

**'You can't do both – something will give':****Limitations of the targets culture in managing UK healthcare workforces****Leo McCann, Edward Granter, John Hassard, Paula Hyde****Abstract**

Based on a three-year ethnographic study of four UK National Health Service (NHS) organizations, we explore the everyday cultural experience of managing clinical and administrative workforces. Although NHS organizations claim to function as enlightened HRM employers, we argue that the inflexible application of metrics-based target systems to clinical and administrative tasks, including HRM operations, can result in dysfunctional outcomes for patient care and workforce morale. Reminiscent of the recent Mid Staffordshire healthcare scandal, the priorities attached to NHS personnel meeting the demands of performance management systems can prove incompatible with them also meeting the fundamental 'human' needs of patients. The everyday experience of healthcare organization becomes one of employees reconciling competing logics of *business efficiency* and *integrity of care*. Trapped metaphorically between shrinking resources and expanding targets, the inclination - on the frontline and at mid-management level - is to extend the integrity of care, although this is sometimes impossible and can prove problematic in terms of system accountability. In response to such organizational tensions the behaviour of many frontline and mid-management staffs ultimately reflects a form of 'street-level bureaucracy' - a situation in which traditional professional norms are re-asserted informally in ways that often transgress prescribed performance systems.

**Keywords:** Healthcare management; National Health Service; Performance targets; Professionalism; Street-level bureaucracy

## Introduction

Efforts to reform and improve the management of work and human resources in healthcare settings have increasingly turned to abstract and numerical forms of control. Such forms include the promotion of 'off-the-shelf' management information systems, quality improvement techniques based on standardization, and 'lean' organizational philosophies (Adler et al, 2003; Gawande, 2010; Waring and Bishop, 2010). In the UK National Health Service (NHS)<sup>1</sup> such technical-numerical systems have often taken the form of rigid performance targets; for example, the eighteen-week 'pathway' for outpatients, the four-hour waiting limits for Accident and Emergency (A&E) patients, and the eight-minute ambulance response time for ('category A') emergency calls (AUTHORS, 2013; Bevan and Hood, 2006; Wankhade, 2012). Targets are indeed becoming increasingly commonplace in HRM systems, with 'hard' HR policies in NHS organizations (or Trusts) stipulating objectives for capacity utilization, roster completion, staff development, and sickness absence. Performance targets for patient care (e.g. waiting lists, response times) and HR management (e.g. sickness absence, staff development) alike carry penalties for their breach, hence the phrase 'targets and terror' (Bevan and Hood, 2006).

Many of the above performance metrics are derived from concepts of systems analysis and 'management by objectives' originally developed by the RAND Corporation and the US Department of Defense in the 1950s and 60s (Hoos, 1972; Talbot, 2010). Such approaches purport to place objective 'metrics' at the heart of the everyday management of organizations. Targets, metrics, and management by objectives are supposedly 'rational' and 'systematic' approaches to measuring and controlling aspects of organizational behaviour. The aim is to ensure efficiency,

enhance productivity and 'effectiveness', increase levels of staff accountability, and avoid errors and failures.

In practice, however, such systems have long been unpopular with professionals in any number of sectors and settings. Professionals often regard these managerial impositions as a form of de-professionalization that drives out personal discretion and weakens occupational control over the delivery of work (Byrne, 1993; Dent, 2008; Hoos, 1972; Wankhade, 2012). Such abstract systems frequently alienate professionals, who are often considered 'difficult to manage'. Medically-trained professionals often resent administrators and managers who have little or no direct knowledge of professional practice, and who they consider under-qualified in comparison to their own occupational groups. This is notably the case in healthcare settings (de Bruijn, 2011; Theodosius, 2008) where even if managerial staff have prior clinical experience they can be criticised as 'remote' from, or having 'lost touch with', the 'real work' of treating patients (Metz, 1981; Tangherlini, 1998).

Conceptually, abstract management systems, and especially performance metrics, have received significant criticism from a number of quarters. Writers regularly point to their capacity for 'goal displacement', whereby the *political* act of showing that targets have been met assumes greater importance than the *practical* completion of the work itself (de Bruijn, 2007: 17-19; see also Hood, 2006). It is argued, further, that both the definition and quantitative measurement of 'effectiveness' are factors that habitually remain opaque (Talbot, 2010: 144-7). Some have argued that the excessive adoption and rigid application of target-based systems can actually foster dramatic organizational failures (Ordonez et al, 2009). As we shall see below, from the perspective of NHS junior and middle managers, many chronic problems with performance targets have surfaced in healthcare management recently. In the eyes

of many frontline and mid-level healthcare employees these systems are part of the problem rather than the solution to complex organizational challenges.

This is not to say, however, that the use of numerical targets is wrong in all circumstances. Commentators have described the effectiveness of numerical-technical control measures in a range of economic sectors. Heavily standardised and metrics-driven systems - such as Lean Production, Six Sigma, or Total Quality Management, for example - can function effectively in automobile manufacture or back-office processing, when work is typically performed on inanimate objects or digital information. But such systems may be inappropriate for the management of healthcare tasks, which often require complex interventions and diagnoses, unexpected surges in demand, and a general capacity for human care and compassion (Theodesius, 2008; Waring and Bishop, 2010). Nevertheless, successive UK governments have pressed for the adoption of metrics-based performance systems throughout the NHS (and in public administration more generally, such as policing and probation, schools, tax collection, and local government) as they attempt to rein in costs and increase control over professional work (Bevan and Hood, 2006; Greiling, 2006; Hupe and Hill 2007).

Recent events, however, may be leading to a rethink of the 'targets culture'. In March 2009 the UK Healthcare Commission's 'Investigation into Mid Staffordshire NHS Foundation Trust' indicated that a prioritization by managers of performance indicators had jeopardised patient safety and care (Commission for Healthcare Audit and Inspection, 2009). The Mid Staffordshire Trust was the overall management structure responsible for a number of NHS care providers, including Stafford Hospital, where due to substandard care perhaps as many as 400-1200 more patients died between 2005 and 2008 than would be expected for the type of hospital.<sup>2</sup> In effect, at the heart of the Mid Staffordshire scandal was the mechanism

whereby organizational and administrative imperatives were prioritized over patient care; a clear case of 'goals gone wild' (Ordonez et al, 2009).

Revelations of abuse and neglect at Stafford Hospital were considered shocking by all sections of the UK press. Widely reported, for example, were stories of patients being left in their own excrement and urine by nurses and ancillary ward staff, patients being given insufficient water and nutrition (Francis 2013: 19), and a tendency for hospital staff at many levels to conceal, rather than address, failures and concerns (Francis 2013: 184).<sup>3</sup> The 2010 independent investigation recommended that the regulator, Monitor, de-authorise Mid Staffordshire Trust's 'Foundation' status and in June 2010 the new (Conservative-Liberal Democrat) coalition government announced that a full public inquiry would report on the scandal. The final report - *The Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC - was published on 6 February 2013, making 290 recommendations, many of which suggested enforcing a new duty of openness, transparency and candour amongst NHS staff, and arguing that increasing 'micro-regulation' may produce serious unintended consequences. The 'Mid Staffs' affair has deeply shaken public and political faith in the effectiveness of NHS provision, with a 'targets culture' often featuring as one of the major reasons behind the failings (Taylor, 2013).

With this background in mind, this paper explores the views of NHS junior and middle management staff about the effects of numerical targets on the management of healthcare organizations, and increasingly on the management of NHS human resources. It is now widely accepted that junior and mid-level line managers (in the case of healthcare usually nurse managers, ward managers, or clinical team leaders) play critical yet often unsung roles in what are usually large organizations (Hassard et al, 2009; Osterman, 2008), especially as intermediaries involved in the translation

and filtering of HR practices (Currie and Proctor, 2005; Hutchinson and Purcell, 2010; Purcell and Hutchinson, 2007; Townsend et al 2012). Our research, however, reports disturbing implications as to the ground-level reality of HR management and the everyday working culture of healthcare organizations. Widespread dissatisfaction with the targets culture was reported by line managers across the four Trusts studied, suggesting multiple problems as regards organizational performance, workforce morale and more importantly patient care.

Based on this research we argue that target-based management regimes can promote a divisive situation in which healthcare staff are torn between two competing demands: the first we call 'business efficiency', and the other 'integrity of care'. These are often impossible to reconcile, leading to problems with service management and delivery. With regards to targets, it became clear that there were profound difficulties in reconciling competing priorities *across* and *between* NHS Trusts, in what was essentially a wider regional healthcare economy. Interview and observational data revealed that mid-level managers in the NHS (many of whom have dual roles as both managers as clinicians), rather than being strictly 'controlled' by targets and metrics, in reality operated as 'street-level bureaucrats' (Hudson, 1989; Hupe and Hill, 2007; Lipsky, 1980; Walker and Gilson, 2004). They adopt this stance as they are forced to find informal ways of navigating this complex healthcare terrain, often by making decisions that 'work around' the formal targets regime.

From our analysis, then, we advocate a move away from dysfunctional 'targets cultures' and suggest instead that a return to professional norms and clinical discretion form the basis for the management of healthcare work and healthcare workforces. We appreciate, however, that such a return to professional discretion almost completely undermines the approach of targets-driven 'hard' HRM. This means that such a turn is unlikely, especially as numbers-based systems will remain

attractive to governments struggling to contain healthcare costs, attempting to hold professionals accountable, and attempting to standardize practices to make them more easily transferrable from publicly-run healthcare providers to commercial and independent contractors. NHS Trusts are keen to maintain organizational control through performance targets because they promise (at least 'on paper') to be 'rational' and 'objective' means of control (Taylor, 2013: 215). Yet these promises, like those in many other historical cases of organizational change in public service, are all-too-often found to be illusory and dysfunctional (Hoos, 1972).

This paper proceeds in four further sections. First we examine the origins of performance management and target-setting in healthcare and briefly discuss how the notion of 'street-level bureaucracy' (Lipsky, 1980) frames our analysis. Second we explain the qualitative methods employed in our research into performance management systems in UK healthcare. Third we present findings from our ethnographic investigations of the use of performance targets to control and manage healthcare work and workforces across our four NHS healthcare Trusts. And finally we interpret the results from our case findings, ultimately suggesting that performance targets are a deeply flawed method of attempting to control and structure healthcare work, one that should be radically scaled back if healthcare providers are to adopt a 'high-road' HRM model that genuinely serves to improve the well-being of both patients and staff.

### **Context: Performance management and targets in the NHS**

Target-setting in the UK NHS is today primarily realised through the use of Performance Indicators. Performance Indicators (PIs) were introduced in earnest to the NHS by the Conservative Party in 1983, although their conceptual heritage goes back to the 1950s and 60s, and even earlier to the development of the post-World

War 2 'organizational effectiveness' paradigm (Talbot, 2010). In the management literature of the 1950s and 60s, the function of targets, objectives, and metrics (e.g. Management by Objectives) was to provide a sharper focus on results and outcomes, and greater coordination of the goals of workers with those set by the organization. It attempted to cut through the ambiguity of occupational and professional norms, and provide clarity, focus, and 'objective' measurement. The 1990s development of the Balanced Score Card approach built on these ideas, attempting also to increase the number of items being measured into a so-called 'balanced' analysis; one that would not, supposedly, prioritize financial results over other goals (Kaplan and Norton, 1996). Since targets-based management presupposes, *ipso facto*, a greater emphasis on and capacity for monitoring performance (in terms of inputs and outputs) in theory it also facilitates and expedites more effective administrative control over the use of resources. This includes control over human resources, an important development when organizational behaviour in healthcare settings has traditionally been governed by professional and occupational, rather than managerial, norms.

As a technology for controlling healthcare professionals, PIs can clearly play a powerful role in limiting their use of expensive treatments, especially given the recent stress on 'austerity measures' (AUTHORS, 2013). Indeed at the summit of the UK's publicly funded healthcare system, the Department of Health has set 'a target of achieving savings of £20bn on a budget of around £100bn by 2015' (Taylor, 2013: 82). In the US, targets are widely ascribed by Healthcare Maintenance Organizations (HMOs) to control professionals and ration their prescription of expensive treatments under the model of 'managed care' (Mechanic, 1999; Scheid, 2004: 63-4; Scott et al, 2000). Similarly in the UK NHS, 'the introduction of PIs was specifically linked to efficient resource use' (OECD, 1993: 78); that is, to control spiralling medical costs.<sup>4</sup> As we argue below, this logic is increasingly being applied to the management of



NHS care workforces, but with highly problematic results. HR managers try to increase efficiency and control costs by setting targets (and related penalties for non-compliance) for capacity utilization, staff training, and sickness absence, yet all the while seeing these targets become harder to meet due to resource constraints.

For the 'New' Labour government elected in Britain in 1997, the use of such a 'management by objectives' philosophy fitted with the spirit of New Public Management; a range of emerging social policy ideas which generally sought to combine the dynamism and customer orientation of the market with the service ethic traditionally inherent in the public sector (Hood, 1991). The emphasis on efficiency and control of resource use was in tune with the policy goals of a new government which sought to 'shake up' what were seen as sclerotic and bureaucratically-bloated public services - organizations in which questionable service provision was obscured behind the screen of professional norms. Thus, by 2004: '10 top-level targets applying to the Health Department in England were translated into some 300 lower-level targets for the various public sector health-delivery organizations for which that department was responsible' (Hood and Bevan, 2006: 515). Townley (2003: 1046) offered a succinct summary of the situation when suggesting:

*'Performance measures are one means of achieving a managerialist rationality that includes reducing the size of the public sector, cutting government expenditures, bringing free-market principles and disciplines into government, developing a more customer oriented focus, and allowing public sector managers to be more autonomous and entrepreneurial.'*

But have targets, systems, and metrics actually achieved their stated aims? Do targets in healthcare actually work to control costs, improve 'effectiveness', raise standards, and establish accountability? A major problem is that targets, at least on

some level, have to be 'reasonable'. In other words, resources must be adequate in order for workforces to have any chance of meeting them. Many NHS Trusts have targets set for them (and also set their own) that appear unrealistic in the light of funding for NHS Trusts steadily contracting. In such times of tough accountability, healthcare organizations have to make difficult decisions about which functions they can devote their limited resources to. In some cases decisions will be made to favour 'integrity of care'. In others the demands of 'business efficiency' will win out. This scenario sees healthcare staff at a number of levels constantly juggling demands that should, in theory, be reconcilable, but which in practice are often not. As we shall see, in such dilemmas, the *informal* norms of discretionary 'street-level bureaucracy' come to inform the decisions of junior and middle-level NHS managers. Despite their strong influence, performance management systems can never fully 'manage out' these kinds of professional behaviour, based as they are on implicit and intangible values, years of experience of services and users, and the simple need for staff simply to 'do what they can' in demanding environments (Ellis et al 1999; Evans and Harris, 2004; Hudson, 1988; Maynard-Moody and Musheno, 2003; Lipsky, 1980; Satyamurti, 1981; Walker and Gilson, 2004).

The resource and operational pressures facing NHS Trusts are severe. Accident and Emergency doctors, for example, have recently warned of further patient safety scandals if levels of staffing and resources are to remain at seemingly inadequate levels, amid rapid increases in patients presenting to A&E<sup>5</sup>. Occupational associations such as the Royal College of Nurses or the Royal College of Midwives regularly complain - along with patient advocacy groups - that there are insufficient numbers of skilled frontline clinical staff available on hospital wards and that patient safety is threatened by understaffing and overstretched human resources.<sup>6</sup> Ambulance Trusts have admitted missing performance targets due to resource shortages and growing demand,<sup>7</sup> with paramedics anonymously claiming that delays

are 'causing harm and deaths', partly because management's pursuit of time targets has meant widespread reliance on solo-crewed response cars rather than dual-crewed ambulances. Rapid response vehicles can arrive at a scene quickly to 'stop the clock', but patients and solo paramedics then often face long and potentially dangerous waits for dual-crewed ambulances to arrive to provide onward transport.<sup>8</sup> The A&E doctors' warning of May 2013 used the language of 'toxic overcrowding' and 'institutional exhaustion' to describe the severity of the situation, while another similar report suggested that emergency departments are 'on a cliff edge', with workloads becoming 'simply impossible' to manage<sup>9</sup>.

In such a problematic context for the NHS, the failings at Mid Staffordshire sit 'at the extreme end of a spectrum which shades gradually from excellent, to tolerable, to awful.' (Taylor, 2013: 187) The kinds of goal displacement inscribed in the attitude of 'what's measured is what matters' (Bevan and Hood, 2006) remains pervasive within the NHS.<sup>10</sup> Other failings, distortions, and forms of 'gaming', which create perverse outcomes and typically result in a decline in morale for public service professionals, are noted in other public sector settings, including policing and probation, school teaching, tax collection, and social care (Carter et al, 2013; Ellis et al 1999; Hoos, 1972; Maynard-Moody and Musheno 2005; Moskos, 2009; Rudes 2012). All four of our case study NHS Trusts show similar failings or near-failings, confirming the recent media evidence of overworked and demoralized staff working in dangerously overstretched organizations.

Our research, therefore, highlights the considerable distance between employee experience of work and NHS Trusts' official policies of high-road HRM. In order for healthcare organizations to provide the best standards of care for patients, it is accepted that healthcare organizations should attempt to provide the best possible working conditions for staff (Hyde et al, 2009; Stanton et al, 2010; Townsend et al,

2011; West et al, 2006). This notion is clearly embodied in the NHS Constitution of 2009, which formally provides four 'pledges' relating to the kind of working environment that staff can expect to find in all NHS organizations, an environment conducive both to staff development and well-being and to patient safety and care quality.<sup>11</sup> But contrary to these HRM goals (or at least HRM 'signals'; see Townsend et al, 2012), our data suggest that the morale of care staff was almost universally poor across the case organizations studied, not least because staff were exasperated with trying to square the circle of business efficiency versus integrity of care, especially in a context of ever-shrinking resources and ever-growing patient numbers. Trust in senior management was low, work intensity was high, work-life balance was poor, and staff generally did not feel valued by management.

Our qualitative data, moreover, suggest that HR systems were unable to provide meaningful staff development, and employees were concerned by the invasion of a targets culture into HRM itself. This mirrors some of the quantitative findings from the NHS's own 2012 staff survey, which were also discouraging in this respect. Just 36% of respondents agreed that their staff appraisals were 'well structured' and well under half (40%) felt that their organization took staff appraisal seriously; this number fell to just 23% for respondents employed in Ambulance Trusts (Department of Health, 2013: 2). Across 'NHS England' only 35% of survey respondents agreed that communication between management and staff was effective, with this figure again being lowest for Ambulance Trusts, at just 20% (Department of Health, 2013: 2).<sup>12</sup> Our case study data provides strong evidence from across the NHS of disquieting work climates, with potentially severe implications for staff well-being, patient care and patient safety. As our analysis shows, the 'targets culture' is a major conduit through which these problems flow and from which conflicts emerge, both within and between NHS Trusts.

So difficult is this situation that junior and mid-level healthcare managers - in keeping with experiences reported in other public sectors (Ellis et al 1999; Rudes 2012; Walker and Gilson 2004) - regularly act as street-level bureaucrats by enacting a range of informal coping mechanisms to handle their 'otherwise overwhelming' workloads (Ellis et al 1999: 262). The concept of street-level bureaucracy, as originally developed by Lipsky (1980) and colleagues (Prottas, 1979; Weatherley, 1979) refers to the ways in which front-line and mid-level employees in public service actually experience their workloads, and especially the 'dilemmas of the individual' in attempting to provide adequate public service. The perspective places considerable emphasis on how excessive workloads, inadequate resources, complex demands and unclear rules lead those charged with delivering services often to take discretionary action which confounds the official, top-level policies of public service organizations. Management will typically try to find ways of making street-level bureaucrats more 'accountable', but these attempts at regulating, standardizing and controlling the behaviour and mindset of street-level bureaucracy are often problematic and dysfunctional (Hudson, 1989: 48-9; see also Lipsky, 1980; Prottas, 1979; Weatherley, 1979). As our study will show, these long-standing concerns remain highly relevant to healthcare employees. Junior and middle managers across our case organizations continued to confront Lipsky's 'dilemmas of public service' as they tried to deal with the often clashing imperatives of business efficiency and integrity of care. These competing priorities were often manifested most sharply in the form of performance targets.

### **Methodology: Researching the 'targets culture'**

Before we explore our data in relation to the themes discussed above, we turn to a description of the methodology employed in carrying out the research. Our research involved an examination of workplace culture and performance management in four

UK healthcare settings: an Acute Hospital Trust, an Ambulance Trust, a Mental Health Trust, and a Primary Care Trust. In terms of fieldwork, this has seen the development of an ethnographic approach to investigation, one founded on two research techniques - interviewing and observation.

Our interviews were based mainly on a semi-structured instrument directed at addressing issues related to performance management and target-setting. The interview process generally saw junior and middle managers interviewed at their place of work, and commonly in their offices, or else a private room if a manager worked in a shared office or open-plan setting. The duration of interviews was generally between 60-90 minutes. The process of interviewing saw one or two members of the research team meet a single interviewee and record the discussion on a digital recorder. These recordings were transcribed subsequently by an external agency. On one or two occasions, however, interviewees were reluctant to have their views digitally recorded, and so the interviewer(s) took detailed notes by hand. In total 80 interviews were conducted during the period of field investigations.

In addition to semi-structured interviews, our fieldwork involved periods of observation, specifically non-participant observation. This research concerned, in the main, observations of employees at work, in team meetings, and in training sessions. Data were recorded mainly by hand-written notes, made either at the time of observation or in the period immediately afterwards. These notes represented the direct description of events, plus reflections and comments on particular issues and incidents. During the fieldwork, the team conducted 63 periods of non-participant observation. A period could represent, for example, anything from a one-hour staff meeting, to a training session lasting several hours, to a whole day spent 'shadowing' a healthcare employee.

The process of analysis has largely been that of traditional ethnographic interpretation in organizational settings (Turner, 1972; Van Maanen, 2011; Watson, 1994; Watson, 2011). Rather than deploying a qualitative software package for the coding and classification of data, the research team generated its own grounded criteria relevant to the project. It can be argued that this approach is more closely aligned with the interpretivist philosophical assumptions (ontological and epistemological) of ethnographic organizational enquiry. Our research has attempted to shed light on the grounded, everyday actions of junior and mid-level NHS managers as they make difficult decisions and wrestle with tight resources. It follows in the traditions of research on street-level bureaucracy in that it highlights the importance of various kinds of 'pragmatic improvisation' (Maynard Moody, 2003: 165) carried out by public servants as they face up to the everyday realities of providing services while confronted by growing caseloads and the proliferation of targets-based systems. In the words of Hudson (1989: 53):

*'academically, the pressing need is to find out more about how street-level bureaucrats are actually behaving. Getting at the truth would be problematic, but must be confronted. If we wish to understand policy implementation, we must understand the street-level bureaucrat.'*

Whilst somewhat reluctant to define our interviews and observations as representing the organizational 'truth', we nevertheless argue that our research answers a call to 'get inside' public service workplaces in order to understand 'how things work' on an everyday basis (Watson, 2011). In our work, this is done to understand how organizations attempt to control healthcare workforces by using an array of supposedly rational targets and metrics. As we shall see, our interviews and observations record the complex and often morally difficult decisions of NHS

employees, as well as their subjective interpretations, as they attempt to account for their everyday actions.

We now, then, turn to discussion of the ethnographic interview and observation data we gathered. We start by exploring the ways in which the targets culture had grown to structure organizational behaviour generally. We then move on to demonstrate how this culture 'crept' into specific HR structures and the incentivizing of middle managers themselves. Throughout the three years of case research performance metrics were applied in the form of rationing resources and punishing 'breaches' of targets. Narrow, and often questionable, conceptions of business utility appeared to be championed by senior management at the expense of professional norms and the 'human' needs of patients. Moreover, the spread of the targets culture into areas of people management appeared to undermine and restrict the development of professional and strategic forms of HRM. This was a situation that ultimately proved dysfunctional when contrasted with the stated goals of these organizations; that is, of becoming effective and patient-focused healthcare providers with progressive employment practices (Aiken et al, 2001; Leggat et al, 2010; Townsend et al, 2011).

### **Analysis: Working with 'very bizarre' targets**

Our analysis explores a number of broad and overlapping themes that emerged from the qualitative data collected during the period of research. These themes include the gaming of targets, clashing incentives, and daily struggles around the provision of adequate levels of patient care. Such 'street-level' themes are embedded within what emerged as an often perverse targets culture within our focal organizations - one which was routinely criticised by many of the NHS junior and middle managers who had to work within it.



When issues of the setting and monitoring of targets were first raised by our NHS managers, the impression we formed was that such systems and techniques were being explained as objective and rational phenomena. However, it often did not take long before problematic issues began to surface. For example, initially an Estates Manager at the Acute Hospital site appeared to suggest that performance targets had been adopted as a logical way to organize and manage essential maintenance work:

*What we do is we classify work in terms of 'immediate', 'urgent' or 'routine'. Anything that is 'immediate' has a target of a response within three quarters of an hour and completion within two hours. If it's 'urgent' it has a response within four hours and completion within eight, and if it's 'routine' it has a response within three days and completion within five. Those are the targets, and then what we set ourselves is to meet those responses in 85% of the cases for the 'routine', 90% for the 'urgent' and 95% on the 'immediate'. (Deputy Head of Estates, Acute Hospital Trust)*

So far, this seems sensible and reasonable. But as the narrative continues the essence of the approach, as with other targets-based systems, appears to be premised on questionable assumptions. Even in its own terms - as providing objectives for rationing resources and creating business efficiency - the system did not seem to be exclusively 'functional'. One interviewee at the Acute Hospital Trust offered a telling phrase - 'it wasn't based on any market analysis, but I *had* to make it work':

*Sometimes the execs have a habit of just drawing up plans, then we have to deliver the plans, then the plans become my problem if they don't get delivered ... I was told we were doing a 15 bed unit and I had an income target of it being full for 90%. It wasn't based on any market analysis but I had to make it work. That happens quite a lot. If it didn't work it would totally become my problem and I would be performance managed and judged by that ... They say 'well let's put in that, we'll do four new units and make a million or two, and we'll worry about it later' ... But what happens is, we don't worry about it later. It becomes my problem. (Service Director, Acute Hospital Trust)*

The 'quick reference' component of the performance system meant that staff were able to prioritise a maintenance job by rating it a high risk (scoring 15+ out of 25). This would see a job go straight to the task board for action. But in a classic case of street-level bureaucracy there was a suspicion that junior and mid-level staff used the numerical system to 'over-rate' risks in order to bring their jobs to the top of the list. Estates managers were thus engaged in trying to assess the 'real' level of risk and negotiate these ratings down:

*You sometimes wonder ... is this really a 16 ... have they given it that just to make sure that it goes in front of the board, and then it'll get some attention, it'll get some resource? (Head of Estates, Acute Hospital Trust)*

In the Ambulance Trust, a senior HR manager explained in detail the range of competing targets his organization had to face. Resource constraints meant that choices had to be made about which goals the organization simply had to hit, and

others which could be allowed to slide. On the one hand government regulators (such as the Healthcare Commission's successor, the Care Quality Commission) put pressure on the Trust to upgrade and expand its clinical training for paramedics, with the long-term goal of more patients being treated at the scene or at home by paramedics rather than being transported to overstretched A&E departments. But, on the other hand, rolling-out enhanced training of its workforce would mean taking clinical staff 'off the road' for days at a time and therefore making it harder for the Trust to hit the much more urgent and immediate 8-minute response times for arriving at 'Category A' emergency scenes. This was a typical case in which street-level bureaucrats were confronted with 'multiple demands for accountable behaviour' (Hupe and Hill, 2007: 290). As an HR manager explains:

*If we are below target it is not easy to remedy it. We can't poach staff from other NHS organizations. We train in-house [for several roles], and there is a minimum of four weeks, probably longer. There's driver training also. Some of them fail the tests and have to retake. Ordering new ambulances takes time. You can't just go and buy them, they are bespoke ... We have a management development programme. We release staff and managers for this where we can. CQC criticized us for not being up to date on clinical training. But we can't take people off the line easily. We're damned if we do and damned if we don't.*

(Senior HR Manager, Ambulance Trust)

At a more junior level, an Ambulance Trust Sector Manager noted the prominence of financial imperatives, claiming that 'if we don't meet the care package, we don't get paid. It's becoming more ruthless if you like, more cut-throat.' Given fundamental resource constraints, certain targets were clearly more important to hit than others,

even those officially defined as 'mandatory'. To illuminate this further, we offer observation field notes from a Senior Management Team meeting at the Ambulance Trust; in which the issue of 'what's measured is what matters' (Bevan and Hood, 2006) surfaces explicitly in discussion:

*The meeting is taking place in a well-appointed room in the Ambulance Trust HQ. Large flip-chart pages are stuck on the walls, windows, or hung from the picture rail. There were around 15-20 of these pages, covering a wide array of vital issues and tasks for discussion. The chair of the meeting [Senior Manager] quickly called the meeting to order and explained that this meeting is taking place during what has been a two-day session working on a new commissioning process, hence the paper over the walls. [...] 'These things needed to be sorted out very quickly, we're under a lot of pressure' he says [...] A Senior HR manager starts to explain the 'exceptionally challenging' issues she has to report from a recent weekly meeting in which performance management KPIs were under discussion:*

*'Our targets on KSF<sup>13</sup> and mandatory training is 90% through mandatory training by the end of March. This will go by the wayside. We've committed to 35%.'*

*Other middle managers (mostly heads of geographic sections) discuss this for some time, saying they cannot release staff from their teams easily for mandatory training or for KSF review. A consensus comes out that we should all 'under-promise and over-deliver.'*

*The chair of the meeting mentions that 'What gets monitored gets done.'*

*[...]*

*A middle manager warns that 'We should not raise expectations too high. Taking a lot of people off the road for review is not sensible.'* (Observation field notes, Senior Management Team meeting, Ambulance Trust)

Thus decisions and actions at local levels are characterized by a sense of enforced 'gaming', in that the organization chooses which targets it believes are the most important for it to try to meet, based on an informal and experience-based 'rationalization' of which have the heaviest penalties for being missed. Resources are so short that middle and senior managers are acutely aware that not all targets *can* be met. This encourages staff to 'game' the system by selecting targets they believe they can 'get away with' missing. Such forms of goal displacement and distortion were endemic in our organizations, not just at front-line levels, as per the classic formulation of Lipsky's 'street-level' bureaucracy, but also across middle management, and notably in ways that are sometimes unofficially tolerated by more senior Trust management.

Resource constraints, ever-present and worsening in the NHS due to austerity measures, had direct impact on the choice of which targets to prioritize. At the soon-to-be-abolished Primary Care Trust, employees in both functional wings of the organization - commissioning and providing care - appeared to face increasingly heavy workloads (see also Hyde et al, 2009: 718-9). What is more, they were now obliged to work with a numerical-technical 'off the shelf' management information system (known as Lorenzo) that many staff found problematic. Lorenzo's functionality did not readily match with the kinds of tasks and processes that Allied Health

Professionals (AHP) (e.g. audiologists, podiatrists or occupational therapists contracted to or directly employed by the PCT) needed to complete. These care providers faced constant pressure from PCT senior management to quicken the pace and shorten the length of care episodes: essentially to spend less time and 'resource' with each patient, so that the work could be 'logged' and ideally 'resolved' through the Lorenzo system. Cynicism was a common reaction, such as below, where an embattled PCT middle manager/AHP suggests, with gentle sarcasm, that 'points make prizes:'

*It's gruesome, honestly ... They set targets and every month you get how many patients you've seen in that month. And that is online for you to reach your target at the end of the year, because it's 'points make prizes'. So the PCT gets paid depending on activity. (Middle Manager/AHP, Primary Care Trust)*

In a segment of the interview that provides a powerful example of a Lipskian 'dilemma' of public service, this manager went on to outline the nature of this problem in more depth; something she describes as 'a quandary.' That is, should a manager, as a matter of course, allow the targets to breach as a kind of warning mechanism? This is perhaps reminiscent of aspects of the Mid Staffordshire case, where the Francis report criticised staff for not speaking out about the length of the waiting lists and the prevalence of substandard care episodes. Perhaps if targets were allowed to be breached then managers would at least be alerted to the mounting workloads and tightening resources:

*You get in a quandary. So, what do I do? Do I really bust a gut and work every hour I can and keep on top of this 18 week*

*waiting list, which then actually doesn't tell the powers that be over there that we've got a problem? Well actually if we see those [patients] within the 18 week timeframe what do we do with them after that? We haven't got the staff to see them. But which is best? Do we see them and then know the problems we've got on a 'waiting for' [treatment] list; or do we not see them and let our waiting list grow? And then they'll complain over there at PCT HQ, and then we can say, 'Yes but you've cut our staff'. You know, 'You've taken two full time equivalents out of my team in the last three months who've gone on maternity leave and aren't being replaced. So you've got to expect that my waiting list's going to increase.' But then you get more complaints ... You're in a no-win situation really and that's what I think we're going to do at the moment is, you know, I'm going to see as many as I can see, but that waiting list is going to rise over 18 weeks. (Middle Manager/AHP, Primary Care Trust)*

At the PCT, senior managers and HR managers were described by junior and middle managers/clinicians as 'remote' and 'detached'. The perception often expressed was that they had no clear idea about the realities of frontline or mid-level work, especially when this work was focussed on the clinical needs of individuals. (Similar views are reported in Townsend et al's (2012: 275) qualitative study of an Australian hospital.) In our case, many patients' care needs were long-term and simply not amenable to being 'resolved' in a targets-based system. At times the pressures not to provide an adequate level of care seem to border on Mid Staffordshire style dysfunction: a Primary Care Trust that won't deliver Primary Care:

*We have annual targets that we have to meet and that in itself poses a massive problem because the person who sort of devises our quota for the year actually doesn't know what we do. So they can say, 'right well you know if you look at [a different clinical specialism], they can see I don't know how many thousand people in a year'. And they say, 'you know, the appointments are five, ten minutes each: in out, in out'. [So the implication is] How come [my clinical staff] are only seeing six [patients] in a day? (Middle Manager/AHP, Primary Care Trust)*

Respondents remarked that monitoring problems could arise in situations in which there was a lack of appreciation or sensitivity on the part of some management functions - notably HR - to qualitative differences in the nature of (and demands placed upon) different clinical areas. In what was a clear example of a public servant facing the 'dilemmas of the individual' - a classic feature of street-level bureaucracy (Lipsky, 1980; Maynard-Moody and Musheno, 2003) - one of our respondents provided enlightening views on this problem. Here, junior and middle-level healthcare employees are not so much working according to the imperatives of target demands, but instead in accordance with the needs of 'real people:

*Well we're a bit different to somebody with a [minor medical problem]. You know, and every [patient of ours] is very different... So I've had arguments with the guy over there [in HR] ... [who] said, 'So, looking at your diary on Lorenzo, you see one [patient] for half an hour but your next [patient] you see for an hour?' Well yes, the half an hour is a review of a [patient] that I gave a home programme to, so I'm just checking him. Actually a new one is a lot more complex and needs an*



*hour. And [HR say] how come with some [patients], you can see them in a group? So why don't you see all [patients] in groups because that way you can see six in an hour? But [we say] not every [patient] fits in a group. So you're working with mathematicians [in HR] and we're working with real people here. (Middle Manager/AHP, Primary Care Trust)*

Another PCT manager described the widespread setting of 'sometimes very bizarre targets for us that we're expected [to meet]'. This is a situation where financial goals rather than patient outcomes were (as above) clearly dominant. Yet another interviewee reported that senior management was pressuring care staff to reduce the amount of time and resource spent on each patient:

*One of the questions was, 'how many times do you need to see a [patient] before you cure them'? You know, I saw a [patient] last week who I cured there and then on the spot. Finished. [But] another [patient] you think, I'll have him until he's sixteen ... But that's what the management don't realise ... And that is what is so frustrating in our role that we want to deliver a service but actually we're having this made more and more difficult. (Middle Manager/AHP, Primary Care Trust)*

The PCT case clearly highlights a potential contradiction between the demands of business efficiency and integrity of care. This situation is contradictory in that the squeeze on resources was pitching healthcare providers into an ongoing battle with healthcare commissioners, who seem to be prioritizing business efficiency simply by reducing the spending per patient, or trying to force medical practitioners to cut back on 'integrity of care'. Middle managers at the point of service delivery tried, where

possible, to find a solution that at least partially satisfied the demands of 'integrity of care', hereby drawing on experience-driven and informal methods of street-level bureaucracy to do so.

Elsewhere the extension of private sector provision into the NHS healthcare economy was often viewed by Trust managers as a means of diverting patients away from busier parts of the healthcare system. Target systems were generated to incentivize NHS staff to re-direct some of the 'easier' patients to private sector care providers. One of the examples we encountered was the case of ambulance staff being encouraged to take patients to private sector 'Urgent Care Centres' rather than to NHS hospital Accident and Emergency departments. In this case, however, many frontline ambulance staff we consulted were wary of this policy, because it was often difficult for road crews to categorically diagnose certain patients as being at 'lesser risk'. As such, crews tended to default to the 'safety-first' option of taking almost every patient to the better-staffed and more comprehensive A&E departments. This meant ignoring the target about transporting a certain proportion of patients to the private sector Urgent Care Centre. It also contributed to the Hospital Trust's A&E workload and often meant long waits for ambulance crews and the increased likelihood of the Ambulance Trust missing its response time targets. But the patients' needs had to come first. In our observation field notes (reproduced below) from a management training day at the Ambulance Trust, we learn that a private contractor is now also running the reception of the A&E department of a major NHS hospital, creating further friction with core NHS staff, who keep 'insisting' on taking their patients to the acute hospital for treatment, when under 'business-efficient' thinking they should take them to the private-sector Urgent Care Centre instead:

*A Paramedic Emergency Services manager starts to complain about the private company that has won the contract to run the administration/front desk/reception for the A&E at a hospital in a nearby town. They also run a medical centre in the area. 'Up to 40% of our A&E patients are supposed to go to their Urgent Care Centre. This is creating conflict – they are a private company running A&E reception. They're jammed up, the 4 hour waits are about to trip, they're snowed in, and we bring them more patients. We're the fly in the ointment. They want us to take them elsewhere.'* (Observation field notes, Training course - 'Commissioning', Ambulance Trust)

In this case, NHS staff were able, up to a point, to exercise their own professional judgement using street-level bureaucracy in order to rebuff the official, 'business-driven', line. Paramedic crews felt that by doing so they were putting patients first, at least for as long as possible, until rationing and organizational demands close off this avenue. Across our case studies, the split between notions of being 'business-efficient' and 'care-efficient' was making life extremely difficult for frontline and middle management roles. The targets regime was forcing them to try to please two masters, and in the process incentivizing them to move in two very different directions. A middle manager in the Ambulance Trust explained this in a very simple phrase: 'you can't do both – something will give':

*We haven't got the resources to go out and deal with the jobs the way that we are doing. So things need to change for that, but we've still got the same targets that we had, you know, we've got targets to make. I think quality and performance need to be dealt with separately in the Trust. Because we're trying to meet*

*performance, and that's up here, where actually we're supposed to be a patient care and quality type organization, and the two things don't always ... [she tails off] You can't do both, something will give. (Middle Manager/Paramedic, Ambulance Trust)*

In a situation regularly rehearsed in studies of NHS middle level managers (see Hutchinson and Purcell, 2010) greater work intensity was apparent in all four case study organizations, mostly as a result insufficient staff resources. Work intensity and resource paucity were both perceived to contribute to long-standing problems with morale. Both were potentially worrying as regards patient safety and care quality; precisely the kinds of problems that enveloped Mid Staffordshire. According to the national NHS survey, only 30% of staff perceive there is sufficient human resource capacity to enable them to do their jobs effectively, with the figure for ambulance staff being just 21% (Department of Health, 2013: 4). Such issues were highlighted from data derived from our Mental Health Trust case study. Here a ward manager provides an instructive case, as she seems to inadvertently admit that the fundamental act of spending time with patients - seemingly a core competence of NHS organizations - has now been problematized by the targets culture:

*I probably still spend quite a bit of time with patients, but that's because my time management's really poor... at the same time there's the requirements from the Trust perspective and from legislation that, you know, we have to be achieving certain targets and audits have to be completed and the documentation that goes with that and the administration, so you're, kind of, you're very much split, really. (Middle Manager/Clinician, Mental Health Trust)*

Administrative demands for clinical and managerial accountability to the various systems of performance management were also time-consuming in themselves. Another mid-level manager/clinical at the Mental Health Trust explained her exasperation with these demands, (some of which seemed to arrive without warning), which contributed to an alienating work culture of 'chasing targets' in which patients 'are a number':

*I can't even remember who wanted it, and it was called 'Patterns of Care' and it was about people having a review recorded on [an electronic records system] [laughs]... nobody had told us we needed to record this on [that particular system]. So for the whole year we had to go back and find the review date, what [staff certification level] they were on; who attended the review, dah-dah-dah-dah-dah. And it took all weekend. We were just in here all weekend doing it off pieces of paper we had archived and it was just a nightmare; absolute nightmare. We sent it in and that was that, and there was no even, "Oh thanks for all your hard work," or anything. We just sent it in and that was that. And what difference that made I don't know. I am sure it got us out of a bit of hot water with some registration authority, but it didn't make any difference to the care that the patients got on the ward. It didn't change the care that the patient gets on the ward [...] You have to deliver on a target every month because that's the way the service is funded, but it's not about the quality of care somebody is getting; it's about meeting a number [...] number of contacts; number of episodes, number of referrals [...] and it's not meaningful and you are just chasing, chasing targets and what you are doing is then not meaningful because you are seeing somebody because they are a number. (Acute Services Manager, Mental Health Trust)*

Heavy workloads were exacerbated by the penetration of the targets culture into HR management. Just as targets often served to reduce clinicians' scope for discretion in patient care episodes, HR targets limited the levels of discretion that middle managers could use in managing healthcare staff. In the Ambulance Trust middle managers were targeted to have the weekly roster fully-staffed 98% of the time. They were barred from having any more than 15% of their 'resource' on leave at any point in time, and were working to 5% or less as a sickness 'target'. (Ambulance staff are often prone to lifting injuries, for example.) But even in this often very tough working environment - one that scores well below the NHS norm on almost all work satisfaction indices (Department of Health, 2013) - the dedication of the majority of the workforce was readily apparent. Ambulance staff did not want to be absent and took pride in their roles:

[Being a paramedic] *It's a hard job. There's no doubt, it's a hard job. But I wouldn't want to do anything else. If I got injured and couldn't do this job anymore I'd be destroyed. My life would be destroyed.* (Team Leader/Paramedic, Ambulance Services Trust)

Such dedication and professionalism was visible across the healthcare professionals and middle managers we interviewed and observed in the case studies. However, confronted by the harsh reality of an abstract and often 'bizarre' targets culture, their morale was often low and they expressed critical views about the effectiveness of their Trusts as both employers and care providers. These organizations need to build on the dedication of their staff and not allow goodwill to evaporate (Bartram et al, 2007; Khatri et al, 2006; Leggat et al, 2010). But with HR hamstrung by targets, the everyday operational needs of the organization naturally took precedence over staff

development, which either fell away completely, or else became an empty and ritualized form of target-driven 'box ticking', such as the much-maligned KSF programme.

After all, the ostensive aim of socialized healthcare organizations is not profit (business efficiency), but rather care for human beings (integrity of care). The NHS staff we interviewed were keenly aware of financial imperatives and very sensitive to this part of the modern healthcare 'quandary'. Indeed employees often stressed the need to 'do everything you can to win the contract', and to constantly 'demonstrate their cost-effectiveness', or to 'look at every penny' in the face of cost-reduction and the expansion of private contractors, who can increasingly outbid NHS organizations to win 'care packages' (see Pollock, 2005). With the state-run provision of healthcare facing a major funding crisis (Davis and Tallis, 2013), many NHS junior and mid-level employees believe that resources will become ever more tightly rationed. One can therefore expect the 'dilemmas' of public service to become increasingly severe.

The importation of management by targets from the corporate sector would seem to suggest a greater emphasis both on control and business efficiency. Yet the actual effectiveness of organizational control falls below what the targets and systems procedures promise. If there are too few resources to 'do both' then 'something will give', and in the case of most healthcare professionals what will give will be the financial and business efficiency goals. Wherever possible, NHS staff will utilize the professional or para-professional norms of street-level bureaucracy in order to provide optimal healthcare provision (Lipsky, 1980). This, however, can cause friction across NHS Trusts, and serve to raise the question of whether targets are not only unpopular with frontline and middle management staff, but also inefficient and ineffective, even for senior management. We are minded of Lynch's (2004) characterisation of such systems as part of an attempted top-down strengthening of

abstract control, a form of control that is sadly inimical to care for patients and to the meaningful career development and well-being of healthcare staff.

### **Conclusion: The tangled web of targets**

A prominent argument amid the clamour of responses to the Mid Staffordshire scandal is the advocacy of ‘outcome measures’<sup>14</sup> as a replacement for ‘performance targets’; an argument, indeed, that some have been making for over fifteen years (see Taylor, 2013: 213-5). At face value, ‘outcome measures’ appear superficially more attractive than performance targets, as the former are more clinically focused and patient focused, whereas the latter are all-too-commonly a much narrower, managerial tool which aims to control certain forms of employee behaviour. In keeping with the concept of the street-level bureaucracy, however, our data suggest that in many cases expected clinical outcomes are in practice prioritized by mid-level as well as junior staff wherever possible. This also implies that the practices and logics of street-level bureaucracy extend upwards into the activities of more senior management levels. It can be helpful, therefore, to regard NHS managers as involved in managerial *work*, and thus to conceptualize them as both ‘managers’ and part of ‘the managed’ (Hassard et al 2009: 45; see also Osterman, 2008).

This is not to say that business efficiency and the ethic of care are always irreconcilable. But given the enormous complexity inherent in the wider healthcare economy a melange of targets exists across organizations, a situation characterized by sets of mutually incompatible demands. For example, ambulance managers were often told by managers of A&E departments that their departments were full, meaning long turnaround times for ambulance crews who have to wait for beds to become available. This means that ambulance crews are ‘tied up’ at hospital and unable to ‘go back active’ and respond to emergency calls, possibly contributing to



Ambulance Trusts missing their own 8-minute target response times. Furthermore, the pressure on ambulance crews to hit their targets can potentially mean more patients are taken to A&E departments than is necessary. This is because the short-term demands of the targets culture deprive Ambulance Trusts of the time and resources to train their staff to a degree where paramedics are willing and able to treat patients at home or at emergency scenes.

Our interviews and observations have shown that, in reality, targets are selectively prioritized by Trusts across a healthcare economy, for each Trust is measured by different, sometimes contradictory, objectives. Our data also suggest that reconciling an ethic of care with one of business efficiency can be extremely problematic. In terms of everyday practice, NHS staff, at a number of levels, act as street-level bureaucrats in seeking the best clinical outcomes for patients. This can involve contravening, ignoring, working around, gaming, or otherwise fudging the narrower, technical needs of business efficiency (Hyde et al, 2009). The 2012 NHS survey demonstrated that 62% of staff believed that patients and allied service users were their organization's number one priority (Department of Health, 2013: 2). As we have seen above, when NHS healthcare workforces 'can't do both', what will 'have to give' - at least from the perspective of medical professionals - will be the managerial targets, or at least certain elements of them.

Whether workforces and work tasks are monitored by 'outcome' or by 'performance' measures, it seems that neither will resolve this tension inherent in healthcare work. Local-level discretion at the site of service delivery, or street-level bureaucracy, can never be fully 'managed out' by such 'rational' administrative logic (Hupe and Hill, 2007; Lipsky, 1980; Prottas, 1979; Weatherley, 1979). In the words of Maynard-Moody and Musheno (2003: 3-8) street-level public servants 'deal with faces'. They will tend to find a way to deal with these 'faces' wherever possible and to limit the

degree of organizational interference over the ways in which they are dealt with, whether at ward level in an Acute or Mental Health Hospital or literally at 'street-level' when paramedic crews arrive at emergency scenes. Healthcare staff will typically want to put patients' needs above those of business efficiency whenever possible - the traditional 'money is no object' model of healthcare (Taylor, 2013: 55). Clinicians, as professionals, often want little to do with the financial matters of healthcare organization. Yet the advent of managed care (Scott et al, 2000; Light, 2001; Scheid, 2004: 63-4) and related developments in the NHS (Davis and Tallis, 2013; Fairfield et al 1997; Pollock, 2005; Taylor 2013: 83) has introduced all manner of administrative systems that aim to limit and control the scope and expense of patient treatments. Targets and metrics also promote the sort of quantification that makes services more readily transferable across providers. Coupled with today's increasingly challenging environment of public sector 'austerity', the much-maligned performance metrics reveal ever more clearly that resources are not only finite, but increasingly tightly rationed.

In terms of employee relations, our research into junior and middle management across four NHS organizations highlights what often appears to be a potentially dysfunctional work culture - one suggestive of worrying similarities with the infamous failures at Mid Staffordshire. Professional discretion, as reflected in both the treatment of patients and the operation of HR, has been increasingly sundered by a narrow focus on 'making the numbers'. While there is a significant literature critical of those forms of professional power that have traditionally dominated healthcare organizations (see Freidson, 2001), we argue that a return to professional authority may be preferable to the current scenario. If similarly professional forms of HRM could be developed, this would also be a welcome step towards an ethic of care for workers and employee advocacy that may boost morale and operational effectiveness (Hyde et al, 2009; Stanton et al, 2010; Townsend et al, 2011; West et

al, 2006). In other words, if such developments could be realised then healthcare organizations would be able to go about their *real* business of providing care and attention to patients and allied service users.

As long ago as 1972, Ida Hoos, in a critique of the application of systems analysis into public services, forcefully argued that the adoption of such supposedly 'rational' and 'objective' means of measurement and control would lead to widespread dysfunction. She argued specifically that:

'Contrary to the presuppositions of "systematic" planners, public health is not virgin territory. Like education, it is an area of longtime concern to persons with professional competence and experience. The excuse that programs do not function as well as intended or that "delivery systems" are not as effective or efficient as might be hoped is not sufficient reason to bring in "technical experts" who mistake ignorance for objectivity and whose objectivity is suspect.' (Hoos, 1972: 192)

Our data suggest that these controversies remain highly relevant today. In the complex world of healthcare - in which both the 'cost' and 'effectiveness' of care episodes are notoriously difficult to measure - management by targets is deeply problematic, as dysfunctional performance measures become the reality, even while so often distorting it. Moreover, street-level bureaucracy, informal discretion and professional norms cannot be fully eradicated, despite the efforts of the system designers; for they so often re-emerge, as public servants try to handle the contradictions and dilemmas that 'rational' control measures help to create (Evans and Harris 2004). Targets are a constant bugbear for both healthcare professionals and middle managers and in the wider sphere a major source of tension between NHS Trusts.

Moreover, the dysfunctional dependence on inflexible metrics has now 'crept' from the management of patients into the realm of healthcare HRM, undermining the prospects for the development of progressive or professional 'SHRM' (Strategic Human Resource Management). We advocate a return to more traditional concepts of healthcare management, putting the emphasis back on professional norms and professional discretion for both healthcare work and the management of healthcare workforces. Professional control, while problematic in its own way, is infinitely preferable - in moral and practical terms - to the widely discredited numbers-based systems for handling workforces and tasks which are complex and human-centred. In short, such tasks are better evaluated in terms of care, professionalism and compassion than throughput, metrics and 'efficiency'. As our analysis of healthcare settings shows, professional norms (even informal ones) can remain active - and to a large extent organizationally and culturally legitimate - even when systems and targets try to constrict and control them.

Reforms that return us to a professional dominance model (Freidson, 2001) and the building of 'better bureaucracies' (Adler, 1999) - rather than 'targets and terror' (Bevan and Hood, 2006) - are perhaps the only really 'rational' means to manage the complex and often unpredictable needs of patients and healthcare workforces. This situation will never be perfect, and increasingly expensive healthcare resources will have to be 'rationed', just as they always have been. But if the NHS lessens its emphasis on performance targets as the main structuring dynamic of organizational control, and takes steps towards re-legitimizing appropriate forms of professional discretion, then at least the rationing may be justified on more genuinely clinical grounds. In such a situation, the deep tensions and struggles experienced by 'street-level bureaucrats' in the NHS might be at least partially alleviated.

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## Endnotes

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<sup>1</sup> The NHS is one of the world's largest 'free at the point of use' health services. It is a state-run system employing over 1.3 million staff, and funded primarily by central taxation and government borrowing, with care mostly provided free of charge. Health services are primarily provided by state-owned, non-profit 'Trusts' (such as Acute Hospital Trusts, Ambulance Trusts, Mental Health Trusts). The entire system, however, is undergoing substantial reform. Primary Care Trusts are being dissolved and services are increasingly provided by private-sector contractors, with cost-control becoming a paramount issue for Trust senior management (for an overview, see Taylor, 2013).

<sup>2</sup> See, for example 'NHS targets 'may have led to 1,200 deaths' in Mid Staffordshire', *Daily Telegraph* 17 Mar 2009

<sup>3</sup> The accuracy of the macro excess death figures and the micro examples of care failures is a matter of some dispute, with certain sections of the press questioning the extent and nature of the failings at Stafford Hospital. For example, although lack of access to water, food, and dignity were indeed findings of central importance to the Francis Report, there is no mention of the very widely-reported 'patients forced to drink from flower vases' incident in any of the three volumes of the final report (Francis 2013). Suggestions have been made, therefore, that much of the media coverage was sensationalized, perhaps as part of a wider attack on the publicly-funded NHS amid government austerity measures, see for example 'Stafford's A&E set for closure as anger grows at 'crucifixion of a good hospital'', *The Guardian* 28 July 2013

<sup>4</sup> Similar administrative models have also been applied to help reduce costs, rein in professional discretion, and standardize practice in social care settings, see for example, Ellis et al (1999).

<sup>5</sup> 'Top A&E doctors warn: 'We cannot guarantee safe care for patients anymore'', *Independent*, 20 May 2013

<sup>6</sup> In May 2013 the Royal College of Nursing, the public sector trade union Unison, and the Patients Association formed a 'Safe Staffing Alliance' to draw attention to inadequate staffing levels across hospital wards in England. 'Nurse staffing levels unsafe, says Safe Staffing Alliance', *BBC News*, 12 May 2013

<sup>7</sup> 'East of England Ambulance Service 'fails on response times'', *BBC News*, 25 February 2013

<sup>8</sup> 'Paramedic: Ambulance delays 'causing harm and deaths'', *BBC News*, 4 May 2013

<sup>9</sup> 'A&E units on cliff edge, say NHS leaders', *BBC News*, 21 May 2013

<sup>10</sup> Another scandal involving allegations of falsification of targets data, poor patient care outcomes, and bullying of staff broke at Colchester General Hospital in November 2013. 'Colchester hospital hit by fresh fears over falsified cancer records', *The Observer*, 9 November 2013

<sup>11</sup> The NHS Constitution contains the following four 'Pledges' as regards NHS organizations' duties as employers:

**Pledge 1:** To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers, and to communities.

**Pledge 2:** To provide all staff with personal development plans, access to appropriate training for their jobs and the support of line management to succeed.

**Pledge 3:** To provide support and opportunities for staff to maintain their health, well-being and safety

**Pledge 4:** To engage staff in decisions that affect them and the services they provide, individually, through representative organizations and through local partnership working

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arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

(Department of Health, 2013: 1)

<sup>12</sup> It is perhaps likely that Ambulance Trusts' comparatively low scores in the national staff survey are related to a long history of industrial relations strife in this sector, a low-Trust working climate, and a 'blame culture' (AUTHORS 2013; Wankhade 2012).

<sup>13</sup> KSF stands for Knowledge and Skills Framework, an HR development / performance management system linked to the NHS's *Agenda for Change* pay grades and job evaluation criteria.

<sup>14</sup> Outcome measures have been defined as "a measure of change, the difference from one point in time (usually before an intervention) to another point in time (usually following an intervention)." (Kendall, 1997: 11).

**Disclaimer:** The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

**SDO Funding Acknowledgement:** This project was funded by the National Institute for Health Research Service Delivery and organization Programme (project number 08/1808/241).