbols of [culture](#) such as where you meet make all the difference. It reflects too the shifting boundaries in health and their increasing permeability: between acute and primary care; between doctors and patients; between specialisms and professionals

Differently from story 3, but like story 7 however, it was important here to let people sound off about immediate past problems of restructuring, to deal with resentment before moving on. Perhaps as a mandated change [hyperlink to reasons as above] that no-one, even the leaders, really wanted initially meant that these feelings had to be acknowledged rather than passed over. The question remains: what would have made the whole re-structuring a better process ? Did those in more senior positions make their



purposes clear and 'market' them? [Bartlett and Ghoshal (1994)] The case also raises key aspects of support to different professions and relationships between managers and health professionals. It shows how the levels and specificity of support to individuals must be taken account of and how layers of different kinds of support can interact. The new team recognised and explicitly worked on this support, which has had a positive impact on their staff and on overall culture in the new directorate. On the other hand while clerical and admin staff seem to appreciate new focused arrangements for their function, some clinical staff would still prefer separate site based clerical and admin staff