# PRECARITY AMONGST SERVICE MANAGERS IN THE NHS: A REVIEW IN THE MIDST OF AUSTERITY AND BREXIT

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## ABSTRACT

*With a national agenda for public service integration and realising the need for a diverse and resilient NHS workforce, recent political movements in the wake of austerity and Brexit challenge the very capability of the NHS to achieve this agenda. Health service professionals (service managers amongst them) in the NHS, who already found themselves in a state of operating amongst unclear processes, blurred boundaries and expanding remits, are now also faced with increasing work insecurity in light of recent political developments. The most crucial macro-level developments that form the context for this study are Brexit and the recent austerity measures to cut and cap redundancy entitlements for NHS staff in the UK. Brexit implies much confusion and uncertainly for the NHS and public services in general across the UK. The implications are potentially large for the significant number of service managers that widely serve health and social care. This comes at a time where the NHS in itself faces a staff shortage crisis and where UK Public Service financing is expected to deteriorate. The paper uses the theory of Precarity to explore the ways in which service managers in the NHS understand and view precarious employment and changes in their work as a result of socio-political developments that dominate organisational change. While Precarity has been a topic of interest in education and how you can account for it in the modern-day workplace (Vallas, 2015), there has been very little focus, if any, on examining managers and employment insecurity in the NHS using the lens of Precarity. Precarious employment, and precarious working, in the NHS are often overlooked and under studied since the NHS system is one dominated by politically set targets and managerial efficiency, a complex and shifting structure, a culture where mistakes are feared by frontline staff and where the nature of work is intangible (Cotton, 2016). From both an organisational and management perspective, there is a need therefore to better understand and reduce labour Precarity in public services, particularly the health service (Farr-Wharton et al., 2015). This study engages with a systematic review of Precarity in the NHS, taking on the challenge of examining and understanding precarious employment for managers to date in the context of British healthcare services while focusing on the future NHS. The systematic review addresses the question: 'How do service managers in the NHS understand and view precarity in employment and how do they experience precarious working during austerity and Brexit'? As an ongoing study, the paper proposes to engage in cognitive interviews with service managers in NHS England and obtain their views and experiences about austerity-led and Brexit-fuelled changes. This working paper provides us with a review of the evidence and enables us to theorise Precarity amongst service managers in present day NHS and more widely, in UK public services during a challenging time.*

## INTRODUCTION

This paper is interested in how service managers in the NHS understand and view precarity in employment and how they experience precarious working during austerity and Brexit. By precarious work, we refer to all forms of work involving job insecurity, limited entitlements at work, low wages and high risk to health (McDowell, 2006: 7). We attempt to build on the theoretical assumption and argument of Vosko (2006) that even though precarious work is a defining feature of the modern day workplace, it is poorly understood. Precarious forms of work are shaped by a variety of employment status and forms of employment and labour market dimensions. The ILO (2005) define precarious employment as a work relation where employment security is lacking and the term encompassing subcontracting, at home work, temporary and fixed term contracts. Benach et al. (2014) who identify various historical, economic and political factors that relate precarious employment to health argue that employment precariousness is a major social determinant of health. Precarious employment accounts for complex and diverse individual career and work trajectories and to study the health impact of these different employment trajectories can help to better understand the economic and social implications for unemployability as well as employability (in its various complex forms). The challenge ofcourse is to capture the different dimensions and forms that precarious employment can take since it is difficult to convincingly measure the extent to which precarious employment (or precarious working) exists (Benach et al. 2016). But what is certain is that there has been significant growth of precarious work in Britain over the past two decades (Wright, 2013). We suggest that there is an elemental need to develop definition and understanding of what precarity in an era of Brexit will mean. Quinlan et al., (2001) also suggest five broad categories of precarious employment that help understand it better; these are temporary workers; workers subject to various forms of organisational change that result in job losses and a subsequent increase in job insecurity among those who remain; outsourcing/home based work; part-time work and small business. The second category of workers subjected to various forms of organisational change is of particular interest to us given the changes that austerity and Brexit bring about for service managers.

## SERVICE MANAGERS AND CHANGE

This paper provides focus on service managers who deliver healthcare services and we account here for both hybrid and non-hybrid managers across the possible range and types of organisations in the NHS. For classification purposes, Hybrids, are professionals engaged in managing professional work, professional colleagues, and other staff (Fitzgerald and Ferlie 2000; Montgomery 2001). ‘Hybrid’ roles, framed by both professionalism and managerial logics, diffused across the NHS including clinical managers (e.g., medical managers, nurse managers) in the UK. For the purposes of this study, “middle management” includes all staff in managerial roles both non-hybrid (or “pure plays” such as general, business and service managers and department heads) and those in roles combining clinical and managerial responsibilities (hybrids).

Middle managers constitute important functional (middle) tiers of the organisational hierarchy across the breadth and width of the NHS. Their role is of supreme importance as they have the responsibility to oversee and indirectly control the work of others (Livian, 1995). They not

only organise and coordinate across units, both intra and inter organisation, but are also responsible to maintain the external relations, reporting and accounting for smoothness of operations, and level of business performance that ensues (Hales 2006).

Being responsible for communicating with the organisation in different directions: upward, downward and lateral, they span boundaries and negotiate new remits through work that is characterised as being complex, messy and pressured (Memon and Kinder, 2016a). Their work is 'indeterminate', 'chaotic' and 'un-planned' because increasingly, managerial work has indeterminate boundaries and managers are willing to decide on the boundaries of their work (O'Gorman et al., 2005)

During the 1990s, in line with the notion of 'New Managerialism', middle managers were empowered in organisations that underwent downsizing and delayering. However, they were not willing to delegate responsibilities to their subordinates as they were still held accountable for the accomplishment of the task and the overall performance. Middle managers seemed more of a 'coordinator' rather than a 'technical expert'. They did not delegate responsibility to their subordinates as they perceived themselves as the subject to extensive performance management that would hold them accountable for the failure of 'empowered subordinates'.

Overall, despite the rhetoric of post-bureaucracy and empowerment of employees in 1980s and 1990s (Pollitt, 2009), middle managers remained as supervisors and co-ordinators. They remained in the process of dealing with increased pressure to meet the performance management targets (Checkland et al., 2011). Service managers faced the expectation of rapid results and blurring of work boundaries as well.

On the other hand, the number of middle managers was reduced as a result of the move from large bureaucratic organisations to more flat and flexible ones (Currie and Procter, 2005). The literature identifies several reasons for decreasing the number of middle managers under the NPM. First, the increasingly knowledgeable employees needed to have more autonomy than command and control and the rise of knowledge management enables more control over subordinates and control at a distance. Second, the ever more highly developed information technology led to the reduction in the managerial costs. Third, performing the managerial role in highly uncertain and unstable environments required more responsiveness and dexterity, as well (Livian, 1997; Hales, 2001).

In some of the management literature, middle managers have been criticised for being a block between operational and strategic levels of the organisations. They are seen as being costly, unable to act as entrepreneurs, political instead of problem solver and inefficient to link the top-level to the front-line managers (Scarborough and Burrell, 1996; Balogun, 2003). Middle managers have been the agent as well as the target of the change. Therefore, it is not surprising that they sometimes resist the organisational change (Balogun, 2003). Despite the environmental pressures in the late 1990s and early 2000s, the middle managers still play an important role in organisations (McGurk, 2011, p. 15). Middle managers have to play several roles with regard to the varying conditions. These roles, however, have been changed recently. Some of the scholars have emphasised the role of the middle managers in strategic change (Currie and Procter, 2001, 2005). In some of the studies, the importance of the middle managers' position in the middle stretch of the organisations has been

highlighted. It is argued that their position assists them to process the new ideas and information effectively and enable them to innovate and initiate change.

One may argue that managers have given more weight to leadership than management in the recent times. This is attributed to the increased number of flat organisations as a result of decentralisation and post-bureaucracy. The argument is that flatter organisations can be more responsive, flexible and adaptable to the competitive environment (Handy, 1990). Hales (2002, p.55) argues that there is more need for leadership in flatter organisations that have less standardised processes and hierarchies. Such organisations need leadership as consultative coordination, coaching, and inspiration rather than formal managerial control and performance monitoring (McGurk, 2011, p. 17). However, it is argued that centralised, bureaucratic organisations have not necessarily been replaced by flexible and dynamic organisations (Farrell and Morris, 2003; Hales, 2002). Rather a simultaneous centralised and decentralised form of bureaucracy called 'neo-bureaucracy' is being witnessed (Farrell and Morris, 2003).Therefore, it can be concluded that middle managers in organisations play both a formal managerial role, associated with organising and coordinating and an informal leadership role such as inspiring and influencing the employees. The extent to which middle managers play 'managerial' and 'leadership' role can be different in different contexts.

The middle manager came into power as a result of the inception of the internal market (1991) and general management (1985) policies introduced under the NPM paradigm. The internal market or quasi-market as some call them aimed to split the purchasers and providers of the health care, generating competition for service delivery within the suppliers (Currie and Procter, 2005, p.1330). In such a context, Currie (2006) identifies managers in healthcare organsiations as 'change agents'. The introduction of general management in the mid-1980s encouraged private sector managers to move into NHS managerial positions, for instance as HR managers. However, the central government control, doctors' power, and the political context of health care organisations limited their ability to operate fully as managers. At the same time, the middle management positions in the public health sector organisations were increasingly occupied by health care professionals who had received the management education.

These managers were expected to enact strategic roles, but they were the targets of redundancy precarity at the same time (Currie, 2006). The coalition government at the start of the decade had the plan to reduce the managerial cost by 45% which was one the largest reductions in the managerial costs in the history of the NHS (Walshe and Smith, 2011). Added to this, decentralisation under the public management reforms has led to increased demand for the HR professionals (Meyer and Hammerschmid, 2010). The decentralisation and the devolution of HRM to line managers are taken as interrelated activities (OECD, 1996; Lonti, 2005). McConville (2006) states that middle managers consider HRM as part of their role, and they are willing to get involved in the HRM practices. However, taking this role has put the service middle managers in a difficult position, as they have to deal with the senior managers' demands to their subordinates and the requirements of the customers at the same time (McConville, 2006, p. 646). However, burdening the middle managers with multiple roles has been a recurrent theme of the shift in the policy under the NPM (Conway and Monks, 2010, p. 364). The focus on the roles that each of them plays in the delivery of HR activity perhaps draws attention away from the fact that middle managers are not only

responsible for implementing the HR policies, but also contribute to the formulation of HR strategies (Floyd and Wooldridge, 1997; Currie and Proctor, 2005).

To encourage middle managers to contribute to the HR strategies is a trajectory that is likely to realise HR strategy through a process as termed by Currie and Procter (2001) as 'negotiated evolution' with middle managers and the HR function coming to serve task (Hutchinson and Wood, 1995, p. 66).

In terms of the institutional factors affecting managers in the context of healthcare, Currie (2006) refers to central government control and doctors' power as two main factors that influence middle managers' autonomy. Therefore, the relationship that managers have with the external bodies such as Department of Health is very influential on managers' beliefs and practices of professional freedom, jurisdiction, discretion and accountabilities (i.e. autonomy). These Vertical or political relationships therefore, become are important to managers. Central government targets and policies serve as the determinants of the managers' agenda in practice while at the same time these limit the managers' autonomy (Harrison and Lim, 2003; Gatenby et al, 2014).

In summary, it is argued that service managers traditionally acted as diplomat administrators in the NHS. They came into power with the introduction of the internal market. They became the general managers in charge of meeting the government targets. More recently, in the debates that surround the public service manager, there is an emphasis on entrepreneurialism and enacting strategic roles. However, an array of central government targets and policies, clinicians' powers, complex relationships and dependencies on external bodies, put constraints on managers to enacting the more proactive and innovative roles.

## METHOD

The paper intends to carry out a systematic review in the attempt to address the research question. Following this, the next stage of the research seeks inclusion of an empirical data set via cognitive interviews with service managers in the NHS. To date, the following method and process has been applied:

To begin with, a clear research question was identified and then we set out to locate studies that can inform the research question. To do this, four different database search engines (Google Scholar, Web of Science, Pub Med and an in-house ICAT system) were deployed. Then, particular search terms and key word combinations were used in each search engine to locate relevant papers *(see table 1 below).* The search criteria was set to identifying and locating papers which featured any of the search terms and key words in their Title and Abstract of each search hit and this limited to first 3 pages per search engine. This resulted in the access and download of 43 articles.

| Key Words (and combinations) | Total Papers identified and selected |
|---|---|
| Precarity and NHS | **43**<br><br>(papers selected were those that featured one or more of the search terms and keywords (left) in their Title and/or Abstract) |
| Precarity and Managers | |
| Precarity and NHS Managers | |
| Precarious Employment | |
| Precarious employment and Austerity | |
| Precarious working and NHS | |
| Precarious working and NHS Managers | |
| NHS Managers and Change | |
| Austerity and NHS managers | |
| Brexit and NHS Employment | |
| Brexit and NHS | |
| Brexit and NHS managers | |

*(Table 1: Search terms and combinations used)*

Once studies were identified, the next step set was to develop and apply an inclusion and exclusion criteria for selecting studies, which was applied to each paper. Using this criterion enabled us to determine which studies were to be used and left out from our paper. This process was carried out by both authors working together. The rationale for the inclusion and exclusion criteria's is provided below *(see table 2 below).* Resulting from this process, key studies were then identified as potentially eligible for systematically reviewing.

| Factor | Inclusion | Exclusion | Rationale |
|---|---|---|---|
| Hybrid managers | √ | | Managers with a clinical/medical background and/or in a simultaneous clinical role |
| Non-hybrid managers | √ | | Managers not with a clinical/medical background and/or not in a simultaneous clinical role |
| Level of Managers | | √ | This paper does not distinguish between level of managers as we are interested in precarity for managers in the NHS irrespective of level. |
| Time period (Pre 1998 Papers) | | √ | Tie period chosen as 1998 onwards since New Labour Government and the Comprehensive Spending Review were then introduced. |
| Health Services (Primary and Secondary) | √ | | Interested in service managers across all types and forms of health service delivery |
| Social Care / Local Authorities and NHS | √ | | Interested in service managers placed in collaborative and partnership based health service delivery |
| Other public services (except Health and Social Care) | | √ | Excluding other services such as housing or voluntary sectors as we want to keep a focus on service managers involved in delivering health services. |
| Peer reviewed (2, 3 and 4 star journals) | √ | | Interested in Peer reviewed publications of international accepted standard |
| Professional body/association publications | √ | | Interested in literature and current issues covered in professional body and professional association publication outlets. |
| English language | √ | | The systematic review is limited to publications in the English language as we aim to present the paper and publish in a English language outlet. |
| Studies specific to UK and EU | √ | | Focused primarily on UK & EU based studies since austerity and Brexit are relative to these contexts. Furthermore, the UK and other EU states holds a history of universal welfare health service provision. |
| Studies specific to Non-EU study/sample | | √ | Other countries hold very different contexts and systems of health services (i.e. a two tier system) |

*(Table 2: Inclusion and Exclusion criteria for selection of studies)*

By initially locating relevant studies for the review (43 papers), and then applying our developed inclusion and exclusion criteria, we were now able to select a final set of studies eligible for insertion in our work. The inclusion and exclusion criterion was applied to the Abstract and Introduction sections of every individual paper to determine eligibility of each study. As a result, a total of 19 studies (papers) were eligible, and which have been included and reviewed in this paper.

We then engaged with the analysis and synthesis of the 19 studies to examine and dissect them to see how they related to our research question, reviewing them in great detail. This has enabled us to bring findings from the various studies under a common framework for presentation. The matrix method (Garrard, 2007) was adopted here as a means of analysing and comparing across all 19 studies. The studies are classified in the matrix by *Author and date of publication, Purpose of Study, Conceptual Framework used, Subjects of the study, Study Design, Study Findings (see table 3 below).* The use of the matrix enables clarity of concepts and is a useful tool to use when engaging in a systematic review of literature.

Following this, we engaged in the writing up of our systematic review (Findings and Discussion section), which is presented in the form of this paper. Moving forward, we seek empirical data that will form the next component of this ongoing study. It is worth pointing out that additional literature has been used in writing this paper in order to develop the background and context to the NHS, Austerity and Brexit as well as to develop a backdrop about service managers in the NHS.

| | Study Purpose | Conceptual FW | Subjects | Study Design | Study Findings |
|---|---|---|---|---|---|
| **Speed (2015)** | Review state or position of service providers during austerity | Hendrikse and Sidaway (2010) Neoliberalism | Service Organisations (no managers) | Conceptual Editorial Overview on topic. | Market and state tangled in contradictory projects of reduced public spending coupled to corporate profit making on back of health and social care provision. |
| **Bolton (2004)** | Investigates the responses of nurses to NPM. Using data, it show how nurses, over a period of time, develop their own ways of reinterpreting Management's desires and deal with management control. | NPM and Taylorism | NHS Nurses, managers, clerical Staff, and doctors | Presents data collected as part of a longitudinal study carried out in an NHS Trust hospital and charts the changes which have occurred in nursing labour processes over a six year period. | Using data, shows how nurses, over a period of time, develop their own ways of reinterpreting management's desires. Argues that management is more likely to continue to rely on nurses' traditional autonomy in the delivery of health care and may resist some yet accommodate many of the demands made of them. |
| **Vallas (2015)** | To comment and discuss modern work arrangements under the influence and condition of Precarity. Accounts for recent studies on labour market uncertainty. | Kallerberg labour market segmentation; Austerity and Precarity theory. | Review of secondary studies | Critical retrospective essay that reviews other works on Precarity. | Complex matter. Perhaps the growing attention to economic precarity itself can create new political ideas and practices when the merits of virtues of workplace flexibility can now be challenged. |
| **Marang-ozov et al. (2016)** | Assess key risks to the Nursing Workforce in England. Intends to encourage discussion on Brexit and its risks for NHS staff. | Supply and Demand theory and modelling. | NHS staff and NHS organisations | Analysis of secondary data and statistical analysis of workforce data and population projections. | Findings are based on an analysis of two projected future trends: a reduced supply of European Union nurses following Brexit, and population growth-related demand for health services. Brexit created uncertainty puts pressure on NHS workforce planners to consider various workforce supply and demand scenarios to address ever increasing demand. |
| **Cunningham et al. (2016)** | Explores the impact of austerity on the conditions and experience of employment in social services agencies and their shifting labour processes. | Clarke (2014) conceptualisation of austerity; Labour Process Theory | Senior operational managers, front line managers and front line care workers across two organisational cases. | Interview data from 2 qualitative case studies (public service organisations). Conducted with range of actors in each organisation | Even though austerity is articulated differently in different contexts, and national and local austerity policies may differ, the experience of austerity is a common one and dominated by insecurity and changes in workplace control. Precarity represents an expansion of management power and reduced arena for formal organised worker representation. UK cuts in public expenditure, pay freeze have made managers experience significant shocks with regard to job security, work intensification and working time. This is fuelled by the broader trend for temporary employment, increasing under employment and recent growth of zero hour |

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| | | | | | contracts. |
| **Munro (2002)** | To create debate about employee involvement and explore ways in which individual and collective aspects interrelate in NHS initiatives. | Collectivism and Employee Involvement; Unitarist and Pluralist traditions of industrial relations. | Senior and Line Managers in NHS – single organisational case study | Individual and Group interviews | Tensions between individualism and collectivism arise lower down in organisation where line managers must implement change. This may discourage partnership amongst working groups and discourage forms of collective organising. The meanings middle managers attach to employee involvement and how they interpret and understand their involvement in the emergence of a particular context becomes significant. |
| **Postle (2002)** | Argues that the work of care managers becomes uncertain and uncomfortable due to a change in the context brought about by the inception of Health and Community Care Act 1990 | NHS and Community Care Act 1990; Managerial Change and Complexity | Qualitative study involving observations and interviews with two teams | Health and Social Care Managers. | Events/periods of major change and uncertainty (i.e. NHS and Community Care Act 1990) have an influence on managers work conditions, and contribute to increasing ambiguity and stress levels that adversely affect the quality of service provision. While work becomes complex, processes for dealing with complexity become increasingly reductionist. |
| **Granter and Hyde(2015)** | To demonstrate that managers play a necessary and important role in difficult and complex circumstances to deliver healthcare while constantly dealing with change. | Change and Complexity in the NHS | Service Managers | Interviews and Observations | Constant change in the UK has been defined by cost cutting and increasing efficiency has demonstrated diminished returns. In an austerity era, there should be attempts to bring a period of stability. NHS managers in the NHs important mediators between health policy and practice and should be seen as important partners in the health service. |
| **Benach et al. (2016)** | Precarious employment an emerging social determinant that affects the health of workers and therefore, propose an agenda for research that expands Understanding of health-related employment precariousness and the evaluation of policy programmes. | Precarious employment and public health. | Meta-review of studies | Secondary Data: Health and employment indicators | Precarious employment an emerging social determinant that affects the health of workers and their families. Yet its study remains in its infancy.<br><br>Need to develop more precise definitions, a detailed understanding of the pathways and mechanisms (how and why precariousness might affect health) and better tools for the design, implementation and evaluation of policies. |
| **Quinlan et al. (2001)** | To review studies on health and safety effects of precarious employment in industrialised societies published since 1984. | Conceptualise precarious employment and occupational health | Literature review of studies | None | Further research needed to link the effects of health, business practice and precarious employment. |

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| **Costa-Font** | Implications of Brexit on Cost of labour, and Staffing and work environment. | Review of previous empirical studies | Literature review | None | Brexit will imply a hectic time for the NHS. The NHS will need to balance quality cost conundrum and deal with potential high cost of staffing if it intends to maintain traditional quality standards. |
| **Sullivan et al. (2013)** | Explores the future of collaboration in an era of austerity | Boundary Object Theory; Collaboration theory | Review of literature | Content and Discourse Analysis | Public service agencies (i.e. the NHS) will need new discourse and insight on collaboration during austerity. It will need to reconsider future collaborative options for health service delivery in austere times. SO far collaboration has been deployed in the quest for efficiency (influenced by neoliberalism and NPM) |
| **Kolehmainen -Atkinson (2004)** | The impact of decentralisation on health managers and health workers | Decentralisation and Devolution theories. | Comparative country cases | Review of literature | Decentralisation and devolution creates new responsibilities for health managers at the local level since they take on the agenda to improve the way health services are designed and delivered locally. More accountability to stakeholders and users surfaces as a result of devolution and required more delegation. Yet at the same time national health directives and legislation continue to give directives to local health managers, particularly during times of uncertainty. |
| **Roberts et al. (2012)** | Evaluating funding pressures facing the NHS from 2011 to 2021 | Impact Study | NHS England infrastructure | Analysis of public and NHS spending data. | NHS to face continued austerity measures into the 2020's. No real pay growth in NHS pay and with a pay freeze in place that does not even adjust for annual inflation, will mean a risk of losing staff and increasingly low morale. |
| **Hewison (2010)** | Implications for nursing managers arising from financial pressures in health care in England. | Productivity and Leadership theories | Literature Review | Nursing and Nurse managers. | In the midst of a financial storm, there is significant imperative for change. Nurses must ensure to work with the rest of the health care workforce to ensure patient care is not adversely affected. Challenge for managers at the local level is to inspire and motivate staff at a time where employment futures are challenged by uncertainty and organisational changes. |
| **Buchanan et al., (2013)** | To explore the incidence of extreme jobs among middle managers in acute hospitals and identify implications for HRM. | Extreme job dimensions (Hewlett and Luce, 2006); Talent retention and work design. | Managers (hybrid and non-hybrid) | Interviews; Focus groups. 12 item diagnostic pilot; Survey; Briefings. Analysed using descriptive statistics. | The incidence of engaging with work for middle managers in the NHS is one where 3 out of every 4 middle managers in hospitals have 'extreme jobs' characterised by varied, intense, faced paced roles with responsibility, long hours. The roles of middle managers through the course of the 1990's and up to now has seen more hybridisation and increased performance pressure and the blurring of work boundaries. |

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| **Taylor-Gooby and Stoker (2011)** | Discusses neoliberalism, austerity and health and social care act of 2012. The implications of coalition government for NHS and its workforce. | Neoliberalism theory and Austerity theory | Health, Social Care and Public Service Organisations; Government. | Review of literature and policy analysis. | Assesses impact of coalition policy from an employment perspective and suggests that the reduction and reorganisation in the NHS workforce and its subsequent fragmentation (due to a maturing market for private and voluntary health care provision) will have a detrimental impact of the quality of their working lives. Suggest that majority of NHS workforce will end up as the losers of the coalition programme for healthcare. |
| **Benach et al. (2014)** | Identifies the historical, economic and political factors that link precarious employment to health and quality of life. Argues that employment precariousness to be a social determinant that affects health. | Austerity theory; Flexible work theory | Review of literature and empirical studies examining epidemiological research on flexible and precarious employment | Systematic review | Argue the need to expand understanding of employment precariousness and to develop and evaluate policy programs that eliminate its health impacts. |
| **McDowell et al. (2009)** | To examine the impact of insecure work and impact of migrants employed in the UK labour market. | Employment theory; Division of Labour; Precarity theory | Interview based case studies with NHS workers | Review of empirical case studies in NHS | Precarious work fuelling divisions of labour and radicalisation on ethnic and social basis and will lead to long term negative consequences for social cohesion. . |
| **McDowell and Christophers on (2009)** | Review of literature on forms of employment and their regulation in relation to precarious employment | Precarity theory | Review of literature | Global studies | How can it be defined and what are the issues related to it regarding forms/types of employment. |

*(Table 3: Matrix of studies reviewed)*

## RESULTS AND DISCUSSION

In the review of the relevant 19 studies, 6 studies involved primary empirical data, 6 studies involved analysis of secondary data, while 7 studies engaged with a review of literature (i.e. past studies). Of the 19 studies reviewed, 9 studies were focused directly on managers in the NHS while 10 studies focused on organisational cases and policy evaluation in relation to healthcare services.

With the intention to explore how service managers in the NHS understand and view precarity in employment and how they experience precarious working during austerity and Brexit, this paper engages with a systematic review of studies dating back up until 1998. We focus on this period of 1998 and onwards since a year after the first elected New Labour government of 1997, this new Labour government inherited and embraced the conservative agenda for reform of public service delivery with its 'comprehensive spending review' (Conley, 2006). The first set of public service agreements were put in place during 1998 which can be viewed as the kick start of austerity: when cut back measures were put in place and the point at which a performance-efficiency-target driven culture was promulgated and instilled that began to have an impact on employability in the NHS. What followed in the few years was a re-elected Labour government's Modernisation Agenda, which introduced the principle and practice of 'flexibility' as part of this agenda alongside other principles including consumer choice, devolution to front line staff and national targets (Conley, 2006). This principle of flexibility, when translated into practice over time resulted in a move towards more flexible systems of pay and work arrangements that suited the employer. This coupled with the notion of consumer choice meant more accountability to users in localities for line managers and front line staff, while it also meant complying and striving more than before to deliver national driven targets.

The landscape for the working service manager ofcourse had changed. Such numerical flexibility at the hands of NHS employers (coupled with a rise in agency staff provision) undermined various aspects of public service delivery such as recruitment and selection, equal opportunities and work-life balance (Conley, 2006). McDowell and Christopherson (2009) suggest that since then, as the recession has worn on, questions regarding this flexibility and employment insecurity have become urgent because improved productivity squeezes more work out of lesser workers. McDowell et al. (2009) examine the impact of such insecure work and the impact of migrants employed on the UK labour market and the NHS. They find that precarious work is fuelling divisions of labour and radicalisation in the workplace on ethnic grounds and will lead to long term negative consequences for social cohesion. .

Entering a new decade with a coalition government in place and strong commitments to neoliberal values, the Coalition agenda for the NHS was introduced seeking a reduction in the role of the state in the provision of healthcare services. This has promoted devolution while also promoting private enterprise (for health service delivery) in the context of a competitive market, all much under the auspicious of the Health and Social Care Act of 2012 (Taylor-Gooby and Stoker, 2011). In terms of the impact on the NHS workforce, this has meant labour force reductions in the forms of restructuring and redundancies and a fragmentation of the workforce in terms of a maturing private and voluntary healthcare provision. Kolehmaine-Atkinson (2004) argues that decentralisation creates new responsibilities for health managers at the local level since they take on the agenda to

improve the way in which health services locally are designed and delivered. For instance, if health services in any particular locality are 'star rated' below par for a given NHS Trust in any given period, the Secretary of State for Health may remove the senior management from that Trust: which is something that is actually implemented (Greener, 2004). Hence, managers in the NHS are aware of vulnerabilities and are at risk of losing their jobs on performance output basis. Cotton (2016) in line with this argues that the NHS workforce generally avoids talking about Precarity since the working culture is generally one of fear. Vallas (2015) appreciates that accounting for precarity is a complex matter but nevertheless, growing attention can now be given to the matter since we have both evidence and theory to challenge the merits of employment flexibility that was not there previously. Even though austerity is articulated differently in different contexts, and while national and local agendas for service delivery may differ, the actual experience of austerity is a common one (having commonality) and is dominated by insecurity and change in the workplace (Cunningham et al. 2016). Hence the need to explore the views and experiences of managers can be supported here.

Challenges do remain. More accountability for health managers to stakeholders surfaces as a result of devolution where managers must learn to delegate and lead better, yet at the same time, national health legislation and directives continue to give direction and agendas to local health managers, particularly during austerity. We can assume that this will only accelerate in the period of Brexit negotiations over the coming years as the impact of it on public services is yet to be determined. Taylor-Gooby and Stoker (2011) suggest that this reduction and restructuring of the NHS workforce and its further fragmentation will have a detrimental impact on the quality of their working lives. And that the majority of NHS workforce will end up as the losers of coalition programmes for healthcare. But what does being among the losers mean in such a context? Postle (2002) through a study of health and social care managers (who underwent a period of change arising from the NHS and Community 1990 Care Act), suggests that events or periods of major change and uncertainty have an influence on managers working conditions and contribute to increasing ambiguity and stress levels that adversely affect the quality of service provision. And as their work becomes complex, processes for dealing with complexity become increasingly reductionist. In the midst of change Munro (2002) argues that tensions between individualism and collectivism arise lower down in organisation where line managers must actually implement change: which may discourage partnership amongst working groups and discourage forms of collective organising. For this very reason, it is key that middle managers be aware of their involvement and be able to interpret and understand it in the emergence of a particular context becoming significant. When more a need for such than during Brexit.

Sullivan et al. (2013) argue here that public service agencies like the NHS will require new discourse, insight and reconsideration of future collaborative options for health service delivery in austere times because so far, collaboration has been influenced by NPM and deployed in the quest for efficiency. Support for this argument is clearly available through a wide body of scholarly evidence that demonstrates how collaborative partnership arrangements have emerged in the pursuit of mere cost saving and resource efficiency (see Memon and Kinder, 2016b; Radnor and Osborne, 2013; O'Flynn, 2007; Stoker, 2006; Radnor and Walley, 2008). Granter and Hyde (2015) point out that the constant change in the NHS defined by cost cutting and increased efficiency has demonstrated diminished

returns. With the sudden yet patchy emergence of the Brexit context, what seems certain is that Brexit will deepen the financial crisis for the NHS by increasing the cost of hiring employees and impose new transaction costs to accommodate cross-border patient and public health needs (Costa-Font, 2017). Leaving the EU translates to restricted labour mobility and rising labour cost. An example of this would be the increased need for temporary agency staff where vacancies and already short-staffed hospital departments cannot be filled. Putting aside any Brexit nightmares to come, the NHS as it is long continues to suffer from staff shortages and an inability to retain permanent staff. Costa-Font (2017) points out that even where withdrawing from the EU lifts the restrictions of the European Working time Directive that will opportunistically enable British workers to work more hours, this will soon after lead to a deterioration in the quality of NHS employment and make working in the NHS much less attractive.

Envisioning such a state of affairs, service managers will end up having to deal with the brunt of complacency and negativity that arises from any deterioration of service quality. Buchanan et al. (2013) based on an extensive empirical study, argue that as it currently remains, the experience of engaging with work for middle level managers in the NHS is one where 3 out of every 4 middle managers in hospitals have extreme jobs that are characterised by varied, intense, faced paced roles and long hours. Buchannan et al., (2013) suggest that hospital middle managers who have jobs with extreme characteristics report high levels of fatigue and stress. Exhaustion from long hours and intense pressure can have implications for work-life balance while fatigue and burnout can increase the incidence of errors. As many hospital middle managers have “hybrid” clinical-managerial roles, extreme jobs may also put the quality and safety of patient care at risk. The roles of middle managers through the course of the 1990’s and up to now has seen more hybridisation, increased performance pressure and the blurring of work boundaries. Cunningham et al (2016) support this position suggesting that current UK cuts in public expenditure, along with a pay freeze have made managers experience significant shocks with regard to job security, work intensification and working time. This is fuelled by the broader trend for temporary employment, increasing under employment and recent growth of zero hour contracts.

Going forward, how can such ‘extreme jobs’ held by service managers in the NHS be sustained given the workforce shortages that Brexit will create? This is a difficult conundrum since the British market and state for the foreseeable future are entangled in contradictory projects of reduced public spending coupled with corporate profit making on the back of health and social care provision (Speed, 2016). In such circumstances, Bolton (2004) based on a longitudinal study of nurses and nurse managers, argues that they develop their own ways of reinterpreting what is demanded of them and develop their own ways to deal with management control. Bolton’s (2004) evidence would suggest that ‘management is more likely to continue relying on the traditional and inherited autonomy of health professionals (i.e. Nurses) in the delivery of healthcare, in recognition that they may resist some but accommodate many of the demands made of them’ (Bolton, 2004: 317). Cunningham et al (2016) on the basis of empirical data obtained from various levels of managers in healthcare assert that precarity represents an expansion of management power and a reduced arena for formal organised worker representation.

Costa-Font (2017) describes ‘Brexit as a critical moment’ because Brexit will imply a hectic time for the NHS where it must balance the quality-cost conundrum and deal with high costs of staffing if it intends to maintain traditional quality standards. This is all made worse given

that the NHS is to continue facing austerity measures into the 2020's where no real pay growth is envisioned and a public sector pay freeze is in place that does not even adjust for inflation: reinforcing the risk of losing staff and increased low morale. Marangozov et al (2016) assess key risks, for example, for the nursing workforce in England through NHS staff organisational cases and project two important future trends: a reduced supply of European Union nurses following Brexit and a surged population growth-related demand for health services. They argue that the uncertainty created by Brexit puts pressure on NHS workforce planners to consider various workforce supply and demand scenarios to address ever increasing demand, which reasserts Costa- Font's (2017) point that the NHS must deal with the quality-cost conundrum and high costs of staffing in the wake of Brexit. A valued suggestion by Granter and Hyde (2015) in this context, based on interviews and observations of NHS service managers, is that there should be deliberate attempts to bring a period of stability. At the same time, NHS Managers being important mediators between health policy and practice should be treated as partners in the innovation of health services (Memon and Kinder, 2017; Granter and Hyde, 2015). On the part of service managers, Hewison (2010) argues that managers must ensure to work with the rest of the health care workforce to ensure patient care is not adversely affected. Hewison (2010 suggests that at a time where employment futures are challenged by financial cuts, uncertainty and organisational changes, the challenge for managers at the local level will be to inspire and motivate staff.

## CONCLUSION

Broadly speaking, factors such as technological change, financial reorganization and greater competition in markets are causing greater precarity and insecurity in work. Precarious work in the modern day is increasingly translated into notions and experiences of working for multiple employers, uncertain forms of employment, reliance on personal savings for retirement and not belonging to unions: which may mean that managers are missing a collective voice and more likely therefore to be exposed to unsafe working conditions (Cappelli, 1999; International Labour Organization, 2012), and more likely to lack control over labour processes due to work intensification. Precarious work in an austerity and Brexit era is here to stay. In terms of potential implications for the work of managers, Brexit coupled with continued austerity, diminishing resource and a political will for devolution experiments, will only further aggravate employment precariousness for service managers in the NHS, while also encouraging finger pointing towards vulnerable groups of the NHS workforce.

The studies reviewed in this paper would suggest WHY we need to better understand precarity amongst NHS service managers in an extended period of austerity and in the wake of Brexit. But little or no prescription is available for HOW to do this. Purely because the answer to this is never a straight forward one. A useful suggestion or starting point for how to do this lies in the suggestion that as researchers, we must attempt to bring together 'knowledge' and 'knowing' in a more obvious and relational way that rests little on superficial models or frameworks of change, but more on techniques such as story-telling, narratives and sharing of examples: ways that can help improve managers' abilities to solve problems, develop logic and help make the tacit knowledge of managers more explicit for other

managers (and academics) to absorb and learn from (Greener, 2004: 332). More empirical studies need to be generated in this area and as Locke (2007) argues, any attempt to do this will be better suited through inductive research that is grounded in data while acknowledging that the process will be driven by intuitions and hunches. It is important here to also acknowledge that any theorisation of precarity will be done in specific ways and in particular contexts, rather than under a monolithic blanket of impacts and outcomes (Cunningham et al, 2016: 457). This limitation that is true to the nature of most social research done on people and organisations.

Reverting back to the question asked in this paper and reflecting on the review we have carried out, we can say that there are certainly no answers to provide, but rather better understanding of how service managers in the NHS view and understand precarity in employment and how they experience precarious working during austerity and Brexit is available. It is clearly evident from the studies reviewed that the majority of studies (12 out of 19) examining precarious work for managers in the context of the NHS are concentrated around matters of industrial relations, market employability, occupational health and political and policy change. There are limited studies (6 out of 19) that are concentrated on matters of organisational change and the impact on the work of managers. This would support Quinlan (2001) assertion that further research that can link business and organisational practices and precarious employment are needed. Hardly any studies can be identified that empirically examines the state of service managers in the NHS in the context of precarity arising from austerity and Brexit. Certainly, no comprehensive study has been identified which examines (from the standpoint of managers themselves) how service managers in the NHS understand and experience precarity in their work during austerity and Brexit. For this reason, our paper serves an important purpose of laying the foundation and is one step forward in such a line of enquiry. Pointing out Greener's (2004) argument of the need for techniques (such as story-telling) and the need to make the tacit knowledge of managers more explicit as a way of improving theoretical and practical understanding, we seek participation of NHS service managers as the next step of this ongoing and comprehensive study, which is interested in the viewpoints of managers about precarious working. Further research is needed to conceptualise and understand the association between precarious work (and precarious employment) and what service managers do in the midst of austerity and in the process of Brexit. There are implications here for how service managers deal with change and deliver healthcare in the future, which more widely enables us to better theorise precarity for managers in the NHS and UK public services in general: something which is presently missing.

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