The effect of introducing new public management practices on compassion within the NHS

Talking points

1. The principles of neo-liberalism were imposed on the NHS in the form of new public management (NPM).
2. The creation of a non-clinical manager class brought with it a controlling leadership style not suited to the caring professions.
3. Compassionate and collegiate leadership is needed if the NHS wants to increase staff wellbeing.
4. The problem with the individualistic paradigm of mental health is that it implies a personal deficiency.
5. The findings of social psychology should inform the training of senior NHS managers.

Author Melanie George is principal clinical neuropsychologist, Kent and Medway NHS and Social Care Partnership Trust.

Abstract Over the past 30 years, leadership and management in the NHS have been shaped by political and economic drivers, most notably the neo-liberal principles of new public management (NPM). In this article, the author argues that NPM has harmed the organisation, as laid bare by the Mid Staffs scandal. She takes us through these historic changes, delves into the psychology of healthcare staff’s responses to stress, and affirms the need for the NHS to rid itself of a noxious legacy, which she deems incompatible with the aim of increasing staff wellbeing and providing more compassionate care. In another article, published simultaneously, the author describes insights on staff stress and wellbeing gained from a study into the benefits of Schwartz Rounds.

Citation George M (2017) The effect of introducing new public management practices on compassion within the NHS. Nursing Times [online]; 113: 7, 30-34.
routinely employed pace-setting and top-down techniques, encouraging staff to give priority to organisational targets (Cunnane and Warwick, 2013). In many cases, these management methods had spilled over into bullying and blame (Arbuckle, 2012).

Francis argued that sustainable culture change would only happen if the NHS adopted compassionate and collegiate styles of leadership. A subsequent report on patient safety echoed these sentiments, concluding that leaders should: “abandon blame as a tool and make sure pride and joy in work, not fear, infuse the NHS” (National Advisory Group on the Safety of Patients in England, 2013).

Disappointingly, the tabloid media initially overlooked the fact that staff had suffered too and lambasted nurses for having “stopped caring” (Coward, 2013). Keen to allay the public’s fears, the government hastily announced plans to mandate compassion and criminalise neglect (Bibby and Tomkins, 2014). This response was later criticised for compounding the demonisation of staff (Valle, 2014). It was also naive, because it addressed the symptoms of the problem, rather than its cause.

The need to improve quality of care is indisputable. However, focusing vigilantly on the needs of the people who use the NHS is only one part of the solution.

Seeing the bigger picture
In October 2014, the NHS Five Year Forward View (NHS England, 2014b) said the NHS remained too focused on disease-based care and needed to realign itself to focus on prevention. It argued that success hinged on staff moving from curative to person-centred models of care. A glaring omission was that it did not address whether frontline staff had the emotional resources and support to provide better relational care.

Staff in health and social care experience significantly higher work-related stress than other professional groups (Health and Safety Executive, 2015). Figures released under the Freedom of Information Act in 2015 have shown that in the NHS, absence due to mental health difficulties has doubled in recent years (Paton, 2015). This equates to a loss of 1.6 million working days (Binney, 2015), with an estimated cost of £2.4bn per annum (Health and Social Care Information Centre, 2015).

The NHS evidently needs to do more to protect its most valuable asset – its staff.

As a first step, it needs to learn how to take psychological responsibility for them.

Blaming managers is too simplistic
In 2013, Heather Tierney-Moore, chief executive of Lancashire Care Foundation Trust, called for leadership behaviours to align with the business that we are in: health and social care (Torjesen, 2013). However, it is not possible to simply mandate leaders to show compassion.

In my experience, many managers distance themselves from the reality of staff’s experiences, as well as their own (Hartley and Kennard, 2009), because they are struggling too. An increasing number of talented chief executives are leaving the NHS because there is a lack of explicit support to help them to bear “the brunt of the negativity” (Webster, 2015).

Traditional leadership training has not helped because it encourages self-control and the repression of emotions (Hirschhorn, 1988). This leaves managers vulnerable to being dehumanised by staff, who do not recognise that they have emotions too (Lynch et al, 2012).

Addressing the root of the problem
The predominant pace-setting leadership style that concerned Francis has its roots in neo-liberalism, which encourages free markets, privatisation and reduced public spending for services such as education and healthcare (Evans and Sewell, 2013). These principles were imposed on the NHS in the form of NPM, during Margaret Thatcher’s premiership, by Roy Griffiths, a British businessman and future chief executive of Sainsbury’s.

Griffiths was asked by the health minister at the time to review the clinically led NHS, and concluded that it was beset by “institutional stagnation” (Griffiths, 1985). His solution was to employ general managers and make them accountable for income and expenditure. We are now beginning to see the damage wrought by this decision.

Lewis recently labelled the creation of a non-clinical manager class in the NHS as the general management “mistake” (Lewis, 2016) and Jeremy Hunt, current health secretary, conceded that this may have been “a historic mistake” (Spencer, 2016).

Culture clash
Although controversial at the time, Griffiths was convinced there were overwhelming similarities between health and business management. This planted the seeds for a move away from managing people to managing their performance (Iles, 2014). The new cadre of managers directed frontline staff to home in on targets by instituting “controlling and reporting” systems (Badie et al, 2011). The impact was profound: employees who had been drawn into a caring role were required to shift their focus to audit outcomes and other activity data.

The managers’ approach could have been moderated by an understanding of frontline care work. However, on the whole, they had never worked in health-care (Cunnane and Warwick, 2013). This culture clash, coupled with the managers’ limited repertoire of (mostly technical) ‘hard skills’, meant that aspects of health-care that are difficult to quantify – for example, providing care to people who are frightened, agitated or in their final moments of life – were overlooked. Over time, the differences between the two professional groups contributed to a deep divide, underpinned by mutual suspicion and labelling (Nath, 2015). This provided fertile ground for some managers to impose a top-down control regime in an attempt to gain the desired organisational results (Arbuckle, 2012).

The introduction of NPM also had a significant impact on the way frontline employees viewed their personal effectiveness. Hard skills came to be seen as synonymous with intelligence, precision and strength, whereas ‘soft skills’ such as sensitivity were viewed as markers of weakness (Williams and Keep, 2015). One implication of this was an increase in emotional labour for staff; another was the erosion of the value ascribed to caring skills – the very skills that are now being called upon.

Box 1. What is new public management?
The term ‘new public management’ encapsulates the process whereby ideas and techniques drawn from the private sector were imposed on the public sector in the 1980s. The objective was to make public services more business-like and, ultimately, more efficient (Ward, 2011). Proponents rejected the notion that public organisations have a unique culture, arguing that they should be managed in the same way as any private-sector organisation.
Organisational blind spot

Management theorists have traditionally viewed ‘employee casualties’ as an inevitable sacrifice when it comes to ensuring that organisations remain profitable and productive. In the NHS, staff support was effectively disowned by managers and delegated to occupational health (Huffington et al, 2004). At the same time, managers shifted their focus to patient contact. This meant the costs of staff stress, including high rates of sickness (Conn, 2015) and attrition (Campbell, 2015), were missed.

The approach that was adopted by the NHS is starkly different from that of other helping or caring professions. In the field of psychology and psychoanalysis, for example, anxiety and countertransference are viewed as a normal consequence of caregiving (Sussman, 2007), and the provision of clinical supervision and reflective spaces is seen as a prerequisite for safe practice and continuing professional development.

Placing staff wellbeing on the agenda

In the same month that the NHS Five Year Forward View was published, the Care Quality Commission (2013) announced that it would be transforming its regulation process. In the wake of the Francis report, the organisation had been criticised for failing to detect problems such as those found at Mid Staffordshire (Adams, 2013). The new regulatory framework awarded a higher priority to staff wellbeing and, for the first time, included an assessment of staff engagement.

This shift in focus – coupled with increasing evidence that staff wellbeing is a prerequisite to, rather than a consequence of, high-quality care – helped to raise awareness of the implications of staff stress at policy level (NHS England, 2014a). In 2015, NHS England and NHS Employers responded by launching a range of initiatives, including improved nutrition and fitness schemes (NHS England, 2015) and a self-help ‘emotional wellbeing’ toolkit (NHS Employers, 2015).

Although these initiatives are a step in the right direction, however, they may inadvertently send the wrong message, because they infer that the “locus of the disturbance” (Balme et al, 2015) is within the individual. In so doing, they fail to pay due regard to the critical role of external social and organisational factors highlighted by the Francis report. The initiatives reflect one of the principles espoused by conventional psychiatry in the West: that emotional distress can be treated in isolation, with no consideration given to circumstances beyond the individual’s “pathology” (Ginn, 2008).

Unaddressed anxiety

The notion that nursing staff dehumanise and distance themselves from those in their care was introduced by the psychoanalyst Isabel Menzies. After a four-year ethnographic study in a teaching hospital, she concluded that nurses used unconscious defence mechanisms to cope with the “primitive anxieties” aroused by working with people who were ill or dying (Menzies, 1960).

Critically, she asserted that the “defence system” within the hospital not only failed to address nurses’ anxiety, but also created secondary anxiety by overlooking their need for reassurance and satisfaction. Although the findings were acclaimed by scholars, they did not translate into meaningful changes. Lawlor (2009) later suggested that this was because Menzies did not “address adequately what to do about [the anxiety]”.

Emotional labour

A more contemporary theory of staff withdrawal, which has achieved broader appeal, is that of “emotional labour” (Hochschild, 1983). This has been defined as “suppressing private feelings, in order to show desirable work-related emotions” (Mastracci et al, 2012). A tenet of the theory is that service workers are routinely subjected to regulation and control of their feelings, emotional expression and personality (Hochschild, 1983). Over time, the mismatch between expressed and felt emotions is thought to lead to “emotional dissonance” (Zapf and Holz, 2006), and ultimately to emotional strain. This, in turn, increases the risk of burnout, characterised by emotional exhaustion, reduced professional efficacy and cynicism. Staff withdrawal from patients, and depersonalise or objectify them, in order to cope (Grandey, 2000).

However, the applicability of the emotional labour theory to healthcare is undermined by the fact that it does not capture the complexity of the relationship between care provision and the feelings that lead to withdrawal. This relationship is not consistent: staff who have an insecure attachment style (Leiter et al, 2015; Franczek, 2012) or previous experience of trauma (Newell and MacNeil, 2010) appear to be more vulnerable to burnout. Moreover, wider aspects of organisational culture have been found to play a much greater role in the development of burnout than patient care (Watts et al, 2013) or individual factors (Green et al, 2014).

Stress: the antecedent of withdrawal

Emerging research suggests that withdrawal in healthcare settings might be explained by a more basic psychological model of stress. The experience of stress has been defined as: “the psychological and physiological state of a person responding to demands that stressors in an environment place upon them (that is, strain) under conditions where those stressors are perceived to be threatening to the self and wellbeing” (Haslam et al, 2009).

This definition is helpful because it draws attention to the fact that individuals’ experience of stress is mediated by their appraisal of it. It can be understood more clearly if we recognise that the primary evolutionary function of stress is self-preservation (Steimer, 2002). What
has not hitherto been recognised – although it makes intuitive sense – is that this brings with it a reduction in compassion for others.

Psychologists have known for some time that anxiety triggers changes in brain activation (Arnsten, 2009). This apparent evolutionary survival response is adaptive in some circumstances because it leads to a narrowing of focus, demonstrated by improvements in selective attention (Robinson et al, 2013). Todd et al (2015) further elucidated this process by demonstrating that feelings of stress also heighten “self-focused attention” which, in turn, undermines perspective-taking. Converging research subsequently revealed that this is associated with a reduction in empathy for others (Martin et al, 2015).

A self-perpetuating process
Emotional responses are natural in the context of providing care to the most vulnerable and dependent in society, particularly when the demand on care services is outstripping supply. The glaring problem with the prevailing individualistic paradigm of mental health is that it reinforces the notion of personal deficiency.

In my experience, the potent fear of negative social evaluation often prevents staff from disclosing to colleagues how they are feeling. Withdrawal, as a form of coping, seems like the only option. This unfortunate self-perpetuating process cuts them off from their colleagues and therefore also from an opportunity to reframe and normalise their feelings (George, 2016) (Fig 1).

Reversing the damage
Griffiths’ analysis of the type of leadership the NHS needed was fatally flawed because he viewed his brief from a dispassionate and reductionist standpoint. NPM practices are clearly incompatible with the NHS’ goal to improve staff wellbeing and increase compassionate care. They were developed for the manufacturing industries and honed in business schools. They were not designed to cultivate the talents of people drawn to the caring professions, who typically share the capacity to be attuned to the needs of others.

A barrier to reversing the damage done is that the mechanisms underpinning the “unassailable link” between compassion shown to patients and that shown to staff (NHS England, 2014a) are mediated by psychological processes that are not widely shaped by culture (Gurung and Roethel-Wendorf, 2008). People from collectivist cultures, such as China (Reeder, 2013), tend to use situational explanations for human behaviour (Mason and Morris, 2010). In contrast, individualistic cultures, such as North America and Western Europe, are more likely to emphasise “personal causality” (Reeder, 2013).

Fig 1. Proposed model of the link between stress and withdrawal in healthcare staff

Source: Adapted from George (2016)
understood by leaders. Psychological
defences are born out of deep-rooted fear
and distress; however, to date, organisations
have failed to seek the specialist support
they require to address this. Psychoanalysts
have diagnosed the problem of institutional
anxiety in the NHS, but have largely
remained an untapped source of expertise.

Healthcare is delivered by groups of
people. The literature on the social psy-
chology of organisations should therefore
also be brought to bear, particularly with
regard to training senior staff. Social psy-
chology theories help us pay due regard to
societal norms that can contribute to unhelpful assumptions about mental
health; they also help us understand group
dynamics and the importance of trust
(George, 2015). As I make clear in my article
on staff wellbeing and Schwartz Rounds
(George, 2017), the need for this type of
training is now more pressing than ever.

“In the NHS we need to learn
how to take psychological responsibility for its staff”

This article is drawn from original
research by Melanie George, which is
available in open access at: Bit.ly/
GeorgeSchwartz. Melanie George’s other
article on how traditional management
can harm staff wellbeing can be found at
nursingtimes.net/NTJCStaffStress

ideology, policy, and social effects. In: Hall PA,
Lamont M (eds) Neonatal Resilience in the Neonatal
Flynn M, Mercer D (2013) is compassion possible
Francis R (2013) Mid Staffordshire NHS
Foundation Trust Public Inquiry. Bit.ly/
FrancisPublicInquiry
Franchak K (2013) Attachment styles and the ways
of coping with stress in Polish nurses. Advances in
Palliative Medicine; 11: 2, 62-73.
George M (2017) How traditional management
techniques can damage staff wellbeing. Nursing
Times [online]; 113: 7, 35-38.
George M (2016) Stress in NHS staff triggers
defensive inward-focussing and an associated loss
of connection with colleagues: this is reversed by
Schwartz Rounds. Journal of Commpassionate
Green AE et al (2014) The roles of individual
and organizational factors in burnout among
community-based mental health service providers.
Psychological Services; 11: 1, 41-49.
Gurung RA, Roethel-Wendler A (2008) Stress,
emotional labor, and mental health. In: Eshus S, Gurung RAR (eds)
Culture and Mental Health. Sociocultural
in the Helping Professions: Principles, Practice and
Haslam SA et al (2005) Taking the strain: social
identity, social support, and the experience of stress.
Health and Safety Executive (2015) Work Related
Stress, Anxiety and Depression Statistics in Great
Britain 2015. Bootle: HSE.
Health and Social Care Information Centre (2015)
NHS Sickness Absence Rates, Proportional Statistics:
Hirschom L (1988) The Workplace Within: Psycho-
Hochschild AR (1983) The Managed Heart:
Surface: The Emotional Life of Contemporary
Iles V (2014) How good people can offer bad care:
understanding the wider factors in society
that encourage non-compassionate care. In: Shea S et
al (eds) Providing Compassionate Healthcare:
Lawlor (2009) Test of time: a case study in
the functioning of social systems as a defence against
anxiety: rereading 50 years on. Clinical Child
Psychology and Psychiatry; 14: 4, 523-530.
Leifer ME et al (2013) Style, structure style at work:
measurement, collegial relationships, and burnout.
Burnout Research; 2: 1, 25-35.
mistake’. The King’s Fund Blog; 14 December.
Bit.ly/KFGeneralManagementMistake
in Education: Commercialization, Carelessness and
emotional contagion of pain in mouse and human
Mason MF, Morris MW (2010) Culture, attribution
and automaticity: a social cognitive neuroscience
view. Social Cognition and Affective Neuroscience;
Mastracci SH et al (2012) Emotional Labor and
Crisis Response. Working on the Razor’s Edge.
Amnesty, NY: ME Sharpe.
Menzies IEP (1960) A case-study in the
functioning of social systems as a defence against
anxiety: a report on a study of the nursing service of a
Nath V (2015) A return to values-driven leadership
or more of the same? The King’s Fund Blog; 15
June. Bit.ly/ValuesDrivenLeadership
National Advisory Group on the Safety of Patients
in England (2013) A Promise to Learn: A
Commitment to Act – Improving the Safety of Patients in England. Bit.ly/Berne2013
Newell JM, MacNeil GA (2010) Professional
burnout, vicarious trauma, secondary traumatic
stress, and compassion fatigue: a review of
theoretical terms, risk factors, and preventive
methods for clinicians and researchers. Best
Practice in Mental Health; 6: 2, 57-68.
Toolkit. Bit.ly/NHSEmpWellbeingToolkit
major drive to improve health in NHS workplace.
NHS England News; 2 September.
Leadership: Leadership with Compassion. Bit.ly/
NHSLeadershipCompassion
NHS England (2014b) NHS Five Year Forward View.
Bit.ly/NHSFVFV
Paton N (2015) NHS sickness absence rates up due
Effect' at Risk but not Dead,” says Charity
Supporting Strong Growth of Schwartz Rounds.
Bit.ly/PocFtFrancisEffect
Reeder GD (2013) Attribution as a gateway to
social cognition. In: Carlisle DE (ed) The Oxford
University Press.
upon cognition: perspectives from human threat
Spencer B (2016) Jeremy Hunt attacks the NHS'
middle managers and says doctors and nurses
should be put in charge of hospitals. Mail Online;
30 November.
Steimer T (2002) The biology of fear- and
anxiety-related behaviours. Dialogues in Clinical
Neuroscience; 4: 3, 231-249.
Sussman MB (2007) A Curious Calling:
specific emotions influence perspective taking.
Journal of Experimental Psychology; General; 144: 2,
374-391.
Torjesen I (2013) A new culture of management in
the NHS. The Guardian; 5 June.
Valle J (2014) ‘Being a nurse-leader is a tough role’.
Ward SC (2013) The machinations of
managerialism: new public management and the
diminishing power of professionals. Journal of
Cultural Economy; 4: 2, 205-215.
leadership must stop spinning. HSJ; 18 September.
Williams S, Keep J (2015) Resilience building has a
hidden cost. HSJ; 125: 6460, 16-17.
Zapf D, Holz M (2006) On the positive and
negative effects of emotional work in organisations.
European Journal of Work and Organizational

For more on this topic go online...

Stress and coping strategies in renal staff
Bit.ly/NTStressRenal

Copyright EMAP Publishing 2017 This article is not for distribution

Nursing Times [online] July 2017 / Vol 113 Issue 7
34 www.nursingtimes.net