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# The Influence of Middle Managers in the Business Planning Process: A Case Study in the UK NHS

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**The paper takes a processual approach (Mintzberg and Waters, 1985; Pettigrew, Ferlie and McKee, 1992) in conjunction with a typology of middle-management influence upon strategic change (Floyd and Wooldridge, 1992) to investigate the role of middle managers in business planning in the National Health Service (NHS). Over time, as the business planning process becomes increasingly one which adopts a top-down approach, the main influence middle managers have is upon the implementation of deliberate strategic change. Middle managers modify the implementation of deliberate strategy by contesting the performance indicators that form the basis of the business planning framework. In particular they draw upon features of inner and outer context of the organization to question the legitimacy of business planning. However, the findings also show, albeit to a limited extent, that middle managers are purveyors as well as recipients of change. That middle managers can have upward influence has important implications for policy-makers since potentially, middle managers can enjoy an enhanced role and add value to organizations, in this case to patient care. Therefore recent attacks upon their numbers and role may be misplaced. In addition a high degree of central intervention in the NHS generally may be inappropriate, since it militates against an enhanced role for middle managers.**

## Introduction

This paper examines the business planning process in the National Health Service (NHS). In particular it considers the role of middle managers within the business planning process. The contention of the paper is that business planning processes in the NHS are of a top-down rational planning nature and that this does not allow for the influence, both downward and upward, of middle managers. To investigate this contention the paper takes a processual approach (Mintzberg and Waters, 1985; Pettigrew, Ferlie and McKee, 1992) in conjunction with a typology of middle-management influence upon strategic change (Floyd and Wooldridge, 1992) to investigate the role of middle managers in business planning. On one hand this addresses a research gap about the process of business planning in general. More importantly, there is a need for more empirical studies of the role of middle management (Dopson and Stewart, 1990), particularly those which address the 'unjust' neglect of the public sector from academics carrying out research from a strategic management perspective (Ferlie, 1992; Lyles, 1990).

## The role of middle managers in the NHS

There is an apparent lack of consensus in debate around the role of middle managers in organizations, which is reflected in the titles of papers or books, both populist and academic. On the pessimistic side of the debate, there are titles such as – 'Cutting Out the Middle Manager' (Arkin, 1990), 'An Endangered Species: The Disappearing Middle Managers' (Syedain, 1991), 'Too Much Round the Middle' (Oates, 1992) and *Reluctant*

*Managers: Their Work and Lifestyles* (Scase and Goffee, 1989). These vie with titles which assert a more optimistic future for middle managers such as 'Putting Management back into the Middle' (Lebor and Stofman, 1988), 'The Middle Manager as Innovator' (Kanter, 1982) and 'Moving from Crisis to Empowerment' (Frohman and Johnson, 1993).

The former pessimistic view tends to be emphasized (for example, see Redman, Wilkinson and Snape, 1997). However, while Redman *et al.* support more pessimistic assertions for the role of middle managers, they also argue that their findings may be context specific. That their findings are described as context specific is an important point, since it suggests that research should attempt to gain a richer in-depth understanding of the changing role of the middle managers within specific contexts. As Dopson and Stewart (1990) argue, insufficient attention has been paid to industry- and organization-specific developments:

> 'If writing in this area is to amount to anything more than armchair theorising, it is crucial that more empirical work is done. Failure to do so may lead to yet more sweeping assertions about the future of middle management.' (p. 15)

In later work Dopson and Stewart (1993) emphasize that studies of middle management need to recognize a distinction between public- and private-sector organizations. In taking account of this, in the NHS, at least until recently, the situation can be described as one whereby middle managers were in the ascendancy. The Griffiths Report (DHSS 1983),[1] which represents the keystone document of the NHS reforms under the previous Conservative government, appeared to strengthen the hand of middle management in the NHS, and this continued following subsequent reforms (Harrison *et al.*, 1992; Pollitt *et al.*, 1991; Stewart and Walsh, 1992). At the time, such strengthening flew in the face of contemporary trends in organizations to de-layer middle management (Cameron, Freeman and Mishra, 1991; Cascio, 1993; Dopson, Risk and Stewart, 1992; Palmer, 1995).

However, recently there have been attempts to marginalize and attack general managers in the NHS, which reflect more general organizational trends to restructure and 'thin out' layers of management (Drucker, 1988; Kanter, 1989; Peters, 1987, 1992). Within the NHS, managers have been attacked as the 'men in grey suits' (for example, Hancock, 1994; *Health Service Journal*, 1994a, 1994b). Such a theme has been continued by the Health Secretary in the Labour government, who announced a target of £100 million cuts in management costs in 1997–98. Over time, manager bashing has become an occupational hazard in the NHS for many years, to the point where even the managers themselves believe that the NHS has too many managers (Pettinger, 1998).

Thus, there has been a process of de-layering in the NHS which is similar to the more widespread organizational trend to de-layer middle management, but there has been a considerable time lag. In the 1980s the number of middle managers increased, and they were encouraged to be proactive in driving change. In contrast, from the mid-1990s onwards, their numbers have been reduced and their role questioned. What has not been apparent in the NHS is the view expressed by Frohman and Johnson (1993) and Smith (1997) amongst others that following de-layering the remaining middle managers can have an enhanced role. The paper now turns to an empirical investigation of the role of middle managers in the NHS, considering whether middle managers can enjoy an enhanced role, despite decreasing numbers. Investigation of the business planning process utilizing the strategic change literature as a sensitizing device illuminates this question.

## Business planning in the UK NHS

Business planning is a concept drawn from the private sector. In this context a business plan is 'a statement of the actions and resources required by a business to sustain and develop a discrete area of "commercial" activities over time' (Coopers and Lybrand, 1993). However in the NHS there are a number of contextual characteristics which impact upon business planning, and mean that the business plan differs from that seen in the private

[1] The Griffiths Report promoted the concept of general management within the UK NHS. General management rests on the argument that there are profound similarities between all organizations. Anywhere and everywhere you look much the same practical problems occur, problems which are most effectively solved by a common set of managerial methods (Strong and Robinson, 1990).

sector (Thompson, 1996). In particular, sources of income are relatively inflexible, there is a great deal of political intervention from national level of government and the medical profession is a major cost driver and definer of services provided.

Despite the presence of business planning in the NHS and the amount of energy devoted to it by top management and middle managers, the focus in the academic literature is upon policy issues rather than micro practices such as business planning, which institutionalize attempts to manage public-sector performance through performance indicators. Special editions of journals testify to this emphasis in academic debate upon the policy of setting performance indicators for the public sector; for example, *Public Money and Management* (1993), *Health Services Management Research* (1998). Within this debate it is emphasized that the performance indicators upon which business planning is based are problematic and that the implementation of performance indicators is a top-down initiative (Jackson, 1993a, 1993b). That it is a top-down initiative is important, since this is likely to restrict the influence of middle managers in the business planning process.

In this paper the important idea in the above is taken forward that business plans in the UK NHS inscribe performance indicators which are imposed in a top-down way upon middle managers. The performance indicators which form the basis of the business planning framework may be contested by the middle managers. That this may be so is confirmed by other studies. For example, Langley (1986) raised the issue of control and the importance of negotiation and persuasion in her study of formal planning in healthcare. In her study hospital plans are a blunt instrument of control which are strenuously resisted by those outside top management. A critical point raised is that the indicators on which business planning is based need to be problematized so that they take account of practices at the operational level. Langley asserts that the business planning process almost has to raise tensions if it is to be any use at all in a hospital.

Thus, the top-down approach, which the business planning framework demands, should be put aside in favour of one which encourages a greater degree of participation from the middle-management group who control the individual clinical directorates. Where it remains a top-down process may mean that its outcome, the business plan, is consigned to 'gather dust' by middle managers (McTaggart, 1994) since there are multiple definitions of a problem and contradictory objectives in the NHS (Clarke and Newman, 1997). Importantly, given the contested terrain in which the business planning process takes place, business planning has both intended and unintended consequences that illuminate the strategic change issue in the NHS in general.

## The conceptual framework

Within the context of organizations in general, including the NHS, this paper argues that the conception and implementation of strategic change is crucial for the role of middle managers. That the strategic change literature may be illuminating in considering the role of middle managers is argued by Dopson and Stewart (1990). They cite studies of the role of the middle manager in strategic change (Guth and Macmillan, 1986; Schilit, 1987) to substantiate a more optimistic view of the role of the middle manager. Thus, the intention of this part of the paper is to set up a framework for a more optimistic reading of the role of middle managers in strategic change against which empirical findings can be set.

In relation to the management of strategic change, a fundamental problem in the 1970s was the development within the NHS of service policies for massive change, without building up the organizational capacity to translate this ambitious change agenda into practice. Inherent in this was a rather simplistic notion of rational process and top-down directives (Pettigrew *et al.*, 1992, p. 6). This was despite a focus which moved from concern with 'policy' to a concern with 'strategy' (implying greater concern with securing action around the espoused policies) whereby top-down restructuring has been complemented by a focus upon organizational culture and cultural change. A crucial problem is that policy-makers have seen organizational culture as manageable or 'plastic'. This view has been criticized on the grounds of its unitarist assumptions (Ogbonna, 1992; Ray, 1986; Sackmann, 1992; Van Maanen and Barley, 1985; Willmott, 1993). While policy aspirations in the NHS reflect a desire to manage culture, empirical studies suggest policy intentions are not realized (Harrison, Small and Baker, 1994; Harrison *et al.*, 1992). Therefore, the problems of implementation failure remain with us in the

recent reforms despite an emphasis upon strategy and culture.

Why this should be so is because the approaches to strategic change in the NHS still separated formulation of strategic change from implementation. More importantly they did not allow for any consideration of middle managers beyond a mere implementation role. In contrast, the processual approach to strategy (Mintzberg and Waters, 1985; Pettigrew *et al.*, 1992) is based upon a definition of strategy as 'a pattern in a stream of decisions' (Mintzberg and Waters, 1985). From this perspective strategy is emergent as well as being solely deliberate, rational and top-down. Strategy as process not only reflects the views of top management, but represents a set of pragmatic compromises between various stakeholders in the organization (Pettigrew, 1985). This allows for consideration of middle managers in strategic change beyond implementation of deliberate strategy.

Following the contention that strategic change is better viewed as emergent, the paper will now draw upon the framework developed by Floyd and Wooldridge (1992). This is useful as an initial sensitizing device to identify examples of the influence of middle managers in the business planning process. The use of this will be complemented by a particular concern with legitimacy for middle-manager influence (Pettigrew *et al.*, 1992).

Floyd and Wooldridge (1992) outlined a typology of middle-managers' influence, which emphasizes emergent strategic change. This sets out a framework outlining upward and downward influence of middle managers in the strategic change process, which allows for a consideration of an enhanced role for middle managers. In terms of upward influence, roles taken up by middle managers are 'championing alternatives' (see also: Burgelman, 1983a, 1983b; Kanter, 1982) and 'synthesizing information' (Nonaka, 1988). The former is seen as a product of divergent ideas from organization thinking whereby there is persistent and persuasive communication of strategic options. The latter is more integrative, since middle managers interpret and evaluate information concerning internal and external events, which they then supply to top management. In terms of their primary role, downward influence – that is the carrying out of strategy (Schendel and Hofer, 1979; Schilit, 1987) – middle managers 'facilitate adaptability' and 'implement deliberate strategy'. The former may be divergent since here the middle manager is concerned to nourish adaptability apart from the plans embedded in deliberate strategy, or sometimes in spite of them (Bower, 1970; Kanter, 1983). The latter is often considered the key strategic role of middle managers (Nutt, 1987; Schendel and Hofer, 1979) and is defined as managerial interventions that align organizational action with strategic intentions.

The emphasis in this paper is to investigate when and where the type of influence middle managers exert, identified above, is seen as 'legitimate'. This includes the influence of middle managers in questioning the legitimacy of top-management intentions in the implementation of the deliberate business planning process. It also includes consideration of how middle managers create legitimacy for their upward influence generally, and their downward influence in adapting flexibility. Legitimacy here is conceived in the terms of its usage by Pettigrew *et al.* (1992), who place the concept of 'management of meaning' centrally. 'Management of meaning' used in this way refers to the process of symbol construction and value use designed to create legitimacy for one's own ideas, actions and demands, and to question the legitimacy of the demands of one's opponents. One of the most critical connections identified in the work of Pettigrew *et al.* is the way actors in the change process mobilize the contexts around them, and in doing so provide legitimacy for change. Using this framework, the circumstances under which middle management opposition is successful or unsuccessful can be examined in the implementation of the deliberate business planning process. In addition, the extent to which middle managers can create legitimacy for their ideas and actions in the business planning process, and therefore have upward influence by defining meanings for top management, can also be assessed.

## The case study: the Florence Hospital

Following the Griffiths reforms (DHSS, 1983) the previous Conservative government went on to introduce market mechanisms into the UK NHS via a White Paper *Working for Patients* (DoH, 1989a) and legislation *Caring for People* (DoH, 1989b). This legislation necessitated that NHS trusts prepare strategies on the basis that they are business units, which should provide services that

meet purchaser needs, attract income and be financially viable in order to survive. The Department of Health, in the initial applications by health-care organizations for trust status,[2] saw business plans as crucial to being businesslike. The production of business plans also meets the National Health Service Executive (NHSE) requirements, which ask for an annual plan from NHS trusts setting out their strategy for the ensuing financial year in detail and a further two years in draft form. In addition trusts have to submit a five-year strategic direction document every three years.

The case study under consideration – the Florence Hospital – was one whose initial application for trust status was turned down on the basis that its business plan was not viable and that clinicians were not sufficiently integrated into the management structure. However it was accepted for trust status in a second wave of trust applications having addressed these issues, and gained trust status in 1992. It employs 3000 staff and dealt with 37 000 inpatients and 63 000 outpatients in 1996/97. As well as a Surgical Services Directorate, Medical Services Directorate, Trauma and Orthopaedics Directorate, Critical Care Directorate and Radiology Services Directorate, it has an Accident and Emergency Directorate within its portfolio of services.

The actors in the case can be divided into two groups. First there are senior managers. These are those in the Central Directorate who set the business planning framework within which the individual clinical directorates have to work. Second, there are middle managers. These are those managers in the clinical directorates who draw up the individual business plans. In the Central Directorate the Business Development Department plays a key role in managing the business planning process. As a reflection of the department's importance, the Director of Business Development has a place on the Trust Board.

Each of the clinical directorates is headed up by a General Manager who works in conjunction with the Clinical Director, although in most cases the latter takes a 'hands off' role in the management of the directorate. The Service Manager, who takes operational responsibility for the directorate, is the main support for the General Manager. In most cases the General Manager and Service Manager have a professional background appropriate to the directorate activity area. For example, in Medical Services, both the General Manager and Service Manager were nurses. The General Manager and the Service Manager are considered to be the middle managers in this paper and take the lead role in the business planning process at individual clinical-directorate level.

The business planning cycle begins in August with the production of a template for the business plan produced by the Business Development Department, which the individual clinical directorates have to work to in producing a business plan. Typically, having produced a business plan which fits in with the template, the General Manager and Service Manager consult the ward sisters or team leaders as well as the Clinical Director, before putting it forward to the Trust Board for consideration. Usually the individual clinical directorates are asked to modify their business plan by the Trust Board before the Board finally accepts it in February. However, the contracts with the purchasers for health-care provision are not agreed until the end of the financial year in March. Thus the business plans are developed before contracts are agreed and are necessarily based on the previous year's contracts.

## Methodology

The methodology adopted in this research study is best described as qualitative (Taylor and Bogdan, 1984) with features of case-study research (Yin, 1994) and ethnographic principles (Hammersley and Atkinson, 1995). Interview data was gathered in three phases over a time-period of two years from spring 1995 until summer 1997 and this was complemented by continuous observation and collection of relevant documentation.

In the first phase, 14 exploratory interviews were carried out with middle managers, asking them to describe changes they encountered in their managerial practice and their feelings about these changes. In addition, general observation of the hospital environment was undertaken. For

[2] The National Health Service and Community Care Act (1990) allowed hospitals to opt for becoming independent agents for the purpose of setting prices for their services if they met certain conditions laid down by the Department of Health in order to become independent trusts; e.g. financial viability had to be demonstrated as a non-profit agency.

example, work shadowing was carried out and the researcher attended meetings such as the patient-focused care steering group.

In the second phase, data was gathered via informal interviews (25 in number) with Executive Directors (three), General Managers (two), Service Managers (five), and other stakeholders in the process (for example, Organisation Development Manager, Patient Focused Care Manager). Notes were taken in these interviews. In this phase, management development activities were also observed.

In the third phase, further observation was undertaken – for example, marketing workshops were attended. In addition, a wealth of documentation was gathered. In particular, business plans provided a valuable insight to the strategic change process. Thirty-one formal interviews complemented the data gathered via documentation. These interviews were taped and transcribed. Five of the six general managers were interviewed. Eleven service managers and five senior sisters were interviewed. In this third phase, formal interviews also took place with four executive directors (including the Director of Business Development), the Chief Executive, the Business Development Manager with responsibility for marketing, the external marketing consultant, the Organisation Development Manager, the Patient Focused Care Manager and the Clinical Effectiveness Manager. Following the final set of 31 interviews the themes were identified which follow in this paper.

## Research findings

There are two main narratives identified in the case study in relation to the business planning process:

1 The Central Directorate (Business Development Department and Executive Directors).
2 The Middle Management (Service Managers and General Managers).

Drawing on the work of Pettigrew *et al.* (1992) it can be expected that middle managers as well as top management exert upward and downward influence. Both groups mobilize features of inner and outer context around the business planning process to create legitimacy for their differing views and actions and to question the legitimacy of the views and actions of others.

## The change narrative of the Central Directorate

*Derivation of business planning framework*

In its initial stages there was a receptive context for the introduction of business planning, since there was scope for the directorates to include their own internally generated developments in the business plan alongside indicators set at national level and purchaser level. In addition, Florence Hospital was regarded as 'second rate' by its own members, because it had been turned down for trust status at the time a business planning process was implemented. This created an impetus for any new initiatives.

However, despite early indications that there might be significant bottom-up influence, business planning remained a top-down initiative:

> 'The Central Directorate wanted clarity around the objectives of the organisation and to put a performance framework around it and the business planning process facilitated this. They wanted to co-ordinate the different services so that they were moving in the same direction towards these set objectives. They regarded the business planning framework as a rational decision-making system because it was transparent, shifted the focus from professional interest to patient interest, and recognised resource constraints within a longer time horizon than was traditionally the case.' (Business Development Manager)

As far as objectives are concerned, the main function of business planning was as a resource-allocation mechanism. However, it was also seen by the Central Directorate as a way to raise the profile of certain issues. The Chief Executive made the Clinical Effectiveness Manager responsible for 'more qualitative performance indicators'. She viewed the business planning process as a way in to developing this at clinical directorate level:

> 'The Chairman and Chief Executive said we are sick of seeing performance indicators as the only measures of quality in the organisation.' (Clinical Effectiveness Manager)

*Middle managers are the blockers to change*

Middle managers were identified as the fulcrum for the business planning process. However, the Central Directorate also recognized that they were

subjected to a great deal of ambiguity in their roles. Their role in the business planning process reflected this:

> 'They [middle managers] are closest to patients. They see the dilemmas and paradoxes of having to match the demands made to them by patients in beds and by relatives, who don't feel they can cope with the patients at home, with the performance criteria imposed upon them in the business planning framework such as bed utilisation and contract targets. If anyone is the jam in the sandwich, it is them.' (Organisation Development Manager)

However, operational 'reality' meant that the success of the business planning process was dependent upon the characteristics of each directorate. For example, the business planning process was one whereby a number of separate mini business plans were developed within each directorate and then these were joined together. In the Surgical Services Directorate there were discrete areas which could develop mini business plans separately which could then be easily integrated. However, in the Medical Services Directorate the integration of mini business plans with each other did not work because areas within the directorate were closely linked.

Given these contextual differences, whilst members of the middle-management group were seen as key players in the implementation of business planning, they were also regarded as potentially blocking change in the trust, because they could argue their operational context was inappropriate for change attempts. Business planning represented a mediating strategy towards the management of this group so that the ends prescribed by the Central Directorate were met:

> 'The end product is partly about control ... Decisions made about resource allocation then become the basis for performance indicators for the next year.' (Chief Executive)

> 'Business planning is a strategy which allows us to manage professionals ... but allows them to manage the means towards managerially prescribed ends.' (Organisation Development Manager)

*External environment*

That some outcomes of the process were not what they could be was blamed upon external factors as well as the disjunction between the targets set in the business planning framework and operational 'reality':

> 'We didn't get the integration of [business planning in to] directorates quite right ... this was linked to the fact that purchasers didn't set contracts until the last two weeks in March ... the health authority were very reluctant to give clear decisions on priorities ... so there was no time for internal dialogue between areas.' (Chief Executive)

An additional external constraint was the unpredictable nature of government directives, such as requests for efficiency gains or managerial restructuring. This was particularly so because the third strand of the business planning framework, that of internally generated initiatives, was compromised by financial constraints:

> 'To start with we were actually able to deliver a lot of the things set out in the business plans ... such as the WIN Project [a customer care programme] ... I would say for the first three years this was possible but less so in later years ... financial constraints set by the government were very tight.' (Chief Executive)

Evidence of diminished scope for middle managers at clinical-directorate level to gain support for internally generated developments in the business plan was provided in documentation. In October of each year the Chief Executive sent out a memo to clinical directorate managers, setting out targets for the next financial year which would form the basis of the business plan for that year. The framework set out became more prescriptive over time. In the memo prior to the 1993/94 business planning cycle there were general statements that: 'I [Chief Executive] want to discuss CIP [cost improvement targets] and possible areas for next year including market testing, materials management and inter-provider targets'. It was also stated that: 'I wish to discuss and assess performance over the first four months of the current financial year'. In the memo which preceded the 1994/95 business planning round, the wish that there be an interim report on performance so far was maintained. However the framework set out for the business plans was one which emphasized 'critical success factors' as laid down by national and regional level bodies as well as purchasers.

Thus, as a reflection of this, summary reports were produced for each clinical directorate and specialties within each directorate, which provided feedback on national, regional and purchaser-defined performance indicators throughout the financial year. These were then aggregated and summarized in the business plans produced for the next year to show the benchmark against which clinical directorates intended to make improvements. Government requests for efficiency gains in costs provide a good example of outcomes of externally prescribed criteria, which are taken on board via the business planning process. In the memo which went out from the Chief Executive prior to the 1994/95 business planning round it was stated:

> 'Finally, you will be aware of the efficiency targets Florence is required to meet. In 1993/94 this was two per cent and until the announcement in the autumn, I am assuming it will continue at two per cent. I would therefore like to discuss your contribution to this.'

The extent to which the environment was unpredictable was also reflected in that business planning round since there was a subsequent statement in the autumn of 1995 where the Health Secretary asked for a specific 2% efficiency gain in management costs at middle-manager level. This had not been included in the business planning framework, since it was an unexpected political intervention.

## Change narrative of middle management

*Middle-manager practice*

Middle managers expressed a view that much of the content of the business plan was produced by them to satisfy the requirements of the template prescribed by the Central Directorate. They felt that it did not represent a working document for the next year of operations. Middle managers suggested that information on which business planning was based was very poor. The business plan remained confined to the bottom drawer in some instances. This was vividly illustrated in two interviews where the bottom drawer was opened and after a great deal of shuffling around the business plan for that year was produced. Perhaps not surprisingly managers in one directorate commented:

> 'Paula [General Manager] does it [business plan] at home and we [Service Manager and Clinical Director] sign it without knowing what's in it. It doesn't matter because it's not relevant.' (Service Manager, Medical Services)

Middle managers regarded the Central Directorate, and those at national, regional and health authority levels, as not understanding what went on at the 'coal-face'. The middle managers referred to them as those from the 'Planet Zanussi' to reflect this. They emphasized that the business planning process did not reflect local clinical and managerial practice, since it was difficult to standardize clinical interventions in the way demanded by the business planning framework:

> 'You don't know what is going to come through the door, particularly with the elderly. Maybe their partner has died or even their cat and they want the doctor's attention. They can tell him and it does have a bearing on their physical condition. It does!' (Service Manager, Medicines Outpatients)

Thus it remained difficult to allocate 20 minutes to each 'consultant episode' as was asked for in the business planning framework. However, the middle managers were forced to do this and then manage the consequences of clinics overrunning when providing reports about business-plan targets. Many areas exceeded contract agreements because they were reluctant to turn patients away and then found that funding did not follow the patient despite costs incurred. Again the middle managers were told 'it is your problem'. In one instance a ward in Surgical Services was closed down temporarily because the area had been 'too efficient' (General Manager, Surgical Services) in throughput terms and GP fundholders had spent their budget by November. Thus physical space and consultant time and expertise remained largely redundant until the new financial year began in the following April. In addition, to a large extent services remained professionally defined. This had an adverse impact upon business measures of performance:

> 'The problem here is that we are more specialised in vascular surgery as opposed to general surgery.

> They stay longer in hospital, need more expensive kit. It's an expensive specialty and we get squeezed because Pride Hospital Surgical Services have better throughputs in beds and FCEs [Finished Consultant Episodes]. The reason [for the choice of service provided] is we have two vascular consultants.' (Service Manager, Surgical Services)

Middle managers criticized the type of indicators, which were included in the business planning template imposed upon them. They felt that they had to put 'a very good business case' for service development to the Central Directorate. To obtain extra resources it was necessary to emphasize efficiency gains in making a 'business case' to which quality issues were described as secondary. A further problem was the fragmented nature of business planning. Middle managers felt that they carried out their business planning in isolation from other directorates:

> 'For instance before the pharmacy business plan is signed off we ought to have some input. If we are looking at providing a new treatment that has a drug implication it can have massive effect upon their budget.' (Service Manager, Physiotherapy)

Finally, and importantly, the business planning process was criticized as lacking sensitivity to the 'caring' aspect of the health service. In a management-development workshop, the Hospice Manager, whilst accepting a need for processes such as business planning, 'because we must manage resources more effectively in trustland', commented:

> 'However, it's about caring for people so we can't follow the cost-cutting principles of management as promoted in the industrial model.'

*External imposition*

A further reason cited for the irrelevance of the business plan was that there was difficulty in planning ahead in the face of unpredictable changes in the environment, particularly at national level:

> 'We try to push the service forward and ensure resourcing meets service provided. But then suddenly you hit a brick wall when massive cost improvements are demanded by the government.' (General Manager, Therapy Services)

In addition, the potential to develop business in the clinical directorates had diminished, not just in the face of government financial constraints, but also through host health-authority intervention:

> 'We've been actively discouraged from taking any more GP direct access service business by the health authority. There's a limited pot of money and other directorates within our hospital or other hospitals lose out.' (Service Manager, Physiotherapy)

That this was the case was exacerbated with the recent announcement by the host health authority that there was to be a proposed rationalization of services in the city.[3] Many of the clinical directorates within Florence Hospital were to be adversely affected, albeit over a lengthy period of implementation of the rationalization plans over eight years.

Increasingly over time, both the host health authority and GP fundholders asked for business-planning documentation in renewing or switching contracts. This increased the feeling of middle managers that they were squeezed in their roles. On one hand, their background was one of being clinical professionals, most typically nurses, for a lengthy period. On the other hand, they were currently undertaking a general management role, and in this role they constructed business plans along narrow managerialist conceptions of performance:

> 'I need to plan what might be called the "business". There is a part of me which asks, "why did I do my three years training and ten years working as a physio to push bits of paper around". What should I really be doing?' (Service Manager, Physiotherapy)

Middle managers also felt 'disempowered' by their relationship with the Central Directorate within the hospital. There had been some talk of a move from clinical directorate arrangements towards 'Strategic Business Units'. However, this had 'been put on the backburner' (Chief Executive) because there was not yet 'a critical mass of support' (Chief Executive). As a result middle

[3] See Currie and MacKay (1998).

managers faced a situation where there was still a great deal of central control:

> 'There are so many things I have to refer back on and say, "Can I do this?" I don't have any money where I can say, 'Well I am going to make that decision to develop outpatient services.' (Service Manager, Outpatients Medical Services)

On a more positive note the criteria imposed by the Central Directorate in the business planning framework led to certain emergent operational practices which actually gave rise to more effective patient care. An example of this was the attempt in medical services to reduce nurse absenteeism in line with the target of 3.5% set in the business planning framework. This had been imposed by the Central Directorate upon all directorates at the suggestion of a non-executive director because this was the figure set by a local manufacturing concern for which he sat on the Board. Thus, the Service Manager spent a large proportion of her Monday morning undertaking 'return to work' interviews to manage absence towards this target. That such an approach was successful in Medical Services meant that in the subsequent years the 'return to work' interview process became a policy imposed by the Human Resources Department upon other middle managers. Middle managers in the clinical directorates were then asked to report upon their absenteeism statistics in the business plan and set out absenteeism targets for the next year.

Despite the concerns of middle managers, many middle managers felt business planning potentially was beneficial to the whole hospital as well as individual directorates, because it was fairer in terms of the resource-allocation process. Many of those areas marginalized as 'unimportant' under previous resource-allocation processes obtained leverage for extra resources under the new system. For example, Occupational Therapy invoked 'safe discharge' for patients to bid for extra resources. The Private Patients Department could show revenue gains for the hospital from investment in additional private patients' facilities. However, in some cases potential benefits were not realized. This was explained as follows:

> 'I think it's good ... that we've moved from a situation where those who shout the loudest get the resources towards one where a business case needs to be put ... Although I think we go through the motions sometimes of putting a case through business planning and in reality the court remains the same.' (General Manager, Trauma and Orthopaedics)

*Business planning outcomes*

That the business planning process was criticized by middle managers may have been due to its comparison with what had gone on previously:

> 'Prior to that [business planning process] money wasn't a problem. We could do more or less what we wanted.' (Service Manager, Theatres)

However, there was evidence that the middle managers were taking note of the narrow performance measures to which they were being subjected in constructing the business plans. In some areas, such as Genito-Urinary Medicine, problems were addressed of a uniquely contemporary nature, such as HIV/AIDS infection, into which money was being directed from national level. Therefore, managers in this area had greater leverage in putting forward a business case for extra resources in their business plan. Another contributory factor was the electiveness of the service provided by the directorate. Thus managers in Surgical Services were more favourably disposed to the business planning process since many of the services they offered were subject to competition from within and outside the area covered by the host health authority.

A feature of the influence of middle managers was that a bid for extra resources through the business plan was more likely to be successful where it was shown that the extra resources would be used to meet targets set in national policy initiatives. Thus, in Surgical Services, funding for an improved outpatients clinic was gained so that the percentage of day-care patients as a proportion of surgery increased. This reflected the past and present government desire that day-care surgery increase so that bed utilization became more efficient. This, in turn resulted in cost improvements for surgical interventions. The development of an outreach clinic proposed in the business plan of Trauma and Orthopaedics was supported on the basis of the argument from middle managers in the area that this was what

was wanted by GP fundholders, who were the main group of purchasers within the health authority area. Trauma and Orthopaedics also made a successful case for extra resources to support a Patient-Focused Care[4] pilot that was driven at a national level and had pump-priming funding attached.

However, in contrast, where 'business' was generated from other directorates within the hospital, the managers had no discretion over their activity and were not inclined to review the business plan once produced 'unless forced to by the centre' (General Manager, Critical Care Services). Where there were lengthy waiting lists, such as for hip replacements, managers were also likely to regard the business planning process as a paper exercise only. Even in those areas favourably disposed to business planning, managers admitted:

> 'It's taken me a long time to think like this. It's only because I've worked closely with the Business Development Manager that I see the sense of it all.' (General Manager, Surgical Services)

## Discussion

In the case study, there is an emphasis upon business planning as a top-down rational planning process, and its top-down nature is increasingly evident as the government's agenda prioritizes financial constraint. In particular business planning is seen as a process, which will mediate middle managers' resistance to change, by obtaining their 'buy in' to a rational decision-making system. That it was important to obtain their 'buy in' was due to their role as 'linking pins' (Likert, 1961) in the organization whereby they were close to the operations of the business.

Yet, even given an unfavourable financial climate, business planning takes place within a receptive context in the case, because there is a will within staff in the hospital to overcome the positioning of the hospital as 'second rate'. In addition, at least initially, there was some discretion for middle managers to have an upward influence upon resource-allocation decisions by 'championing alternatives' in their directorate through 'synthesising information' via the business planning process. To an extent the more rational framework within the business planning process was seen as a fairer method of allocating resources than previous less-structured mechanisms. Even in the less receptive context, which became apparent over time, there remained examples of upward influence of middle managers. Importantly, such influence was necessarily integrative rather than divergent if it was to have legitimacy. So middle managers' attempts to 'champion alternatives' when making requests for additional outpatient or outreach clinics, were framed within a rationale imposed by the Central Directorate. It is worthy of further note that receptiveness was enhanced by favourable national funding circumstances, for example in relation to HIV/AIDS infection.

Features of inner context in particular are seen in the case to mean middle managers are more or less receptive to business planning, even where the centre at a national level is calling for financial constraint. For example, the business planning process was accepted as appropriate in areas such as Surgical Services where there was a high degree of elective work. However, even here there was a need for input from the Business Development Manager to ensure a receptive context. In the case, there is an example of divergent downward middle-manager influence where the middle manager 'facilitates adaptability' – 'return to work' interviews were widely adopted across the hospital following their successful use in the Medical Services Directorate. This is facilitated by a national drive from the government for efficiency gains in the NHS.

However, such examples of upward influence or downward 'adapting flexibility' were increasingly rare over time. The deteriorating financial climate and increasing intervention from the centre at a national level, diluted the influence of middle managers in the business planning process. Downward influence of middle managers in 'implementing deliberate strategy' is more commonly seen over time. This manifests itself in resistance to the business planning process whereby the business plan is drawn up to satisfy the Central Directorate and then consigned to the 'bottom drawer'. When middle managers explain such behaviour, they question the

[4] Patient-focused care is based on a philosophy and a set of principles in which the patient and their experience is the driving factor around which services are organized.

legitimacy of the business planning process by drawing upon characteristics of the individual directorates. For example, middle managers in Accident and Emergency paid lip service to the business planning process because they felt their service was demand led. Similarly, in the outer context, the purchasing health authority is described as being slow to make decisions, so that business planning is seen as less useful. Thus, increasingly over time the business planning process became an ineffective mediating strategy to manage professionals towards a greater business orientation as desired by the Central Directorate.

Crucially for policy implications, contextual features mean the performance indicators on which business planning is based are problematic for middle managers. This problem is reinforced because they are externally imposed upon middle managers. The contemporary quest for improved performance in the public services sees the government, facilitated by the host purchasing health authority and the Central Directorate, imposing 'relevant' performance indicators to which middle managers are asked to work. The middle-management group, whilst agreeing that a business case needs to be made in allocating resources, questions the validity of the imposed efficiency measures and other proxy measures of effectiveness of health care. This is particularly where they do not reflect operational practices. Business planning is undertaken with a lack of commitment by the middle-management group with the result that it ceases to be a working document for clinical directorate operations. Crucially it does not orientate them towards a more businesslike frame of reference. Tellingly, there is one area that has adopted a greater orientation towards the external environment than many others – the Pathology Department. Yet this area has produced 'poor' business plans in the view of the Business Development Manager. However, in this case the external environment is one which threatens the survival of the pathology department because rival trusts and private-service providers are attempting to gain increased market share. Thus, middle managers in this area feel obliged to take action in an 'adapting flexibility' mode to ensure their survival, although not necessarily via the business planning process. Instead they carry out what might be termed 'marketing practices' in relatively informal ways such as visiting GP fundholders.

## Conclusion

The processual literature (Mintzberg and Waters, 1985; Pettigrew *et al.*, 1992) in conjunction with the typology of middle managers' influence developed by Floyd and Wooldridge (1992) allows us to gain a nuanced understanding of the influence of middle managers upon organizational practices, such as business planning. In the case, in the early stages of the implementation of business planning, we see the realization of top management intent in the implementation of business planning is influenced both upwards and downwards by middle managers. However, over time the influence of middle managers is mainly limited to modifying the implementation of deliberate strategy, because increasingly business planning is implemented in a top-down way in the face of financial constraints in the NHS. Therefore it is difficult to fully assess upward influence of middle managers and the value that they can potentially add to organizations. However, there is enough evidence of innovation from middle managers, even latterly within the constraints of business planning in the case, to challenge pessimistic readings of the role of middle managers in the change process. For example, middle managers link proposals in their business plans to national initiatives for which funding is available. In addition, that middle managers are concerned about the relevance of some of the performance indicators imposed upon them, on the basis that they divert attention from operational 'reality', suggests they are placed in a good position to add value to patient care.

Therefore, further research is required in arenas other than business planning which pursues this point. For example, it may be that strategic subsystems, such as human resources or marketing, which allow for middle managers to adopt a boundary-spanning role (Floyd and Wooldridge, 1997), are likely to allow middle managers to add value to organizations. Investigating strategic change in these arenas may provide further evidence of the value of middle managers. Following from this, there are implications for policy-makers. The present trend in the UK NHS to attack middle managers and de-layer middle management in the interests of adding value to direct patient care may be misplaced, since they have a crucial role in strategic change processes. Policy-makers should address the question of what represents an

appropriate balance between the initial elaboration of managerial structures and enhancement of management roles and recent attacks upon them.

Second, where there is a limited conception of the role of middle managers, it may be argued that those concerned with managing change in the UK NHS via the business planning framework should concern themselves with the downward influence of middle managers in the implementation of business planning. So for example, management of meanings by top management could mediate the resistance which middle managers exhibit in the case. On this basis recommendations could be made which encourage those top management concerned with managing the business planning process to mobilize features of inner and outer context to create a more receptive context for change. For example, the provision of an education programme for middle managers, communicating the overall strategic plan for the hospital more effectively or greater integration between individual directorate business plans, may contribute towards a greater acceptance of the legitimacy of the business planning process. However, such recommendations are also overly managerialist, and do not fully address the important issue that the management of performance and the business planning process take place within a contested terrain whereby performance indicators are imposed upon the middle managers through the business planning process.

Therefore, third, if a broader conception of the role of middle managers is taken and it is recognized that performance indicators are contested, then centre-periphery relations are an important issue. This raises the question of the appropriateness of imposition of performance indicators by the former upon the latter. A critical element of change may be the decentralizing of responsibility to middle managers as suggested by Dawson *et al.* (1992). Middle managers can enjoy an enhanced influence upon the business planning process both upwards and downwards, particularly where there is discretion for emergent outcomes, and business plans are not used to prescribe specific outcomes. However, to a large extent, as is evident in the case, performance indicators are imposed upon individual health trusts. They are indicators to which a health trust must respond, because they have resource implications. The performance indicators would seem to be non-negotiable and in setting out a framework for the business plans the Central Directorate in Florence Hospital are reflecting this. It would be a high-risk strategy for a trust to develop a framework that represented consensus between the various professional groups in the health service, including the middle-management group, for appropriate performance indicators on which the business plans would be based. The trust would run the risk of performing poorly in relation to the league tables, which may threaten the survival of the trust. Thus, as a final point, it is important to note that the government and host health authorities have a part to play in this, since health trusts cannot go it alone. The potential for a greater degree of influence by middle managers in business planning would appear inextricably linked to centre-periphery relationships – that is, relationships between national, regional and local level (host health authority) bodies and individual trusts.

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