A STUDY OF NURSES IN MANAGEMENT WITHIN THE NHS IN SCOTLAND 1994-1995

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by

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ABSTRACT

This descriptive study examines the role of nurses in management within the NHS in Scotland between 1994-1995. The general aim of the study was to provide information about the emerging role of nurses in management in the NHS after the Reforms in 1990.

Data collection tools were a postal questionnaire to all subjects (N=284) and later interviews with 27 participants. The Questionnaire was carried out between May-July 1994. Overall response rate was 64.4%. The interviews were conducted in February and March 1995. All nurses in management working in hospitals and the community, in Scotland, with the exception of those meeting exclusion criteria, were invited to participate in the study.

In this study the men were slightly younger than the females and the men were more likely to be married than the females. There were 44 different job titles used by the 158 respondents. Approximately one in four of subjects had a degree. In total 76 (48%) respondents had had a formal "management training" qualification but only 10% had degree level management education. Almost all the subjects stated that their job had changed greatly after the NHS 1990 reforms and their responsibilities had increased. In total 68 respondents perceived the role of nurses in management negatively. In terms of future career developments of the subjects 17% expected their next career step to be a more into general management role within the NHS.

The study provides lessons which will be of value in planning the selection and training of future nurse managers. In this study it was suggested that nurses in management should undertake proper management training that would meet their individual needs. In addition first line managers in particular should be supported and encouraged to take up roles in general management. It was suggested that individuals should take more responsibility for shaping their own careers and the NHS should provide support for their staff. It was also believed that this study provides a benchmark where there is little information.

EXECUTIVE SUMMARY

Introduction

The introduction of an internal market in health care in 1991 was the most radical change to the NHS since its inception. The consequent NHS changes and reforms have had a profound impact on nursing management and inevitably on nurses in management at a personal level. This thesis examines the role of nurses in management within the NHS in Scotland between 1994-1995.

Objectives

In order to identify the role of nurse managers / nurses in management this descriptive study aimed to examine:

i. the current management training(s) and/or management education of nurses in management,
ii. the main job responsibilities, and skills, knowledge and qualities necessary for nurses in management,
iii. perceptions of nurses in management regarding the 1990 NHS Reforms and their effects on their job,
iv. the view of nurses in management regarding their present and future role within the NHS in Scotland.

Method

This study was conducted in two stages, the first being a postal questionnaire followed by a volunteer sub-sample of semi-structured interviews with 27 respondents. Data were obtained using a questionnaire, composed of both open and closed questions, and the responses were then used to develop a semi-structured interview schedule. All nurses in management working in hospitals and the community, (provider organisations- DMUs and NHS Trusts) in Scotland, with the exception of those meeting specific exclusion criteria, were invited to participate in the study. The questionnaire survey was carried out by post between 16 May-22 July 1994. In total 284 questionnaires were mailed out. Overall response rate was 64.4% (N=183) with a usable response rate of 55.6% (N=158).

Findings

In this study the men were slightly younger than the females and the men were more likely to be married than the females. The females tended to be better qualified academically than the men, whereas the reverse was true for managerial

qualifications. The job titles of the respondents varied enormously according to the institutions and/or the job of the subjects. In total there were 44 different job titles used by the 158 nurses in management. Overall approximately one in four of subjects had a degree, but a much higher proportion of the Senior Managers possessed a degree ($p<0.01$). Nearly half of the respondents had had a formal management training. The majority of the respondents thought that on the job training alongside a degree level education in management was needed in order to carry out their job satisfactorily. In total 10.1% (n=16) had a degree level management education.

Human resource management, Quality assurance and budget responsibilities were the most frequently reported main job responsibilities of the respondents. 96.2% (N=152) of the subjects stated that their job had changed greatly after the NHS 1990 reforms and their responsibilities had increased and widened to other areas. Almost half of the respondents perceived the role of nurses in management negatively saying that the role was diminishing and threatened. In terms of future career developments of the subjects 18.1% wanted to expand their current role, 16.7% expected their next career step to be a more into general management role within the NHS and of these 24 only 4 (2.7%) subjects wanted to become a Chief Executive.

Conclusion

This study was devised in 1992 and the questionnaire survey and the interviews were completed in March 1995, well before election of the Labour government. Since then many changes have been taken place in the roles of nurses in management but nevertheless the opportunity to examine the careers of a defined set of managers before these changes took place proved to be a useful one. The study provides lessons which will be of value in planning the selection and training of future nurse managers and/or nurses in management.

In this study it was suggested that nurses in management should undertake proper management training that would meet their individual needs. In addition first line managers in particular should be supported and encouraged to take up roles in general management. It was also suggested that individuals should take more responsibility for shaping their own careers and the NHS, as an organisation, should provide support, encouragement and counselling about career guidance for their staff.

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Finally I am grateful to my husband, Dr. Ulvi Ulusoy, for his support and encouragement throughout.

DECLARATION

The work presented in this thesis was carried out by myself, except where the assistance of others is acknowledged. No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute.

Mrs. Hatice Ulusoy
January 2000

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LIST OF ABBREVIATIONS

In this thesis the following abbreviations are used:

BMA	British Medical Association
CNA	Chief Area Nursing Adviser
CANO	Chief Area Nursing Officer
CHCs	Community Health Councils
CN	Charge Nurse
CNO	Chief Nursing Officer
DHAs	District Health Authorities
DHSS	Department of Health and Social Security
DMU	Directly Managed Unit
DNSs	Directors of Nursing Services
DN&Qs	Directors of Nursing & Quality
DoH	Department of Health
EMS	Emergency Medical Service
ECs	Executive Councils
FHSAs	Family Health Service Authorities
FLMs	First Line Managers
FPCH	Family Practitioner Committee
GPs	General Practitioners
HMCs	Hospital Management Committees
LHAs	Local Health Authorities
MMs	Middle Managers
MDG	Management Development Group
NBS	National Board for Nursing, Midwifery and Health Visiting for Scotland
NED	Nurse Executive Director
NHS	National Health Service
NHSME	National Health Service Management Executive
NO	Nursing Officer
NS	Not Significant
RCN	Royal College of Nursing
RGN	Registered General Nurse
RHAs	Regional Health Authorities
RHBs	Regional Hospital Boards
RMI	Resource Management Initiative
SHHD	Scottish Home and Health Department
SKQ	Skills, Knowledge, Qualities
SMs	Senior Managers
SNM	Senior Nurse Manager
UGMs	Unit General Managers

CHAPTER I

INTRODUCTION

1.1 Introduction to the study

One of the important issues that paved the way to studying 'nursing management' in Glasgow was my position in Turkey. I was going to be a lecturer in a nursing faculty and was expected to teach nursing management to the BN students at a university. In May 1992, when I started to do my PhD, the subject that I wanted to study was 'job analysis in nursing'. As an 'outsider' in addition to my first interest (job analysis) I was also interested in the nature of the NHS and the position of nurses within the health services as a whole.

I spent approximately six months in finding, reading and evaluating the relevant literature on job analysis. During this time I was also discussing the subject with senior nurses and other relevant people including a senior lecturer in Edinburgh, a senior nurse in Greater Glasgow Health Board (GGHB), a Director of Nursing & Quality (DN&Q) in Glasgow and a senior health services researcher from York University. When I was dealing with the literature search and trying to establish a basis for my research I realised that in terms of health care systems, there were enormous differences between Turkey and Britain. At that stage I became aware of simple or 'ordinary' details about the NHS such as more than half of all NHS staff were nurses, with nearly a quarter of all health services expenditure directed at nursing. In addition, unlike Turkey, there were diversities in the responsibilities and job descriptions of all nursing staff within and between each individual hospital or organisation within the NHS. These details were very surprising for me and I began to develop an interest in learning about the position of nurses in the UK.

Ultimately this study directly emerged from that interest and was shaped by an extensive literature search on the subject of the job or role of nurse managers and by long discussions with my supervisors and other 'experts' who were working as either researchers in different organisations or working within the NHS as clinicians.

1.2 Aims of the study

In order to identify the emerging role of nurse managers / nurses in management this descriptive study aimed to answer the following five research questions:

1) What are the demographic and educational features of nurses in management?
2) What is the current management training(s) and/or management education and how has this training contributed to the job of nurses in management?
3) What are the main job responsibilities, and skills, knowledge and qualities necessary for nurses in management?
4) How do nurses in management perceive the 1990 NHS Reforms and their effects on their job?
5) What is the view of nurses in management regarding their present and future role within the NHS in Scotland?

CHAPTER II

LITERATURE REVIEW

2.0 THE DEVELOPMENT OF THE NATIONAL HEALTH SERVICE AND HEALTH POLICY

2.1 INTRODUCTION

The National Health Service came into existence on 5 July 1948 with the aim of providing a comprehensive range of health services to the whole of the population. It was the first comprehensive system to be based not on the insurance principle but on the national provision of services available to everyone. Aneurin Bevan as Minister of Health of Labour Government at that time, was the architect of the NHS.

The purpose of this section is to provide a brief history and development of the NHS in the United Kingdom. It starts with a brief overview about the health services before 1948. The establishment and the structure of the NHS will then be summarised. The reorganisations of the NHS in 1974 and in 1982 and the problems which followed the reorganisations will be discussed.

In this section a number of NHS Reforms and their effects on nursing and nursing management will also be discussed. This section also includes a detailed overview about the position of nursing management after Griffiths and after the NHS (1990) Reforms. It also includes a brief evaluation of the NHS (1990) Reforms. In this section the importance of management training of nurse managers will also be discussed. This section traces the development of the NHS up to 1995.

2.1.1 HEALTH SERVICES BEFORE 1948

Public Health Services

The most important area of state involvement in the provision of health services during the nineteenth century was the enactment of public health legislation. Infectious diseases like cholera and typhoid posed the main threat to health at that time (Ham 1992). The first 1848 Public Health Act acknowledged some state responsibility for the health of the nation through its creation of a central organising body called the General Board of Health (Levitt & Wall 1992). The aim of the act was to provide powers to enable the construction of an adequate water supply, and drainage and sewerage systems as a means of controlling some of

the conditions in which infectious diseases were able to thrive and spread. The Act was only able to achieve a very few reforms because it was opposed by commercial interests who were able to make money out of insanitary conditions (Ham 1992). Other improvements in the field of public health were also owing to Chadwick (and his supporters) who was the secretary to the Poor Law Commission (Leathard 1990).

The Report of the Royal Sanitary Commission 1869 - 1871, led to the establishment of the Local Government Board in 1871 and the Public Health Acts of 1872 and 1875. The importance of the Act in 1872 was that it created sanitary authorities who were obliged to provide public health services (Ham 1992).

Hospital Services

Levitt and Wall (1992) say that by the 1870s the workhouses, isolation hospitals and asylums together with the voluntary hospitals could be described as the public services through which people had access to hospital care when they became ill. Conditions were often appalling by modern standards, and medicine had few effective tools for decreasing disease. Most medical activity concerned care rather than treatment. According to Levitt & Wall (1992), the stimulus to change these inadequate services only came after the experience of war. The Crimean War (1854-56) showed how inadequate the organisation and supply of health care was. The independent voluntary hospitals were built and financed through charitable donations and treated patients often without payment. In contrast the workhouses which had developed in the eighteenth century had to cope with the problems of poverty and destitution.

The voluntary hospitals provided the higher standard of care (Ham 1992). Later on they became increasingly selective in their admissions of patients, leaving all chronic sick and people with infectious diseases except acute cases, to be dealt with by the workhouses. Consequently it was left to the workhouses to care for the groups that voluntary hospitals would not accept, with the result that workhouse conditions were often overcrowded and unhygienic (Levitt & Wall 1992). The number and quality of voluntary hospitals varied widely over the country. Provision of services in any particular area depended mainly on the donations and the legacies of the dead rather than on any ascertained need for hospital services (Abel-Smith 1978).

The 1929 Local Government Act transferred to local authorities all the responsibilities of workhouses and infirmaries and allowed them to provide a full range of hospital treatment. However, there was no compulsion. Thus great variations in standards existed in the provision of hospital services (Levitt & Wall 1992).

With the outbreak of the Second World War the government established the Emergency Medical Service (EMS). As part of the war effort, public hospitals joined the voluntary hospitals in the EMS, an organisation set up to cope originally with air raid casualties but later for a wider category of people whose need for hospital care could be attributed to special war circumstances (Abel-Smith 1978). The EMS, with its regional form of organisation, provided a framework for the administration of hospital services after the war.

During the war the Nuffield Provincial Hospitals Trust and Ministry of Health carried out a series of regional hospitals surveys. The summary report of the surveys, published in 1946, indicated that there were considerable inequalities in the allocation of beds and staff between different parts of the country, as well as the lack of organisation in the service as a whole (Ham 1992).

Mothers and Young Children

The 1902 Midwives' Act made it necessary to certify midwives as fit to practise and established a Central Midwives Board to oversee registration. As Abel-Smith (1960) cited from the Midwives' Registration, Select Committee Report 1893-94, the reason behind the Act was that:

> *"A large number of maternal and particularly infant deaths as well as a serious amount of suffering and permanent injury to women and children is caused from the inefficiency and lack of skill of many of the women practising as midwives, without proper training and qualification" (Abel-Smith 1960, p:77).*

In 1938 the death rate of infants (under one year) per 1,000 live births was 53 in England and Wales, 70 in Scotland and 75 in Northern Ireland (Watkin 1978). Meanwhile, due to the 1918 Maternity and Child Welfare Act, local authorities came to provide a further range of child welfare services. These included antenatal clinics, infant welfare centres, maternity homes for mothers. In 1936 the Midwives' Act paved the way for a development of a salaried midwifery service

(Leathard 1990). 1919 Nursing Registration Act solved the matter of statutory registration of nurses trained to an approved standard. The Nurses Act (1949) incorporated male nurses into the main register but not until the Sex Discrimination Act (1975) were men allowed to train as midwifes.

Mental Health Services

In the 1800s, according to Leathard (1990), the mentally ill who needed care tended to be put into workhouses or in prison, if they could not pay for care in a private madhouse (Leathard 1990). Lunatic asylums were improved following a facilitating Act of 1807. A systematic national policy arose from the Lunatics' Act, (1843), and was consolidated in the Lunacy Act, 1890. The asylums, later seen as institutions to keep the general population from the harm it was assumed mentally ill people might do, were created originally to offer protection to mentally ill people themselves (Levitt & Wall 1992).

The Mental Deficiency Act, passed in 1913, led to the establishment of institutions for people with mental handicap (from 1991 defined as people with learning disabilities). These institutions were often very large - over 2,000 beds in some cases - usually self-contained communities away from centres of population (Levitt & Wall 1992). In the Act mental deficiency was defined as a social condition in terms of idiots, imbeciles and moral defectives (Leathard 1990). By 1948 mental illness hospitals were badly overcrowded, providing a standard of living little better than prisons. According to Levitt & Wall (1992) overall, the expansion of mental health services and the quality of domiciliary care available were variable and unevenly allocated.

National Health Insurance

The 1911 National Insurance Act had provided insurance coverage for general medical (general practitioner) services to be available to manual workers and other employees earning less than £160 a year. However, the scheme excluded children, wives who did not go out to work, the self-employed, higher paid employees and many old people (Watkin 1978).

Meanwhile, through the British Medical Association (BMA), doctors put pressure on the Prime Minister, Lloyd George, to protect their interests. They were anxious about state control of their work, and of the possible financial effects on

themselves. However later on the government agreed that payment should be based on the number of patients on a doctor's list, the capitation system, rather than on a salary. It was decided also that the scheme should be administered by independent insurance committees. In addition doctors were allowed to choose whether to join the scheme, and whether to accept patients. Consequently the professional freedom of doctors was safeguarded and the doctors were successful in changing the administrative control of their work to the new insurance committees, on which they were represented (Ham 1992).

The 1911 National Insurance Act was an important part of the Liberal Government's programme of social policy reform. At the beginning national health insurance covered about one third of the population and by the mid 1940s approximately half of the population of the UK was insured under the Act (Leathard 1990).

2.1.2 THE ESTABLISHMENT OF THE NHS

In the nineteenth century and beginning of the twentieth century, the key legislative developments for the provision of health care were the 1808 County Asylums Act, the 1867 Metropolitan Poor Act and the 1929 Local Government Act, all emphasising the importance of public provision of hospital services (Ham 1992). The Report of the Dawson Committee, published in 1920, noted that

> *"Preventive and curative health services should be integrated and based on a network of primary and secondary health centres. The secondary health centres would be based on existing general hospitals" (Watkin 1978, p:12).*

Later reports from the Royal Commission on National Health Insurance in 1926, the Sankey Commission on Voluntary Hospitals in 1937, and the BMA in 1930 and 1938, all stressed defects in the existing system of services, and made various suggestions for change (Ham 1992). The Royal Commission on National Health Insurance recommended that the 1911 scheme should be extended to other groups in the population. The Report also proposed that health service funding might eventually be derived from general taxation rather than based on the insurance principle (Watkin 1978).

However, the BMA did not agree to this view, and in 1942, the Report of the Medical Planning Commission was published. This report proposed extensions of

the National Health Insurance scheme which would have covered 90 percent of the population, leaving the remaining 10 percent to be provided for by the private sector (Watkin 1978). After the establishment of the NHS, Aneurin Bevan, the Health Minister of the Labour Government, was to persuade the BMA that the service should cover all of the population. In addition, the Service was to be funded mainly out of general taxation, with insurance contributions making up only a small part of the total finance (Ham 1992).

In December 1942, the Beveridge Report on Social Insurance and Allied Services was published. It proposed extensive reforms of the social security system and the extension of National Insurance. It also emphasised the necessity for a national and comprehensive system of health care for improving living standards (Leathard 1990). The Report suggested that all health services should be made available to every citizen on the basis of need. Small charges might be made but they should not be such as to stand as a barrier between the citizen and the service they required (Watkin 1978).

Following publication of the Beveridge Report, the coalition government announced in 1943 that it accepted the need for a comprehensive scheme of health care and announced acceptance of the principle of a national health service. The Minister of Health, Ernest Brown, put forward proposals for a service that would be administered by the local authorities and in which general practitioners would be salaried. These proposals were not well received by the doctors and were abandoned at the end of 1943 (Watkin 1978).

After further discussions the White Paper on the National Health Service was published in February 1944. It was a consultative document which outlined the government's thoughts on a national health service, available to all population. It described a system of administration with central responsibility vested in the Ministry of Health, and which was to be advised by an appointed Central Health Services Council. General Practitioners (GPs) would be under contract to a central medical board with local committees and would be paid, as in the National Health Insurance System, unless they worked from a health centre provided by the local authority - in which case they would receive a salary (Levitt & Wall 1992).

In March 1946 the National Health Service Bill was published by A. Bevan, and its main point was the proposed nationalisation of all hospitals under appointed Regional Hospital Boards (RHBs), with local responsibility delegated to Hospital

Management Committees (HMCs) (Levitt & Wall 1992). Meanwhile, the Bill was strongly opposed by the BMA, as in 1911. The BMA resumed discussions early in 1947 and was successful in winning many concessions: the retention of the independent contractor system for GPs; the option of private practice and access to pay beds in NHS hospitals for hospital consultants; carrying with it large increases in salary for those receiving merit awards; a major role in the administration of the Service at all levels; and success in resisting local government control (Ham 1992).

2.1.3 THE STRUCTURE OF THE NHS

The National Health Service Act was passed by Parliament and received the Royal Assent in November 1946. It set an 'Appointed Day' of 5 July 1948 when its provisions would come into effect. However as Watkin (1978) stated the Act did not immediately create new or different health care. He argued that:

> *"In 1948 the most important changes were in the methods of financing health care... the NHS Act of 1946 created no new hospitals, trained no new doctors...it did not even make available to the poor what had previously only been available to the rich" (Watkin 1978, p:1).*

Although patients did not receive broadly changed services at the point of delivery just before and just after the NHS, the establishment of the NHS represented a radical change in the relationship between the individual citizen and the state, and it established a firm government commitment to developing and improving the country's system of health care (Levitt & Wall 1992). It also involved major changes in relationships- particularly for the medical profession (Abel-Smith 1978).

As set up in 1948, The National Health Service consisted of three different parts (tripartite structure). First, hospitals were administered by completely new bodies: The fourteen Regional Boards (RHBs), subsequently fifteen; Hospital Management Committees (HMCs); and Boards of Governors. Each RHB was focused on a university with a medical school. Teaching hospitals were to be separately administered by Boards of Governors with direct financing from the Ministry (Allsop, 1984). HMCs, numbering some 400 in total, were appointed to run the non-teaching hospitals on a day-to-day basis. The biggest change made on 5 July 1948 was in the administration of the hospitals. The vast majority of the

voluntary hospitals including all the teaching hospitals and all the local authority hospitals were transferred into national ownership (Abel-Smith 1978).

The second part of the tripartite structure was the family practitioner services which were separately administered: the general practitioners, the pharmaceutical service, the general dental service, and the ophthalmic services outside hospitals. They were administered by executive councils and were funded directly by the Ministry of Health (Abel-Smith 1978).

Third, there was the services provided by the local authorities. They provided domiciliary, environmental and preventive health services under the authority of the Medical Officer of Health (MOH) in each area (Allsop 1984). These services included maternity and child welfare, midwives, health visiting, home nursing, domestic help, vaccination and immunisation, prevention of illness, care and after care, ambulances, local mental health services and health centres. Funding of the services was provided partly by central government grants and partly by local rates (Ham 1992). The structure of the NHS between 1948-74 is illustrated in Figure-2.1.1 below.

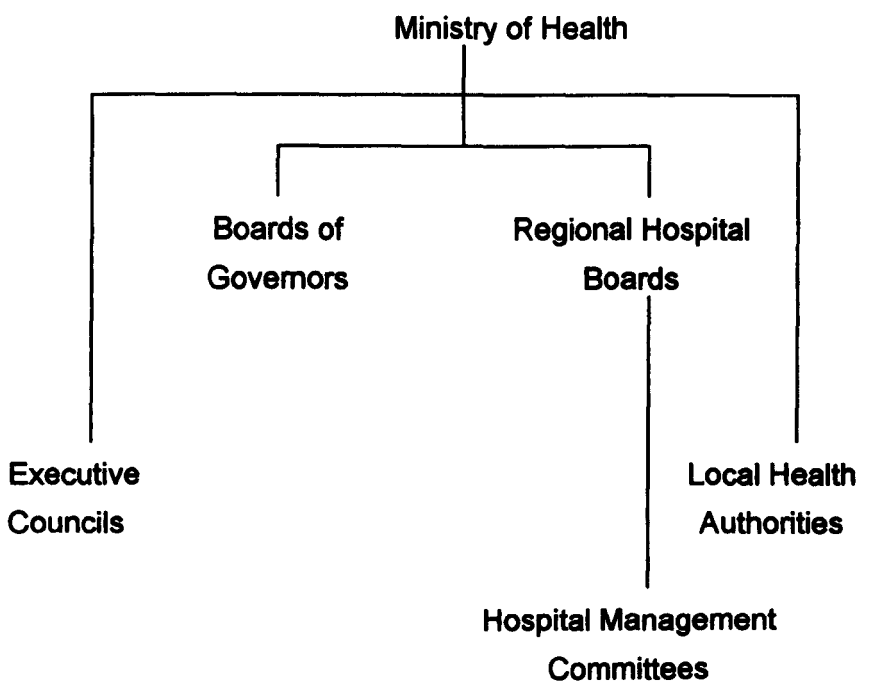


Figure-2.1.1: The structure of the NHS between 1948-74.

Source: Ham, C. (1992) Health Policy in Britain, 3rd Ed., MacMillan, London

2.1.4 THE NHS BETWEEN 1948 AND 1974

According to Allsop (1984) the first years of the NHS were concerned with making the new service work. The immediate concerns of the new service were seen as financial rather than organisational. An unexpected problem was that the demand for NHS care rose very rapidly and resources were often insufficient to be able to meet it. Allsop (1984) reports that

> *"Beveridge's assumption that there was a fixed quantity of illness which would gradually reduce, leading to a levelling out of costs, was a fallacy" (Allsop 1984, p:36).*

Health service spending in the years immediately after 1948 was much greater than had been allowed for in parliamentary estimates and supplementary funding was necessary (Ham 1992).

At the end of 1947 the annual net cost was estimated at £179 million but the actual cost for the first nine months was at an annual net rate of £242 million. For the second year (1949 -50) the net cost, estimated at the end of 1948 at £228 million, turned out to be £305 million. These considerable underestimates of cost became a matter of heated political controversy (Abel-Smith 1978 p:12).

In 1953 the Guillebaud Committee had been set up 'to review the present and prospective cost of the NHS'. Their report was published three years later. The report concluded that 'both from an economic and a structural point of view the Service was on sound lines and it would be early to consider any fundamental change' (Cannon 1989, p:15). The Committee showed that, expressed as a proportion of the gross national product, the cost of the Service had actually fallen from 3.75% in 1949-50 to 3.25% in 1953-54 (Ham 1992, p:18). Abel-Smith said:

> *"The current net cost in real terms (in 1948-49 prices) was only £11 million greater in 1953-54 than in 1949-50 and changes in the size and age structure of the population meant that the real cost per head was almost exactly the same. What was certainly not foreseen was the extent of the demand" (Abel-Smith 1978, p:13).*

The Committee proposed that more money should be allocated to the NHS, particularly to make up for the lack of capital building which needed to be undertaken. They concluded that it would be early to suggest any structural

change on the NHS but stressed the need for greater co-operation between the three parts (Abel-Smith 1978).

In 1962 Enoch Powell, the Minister of Health, produced a Hospital Plan for England and Wales. It was the first attempt since the creation of the NHS to take a comprehensive view of the hospital service (Klein 1989). The Plan proposed capital expenditure of £500 million in England and Wales over ten years up to 1971. It launched a much-needed programme of redevelopment, and was based on the concept of the District General Hospital (DGH). The intention, as set out in the Plan, was to provide DGHs of 600 to 800 beds, and 3.3 acute beds per 1,000 population (Klein 1989).

According to Ham, the 1950s were not, however, wasted years in the hospital service. There were some important developments such as better use of resources. Also, there was an increase in the number of medical staff employed, and the hospital outpatient service was further developed (Ham 1992).

Nevertheless, the establishment of the NHS did not help the eradication of uneven allocation of services across the UK; many inequalities between regions were maintained. According to Levitt & Wall (1992) there was lack of co-ordination between hospital and community staff, with the result that services for the acutely ill tended to improve more rapidly while the needs of the chronically ill, disabled mentally ill and the elderly people were comparatively neglected. Therefore these groups received poor quality of care.

Another problem, related to these two problems, (lack of co-ordination and poor quality of care to certain patient groups) concerned the system of administrative control in the NHS. The neglect of long stay services, and the need for authorities to work in collaboration had already been recognised by Ministers of Health but the difficulty was in achieving and implementing these policy intentions at local level (Ham 1992).

The problem of securing co-ordination between the three different parts of the NHS (Regional Health Boards, Hospital Management Committees, Boards of Governors; Executive Councils; and Local Health Authorities) gained increasing importance in the 1960s (Ham 1992). The Porritt Report, published in 1962, suggested that a change in the tripartite structure of the NHS would be a significant part of the solution (Office of Health Economics 1977). This report

proposed a form of unified administration of the three branches of the service under Area Health Boards. Although not worked out in detail, this report made it clear that the unification of the Service would be accepted (Allsop 1984). However, according to Watkin (1978), the Gillie Report, published in 1963, rejected unification of administration in favour of much greater efforts in developing the role of general practitioners. It suggested that the health services could be co-ordinated through family doctors on behalf of their patient, in relation to individual family and working conditions (Watkin 1978).

During this period, a number of reports were published in relation to the NHS. For example the Cranbrook Report on the Maternity Services in 1959 was highly critical of the division of responsibility between the local authority and hospital maternity services. It also highlighted the need for co-ordination between the three branches of the services (Allsop 1984). The Mental Health Act (1959), radically changed the legislation on mental illness, reducing the grounds for compulsory admission and detention in mental hospitals. The Act followed the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which recommended the development of care in the community for the mentally ill as a more humane and cheaper alternative to care in a mental hospital (Levitt & Wall 1992).

In 1966, the Salmon Report published detailed recommendations for improving the senior nursing staff structure and the status of the profession in hospital management. The Committee recommended a division between managers and practitioners through the abolition of nurse matrons and their replacement by a hierarchy of nurse managers. This Report is discussed in detail in section 2.4.3.

The first Cogwheel Report (1967), (as cited in Allsop 1984) was concerned with the organisation of hospital doctors and encouraged a more efficient use of hospital resources. The Report indicated that many clinicians failed to appreciate fully the importance of their role in management problems. There were two further Cogwheel Reports which indicated that consultants were reluctant to become managers of resources (Allsop 1984).

At the time, it was not only in the health field that reform was being discussed. The Seebohm Committee on the Local Authority and Allied Personal Social Services (1968), recommended that all personal and social services should be unified in

new local authority departments, each with its own committee of elected members (Cannon 1989, p:19).

2.1.5 THE REORGANISATION OF THE NHS WITHIN THE UK (1974)

As pointed out earlier, the NHS had been established in three separate parts. As the NHS developed, the need for greater co-ordination of the health services was increasingly recognised (Abel-Smith 1978). Criticism was levelled at the tripartite structure. It was believed that the necessary continuity of care for individual patients was difficult to perform with staff working in three different systems. The call for a more unified service was behind the major reorganisation which eventually took place in 1974 (NAHAT NHS Handbook 1991).
In July 1968 the first Green Paper was published by the Minister of Health, Kenneth Robinson. It envisaged the replacement of the existing structure by forty to fifty Area Health Boards. These would replace the Regional Hospital Boards, Board of Governors, and Hospital Management Committees and Executive Councils and would take over certain functions previously held by the Local Health Authorities (Levitt & Wall 1992).

The Second Green Paper, entitled 'The Future Structure of the NHS', was published by the Labour Government in February 1970. Under this plan there were to be some 90 new health authorities and there were to be Regional Health Councils who would be responsible for hospital and specialist planning, including medical manpower (Cannon 1989).

In June 1970 with the general election Conservatives came into power. The new government's Secretary of State for Health and Social Services was Keith Joseph. Within a short time he announced that the proposals in the second green paper would not establish an efficient structure for a unified Service and in May 1971 he issued a Consultative Document (Cannon 1989). This strengthened the role of the regional tier of administration and provided a separate channel for local participation in the form of Community Health Councils (CHCs) (Ham 1992).

The White Paper on Reorganisation was published in August 1972. It recommended that Regional and Area health authorities should be set up in a classical chain-of-command structure. Members of these authorities were to include at least two doctors, and for the first time, one nurse, although he or she

could not serve on his or her employing authority (Cannon 1989). According to Dimmock (1985) the Consultative Document and the White Paper in 1972 both emphasised the importance of improving management efficiency in the NHS. These proposals were enshrined in the 1973 National Health Service Act and the new reformed local authorities came into operation on 1 April 1974 (Ham 1992).

The White Paper was followed by publication of the Management Arrangements for the Reorganised National Health Service known as the 'Grey Book'. The Grey Book established the function of each of the tiers in the new organisation, describing the Regional and Area Health Authorities, the District Management Teams, and outlining job descriptions for some of the new posts at all levels (Levitt & Wall 1992). Figure-2.1.2, below, illustrates the organisations of the NHS in England and Wales between 1974-82.

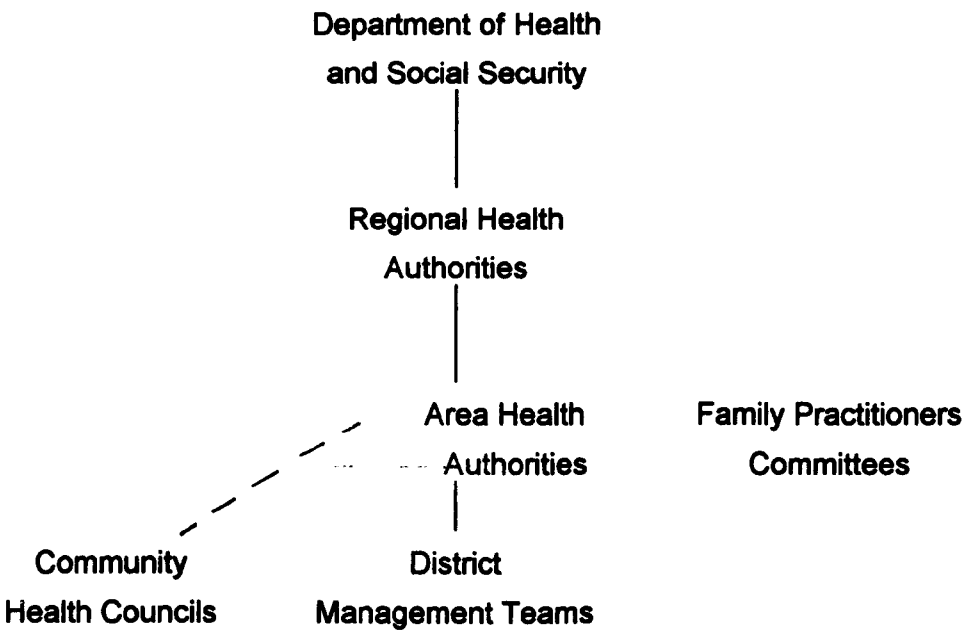


Figure-2.1.2: The organisation of the NHS in England & Wales between 1974-82.

Source: Ham, C. (1992) Health Policy in Britain, 3rd Ed., MacMillan, London

The NHS reorganisation in 1974 had five major objectives:

1. to move away from the tripartite structure towards a more integrated, unified, service which would provide greater continuity of care and more effective services (Allsop 1984);

2. to lead to better co-ordination between health authorities and related local government services (Ham 1992);
3. to introduce better management through multi-disciplinary management teams in which medical, nursing, financial and administrative staff functioned as a team for provision of health care (Leathard 1990);
4. to introduce a more democratic structure of decision making; and
5. to introduce a planning system to ensure the forward planning of service provision to achieve DHHS goals and priorities at a local level (Allsop 1984, p:64).

Nursing's position was confirmed through full-status membership of the management teams at District, Area, and Region following the 1974 reorganisation. Dimmock claimed that:

> *"For nursing 1974 represented the end of 'the long march' for parity of esteem and equality in management decision-making in hospitals. The loss of status experienced since 1948 had been finally retrieved" (Dimmock 1985).*

But many nurses subsequently lost their position when general management was introduced (Klein 1989).

2.1.5.1 THE REORGANISED NHS

The tripartite NHS components were incorporated in the unified structure, with only parts of the environmental health services remaining under local authority control (Office of Health Economics, 1977). The structure of Regional Health Authorities (RHAs) after reorganisation remained in very much the same form as previously. There were still fourteen RHAs in England, although their powers and responsibilities changed. They were to be responsible for the strategic planning of community health services and related functions. Joint Consultative Committees were established to ensure collaboration between the health and social services (Office of Health Economics 1977; Allsop 1984).

In England the ninety Area Health Authorities (AHAs) were new. They had statutory responsibility for the running of the comprehensive health service, including hospitals, community and domiciliary care, the preventive and developmental health services at a local level. Scotland was divided into fifteen

NHS Area Health Boards, Wales into eight AHAs and Northern Ireland into four Health and Social Service Boards. However, unlike the organisation in England and Wales the area level officers in Scotland and Northern Ireland had more direct authority over those at District level and in Scotland the Area Health Boards played a major role in defining and organising the Districts (Office of Health Economics 1977).

CHCs were located at district level. There were around 200 CHCs in England. In Scotland there was no regional tier of administration. Instead, the Scottish Office dealt directly with fifteen Health Boards, a majority of which were divided into districts. There was no separate system of administration for family practitioner services, and the Scottish equivalent of CHCs were called Local Health Councils (Office of Health Economics 1977). The organisation of the NHS in Scotland 1974-1982 is shown Figure-2.1.3 below.

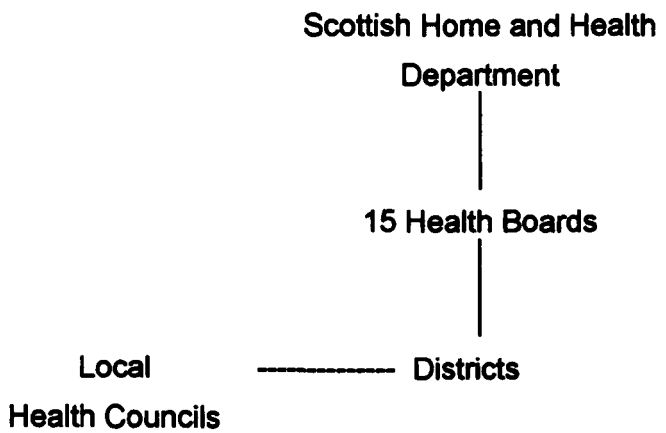


Figure-2.1.3: The organisation of the NHS in Scotland 1974-1982

Source: Levitt, R. & Wall, A. (1992) The Reorganised NHS, 4th Ed. Chapman & Hall, UK.

2.1.5.2 PROBLEMS FOLLOWING THE 1974 REORGANISATION

The reorganisation of the NHS was itself associated with the economic crisis brought about by the rise in oil prices in 1974-75. Thus the first years following the creation of the new structure were characterised not only by the internal stresses

and strains to be expected from such major changes but also by the continuing difficulties and uncertainties resulting from Britain's weak economic position (Office of Health Economics 1977).

The oil crisis precipitated a recession in Western economies, and this in due course forced a revision in the prevailing assumptions about health care spending throughout the world. As the decade progressed medical science and technology continued to advance year by year and this led to increasing demands on health care (Maxwell 1988) There were also demographic changes such as the increasing number of the elderly who made the heaviest demands on health care resources. In addition the number of NHS staff increased in response to rising needs and demands (Leathard 1990).

However, the reorganisation took nearly two years to be implemented (Levitt & Wall 1992). During this period most criticism centered on slow decision-making, the difficulty of establishing good relationships between administrative tiers, and the widespread feeling that there were too many tiers and too many administrators (Ham 1992). As Watkin (1978) noted, there were delays in fixing the salaries attached to the top posts with the new authorities and there was discontent when it was discovered that equal status as members of management teams did not mean equal pay. Administrators and treasurers were paid less than the doctors, and the nurses were paid least of all (Watkin 1978). Also the government's decision to phase out private beds from NHS hospitals was being heatedly debated in the NHS (Royal Commission on the NHS 1979; para 1.4).

Allsop argued that:

> *"The 1974 reorganisation of the NHS had been an ambitious attempt to increase the efficiency of the NHS by increased planning and central control while at the same time introducing more 'democracy'... the effect of the reorganisation on those working in the NHS was traumatic and the years following were associated with industrial disputes, general disorganisation and loss of financial control" (Allsop 1984, p: 125).*

Klein saw the 1974 reorganisation as a;

> *"political exercise in trying to satisfy everyone and to reconcile conflicting policy aims: to promote managerial efficiency but also to satisfy the professions, to create*

> *an effective hierarchy for transmitting national policy but also to give scope to the managers at the periphery" (Klein 1989, p:99).*

2.1.5.3 THE ROYAL COMMISSION ON THE NHS

Arising from a general sense that the new reorganisation was not proving as successful as planned (Levitt & Wall 1992), Barbara Castle, the new Secretary of State for Health and Social Services, in May 1976, asked A. Merrison to chair a Royal Commission on the NHS. The Commission was appointed with the following terms of reference:

> *"To consider in the interests both of the patients and of those who working the National Health Service the best use and management of the financial and manpower resources of the National Health Service" (Royal Commission on the NHS, 1979).*

The Commission received a massive amount of evidence and endorsed the view that there were too many tiers and too many administrators of all disciplines (Royal Commission on the NHS 1979). The government admitted in 1977 that 16,700 extra staff, particularly administrative and clerical, had been recruited because of reorganisation (Levitt & Wall 1992) and that had lead to slow decision taking and the wasting of money. The Commission recommended that there should be only one level of authority beneath the region and also abolition of the area tier and the integration of Family Practitioner Committees into the main management structure to strengthen primary care. This, in particular, would bring greater collaboration between the GPs and other community health services (Ham 1992).

The Commission concluded that 'detailed ministerial accountability for the NHS is largely a constitutional fiction'. The Report described the gap that existed between the formal, detailed accountability enshrined in the constitutional conventions governing the NHS and the realities of managing what in practice amounted to an extremely complex and diverse set of activities (Hunter 1992).

2.1.6 PATIENTS FIRST AND THE 1982 REORGANISATION

In December 1979 the government published 'Patients First', a consultative paper which was their response to the Royal Commission. In the paper the Conservative government announced its agreement with the proposal that one tier of administration should be removed and large areas, especially those containing more than one district, should be broken into smaller District Health Authorities (DHAs), typically serving a population between 200,000 and 500,000 (Allsop, 1984).

The Paper recommended that the District should become the key accountable body in the new structure, responsible for providing and planning health services. It also stated that Family Practitioner Committees should retain their existing status. Districts were to be responsible to RHAs and the Minister of Health, in broadly the same way as in 1974. Regions did not change either their boundaries and functions (Allsop 1984 p:128-29).

The criticism concerning too many tiers of management was not appropriate to Scotland, where health boards encompassed both the Regional and Area roles. 'Patients First' was implemented only in England and Wales but a similar document was issued for Scotland proposing that health boards review their administrative structures with a view to simplifying them. It was also recommended that there should be a reduction in functional management and more devolution to Units. This review was to be undertaken and changes made by the date of the English and Welsh reorganisation, 1 April 1982 (Levitt & Wall 1992).

By April 1982, the AHAs had been abolished and replaced by 192 new DHAs (subsequently 190) and 9 special health authorities in England. Each DHA was responsible for the planning, development, and management of the health services in its district (Cannon 1989). In 1983 it was estimated that the amount spent on management in the NHS had fallen from 5.12% of the total budget in 1979-80 to 4.44% in 1982-83 (Ham 1992, p:30). The structure of the NHS in England between 1982-90 is illustrated in Figure 2.1.4 over.

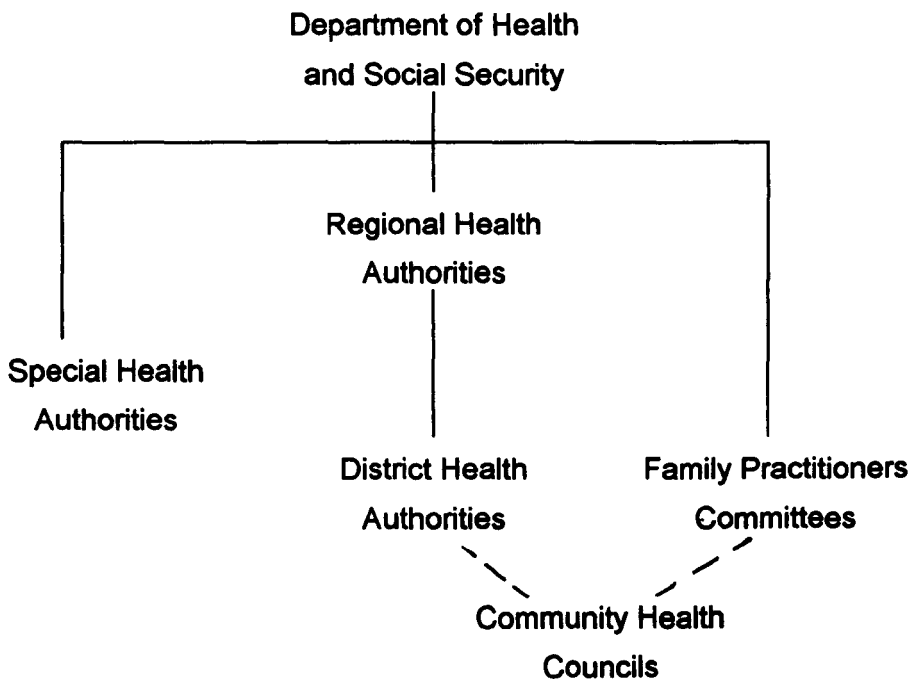


Figure-2.1.4. The structure of the NHS in England between 1982-90

Source: Ham, C. (1992) Health Policy in Britain, 3rd Ed., MacMillan, London

In the rest of the UK different changes were made. In Scotland a varied approach was pursued in the early stages with some health boards deciding to abolish the district tier, and others opting to retain it. However, in 1983 the Secretary of State for Scotland announced that all districts would be abolished and that they would be replaced by a system of unit management from 1 April 1984 (Ham 1992). The organisation of the NHS in Scotland is discussed in detail in later in section 2.2.3.

2.1.7 THE GRIFFITHS INQUIRY INTO NHS MANAGEMENT

According to Levitt & Wall (1992) the first two years of the 1982 reorganisation were beset by doctrinal discussions, especially around the issue of privatisation. The government was trying to control some of the NHS costs. Proposals included encouraging patients to use private hospitals and nursing homes. There was considerable unrest because of financial and manpower cuts in 1983. Consensus management was seen as an excuse to procrastinate by many, particularly

doctors, given that no one member of a District Management Team was clearly identified as having responsibility for taking action (Levitt & Wall 1992).

Leathard sums up the situation of the NHS in the 1980s. She said:

> *"As the 1982 model took shape, so the NHS went through a notably unsettled period. Disruptive effects had to be absorbed, as the new structure was set up. In particular many administrators had to re-apply for jobs. However, hardly had this reorganisation been put into motion when, in 1983, the NHS faced further change" (Leathard 1990, p:81).*

After two massive structural upheavals, the NHS again faced management problems. Thus, in February 1983, Health Secretary Norman Fowler asked Sir Roy Griffiths, Deputy Chairman and Managing Director of Sainsbury's, 'to give advice on the effective use and management of manpower and related resources in the National Health Service' (DHSS 1983). The team consisted of three other members as well. A short report - 24 pages - was published in October 1983. Most of the report was concerned with 'who is in charge' saying that 'if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge' (DHSS 1983).

The Griffiths Report determined the main problem of the NHS as an extensive failure of clearly defined management functions (Leathard 1990). Therefore it recommended the creation of a general manager at all levels - region, district and unit - to be drawn from any of the four disciplines currently represented on consensus management teams and to be appointed from within each authority (Hunter 1984). It proposed that:

> *"At regional and district level a general manager should be charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the Authority" (DHSS, 1983 para 6.2).*

The report argued that:

> *"Clinicians must be closely involved in the management process, consistent with clinical freedom for clinical practice. They must participate fully in decisions about priorities in the use of resources and closer involvement of doctors is so critical to effective management at local level" (DHSS 1983 para: 8.2).*

Another key proposal of the report was to establish a Supervisory Board within the DHSS, chaired by the Secretary of State and charged with the oversight of the NHS. The report also proposed that a NHS Management Board be set up under the direction of the Supervisory Board to 'give leadership to the management of the NHS' and cover 'all existing NHS management responsibilities in DHSS' (Hunter 1984).

2.1.7.1 THE IMPLEMENTATION OF THE GRIFFITHS REPORT AND REACTIONS

The advice and findings of the Griffiths Report were accepted by the Secretary of State for Health and Social Services in 1984 and in June of the same year, Circular HC (84)13 was issued accepting the implementation of the Griffiths proposals forthwith. The Health Services Supervisory Board was established immediately in February 1984. It was also announced that implementation of the report did not include any further structural reorganisation (Maxwell 1988).

As Petchey (1986) reported, the government's response to the report was enthusiastic, as Fowler saw it as an endorsement of the government's approach to NHS management. The BMA, while professing some doubt about some of the proposals, welcomed the report. However the RCN's initial response was rather more hostile, but they, like the BMA, appear to have adopted a strategy of containment. According to Petchey;

> *"The RCN's intention was to limit the consequences of Griffiths by ensuring that as many of the new general manager vacancies as possible were filled by their members. Their uncertainty about the intended outcome meant that their concern was focused principally on the implementation of the report, rather that the intentions lurking between its lines, and to this end they sought assurances that their members would not be disadvantaged in the competition for general manager posts" (Petchey 1986).*

However the BMA was more successful than the RCN in gaining general manager posts for its doctors and therefore continuing to 'safeguard' medicine's historically dominant position within the NHS (Petchey 1986).

Parston (1988) claimed that much of the debate about the Griffiths Report was largely meaningless and focused questions on 'who should be general manager?' rather than on the process of general management with each professional body laying claims for its own members.

In the debate that followed, attention centered on the validity of the Griffiths' critique of consensus management (Ham 1992). The NHS had had a tradition of consensus management, in which a form of shared managerial responsibility between doctors, nurses and administrators had been based on a perceived need and demand for considerable professional autonomy. After the Griffiths Report proposals, a radically different system for NHS management existed in which this shared management structure was to be replaced by a single general manager who would act as a chief executive and be responsible for a Health Authority's total performance (Leathard 1990). It was argued that 'this might lead to autocratic decision-making and might undermine the contribution made by groups such as nurses to management' (Ham 1992, p:33).

For example Carruthers (1983) believed that a general manager would not be more effective than consensus management and stated that:

> *"Consensus management was introduced to the NHS in 1974 and management teams were set up. ...Much time and effort has been devoted to establishing and maintaining team relationships, to seeking to minimise interprofessional rivalries. Suddenly these relationships are threatened by the notion of one member of a team becoming 'primus inter pares' and suspicion and professional jealousies are again to the fore".*

She continued that:

> *"Change is not achieved simply by appointing someone to be a general manager. Nor is 'direction' the same as 'leadership'. This is a distinction which Mr Griffiths and his team seem not to recognise" (Carruthers, 1983).*

She also believed that some recommendations that the Griffiths Report proposed were not new, such as the delegation of decision making to lower managerial levels, involvement of doctors in management, implementation of cost

improvement programmes and that the principles were basically the same as the 1982 restructuring (Carruthers 1983).

Pickering (1991) said that Griffiths tried to introduce a business model of management rather than the professional administrative consensus style. He explained that:

> *"Business management focuses on the management of activity of an organisation rather than the functions or staff groupings... It is about enhanced accountability by individuals... getting authority delegated to the point where the customer comes into contact with the organisation... in contrast professional administrative culture... involves less paper, more walking about, more influencing through verbal communication and reinforcing good practise" (Pickering 1991).*

The Griffiths report was strongly criticised by Petchey (1986) emphasising that Griffiths was proposing 'business' solutions to the problems of the NHS. He said:

> *"He diagnosed the central problem as a failure of management, the symptoms of which were the absence of such things as 'precise management objectives' or 'real output measurement. Griffiths' prescription is a liberal application of private sector management techniques" (Petchey 1986).*

Petchey believed that:

> *"The report is for a variety of reasons, more than usually elusive and cryptic. One reason is the reluctance to recommend radical reorganisation of the NHS,...In several areas therefore there is considerable ambiguity in the document" (Petchey 1986).*

And thought that the brevity of the report was another problem. He continued:

> *"The observations are both short and superficial, so that existing NHS management arrangements are considered and dismissed as inadequate in a couple of sentences. In no way can they be regarded as a reasoned and documented analysis from which the recommendations are logically derived" (Petchey 1986).*

Petchey also criticised the report regarding the involvement of clinicians in the management process to the extent of consistent with clinical freedom for clinical practice. He believed that:

> *"Griffiths fails to see any essential contradiction between the general management function as he conceives it and the autonomy of the medical professions whose daily activities inevitable require them to make decisions concerning resource allocation which in other organisational context could either be made by management... He regards the medical and nursing profession as resources to be managed, rather than as managers, and time spent by them in management as a distraction from their proper duties" (Petchey 1986).*

This recommendation was also criticised by Rye (1991) who argued that:

> *"This argument seems at first sight to be logical , but politically naive, for it assumes that doctors would be both willing and able to undertake this management role. Furthermore, it totally ignores the management position of nurses both historically and in terms of the contribution nurses can make to the management of clinical resources in the future" (Rye 1991).*

Another proposal that the Report suggested was that each Unit should develop management budgets, involve clinicians, and relate workload and service objectives to financial and manpower allocations (DHSS 1983). In 1986 management budgeting was superseded by the Resource Management Initiative (RMI). At first the RMI operated at six acute hospital sites established as pilot projects. Following the Ministerial Review of the NHS, the government announced that the RMI would be extended to all acute hospitals in the UK, to become the principal model for the management of hospitals in the UK in the 1990s. According to Keen & Malby (1992) RMI appeared initially to offer nurses an opportunity to reverse trends that had seen them increasingly marginalized in management processes.

A study, the involvement of nurses in the implementation and operation of resource management in the six acute hospital pilot sites, was carried out between 1988 and 1990 by Keen & Malby (1992). This study showed that nurses did not always grasp the opportunity to enhance their power and practice. They found that at some sites, where the director of nursing had a formal management role, the influences of nursing director depended on the power of personality, and on the

willingness of general managers to take nursing views into account. At other sites, where the director of nursing had no formal power, the influence over management decisions was restricted. Furthermore, in these hospitals, the nurse managers at lower levels within the organisation also tended to be isolated. The researchers reported that, on the other hand, the positive effect of RMI was that nurses and doctors strengthened their collaboration in managing patient care. So, while nurses remained on the margins of management, they were able to influence service delivery at ward level (Keen & Malby 1992).

As a consequence of the Griffiths Report general managers were introduced at all levels, responsible for the total performance of their organisation. Management systems were refined and developed, including the introduction of performance-related pay and individual performance review. Both were later extended to other management levels. The employment package for general managers also included short-term (usually three-year) rolling contracts (Ham 1991, p:30).

Although the Griffiths Report did not involve Scotland, Wales or Northern Ireland, similar changes were introduced although over a longer time scale (Ham 1992). Closely linked to the new managerial modes was the place of information technology. The Körner Steering Group had been established to report on the information systems in the NHS (Leathard 1990). The Group had two purposes: 'to enable both the collection and effective use of reliable up-to-date data about supply, demand and services; and to ensure the best possible patient care within the resource available' (Leathard 1990, p:98). Six main Körner reports were published between 1982-84 and their proposals were fully implemented in the late 1980s (Levitt & Wall 1992). A key element in the reports was the identification of 'minimum data sets'. Following the Steering Group recommendations, DHAs were asked to have the systems for collecting the Körner specified minimum data sets by April 1987.

2.1.7.2 THE POSITION OF NURSING MANAGEMENT AFTER GRIFFITHS

As stressed above, between 1974 and 1984 consensus management teams operated in the NHS. According to Harrison, Hunter & Pollitt (1990) the consensus management group concept enhanced the status of the nurse in health service management. Nurses were equal members of the group alongside the doctor and the administrator. Klein says that after the Griffiths Report:

> *"Within the NHS, the general management revolution swept on. Everywhere, at every level, new managers were appointed...in particular nurse managers lost much of the power they had gained after 1974, in the post-Griffiths era" (Klein 1989, p:209).*

It was widely accepted that the introduction of the Griffiths reforms had led to 'a drastic reduction' in chief nurse and adviser posts (Davidson & Cole 1991). As Horne noted, appointments to all five executive and five non-executive posts in DHAs and RHAs were on the basis of applicants' business skills and experience, not necessarily as representatives of professional groups in health care. She maintains that:

> *"It is therefore quite likely that most RHAs and DHAs will not have a nurse member. This means it will be vital for nurses to articulate their views on the management of their work in a way that business managers- who may not have detailed knowledge of nursing - will understand and appreciate" (Horne 1989).*

The advent of general management caused many nurses to feel uneasy about what was to happen to posts at the top of the organisations (Tattam 1990). The representation of nursing at senior levels became uncertain and the idea of nurses becoming general managers was regarded with scepticism (Ball 1995). According to Young (1986) the changes generated by the Griffiths proposals were the most significant that nurses had had to encounter. As West noted, following the appointment of general managers, many district general managers either abolished the post of District Nursing Officer (DNO) or changed the nature of the role that the influence and standing of the nursing profession was felt by nurses to be badly affected (West 1992). According to Bradshaw (1995) the Griffiths report represented a particular landmark in the curtailment of nursing autonomy. He continued that:

> *"General managers were introduced. Nursing became decreasingly managed by nurses and a substantial part of their career structure was removed as a result. Furthermore, general managers were given a specific brief to take control of nursing budgets and question nursing roles" (Bradshaw 1995).*

The omission of the Chief Nursing Officers (CNOs) at the DHSS from the NHS Supervisory Board set up by Griffiths caused 'dismay and resentment', and was

seen as a deliberate attack on the nursing profession (Owens & Glennerster, 1990). Carruthers (1983) argued that:

> *"Such an omission is unjustified. One can only assume that Mr Griffiths and his team retain an outmoded view of nursing and are perhaps reflecting the views of many clinicians. They have obviously not taken the trouble to talk with many nurses or to consider their role in the delivery of health care. it is essential that nursing should be represented at this policy-making level...there are many senior nurse managers well qualified to undertake a 'general manager' role" (Carruthers, 1983).*

Many health authorities' new management structures had no position for nurse managers at senior level except in an advisory level, often as part of another job such as quality control or directing nurse education (Tattam 1990). Owens & Glennerster argued that managerial posts for nurses at levels above the unit were lost, being replaced by an 'advisory function'. They noted that 'what would happen at unit level was unclear. It was feared that nurses could lose all control over nursing staff here too' (Owens & Glennerster 1990, p:16). Parston stated that:

> *"When one health authority announced a proposed management structure that did not include a chief nursing post at management board level, the arguments about professional accountability and leadership were heightened. The earlier appointment of the first regional general manager from the nursing profession did little to tone down the national debate" (Parston 1988, p:27).*

As stressed previously the Griffiths Report proposed that doctors should be more active taking both clinical and financial responsibility and developing clear lines of accountability to the ultimate authority of the general manager (DHSS 1983). Owens & Glennerster claimed that:

> *"it was uncertain how this would work out in practice for the nurses, but this issue of professional accountability to a manager who was not a nurse, was the first question to be raised" (Owens & Glennerster 1990, p:18).*

According to Harrison another feature of the new managerialism which applied especially to nurses was 'the trend towards greater control of nursing manpower and quality; although work in this area pre-dates Griffiths, the latter has given it

considerable stimulus' (Harrison 1988, p:146). Owens & Glennerster highlighted one important point from the Griffiths Report when they said:

> *"It was suggested that the management structure was top heavy, and that nurse manpower levels needed reassessment. This created major anxieties among the nurses in management who feared losing their jobs, and having their qualified staff replaced by cheaper, unskilled workers. On both counts, the Report was viewed as a threat -a dilution of the power, importance and value of nurses in the NHS" (Owens & Glennerster 1990, p:18).*

Hunter noted that:

> *"...although in theory a general manager is to be identified regardless of discipline, it would be most unusual for a nurse to occupy such a position" (Hunter 1984).*

It was widely discussed that (Young 1986; Petchey 1986; Tattam 1990; Davidson & Cole 1991) as the appointments of general managers at regional, district and unit levels began, few nurses were appointed as general managers and generally nurses did not apply for the post. The vast majority of general managers came from existing NHS administrators. At Unit level 423 general managers had been appointed by February 1986; 60% were NHS administrators; 19% doctors; 10% nurses (Petchey 1986).

A study carried out by the Institute of Health Service Management and the Health Service Journal, examined the characteristics of the newly appointed 687 unit general managers (UGMs) in the NHS and the relationship of these characteristics to different types and grades of units. The data for the study were collected and compiled between October 1986-May 1987. In the study RHAs in England were asked to give details of UGM appointments as they completed or neared completion of appointments for the whole region. In Wales all health authorities and in Scotland all health boards were requested to provide the necessary information. Special HAs in England were contacted individually. Of the managers 606 were from England, 48 from Scotland, and 33 from Wales. The findings of this study showed that the vast majority (62.2%) of the UGMs were from an administrative background in the public sector. The second largest categories were hospital doctors and nurses both 11.2%. In Scotland overall 48 UGMs were appointed and of these 77.1% (n=37) were from administrative background and only 4.2% (n=2) of UGMs were nurses (Disken, Dixon, & Halpern 1987).

Hutt (1986) reported a study that was devised by the Institute of Manpower Studies in 1983 on the backgrounds, training and career experience of regional and district nursing officers in England and Chief Administrative Nursing Officers in Wales. The purpose of the study was to enable the National Staff Committee to improve its advice on career development and planning and to help it identify training and development needs for SNMs. Research methods included formal and informal interviews and a postal survey. The author did not provide the number of subjects included in the study. However it was found that nearly half of the Chief Nursing Officers were men and the younger age groups contained proportionally more men than the older age groups. It was also found that 88% of male chief officers were married compared with 18% of women. The women tended to have rather more educational qualifications than the men. As for non-nursing qualifications, 27% of chief officers held a certificate, diploma or degree related to management or administration. In the study it was reported that over a quarter of Chief Nursing Officers had experienced some difficulty in obtaining training or secondments. The most frequent problems related to funding and absence from the post, the availability of courses and places on them and the lack of systematic appraisal and good career advice (Hutt 1986).

Robinson, Strong & Elkan (1989) reported on a four year study (1985-1988) of the management of nursing and the provision of professional nursing advice after the implementation of the Griffiths Report. The project was funded by the King Edward's Hospital Fund for London. A questionnaire was distributed to all Chief Nursing Advisers (CNAs) (N=193) in England and Wales in March 1988. In total 159 respondents returned the questionnaire providing an 81% response rate. In the study it was found that men were over-represented at CNA level and the marital status of CNAs and their sex and age distribution were found to be quite similar to Hutt's (1986) survey of CNOs. Only a quarter of CNAs perceived their professional role to have been strengthened after the implementation of Griffiths. The authors concluded that no common principles or unifying factors could be identified for the management of nursing, or for the provision of nursing advice at district level. It was stated that after Griffiths, the management of nursing across the country displayed little coherence, and very often a depressing confusion (Robinson *et al* 1989).

As stated by Harrison (1988) nurses expressed concern about the absence of the CNO from the proposed management structure. Nurses also indicated a general

desire to retain consensus management structure and to retain a line relationship between district nursing officer and directors of nursing services within units. They also resisted the idea of nursing budgets being held by non-nurses and the potential for a general manager to compel a nurse to 'act unprofessionally'.

Keen and Malby (1992) argued that the Griffiths Report led to many nurses losing their previously held executive roles at hospital board level, instead becoming 'advisors' to management teams. However, some nurses filled many of the available middle-management posts. Wall (1994) also believed that the introduction of general management was 'bad news' for most senior nurses with only a few nurses moving into new general management roles. He continued that:

> *"Those that did were derided by all. The new general managers treated them badly, and condemned many of them to jobs of considerably lower status, like artists in the Chinese revolution" (Wall 1994).*

Lyne (1983) supported Griffiths recommendations and thought that the proposals made 'common-sense and were written crisply'. She believed that:

> *"The emphasis is on purpose, objectives and direction for the health service, and on tailoring management arrangements and decisions to deliver the goods, and to be seen to deliver the goods. To do this, it is essential to know who is responsible for deciding what is to be done and by when- it is all about getting decisions taken expeditiously to achieve objectives" (Lyne 1983).*

However in the same article Lyne (1983) reported that many, including the RCN, claimed that the Griffiths recommendations would diminish the status of nurses. According to her there were four principal reasons for this type of reaction; the limited references to nursing in the report; the emphasis on the clinician's role; the issue of a nurse reporting to a non-nurse; and possible loss of control of the nursing budget. For the first claim she explained that 'the report is pleasingly short and highlights what is crying out to be done- so nursing must be in reasonable good shape to have so few mentions'. For the second claim she asserted that the involvement of doctors in the management process would not create dominance over nurses but rather a better partnership among nurses. On the issue about nurses reporting to non-nurses, she argued that 'the report talks about the primary reporting relationship of functional managers being to the general manager. Clearly this leaves room for a secondary reporting professional relationship'.

Finally about the erosion of the nurse's budgetary responsibility, she identified weaknesses in functional budgeting and said that:

> *"The functional budgeting system guarded so jealously by nurses and others has many inherent weaknesses; its key weakness is that it concentrates exclusively on 'inputs'. This means that it concentrates on the control of the resources available to the function with little or no regard to the 'outputs'. It also treats the function in isolation and in most authorities it also excludes the bulk of clinicians from the management process" (Lyne 1983).*

However, pressure was beginning to be felt. On 4th May 1984, in Parliament, the Secretary of State approved the view that a CNO should be a member of the Health Services Supervisory Board and that the government should give more thought to the creation of the Unit General Managers. It soon became clear, however, that the government was going to press ahead with Griffiths' recommendations (Leathard 1990).

Therefore in January and February 1986 an expensive RCN anti-Griffiths national advertising campaign in the press tried to reassert the need for professional management hierarchies for nurses disparaging the appropriateness of general management (Cox 1992). According to Owens & Glennerster (1990) the focus of all advertisements was that:

> *"Nurses are best qualified to run nursing, that Directors of Nursing Services should be present in all units, as they are already, and that nurses should not be excluded from important decision-making processes" (Owens & Glennerster 1990, p:17).*

The Griffiths Report was seen in a different aspect by some nurses (Vaughan & Pillmoor 1989). They pointed out that:

> *"It has created the opportunity for a 'real' career in management for those who deliberately choose to follow this path and also it has opened up the chance to reappraise other career options in nursing" (Vaughan & Pillmoor 1989, p:174).*

Also Young (1986) believed that nurses had to accept the challenges that general management offered such as professional leadership. He maintained that there was a very active life after Griffiths and 'nurses must make up their own minds and decide what they want'. Kay (1988) suggested that if nurse managers got positive

support from nurses, 'the Griffiths' reorganisation could be an important liberator of creative and innovative nurse managers'.

Buchan (1989) carried out a questionnaire survey in England to elicit the salient features of restructuring at DHA level and to identify the revised role of the CNO. In the survey the RCN regional networks were used as the channel by which the questionnaire was distributed. Updates of the questionnaires were forwarded to RCN headquarters for collation and analysis. The response rate of the survey was 80%, 150 of the 191 DHAs responded. Buchan reported that prior to the implementation of Griffiths, the most important characteristics of the CNO role were the management of the nursing service within a DHA; participation in, and membership of, the District Management Team (DMT); and provision of nursing advice to the DMT and DHA. A CNO had also budget responsibility for nursing management. He noted that the implementation of the report directly influenced all these roles and only the provision of nursing advice role remained. In Buchan's study three roles were defined as post-Griffiths CNO roles. They were a non-executive role, an advisor/educator role, and a hybrid role which included new non-nursing duties such as personnel management and quality assurance. Buchan concluded that:

> *"The implementation of Griffiths has introduced uncertainty, specialisation and diversity where previously there was stable standardisation" (Buchan 1989).*

2.1.8 WORKING FOR PATIENTS:
(PROPOSAL FOR FURTHER REORGANISATION)

By the autumn of 1987 financial problems in the NHS were causing cuts in services and closures of facilities to a serious degree (Levitt & Wall 1992). Health authorities found that expenditure was running rapidly ahead of cash allocations and many were required to take urgent action to ensure that they did not overspend their budgets. There were also staff shortages owing to financial pressures (Ham, Robinson & Benzeval 1990).

Throughout the 1980s, health authorities were frequently forced to close beds and cancel operations because they had run out of money. But, according to Levitt &

Wall (1992) the pressure were not a direct result of government policy. They argued that:

> *"It was the result of cumulative underfunding and they arose from growing public expectations, advances in medical technology and an ageing population, factors that together put more demands on the systems than it could meet" (Levitt & Wall 1992, p:34).*

As a consequence, a funding shortfall had arisen.

Considering the increased public and professional concern the government announced, in December 1987, that an additional £100 million was to be made available in 1987/8 to help tackle the problems that had arisen. But it bought no relief and in a 'Panorama' programme on BBC TV on 25 January 1988, the Prime Minister, M. Thatcher, announced her decision to begin a fundamental review of the NHS. She established a small committee of senior ministers chaired by herself to conduct the review (Fact File 1991).

During the Ministerial Review a variety of ideas were discussed including the financing of the health service and delivery of health care. In its early stages, because the group began its assignment in a climate of crisis over the funding of the NHS, the committee sought alternative ways of funding the services (Butler 1994). The two main options considered regarding the financing of the NHS were to expand private health insurance and/or to introduce a form of social insurance. It was suggested that NHS funds should be raised through social insurance rather than general taxation. It was also proposed that the government should extend tax relief to those with private health insurance cover. The idea behind this proposal was that this would provide an encouragement for people to use the private sector, thereby reducing the demands made on the NHS (Ham *et al* 1990). But as the review progressed, by the late summer of 1988, the agenda had totally changed and the focus of the group's concern had shifted from issues about the financing of the NHS to those about the efficient use of its resources (Butler 1994). Butler (1994) explained that:

> *"This was partly because of Mrs Thatcher's continuing caution about the political consequences of tampering with the financing of the service, and partly because of the realisation that a tax-funded service is very good at controlling the overall level of spending" (Butler 1994, p17).*

One of the key developments of the 1988 Review, was the decision to split the DHSS into two, the Department of Social Services (DSS) and the Department of Health (DoH) (Ham *et al* 1990).

The White Paper, Working for Patients, which was published in January 1989 (Secretary of State for Health and others 1989), was the outcome of the ministerial review of the NHS and it was followed by a bill later the same year. The bill received royal assent in July 1990 and the reforms were in place for 1 April 1991 (Butler 1994).

According to Brazier & Normand (1991) the NHS White Paper proposals can be categorised under three heading: 'reform concerned with further reorganisation of the NHS management and accountability; encouragement for private sector finance through tax exemption and two proposals to introduce supplier competition'. The two proposals were to increase the role of clinicians in management and resource allocation (Brazier & Normand 1991). Robinson (1994) argued that the reforms embodied in the 1990 NHS and Community Care Act represented the greatest change in the organisation and management of the NHS since it had been established and the key change was the establishment of NHS Trusts. He stressed that with the reforms, an internal market had been created within the NHS (Robinson 1994). However Butler (1994) claimed that the origins of the reforms went back much further than the government's ministerial review. There were a number of key changes to the NHS throughout the 1980s and one of them was the growth of internal markets. He said that:

> *"The notion of an internal market in the NHS was well developed in theory, and to some extent in practice, long before it was adopted by the government's working group in 1988/89. There had actually been a very extensive discussion of the idea in the academic and policy literature throughout much of the 1980s, most notably by Enthoven, who in 1985 had mapped out the skeleton of an internal market for the NHS" (Butler 1994, p: 16.)*

In the White Paper, the government announced that the NHS would continue to be available to all the population and would be financed mainly out of taxation and there were no proposals to extend user charges (Leathard 1990). Tax relief on private insurance premiums was to be made available to those aged over 60, but the significance of this was more symbolic than real. For the vast majority of the

population, access to health care was to be based on need and not ability to pay (Ham *et al* 1990).

The White Paper's two stated main objectives were 'to give patients, wherever they lived in the UK, better health care and greater choice of the services available' and greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences (Secretary of State for Health and others 1989).

The proposals of the White Paper were aimed basically to create a competitive market between hospitals and other service providers (Robinson 1989). The establishment of such an internal market involved the separation of 'providing' and 'purchasing' health care functions (Harrison *et al* 1990). Regional and district health authorities would no longer have to provide all the services themselves. It was suggested that health authorities would purchase health care on behalf of their resident population. They also would be able to trade with each other, with self-governing hospitals and with the private sector (NAHAT NHS Handbook 1991). The introduction of a form of competitive market from 1991, aimed at achieving financial efficiency, reducing paternalism and improving consumer responsiveness. It was also intended to relieve and eventually eradicate the economic and structural problems that inhibited the delivery of efficient, personalised health services (Bradshaw & Bradshaw 1994).

In the White Paper the government proposed that to stimulate a better service for the patients, hospitals would be able to apply for a new self-governing status as NHS Hospital Trusts, but they would remain part of the NHS. The new hospital Trusts would be free to settle the pay of their staff and would earn revenue from the services they provided (Secretary of State for Health and others 1989, p:4 para:1.9).

The White Paper also proposed that large GP practices that served more than 11,000 patients, (later reduced to 9,000) (Loveridge & Starkey 1992) would have the option of holding a budget to cover drugs, hospital-based investigations, outpatient procedures and elective surgery for their patient, if they were accepted as 'fund-holding practices' (Brazier & Normand 1991). In the case of hospitals, funding was to be based on service contracts, and hospitals would be reimbursed for the work done (Ham *et al*, 1990). With the creation of internal markets, the government believed that competition between providers of health care would

produce both greater efficiency and greater responsiveness to patients (Harrison *et al* 1990).

According to Robinson (1989) the belief that a competitive environment stimulated efficiency and enhanced consumer choice had been a central component of the government's economic strategy for the past ten years. With the publication of Working for Patients, the government had put forward its plan for health care. He also notes that the original idea in favour of internal market was suggested by Alain Enthoven, American health economist. In 1985 Enthoven recommended that the efficiency could be improved through trade in clinical services between DHAs (Robinson 1989).

According to Ham *et al*, (1990) the White Paper aimed to strengthen the management structure and endorsed the Griffiths general management reforms. At the national level, within the Department of Health (DoH), a Policy Board and Management Executive was established in place of the Supervisory Board and Management Board. At local level, the composition of health authorities was revised along business lines (Harrison *et al* 1990). Membership of DHAs and RHAs was reduced to five executive and five non-executive members. In Scotland the accountability for Health Services Policy remained with the Scottish Home and Health Department, strengthened by the appointment of an NHS Chief Executive for Scotland. The Scottish Health Services Policy Board was replaced by a new Advisory Council (Leathard 1990).

In England and Wales similar changes were proposed for the family practitioner services, including the replacement of Family Practitioner Committees by Family Health Services Authorities (FHSAs) (Ham, 1992). The White Paper Working for Patients applied to the whole of the UK, although some institutional differences remained (Harrison *et al* 1990). The structure of the NHS in England after 1990 is illustrated in Figure- 2.1.5 over.

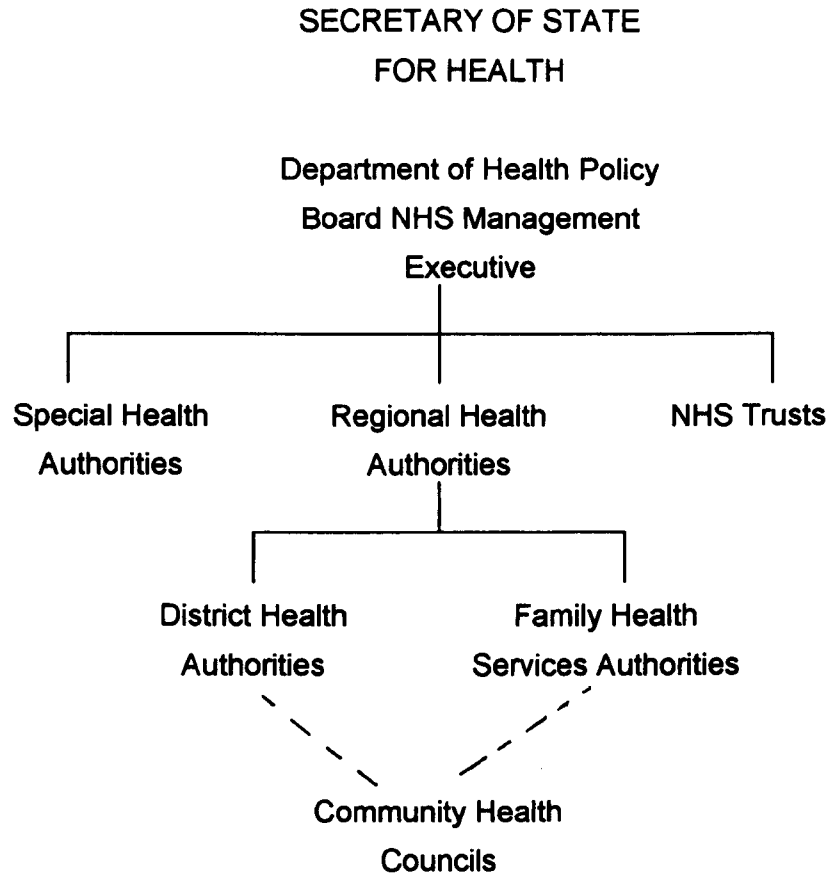


Figure-2.1.5: The structure of the NHS in England after 1990

Source: Ham, C. (1992) Health Policy in Britain, 3rd Ed., MacMillan, London

With the publication of the White Paper medical audit was to become a routine part of general practice and clinical work in hospitals and Family Health Services Authorities (Ham *et al*, 1990). In addition the job descriptions of consultants were more clearly specified in line with hospital objectives and the system of merit awards was linked with management objectives (Brazier & Normand 1991). Alongside these changes, the RMI was an attempt to encourage further participation of doctors and nurses in the management of services (Robinson 1989).

The other recommendations proposed in the White Paper, Working for Patients, were as follows:

- GPs to be given indicative prescribing budgets to assist in controlling drug cost;

- Devolvement of decision - making to local levels of the organisation;
- Resource Allocation Working Party (RAWP) - a means for determining what proportion of the NHS total budget was distributed to regions and Districts' resident populations (Secretary of State for Health and others 1989).

2.1.8.1 THE IMPLEMENTATION AND RESPONSES TO THE WORKING FOR PATIENTS

The initial reaction to the White Paper was negative. Within the NHS the professions embarked on an intensive attack but managers were less negative given the heavy managerial responsibility of the proposed reforms (Levitt & Wall 1992).

Butler (1992) said that the publication of Working for Patients led to;

> *"A battle of propaganda and counter-propaganda that was remarkable for its scale and cost and for the levels of personal vilification to which it sometimes descended" (Butler 1992, p:58).*

A strong opposition was initiated by GPs through the BMA. The BMA had started a campaign against a number of key proposals including self-governing hospital Trusts, general practice budget-holding, and the concept of an internal market. Immediately after the White Paper's publication the RCN, the Royal College of Midwives, the trade unions, patients' organisations, charities, health authorities and political groups had all expressed concern regarding some aspects of the White Paper (Butler 1992).

The RCN was also activating 'public opinion against the White Paper expressing 'grave concern' about its damaging impact upon the quality and continuity of care' (Butler 1992). The RCN General Secretary, Trevor Clay, was concerned that self-governing hospitals could become targets for privatisation. Also, Labour's Shadow Health Secretary, R. Cook, saw the government's plan as the first step towards full-scale privatisation of the NHS (Leathard 1990).

Le Grand (1993) believed that there was a division of opinion about the NHS reforms. He said that the public saw them as a disaster because of the endless series of 'shroud-waving' stories in the media such as hospital closures and the

effects of GP fund-holding. However, according to Le Grand (1993), most health policy analysts viewed the reforms as a success and, 'if they forced to choose between the old NHS and the new, would choose the new'. Le Grand continued that:

> *"...even the NHS itself is split. Managers of Trusts are revelling in some of their new-found freedoms from bureaucratic direction. GP fund-holders are similarly enjoying their new powers. In contrast, some senior consultants, losing power to GPs on the one hand and managers on the other, are bitterly critical of the changes. Some GPs also resent what they see as the fund-holder juggernaut, forcing them to become service rationers rather than advocates for their patients. And there is a worry throughout the service that relationships based on professional ethics and patient trust are being replaced by a market ethos and a commercial culture" (Le Grand 1993).*

Higgins (1994) also believed that although everyone working in the NHS had a strong view about the changes that taken place since 1990, there was a large gulf between those who believed that the reforms were the best thing to have happened to the NHS in 40 years and those who saw them as the first stage in dismantling the service entirely. He said that the NHS reforms divided people into *the doers* and *the done-to* and *the doers* were much more positive about the reforms than the *done-to*. According to Higgins, ministers, senior managers, some senior doctors, authority and board members, GP fund-holders, GP purchasers and commissioners were the doers and they had power, influence and budgets. Higgins said that:

> *"The doers are in control. They can make things happen. They are quick on their feet and anticipate events. They position themselves to respond rapidly and positively to change and grasp the initiative as new scenarios unfold. They have good information and networks and are trend spotters" (Higgins 1994).*

Unlike the doers, the done-to group, which included non-purchasing GPs, middle managers, junior doctors, nurses and other professional groups, administrative and clerical staff, ancillary staff and patients, were badly informed, they lacked the knowledge and resources to position themselves strategically, and could only await instructions. Higgins (1994) continued that:

> *"the done-to are relatively powerless and lack effective control over key changes. Their role is characterised by instability, uncertainty and insecurity. They cannot move laterally, they cannot create opportunities for themselves and they cannot anticipate the direction in which trends are likely to evolve... They feel vulnerable, out of control and fearful" (Higgins 1994).*

Culyer (1994) argued positively for the introduction of market incentives in health care. He stated that the NHS had far too long been driven by providers who had a 'captive audience', with professional priorities and interests rather than the best interests of the patients, and systems of medical audit should help to resolve that issue. Culyer also argued that in the old system there was no way of identifying needs of the community for health care, but with the changes that was clearly the job of the health authorities.

Lilley (1995) supported the belief that 'the NHS should be run like a business'. However he clarified that he did not mean that NHS should be run for profit and neither should people be charged for services. He argued that:

> *"Businesses have customers. If the NHS is to be run like a business we need to recognise the fact that health-care may be free at the point of delivery, but it is far from free at the wage packet. The tax payer is entitled to be thought of as a customer. The word patient implies waiting, queues, necessity, indifference, disempowerment and being sent where it suits. The word customer implies choice, quality, innovation, value for money, reliability and service: Knowing what is good and where to get it" (Lilley 1995).*

He also believed that the NHS was an opportunity arena for staff who had gateway competencies. He defined gateway competencies as business skills and computer competencies. In the case of nursing, he suggested lifetime learning based on the tomorrow's knowledge (Lilley 1995).

In a study carried out in the USA, Everson-Bates & Fosbinder (1994) investigated the critical differences that existed between practising managers who are effective and those who are ineffective in their roles. In the study, 13 nurse administrators and 18 nurse managers were interviewed and five categories of competencies were identified as key indicators of effectiveness for nurse managers. They found that the first and most critical competency was communication. The other

competencies that were identified were leadership, problem solving, staff development and the understanding that health care was changing.

Bradshaw & Bradshaw (1994) were sceptical about the application of markets within the NHS. They suggested that expensive life-saving treatment might not be supplied; that the demand for health care was unpredictable and therefore might not be available when needed and that the 'customers' themselves might not actually be aware of their own health needs. Bradshaw & Bradshaw (1994) believed that the introduction of the internal market into the NHS had happened very much under controlled conditions, with the government keen to ensure that the reforms were seen as 'working'. They continued that 'in theory the reformed service reduces central control and is intended to permit local consumer preferences to govern competition'. However in reality there was little space for the patient to be permitted any freedom of choice (Bradshaw & Bradshaw 1994).

Savage (1993) argued that 'Working for Patients' was misleadingly entitled and instead of patients, managers, accountants, businessmen, computer firms and insurance companies had benefited from the reforms. According to Savage there were five major issues in the NHS reforms:

> *"The loss of focus on the individual patient and her/his needs, personal circumstances and choice; the imposition of a totally inappropriate 'business model'... on a caring service so that co-operation is replaced by competition; the loss of free speech, openness, accountability; the chaos caused by repeated re-organisations of the NHS in the last decade, which have led to the loss of experienced staff, hard-won expertise and working relationships, and consequent demoralisation; the political manipulation of the service by PR techniques, the appointment of Conservative Party supporters, and the direct line management between the Secretary of State and Trust chief executives and chairmen" (Savage 1993).*

Day and Klein (1989) discussed that in the White Paper the government had three main objectives: 'to tighten up the managerial structure in order to ensure central control over the NHS's policies and priorities, to raise efficiency through competition and to increase consumer choice'. The authors claimed that competition could not be equated with consumer choice. If a DHA contracted for services with a particular hospital it would presumably be on price and quality.

There would be no consumer choice, although health authorities could write indicators of consumer convenience into the contract (Day & Klein 1989).

In the case of GPs who were accepted as fund-holding practices, it was discussed as to whether they would discriminate against patients who were older, sicker and more expensive to treat. In the case of indicative prescribing, it was argued that GPs would be prevented from providing their patients with the necessary drugs because of budgetary constraints (Ham 1992). Rowden presented an example. He said:

> *"for instance a child with a rare brain tumour may present to the GP with a vague set of symptoms. If the GP is at the end of the financial year and his budget is tight, he might be tempted not to spent £1 000 on expensive diagnostic tests and sit on the problem" (Rowden 1989).*

Butler (1992) stated that in July 1991 the BMA, while continuing to condemn the reforms, decided to pursue its interests through constructive dialogue with the government, not through further confrontation because its campaign of persuading the government to seek a second opinion about its intentions for the NHS had largely failed. Meanwhile within the medical profession, some of the White Paper's proposals, particularly those relating to medical audit and information technology, were generally well received (Leathard 1990). The response of the private health-care sector to the White Paper was generally positive, though cautious about the short-term threat of new competition (Butler 1992).

Some authors agreed that a number of key issues were not addressed in the White Paper (Ham *et al* 1990; Butler 1992; Leathard 1990). Foremost among these was the charge that it failed entirely to address the problem of funding the NHS. The issue which led to the Review (1988) was therefore not tackled, and this promised to store up problems for a later date (Ham *et al.* 1990); for example, by the end of 1980s, health authorities were again faced with a funding crisis. As Ham reports some 4,000 beds had been closed in 1990 owing to shortage of cash (Ham 1992).

A second concern was that expressed about the White Paper's silence on community care. It was believed that the White Paper was heavily focused on acute hospitals and the relationship between hospital services and GPs, rather than broader aspects of health policy (Ham *et al* 1990). Leathard claims that in the

White Paper prevention was never mentioned and details regarding community care and priority services were insufficient (Leathard 1990).

According to Leathard (1990) and Day & Klein (1989) the White Paper proposals, on the positive side, set a new style for the NHS that promised a more flexible organisation - as with wages and salaries - capable of adapting to new circumstances. In contrast, there remained a very big query against the need for a radical revision of the NHS structure. The NHS had already been reorganised three times in ten years, 1974, 1982, and 1984.

2.1.9 THE REFORM OF PRIMARY CARE AND COMMUNITY CARE

The primary care changes originated from a consultative document issued in 1986 and a White Paper, Promoting Better Health, published in 1987. The White Paper established future policy for primary health care in the community. The essential aims of the primary care reforms were to promote standards of health and health care, to give greater emphasis on health promotion and disease prevention, and to offer wider choice and information to patients (Ham 1992). An important point in the changes was the introduction of a new contract for GPs in April 1990 which involved a considerably increased management role for the new locally contracting body, the Family Health Service Authority (FHSA) in England and Wales (Bryden 1992).

The government's plan for the future of community care was developed in response to the Griffiths Report, Community Care: Agenda for Action, published in 1988. The second White Paper, 'Caring for People', published in November 1989, contained the government's proposals for improving community care and complements the proposal contained in 'Working for Patient' (Secretary of State for Health and others: Caring for People 1989).

The White Paper 'Caring for People' became law in 1990 and was implemented fully in July 1993. The aim of this White Paper was to clarify the increasing confusion over responsibility for those patients with continuing needs, such as the elderly, the physically and mentally handicapped and those people with mental illness (Levitt & Wall 1992). In addition it intended 'to overcome the slow and uneven development of services across the country by giving local authorities the lead responsibility in the planning of community care' (Ham 1991). Caring for

People sought to redress the balance of caring provision away from institutions and back into the 'community' (James 1992).

The government's proposals had six key objectives for service delivery: (Secretary of State for Health and others: Caring for People 1989, para:1.11).

1. "to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible;
2. to ensure that service providers make practical support for carers a high priority;
3. to make proper assessment of need and good case management the cornerstone of high quality care;
4. to promote the development of a flourishing independent sector alongside good quality public services;
5. to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance;
6. to secure better value for tax payers' money by introducing a new funding structure for social care".

The proposals set out in 'Working for Patients' and 'Caring for People' were incorporated in the NHS and Community Care Act, 1990. According to Loveridge & Starkey (1992) the changes proposed in the management of health care delivery set out in the Act were the most radical since the birth of the NHS. Cooms & Cooper (1992) agreed that:

> *"The Act made radical proposals for the use of internal markets to regulate the pattern of health provision and seek greater efficiency. Whilst having distinctive political origins, it is also a further and very obvious manifestation of the managerial direction of development of information systems" (Cooms & Cooper 1992, p:118).*

2.1.10 NHS TRUSTS

The introduction of NHS Trusts was one of the key elements of the 1990 NHS reforms. They were self-governing hospitals and other units which were run by their own Boards of Directors and were accountable directly to the Secretary of State via the NHSME. The Board of Directors consisted of; a non-executive chairman appointed by the Secretary of State, and an equal number of executive

and non-executive directors. In the case of Trusts providing direct patient care, there was also a medical director and a nursing director (NHSME 1990).

Trusts had a variety of freedoms not available to Directly Managed Units (DMUs). These included: to create their own management structure; to employ their own staff; to determine their own staffing structures and set their own terms and conditions of employment; to borrow money within annually agreed limits, primarily for new building and equipment; to acquire, own and dispose of assets to ensure the most effective use is made of them; to make their own cases for capital developments direct to the NHSME; and to advertise their services (NHSME 1990).

But this did not mean that Trusts were completely free to run their services. Since Trusts remained within the NHS they continued to be subject to legislation that applied directly to the NHS facilities. Each Trust was required to prepare an annual business plan, in which the Trust set out its plans to develop services, its financial projections and its capital building plans; an annual report on the previous year's performance and annual accounts. Trusts were also required to provide in-year financial monitoring information. Trusts received no direct funding from the Department and earned all their income from contracts with health authorities, GP fund-holders, and private patients or their insurance companies (NAHAT NHS Handbook 1991).

A key difference between Trusts and DMUs was the existence of a Board of Directors in each Trust with complete responsibility for managing the affairs of the Trust. It was argued that the concept of the self-governing Trust prompted almost more attention than any other issue in the White Paper. To opponents of the government, the idea was clear evidence of a process of privatisation, and despite the Secretary of State's constant rejection of this claim, the opponents of the self-governing Trusts continued to stress this (Levitt & Wall 1992).

The NHS reforms started a year later in Scotland than in England. Initially there were only two Trust hospitals in Scotland. The ultimate goal was some 65 Scottish Trusts, giving a similar total in proportion to that in England (Warden 1993).

2.1.11 EVALUATING THE NHS (1990) REFORMS

After the enactment of legislation, in December 1990 the first 57 Trusts in England and Wales were unveiled and the first NHS Trusts came into existence in April 1991. During 1990, around 400 general practices actively considered fund-holding, and received financial support from the DoH. In April 1991 the first 306 budget-holding general practices were named (Butler 1992).

In 1993, according to Ham, the NHS reforms had reached a critical stage. First he outlines the negative effects of the reforms such as restrictions of hospital admissions. Then he argues that the reforms were not all bad. He said:

> *"...the level of resources allocated to the NHS has been generous in the past two years, and as a result productivity has increased and the longest waiting times have fallen...both health authorities and NHS Trusts have started to use their new powers to tackle long-standing weaknesses in the delivery of services...the introduction of contracts has helped to enhance the accountability of providers to purchasers and has opened up a debate about the standards of care that should be delivered. Many NHS Trust are seeking to increase their competitiveness and enhance the attractiveness of their services to purchasers... general practice fundholders have shown their ability to innovate and to use resources differently" (Ham 1993).*

It was stated that although there was a great deal of anecdotal evidence about the successes and failures of aspects of the NHS reforms, there were few empirical studies upon which to base a judgement (Le Grand 1993; Higgins 1994; Appleby 1994).

Petchey (1993) and Le Grand (1994) agreed that the overall effects of the NHS reforms were difficult to evaluate for a number of reasons. According to Le Grand (1994) the main reason was that the government did not set up a monitoring or evaluating system alongside the reforms when established. Robinson (1994) stated that:

> *"There was at the time widespread criticism of the decision to press ahead with implementation without making any official provision for testing, monitoring or evaluating the impact of the reforms. But the government was unmoved... Secretary of State for Health, K. Clarke, denied the need for formal monitoring and*

> *evaluation and expressed the view that calling on the advice of academics in this way was a sign of weakness" (Robinson 1994, p:1).*

Bradshaw and Bradshaw (1994) also said that:

> *"The introduction of competition without any accompanying economic evaluation appears a high risk political experiment that has no guarantee of success. ...little consideration was given to the strengths and weaknesses of such a system" (Bradshaw and Bradshaw 1994).*

Secondly, according to Le Grand (1994), there had been other major changes in the NHS during the period such as the changes in the GP contract, the Patient's Charter and the parallel set of reforms in community care, all of which had induced significant changes in behaviour by the key players in the system that overlay any changes induced by the reforms. He argued that perhaps more importantly there was a dramatic increase in resources going to the NHS: 6.1% in real terms in 1991/92 and 5.5% in real terms in 1992/93. He said that there were a number of factors, changes which could be taken as indicators of the reforms' success, such as falls in waiting lists and the provision of a greater range of services. However he believed that:

> *"...with increases in resources of this magnitude, it would be astonishing if there were no changes in waiting lists or improvements in the range of services offered, quite independently of any changes in the delivery system of health care, such as those induced by the reforms. On their own, therefore, such indicators can tell us nothing about the progress of the reforms" (Le Grand 1994, p:244).*

In 1989 the King's Fund decided to do an evaluation of the 1990 Reforms. In total 72 research projects were received and seven of these were selected for financial support. These projects were carried out over the period 1990 to 1993 and the results from these seven projects were published as a book (King's Fund Institute 1994). Within this book Le Grand (1994) used examples of both types of evidence from the King's Fund major grants projects and evaluative research conducted elsewhere. He argued that the impact of the reforms should be judged in terms of the fundamental objectives of quality, efficiency, choice, responsiveness, and equity. He concluded that some of the results of the direct and indirect research were positive; such as many hospitals were in competitive states and Trust managers were looking for efficiency savings. Fundholders were reportedly

obtaining quality improvements for their patients and medical audit was affecting the behaviour of clinicians. However he noted that these conclusions were tentative and the results were subject to different interpretations. His main conclusion was the belief that sound policy should be based on firm information (Le Grand 1994).

Petchey (1993) also argued that evaluation of the first year's operation of the internal market was not straightforward. He said that the first difficulty was the wide-ranging scale of the reforms. Secondly the White Paper and the working documents gave only the barest outline of the market framework and left several key issues unresolved; and thirdly, use of the first year of implementation presented problems as a basis for evaluation. The market was established before the information on which it depended was available. As a result most contracting in the first year was in the form of unsophisticated block contracts. In his article Petchey (1993) examined claims that the reforms had improved efficiency by considering three aspects of health services: tax relief on private health insurance premiums for the over 60s, general practice fund-holding, and implementation and transaction costs. Like Le Grand (1994) he claimed that:

> *"...examination of these data suggest that much of the increased efficiency is not owing to the reforms but to increased funding... analysis of NHS spending and activity during 1979-92 points strongly towards this possibility...there had been virtually zero growth in NHS funding during the 1980s, but in 1990-91 and 1991-92 NHS spending rose in real terms by 2.8% and 4.1% respectively" (Petchey 1993).*

Appleby (1994) questioned whether reductions in waiting times and increases in hospital activity were accurate indicators of the benefits of the market in the NHS. He believed that there were three problems with these indicators. First it was difficult to disentangle the effects of the reforms from other factors such as the waiting list initiative on waiting times or the effects of the Patient's Charter, or large inputs of cash to the NHS. Secondly he believed that the statistics cannot always be true descriptions of events. Finally he questioned whether waiting times and hospital activity were the sole appropriate indicators of the benefits of the reforms. He suggested that there should be a more thorough audit of efficiency, equity, effectiveness, comprehensiveness, acceptability and affordability of the NHS.

Ham (1994) believed that the nature of market management had been neglected by ministers and their advisers and urgently needed rectification. He listed the

essential elements of market management as open information and a common vocabulary for contracting; an independent third party to arbitrate in disputes when purchasers and providers cannot compromise; an agreed set of rules for handling mergers and takeovers; the ability to oversee the interaction of purchasers and providers and to spot gaps in service provision; the capacity to fund innovations in service provision; the development of exit strategies for coping with providers who compete unsuccessfully in the market, and to ensure that core values are not sacrificed as competition grows in importance (Ham 1994).

2.1.12 THE POSITION AND ROLE OF NURSES IN MANAGEMENT AFTER THE NHS (1990) REFORMS

The NHS had undergone a period of major changes/reforms which began with the recommendations of the Salmon Report (1966), continued with the implementation of the Griffiths proposals (DHSS, The NHS Management Inquiry 1983) and accelerated with the implementation of the White Paper Working for Patients (1989) and the NHS & Community Care Act (1990). Mulholland (1994) and Bradshaw (1995) pointed out that the NHS has recently undergone the most profound reforms since it was conceived, with the introduction of general management, resource management, the NHS (1990) Reforms, and the establishment of NHS Trusts. According to Bradshaw (1995) the central elements of the reforms were the introduction of a split between purchasers and providers and the creation of competition between NHS Trusts for available business. He stated that competition was regarded as the solution to the economic and structural problems inherent in the centralised, bureaucratically organised health system in the UK. Bradshaw (1995) also pointed out that the changes were motivated by an ideological belief that 'health services do not differ from any other consumer goods'.

Although there was a vast amount of American literature regarding the role of nurse manager, in the UK there were few results of empirical studies. Instead much of the literature pertaining to the role and position of nurses in management and their management training after the 1990 NHS Reforms was largely anecdotal. There had been a little small scale research carried out specifically in Scotland. However there were a few research studies conducted in the UK which therefore included Scotland's nurse and/or non-nurse managers.

In the NHS, efficient management, including that of nursing services is vital. Wright (1993) argued that nurses have the greatest influence on how resources are spent on patients and nurses can affect the quality of patient care more significantly than any other single professional group. He believed that 'whether nurses manage their work well, or whether they manage themselves well will determine, whether patient care is good or bad'.

The need for sound management in nursing is very clear; nurses are the biggest, single group of health care employees in both the public and private sectors. As a result, their wages bill consumes 36% of total revenue expenditure of the NHS. This is more than three times as much as the next largest group, doctors (Thompson & Marshall 1993). Nurses also occupy a large proportion of the individuals with management roles in the NHS. In a study of top managers in the NHS, Wyatt *et al* (1994) found that 9% of all top managers in the NHS in the UK had a nursing background. The third report of this project also showed that, in England, 24% of the managers had a nursing background (Disken *et al* 1995).

Harvey (1994a) argued that after the reforms, defining the senior nurse managers' role had proved an 'embarrassment' for Trusts and most health authorities remained confused about how best to use nurses. She continued that although many Trusts gave a mandatory place on the board to the director of nursing, they were faced with a number of dilemmas such as whether the director of nursing should have overall line management responsibility for nurses within the Trust, or act as an adviser, offering 'professional leadership' for nurses (Harvey, 1994a). However Rye (1992) believed that as NHS Trust hospitals increased in number, two roles were pivotal and not under threat: the executive nursing director and ward sister/charge nurse.

In regard to nurses' position after the reforms, Huntington (1993) believed that:

> *"...nursing's capacity to influence the future direction of the NHS suffered a serious setback with the introduction of general management in 1983. The NHS reforms offered no compensation. Indeed the purchaser-provider split reinforced the confinement of nursing and nurses to operational, rather than strategic, roles and functions" (Huntington 1993).*

It was widely recognised that the reforms created a variety of roles for senior nurses working above ward sister/charge nurse level. However, according to

Bradshaw (1995), in many instances, in order to reduce the costs of the health budget the number of senior nursing posts was reduced. Senior nurses were removed from formal management structures and new roles in advisory, support, and quality assurance were created under the control of a general manager who often had little knowledge of the context in which nursing work is conducted. Rye (1992) said that 'all too frequently, these staff posts were used as a mechanism for slotting in displaced nurse managers when restructuring takes place'. Again, Bradshaw argued that:

> *"...for a small minority of nurses who have retained or assumed significant senior leadership responsibilities the task has changed rapidly from one of administration to one where the exercise of the principles of managerial control have become paramount" (Bradshaw 1995).*

It was also widely argued that in many organisations, the role of senior nurse managers and senior nurses lacked clarity (Rye 1992) and in many instances lines of professional accountability were also becoming blurred or non-existent (Hewison 1993). Withams and Knibbs (1992) undertook research to identify 'how senior nurse managers spend their day and to use this as a basis for understanding ways of helping them to be more effective'. The study used interviews, diaries and observation as its research method. However the authors did not provide the number of subjects who participated the study. They found that some nurse managers showed high anxiety levels in respect of their current jobs, largely based on the changes which resulted in them operating within at least two cultures; that is nursing and the management-oriented business ethic. They also reported that the feeling of marginalisation was very evident in some respondents and that nurse managers perceived a lack of clarity in respect of their roles, in respect of nursing and management and the expectations of others (Withams and Knibbs 1992).

Like Rye (1992), Calvert-Simms (1993) also agreed that with the implementation of the White Paper, Working for Patients the nurse manager's role had become unclear. She said:

> *"...the establishment of clinical directorates, and the elimination of middle management has left many nurses feeling confused and isolated. Within the directorate, there is no guarantee that the general manager will be a nurse and if not, what advisory role the nurse manager will fulfil... It has been stated that only*

> *those persons with the most appropriate qualifications will be appointed as unit general managers. Since the majority of the present nurse managers lack expertise in the crucial areas of business management, their career opportunities can (and will) be limited... It appears as if nursing has been placed firmly under the control of physicians, general managers and the dollar" (Calvert-Simms 1993).*

Some argued that nursing's identity and independence were in jeopardy as the profession came increasingly under the control of General Managers (Bradshaw 1995). For example Rye (1991) discussed that with the development of a general management structure, most organisations adopted a decentralised model and this had, in many cases, resulted in the most senior nursing management role being that of a senior nurse at care group level. Subsequently the director of nursing services' role became obsolete or changed to a non-line role. Especially in acute units, the clinical directorate model was widely established and doctors were appointed as clinical directors. According to Morris-Thompson (1994) 'nurses in this context were commonly stripped of the title 'manager' and took the title of 'adviser', a softer title emphasising a subservient role'.

According to Rye (1991) in order to support the clinical director two roles existed: the senior nurse and business manager. He believed that although in many organisations these roles within each care group lacked clarity, the clinical directorate model was an opportunity for nurses to develop strong clinical nurse manager roles. Capewell (1992) also argued that the clinical directorates offered nurses a double opportunity: 'to ensure that their advice is formally recognised *managerially* by personal interaction with the director, and *professionally* by informing their own DNSs or senior professional manager within the unit'. He also believed that the nurse manager in each directorate was usually given considerable freedom to organise nursing activities.

However Wall (1994) believed that after the 1990 Reforms, clinical directors were rarely nurses and the nurse manager's position within the Trust was likely to be 'number three in the pecking order, after the business manager'. He then continued that:

> *"But maybe nurses are themselves partly to blame. Some have been so anxious not to be thought old-fashioned that they have espoused all the recent marketplace-oriented changes without criticism. Furthermore they have allowed the introduction of discredit practices as though they were the last word in modernity" (Wall 1994).*

Nethercott (1991), a senior nurse business manager, claimed that nurses in management became more removed from the clinical environment because of the pressures resulting from the NHS reforms and implementation of resource management. In a study by Balogh and Bond (1992) it was found that 28% of the participants wanted to maintain a clinical caseload within the remit of a management post. The authors argued that clinical nursing skills could both be defined and practised at the advanced level. Nethercott (1991) also believed that many general managers wanted to replace their senior nurses with cheaper non-nurse managers because nurse managers had maintained an authoritarian approach and often been rigid and inflexible. In addition there was a lack of clarity regarding both a definite clinical role and professional role (Nethercott 1991).

A small scale study carried out by Edmonstone & Havergal (1992) and commissioned by the Management Development Group (MDG) in Scotland, examined the career transition from functional to general management within the NHS in Scotland. Three career transition workshops were held with managers and nurse managers. The participants of the initial workshop were people who had recently made career transitions into general management; into new roles and into the NHS for the first time. The other two workshops were targeted at nurse managers who were in the midst of career changes. Data obtained from these workshops were analysed and 'themed' using the 'SEVEN S' framework which was Strategy, Structure, System, Staff, Style, Skills and Shared Values. The conclusions were qualitative in nature, dealing chiefly with the perceptions, feelings and experiences of people in change. The sample size was small (N=32) but according to the authors of this report, 'conclusions matched intelligence derived from other MDG activities and from the experience of MDG Associates and others'.

The report concluded that most career change was experienced as enforced and involuntary and there was little choice and no preparation available. In the case of NHS staff who were moving to Local Authority control there were feelings reported of being deskilled, marginalized and abandoned. In terms of structure it was found that there was structural diversity rather than uniformity and because of the development of Clinical Directorate structures, both job titles and work content were changing. In the report it was stated that communication at Trust / DMU level seemed extremely fragmented (even fractured) with rumour and counter-rumour rife. Relationships with staff were reported as changing fundamentally, and only a

minority of participants reported feeling excited and challenged by the new relationships with staff. It was also stated that the pace and amount of work had increased significantly to hectic levels (Edmonstone & Havergal 1992).
Regarding the appointment of doctors as clinical directors, Hancock (1993) suggested that the leadership of a clinical directorate should be determined according to patients' needs in an area. She discussed that:

> *"...given the multi-disciplinary nature of the team ... why is it always assumed that doctors should lead the teams? Do doctors themselves feel that only they are qualified to do so? Do their colleagues in other disciplines assume they will? Or it what patients naturally expect?... Can we really argue that because consultants are paid more than many other healthcare professionals they should automatically became team leaders?" (Hancock 1993).*

Traditionally nurses had progressed upwards within nursing, typically first reaching a senior nursing officer post then moving into a general management role. Ball (1995) stressed that after the abolition of nursing officer posts the number of 'newer nurse manager' posts was limited and therefore it was more difficult for nurses to reach senior positions. She suggested that, since it was not possible to move upwards without moving outside nursing, nurses who wanted to reach executive positions should get more general management experience at an early stage in their career. She also believed that by moving into non-nursing posts, nurses were likely to be better prepared to make the transition into general management or fill a nursing executive director post (Ball 1995).

Nevertheless it was widely accepted that the reforms posed a significant challenge for nurse managers (Hennessy & Gilligan 1994) with considerable career development opportunities for those nurses who were able and prepared to contribute in multi-disciplinary teams to meet the modern health service requirements (Walker 1993). It was suggested that although the clinical directorate model had some disadvantages for senior nurses, at the same time it opened up career pathways in management that needed to be exploited by senior nurses who wished to pursue a career in management (Rye 1991). Batehup (1992) also believed that there was a potential for nurses to develop roles in general management within the directorate structure. However, she said that this would be facilitated 'by nurses themselves starting to have a vision of care provision that moves outside of the boundaries of nursing' (Batehup 1992). It was also suggested that there were new opportunities and different career pathways that

nurses could consider, such as quality assurance programmes, resource management, and initiatives associated with the introduction of information technology (Havergal & Edmonstone 1993). A career transitions workshop in Scotland highlighted that a growing number of nurses were taking new career routes but career transitions were little understood and often painful for those who made them. Havergal & Edmonstone (1993) reported that at the workshop, participants stated that:

> *"...the attitudes, comments and behaviour of colleagues had the most significant impact on role change, and these were largely negative. They fell into two categories; resentment... towards people who had moved away from a professional background, or towards those who had moved into territory previously reserved for professionals.* And *accusations of personal instability, flightiness, job-hopping and boat-rocking, directed towards people who felt they were collecting a portfolio of skills and experiences" (Havergal & Edmonstone 1993).*

It was also believed that purchasing offered a tremendous opportunity for nurses and that nurses certainly had the potential to be able to contribute to the full range of tasks involved in purchasing (Harvey 1994b). She reported that most purchasing organisations employed people with nursing backgrounds, although few had a job title with 'nurse' in it. However she also argued that nurses would not got a purchasing post simply because 'they are nurses'. Harvey suggested that:

> *"Individual nurses have to develop a far better understanding of their own skills and competencies and of their relevance to other contexts... Nurse education and training needs not only to alert nurses to the existence of purchasing within the NHS but also needs to be grounded in a multi-sectoral, multi-professional view of health which explains the political realities within which healthcare operates and if nurses are to be effective they will have to pay more attention to developing the broader frames of reference which allow them to interpret and translate their experiences to other contexts" (Harvey 1994b).*

In 1993, '*A Vision for the Future*' was published to provide a strategy for the survival of nursing. This document provided a focus for nursing development. In this document it was stressed that nurses must be involved in commissioning.

> *"If the improvement in the health of population envisaged in the Health of the Nation White Paper is to be achieved; and, if patient choice and quality of services are to*

> *be improved, the nursing professions must have a strong involvement in the commissioning function in the NHS... Appropriately skilled nurses... can make a valuable input to the purchasing and commissioning cycle in a number of areas" (NHSME 1993, p:15).*

A year later an evaluative document *'Testing the Vision'* was published to describe progress in implementing 'A *Vision for the Future*'. It was reported that disappointing progress had been made on this issue and stated that "the professions' input into purchasing needs to be better understood and developed" as this was a newly emerging area for all participants in health care (NHSME 1994).

Blackshaw (1994) believed that although nurses began to establish a valuable and significant role in purchasing, most of the purchasing role had been achieved through the personality, skill and knowledge of individual nurses, rather than through a recognition of the need for a nursing input. Wenderburn Tate (1995) also emphasised the importance of people skilled in information gathering, analysis and synthesis in having a place in commissioning and purchasing. She concluded that nurses could claim the 'right' to be involved in anything only when they could offer this range of skills and specialist expertise (Wenderburn Tate 1995).

As Wall (1994) stressed, although it was a statutory right for nurse managers to have a place on NHS Trust boards, at purchaser level no such provision had been made. Therefore in 1992, a majority of purchasing authorities did not have nursing representation at board level (Blackshaw 1994).

Antrobus and Whitby (1994) emphasised that the NHS reforms represented a challenge to the survival and growth of the nursing profession. New roles from clinician to executive level required nurses to operate with vision and creativity in order to lead services effectively. They argued that especially executive nurse leaders, although they had little or no operational management responsibility, needed to show professional credibility in the development of a corporate vision (Antrobus & Whitby 1994).

Mangan (1993) claimed that a business culture was dominant in the NHS and success and failure were measured largely in financial terms. He believed that:

> *"...nursing will survive not because of sentiment but only if it deserves to. Its place within the market economy of health care will be ensured only if its contribution to the health and care of clients is seen to be worthwhile... it will depend upon the ability to demonstrate the effectiveness of nurses in terms of patient care and cost effectiveness that will determine if it is preferable to employ them rather than a less expensive health care assistant... nurses who have followed management route will have to display, through performance and result, the reason their nursing qualification is so vital to their work" (Mangan 1993).*

Horne, editor of the Professional Nurse, stressed that the implications of the White Paper for community nurses were important, particularly if the reforms put pressure on hospitals to plan for early patient discharge. Community nurses would have to undertake more specialist rehabilitation work, and become involved with sicker patients of all ages. This would require an extension of their skills and knowledge into more specialist areas (Horne 1989).

Under the new arrangements, after the Griffiths Report, there was no direct representation of nurses on some health authorities in England and Wales. According to Rowden (1989) and Horne (1989), this meant that at local level, all nurses needed to see how things proceeded in order to ensure that the nursing profession did have a voice which was both effective and valued (Rowden 1989; Horne 1989). On the other hand, the White Paper suggested that one of the executive directors of an NHS Trust could be a senior nurse. Therefore nurses might have major contributions to make to new thinking and have clear leadership roles at the top level (Rowden 1989). However Rafferty's work on leadership indicated that there was no clear consensus in nursing about 'what leadership is or who the leaders are' (Rafferty 1993). It was also believed that leadership in British nursing had long been neglected by nurses and policy makers (Rafferty 1993; Naish 1995).

Problems of redundancy and job insecurity in the NHS after the 1990 Reforms were discussed widely in the literature (Harvey 1995). Naish (1991) thought that just after the 1990 Reforms, redundancies in hospital Trusts were becoming the order of the day because Trust management wanted to cut their costs to balance their budgets for April 1992. He said that:

> *"Only a month into the reforms, ... the first casualties of the market place machinery have appeared on the scene. Redundancy- the unspeakable, inevitable result of*

> *shiny new terms like efficiency- is the word now haunting nurses who previously thought that if the NHS gave them nothing else, it gave them security" (Naish 1991).*

Snell (1991) also supported the view that in the new system there was insecurity and uncertainty. She said:

> *"For those units which were already having cash problems when they went into Trust status, the picture is still a gloomy one. With Trusts struggling financially, the mood among nurses is one of insecurity and uncertainty" (Snell 1991).*

Hempstead (1992), a nursing director in a Trust hospital, argued that the NHS reforms, and the development of the UK *Strategies for Nursing, Midwifery and Health Visiting,* forced a rethink of the attitudes, values and skills required by individuals to function in the new style of organisation. She disagreed with the people who thought that the reforms were:

> *"...a loss of power and status for nursing; a threat, not opportunity; a hidden agenda for deskilling the profession; an exercise in financial constraint; or as nothing to do with the real business of caring for people and managing health care".*

Instead she believed that 'nurses can influence the delivery of health care in a proactive way'. She said that there was a crisis of confidence in nurse management and leadership. She wrote:

> *"...to readdress this crisis, nurses need to demonstrate and articulate their ability to contribute to the organisation and its goals, to ensure efficient and effective service delivery, be prepared to capitalise on opportunity, share power and knowledge and use education and research to develop their management credibility" (Hempstead 1992).*

She also believed that the arguments 'which relate to the benefits for the organisation as a whole' would convince chief executives that there was a need for nurses in senior positions rather than the arguments such as 'nurses are the largest group of health workers, nursing accounts for almost half of NHS salaries, nurses are skilled professionals, nurses have contact with patient for 24 hours of the day' (Hempstead 1992).

Like Hempstead (1992), Huntington (1993) believed that to claim a role in purchasing and in general management on the basis of arguments such as 'we are the other major professional group in the NHS, so we ought and deserve to have a role' was not enough. She believed that:

> *"...there is a distinction to be made between having a role and having the interest, capacity and, above all, the will to perform it... nurses who want to influence purchasing must be there for the public as service users and not for the profession as providers. They must be there to express a passion for quality, not in the narrower organisational sense.... but in the much broader, strategic, commissioning sense that includes issues of effectiveness, equity and efficiency. There may well be a role for nurses rather than nursing in purchasing if some nurses are excited by the purchasing function" (Huntington 1993).*

Bradbury (1992) reported on a document about standards for nursing management, developed by South West Thames RHA to respond to the NHS reforms, and said that:

> *"We are all trying to make sense of the contracting process, the purchaser-provider relationship, and other seemingly endless changes which envelop us... the nursing management standards should improve client care as it creates a system to assure the quality of nurse management. It also states... how nursing management contributes organisational goals. This can help strengthen nursing within a general management structure, as well as serving as a basis for contracts for nursing services" (Bradbury 1992).*

Hunt (1992) suggested that in nursing there was a need for professional leadership and Directors of Nursing could undertake this role. She said that because of the number of changes that had taken place:

> *"It is essential that nurses give time and attention to influencing the situation so that the direction in which change occurs is congruent with our values and attitudes and provides opportunities for our career and development" (Hunt 1992).*

Historically, nurses' basic education had not prepared them to be managers. As a general rule, nurses were promoted to supervisory roles because of their clinical expertise or capabilities (Forrest 1983). "They have not been well prepared for the

responsibility of managing a diverse work group nor for working within a team of professionals" (King Edward's Hospital Fund for London 1981, p: 25). Mangan (1993) noted that in the past there had been a straightforward career progression in nursing. Now many of the old certainties had disappeared and like other nurses, nurse managers' jobs were coming under threat.

In one report it was argued that "The Salmon Report and the associated Mayston Report on Community Services commented on the problem of the incoherence of nursing administration and these comments led to radical reforms both in the management structure of the profession and in the preparation of nurses for managerial responsibilities" (King Edward's Hospital Fund for London, 1981: p3).

In the Salmon Report it was stated that "...we are aware that these changes we recommend cannot be implemented unless nurses are educated to the job we describe. Accordingly we have proposed a broad scheme of systematic education and training for promotion upwards through first-line to top management, with accent upon progressively increasing managerial skills" (Ministry of Health SHHD, 1966, page 9 para 1.19). This Report defined three levels of management training for nurses on a national scale: senior, middle and first line management. However according to Kelly (1990) those courses were not very effective and often 'uni-disciplinary and rather mechanistic' and course teachers were very different in age, experience and profession (King Edward's Hospital Fund for London, 1977 p:34). The other problem regarding the post-Salmon management courses identified by Beardshaw and Robinson (1990) was that 'the training used industrial and business models which nurses found of limited relevance to their work'.

The need for formal training in management and better preparation of senior nurses for their managerial roles had been well emphasised by many nurse authors writing from a management perspective, and governmental reports following the Salmon Report (SHHD 1966; King Edward's Hospital Fund for London 1977 (Thwaites Report), Smith 1980; Lees 1980a, Lees 1980b; King Edward's Hospital Fund for London 1981; Forrest 1983; Rowden 1987; Barnett 1988; Balogh & Bond 1992; Watt 1992; Hewison 1994). Henderson (1990) pointed out that although nurses received extensive education and training for their clinical roles, they did not have much opportunity to develop their skills in the area of management.

Lees (1980a) writing from the standpoint of a management trainer, and bearing in mind the changes facing the NHS at the time he wrote, asked whether management courses should aim to make managers better administrators, or to prepare them to be more resourceful innovators. He observed that:

> *"Nurse managers are frequently expected to fulfil the requirements of their roles for several years before receiving any formal management training. When they do receive this, it is either in the form of short, in service courses or at the most an external course of several weeks duration" (Lees 1980a).*

Lees felt that this fact implied that:

> *"The behaviours learned during the experience of early nursing are particularly suitable for transfer to managerial position, and that management courses are not really essential; the real training comes from actually doing the job" (Lees 1980a).*

He then agreed that although the latter assumption might be a realistic premise, the former was not, and that conversely, nurse managers' effectiveness was significantly impaired by the transfer of many behaviours learned during nurse training. The tendency of young nurses to follow rituals, accept authority uncritically and emphasise nursing solidarity may prove a handicap in producing managers who are able to encourage innovation, negotiate with other staff and develop their own subordinates (Lees 1980a, 1980b).

Forrest (1983) carried out research with nurse managers (nursing officers and above) and nurse teachers (N=122) within an Area Health Authority in the North of England. The aims of the research were to evaluate the effectiveness of management courses (they were first line, middle line and top line courses); to provide information on training needs for nurse managers; and to suggest how best these needs could be met. The research design was comparative and non-experimental. For the study a questionnaire was designed and participants were asked to assess their perceived level of preparation in 22 managerial skills on a scale of 1-7. Data collection took place over a nine month period commencing from May 1981. The response rate was 64% (n=78). The study results indicated that there was a need for nurse managers for greater preparation in budgeting and financial management. Also a majority of the nurse managers felt that they were only moderately prepared in the listed managerial skills and therefore it was

concluded that the management training courses need either revising or strengthening.

Rowden (1987) also agreed that the post-Salmon first and middle line management courses were not enough for nurse managers.

However increasingly, owing to the changing health care environment, it was also widely recognised that senior nurses, nurse leaders and nurse managers should increase and/or learn new managerial skills, knowledge and abilities such as business management skills if nursing was to do more than survive in the new NHS (O'Donnell-Imle 1991; SWTRHA 1992; Schroeder 1993). In line with this view in 1993, Ong noted that increasingly health professionals realised earlier in their career that they required management knowledge to progress. Jones (1992) had foreseen that because of the development of the White Paper Working for Patients' initiatives and the introduction of greater competition would bring major changes in the traditional role of health service managers. The nurse manager's role of the future would require creative and innovative skills and managerial productivity which are congruent with a general management function. Bradshaw (1995) said that:

> *"For former nurse administrators, resource usage was a secondary consideration. In the new era efficient resource utilisation is the salient concern to the nurse management and this primary task demands a high level of financial literacy, a thorough understanding of business planning and a sound working knowledge of contracting processes and procedures" (Bradshaw 1995).*

Hancock (1994) believed that some nurses in executive positions successfully acquired corporate and business skills necessary to be effective at board level, and at the same time they were able to demonstrate professional credibility and exercise clinical leadership. She also thought that nurses in management needed 'to harness the inside knowledge, the experience and the collegiate network that exists within nursing and make it available to the wider corporate team' (Hancock 1994).

Cleverley (1991) argued that after the NHS (1990) reforms immense changes occurred in the NHS and therefore nurse managers should come out of their traditional roles and learn new skills such as marketing. She said that:

> *"Many nurses will find the business concepts of marketing and the purchaser/provider role distasteful but ... given that these changes are with us and that packages of care need to be sold, it follows that nurse managers need the skills to be part of the marketing process" (Cleverley 1991).*

O'Donnell-Imle also emphasised that the NHS (1990) reforms required new approaches by nurse managers. She said that:

> *"Nurses must become effective managers and leaders in order to fulfil their responsibilities to themselves, to their clients, and to the nursing profession. The innovative nurse managers will be able to use creative problem solving in a highly competitive environment... we must increase our ability to think and plan strategically, develop greater depth in financial aspects of health care and business planning, improve our negotiating skills and broaden our technological knowledge base" (O'Donnell-Imle 1991).*

Neither traditional nurse training or higher education diplomas included these subjects. Rowden (1987) pointed out that 'in basic nursing training, the emphasis was placed on the acquisition of clinical skills, which was fostered as the individual moves through the profession'. In a report, produced by South West Thames RHA in 1992, 14 senior people had been interviewed to examine the challenges facing nursing for the near future. It was argued that 'the traditional development and career advancement of nurses had been pursued on a narrow professional front, so that nurses have not been exposed to broader health care management issues and to opportunities to develop their business management skills' (SWTRHA 1992, p: 6). Mulholland (1994) believed that the NHS changes made it necessary for nurse managers to have a greater understanding of the management part of their role. Therefore those who wanted to be effective managers in the NHS should consider taking formal management education/ training that would give them an appropriate perspective. Nurse managers in the UK were charged to operate the rules of commercial competition (Bradshaw 1995) and to achieve profit. To do this efficiently they needed to be trained.

In Balogh & Bond's study (1992) it was found that there had been a clear tendency for managers first to be promoted from within the system and later to receive training for a job which by then they were already doing: 83% of the respondents felt that they had tended to receive training for positions after taking them up rather than beforehand. The aim of the study was to assist to the

Northern Regional Health Authority to plan investment in management development for nurses in the Northern Region in England. In Balogh & Bond's study first four focus group workshops of senior nurses and general managers (N=25) were convened. A questionnaire was then designed, based on the issues discussed and raised at the workshops. In total 95 respondents returned the questionnaire (the response rate was 78%), of these 63 were nurse advisers or nurses in senior management roles and 32 were Chief Executives or General Managers.

According to Kelly (1990) nurses taking on managerial roles had received little training in this sphere of their work and consequently they were often unable to meet their responsibilities (Hewison 1993). Nethercott (1991) also claimed that the preparation of senior nurses for their management role was questionable. She concluded:

> *"I see the strength of the nurse manager as being able to integrate the concepts of nursing and management. This needs management training and continued clinical experience" (Nethercott 1991).*

According to Watt (1992) the changes and demands for more effective management in the NHS required a review of managerial training of nurses in management. Nurse managers, like other members of the executive group, should make an equal and effective contribution to the planning of health services. One key issue for nursing management was described as 'to contribute effectively to health services manpower and policy development as a key member of the multi-disciplinary team within the general management framework' (SHHD 1990 para 5.2.4). It was argued that nurse managers need preparation for this level of participation. In the case of Nurse Executive Director posts it was emphasised that there was a need to develop nurses for management 'expanding beyond a limited professional remit' (NHSME 1992, p: 23).

In fact in 1977, some 13 years before the NHS (1990) reforms, a report entitled *The Education and Training of Senior Managers in the NHS* suggested that:

> *"Nurses are probably weakest in the numeracy, analytical and conceptual skills. These are essential for participation in corporate planning to which the senior nurse manager must make her own particular contribution equal to that of her team colleagues. Nurses must also possess the ability to discern potentially sensitive*

> *areas and be aware of the changing political, social, and economic climate in the health service. They must have sound judgement, be prepared to take decisions, and be able to explain them (King Edward's Hospital Fund for London 1977, p: 51)*

In 1995 the Nursing Directorate NHS Executive, in association with Newchurch & Company, carried out a project. This study aimed to assess the position of nursing within clinical and organisational management across NHS Trusts and to examine the value that nursing added to the management within the Trusts. The data collection tools for the study were a questionnaire followed by four business meetings with Trust Nurse Directors in the Spring of 1995. The questionnaire survey was subdivided into three questionnaires and distributed to the Nurse Directors, Chief Executives and Clinical Managers of all operational and fifth wave shadow Trusts in England during January and February 1995. The response rate for Nurse Directors, Chief Executives and Clinical Managers were 76%, (n=253); 64%, (n=297); and 60%, (n=1175) respectively.

In the study it was found that apart from their statutory Nurse Director post, the number of nurses at board level was limited. Chief Executives who participated in the study believed that the most valuable contribution of nurse directors was in the traditional nursing roles of quality assurance and clinical practice development, whilst nurse directors believed that their principal value lay in the area of strategic development. It was also shown that the role and function of the nurse director varied between Trusts. According to the study, only 26% (n=66) of nurse directors directly managed all of their nursing services, and nurse directors had a very wide and varied management remit including quality assurance, audit and human resources. In the study it was suggested that nurse directors must develop their ability as corporate team players within the present framework to maximise their specific contribution and they should actively explore means of increasing the nursing contribution at the highest levels of management within Trusts. In this research, although the number of questionnaires available to analysis was high (n=1725), the study was not comprehensive and some certain aspects of the study were not explicit such as the original number of the questionnaires distributed, the number of participants interviewed. In addition in the questionnaire itself, although respondents were asked to give their qualifications, in the report no information was found on this issue (NHS Executive & Newchurch & Company 1995).

The role of Nurse Executive Director (NED) in first-wave Trusts in England was examined in a report produced by the DoH (NHSME 1992). The way in which the role had developed one year on had also been determined. The report was based on interviews with 24 NEDs and it provided a qualitative overview of the roles and highlighted the more uncertain aspects of the roles and the career opportunities for NEDs. In order to identify the common elements of job content, job descriptions of all interviewees were reviewed. Six responsibilities were identified: nursing leadership; development and leadership of nursing practice; direct/ operational management; contribution to corporate leadership and management of the Trust in areas not specifically relating to nursing; human resource management; and quality assurance.

Ball, Disken & Dixon (1995) carried out an initial questionnaire survey in February and April 1994, with 695 Senior Nurses working in the NHS in England. The usable response rate of the study was 69% (N=478). This study was the fourth of the reports on the 'Creative Career Paths in the NHS' (CCP) Project, which was performed by IHSM Consultants for the NHS Women's Unit. The objectives of the study were to analyse the career paths of senior nurses, midwives and health visitors; to analyse the role of NED in the NHS Trusts and other senior nursing roles in terms of the changing nature of the roles and the skills and knowledge required; and to establish the contribution of the nursing professions to general management in the NHS. The principal aim of the project was to survey a wide range of nurses in senior positions. The inclusion criteria of the survey were;

- DoH including NHSME - nursing officers grade 6 and above
- RHAs- the most senior nurse at RHA and the tier below
- Provider Units- the most senior nurse in the organisation -NED or the equivalent in a DMU
- DHAs/commissioning bodies - nurses working at director level and the tier below.

Of the respondents 285 were Nurse Executive Directors (NEDs). For the second stage of the study the authors carried out a series of semi-structured interviews with 21 NEDs in England. From the questionnaire survey it was found that the senior nurses were 45 years old on average, and the men were slightly younger than the women. Also the men were more likely to be married than the women (Ball *et al* 1995).

In 1992 a report, produced by the South West Thames RHA, examined the challenges facing nursing for the near future, proposed an evolving role for the Trust nursing directors and developed a competency framework in support of the evolving role. In order to develop a competency framework, 14 senior people had been interviewed. In the report three potentially overlapping stages of role evolution were envisaged. They were;

> *"a transition stage, characterised by an emphasis on providing the leadership and management of the changes impacting nursing in the near term.*
> *a medium term stage, in which the appointed nursing director assumes increasing responsibility for improving patient care consistent with the strategic and commercial development priorities of the Trust.*
> *a longer term stage, by which time the nursing director, or successor, can take his/her place on the executive as equally equipped as other members to make an effective contribution to the future success of the Trust" (SWTRHA 1992 p:2).*

It was pointed out that consistent with the roles suggested for each stage the nursing director should possess a key set of competencies reinforced by supporting capabilities and management skills. The ability to plan and progress their own self development and to determine their own pace of development was identified as a key competence that all aspiring nursing directors should possess. It was concluded that the results of the study were successfully implemented within the South West Thames RHA 'to assist high potential nurse managers in identifying individually tailored personal development plans focusing on a range of development opportunities' (Hennessy, Rowland & Buckton 1993).

2.1.13 SUMMARY

This section has provided a general overview of the development of the provision of the National Health Services in the UK. It has set out the historical and organisational background to the NHS and described some developments of health policy in Britain. It has summarised also a number of NHS reforms and their effects on nursing and nursing management. In this section the position and role of nurses in management after the NHS (1990) reforms and the need for management training for nurses in management was also discussed. As Petchey emphasised in 1993 the NHS was changing but the nature of the change was unclear. It should be noted that at the time of this study, much of the literature

pertaining to the role and position of nurses in management and their management training was largely opinion-based rather than existing from research-based studies.

In the following section the organisation of the NHS is discussed.

2.2 THE ORGANISATION OF THE NHS

2.2.1 INTRODUCTION

There is no uniform structure of the NHS applying throughout the United Kingdom. The NHS in Wales, Scotland and Northern Ireland have been administratively devolved to the Welsh Office, Scottish Office and Northern Ireland respectively. The NHS in each of these three countries was at the time of this research the political responsibility of the relevant Secretary of State. The most notable difference in Wales, Scotland and Northern Ireland was the absence of a regional tier of organisation. At the time of this study there were nine DHAs in Wales, fifteen health boards in Scotland, and four health and social services boards in Northern Ireland (Harrison *et al* 1990).

2.2.2 THE ORGANISATION OF THE NHS IN ENGLAND

At the time of this study, the Secretary of State for Health was responsible to Parliament for the provision of health services, and he/she was also responsible for personal social services. The Secretary of State discharged his responsibility through RHAs, DHAs, Family Health Service Authorities (FHSAs), NHS Trusts, and Special Health Authorities. These authorities had important autonomy from central government. CHCs were statutory bodies established at a local level to represent the interests of their communities in the NHS, but lay outside the managerial chain (Ham 1991).

2.2.3 THE ORGANISATION OF THE NHS IN SCOTLAND

At the time of this study, although the general principles governing the NHS were the same throughout the United Kingdom, the way health services were organised in Wales, Scotland and Northern Ireland was not the same as in England. The four countries differed notably in terms of their organisational structures, resource inputs per capita, and the health status of their populations. There were also remarkable policy differences between the different countries (Harrison *et al* 1990; Levitt & Wall 1992).

Scotland joined the UK 400 years ago. The policies devised since that time have attempted to recognise Scotland's unique circumstances within the UK. The legislation that originally created the Scottish Health Service was the National Health Service (Scotland) Act (1947), passed on 21 May 1947, establishing an organisation based on the same tripartite principle as in England and Wales (Levitt & Wall 1992).

As noted earlier the most important difference between Wales, Scotland and Northern Ireland was the absence of a regional tier of organisation. This was removed with the 1974 reorganisation and replaced by a common services agency function but jointly managed by government and the health service (Harrison *et al* 1990).

From the Griffiths Report of 1983, changes in management arrangements for Wales, Scotland and Northern Ireland have followed those in England. The major difference has been one of timing with England after taking a leading role. In Scotland, there were 15 health boards and these boards were responsible for family health services as well as hospital and community services. There were no separate FPCs (Family Practitioner Committee) administering GP (and other) services.

The Secretary of State for Scotland was, through NHS legislation, personally accountable to Parliament for the Scottish Health Services. In Scotland, the supreme government department was the Scottish Office. The department responsible to the Secretary of State for the central administration of the Scottish NHS was the Scottish Home and Health Department (SHHD). There were a number of professional and administrative bodies with important duties in the

Scottish National Health Service including the National Board for Nursing, Midwifery, and Health Visiting for Scotland (NBS) (Levitt & Wall 1992).

Scotland spends more on the NHS per capita than England and Wales (Ham 1992). Expenditure also varies between different regions and areas within each of the countries. In 1988/89 the estimated gross public expenditure per head of population on health services in England was £390 compared with £425 in Wales, £430 in Northern Ireland and £485 in Scotland (Harrison *et al* 1990). This was partly accounted for by higher staffing levels. In 1985/86 for example, Scotland received 19% more NHS revenue finance per capita than England. Despite this, and compared with England, Scotland suffered significantly higher age-standardised mortality rates for both men and women. Health indicators showed a worse picture in Scotland than elsewhere in the UK, particularly for heart disease, where the incidence is among the worst in the World (Levitt & Wall 1992, p:114).

In terms of community care in Scotland, two policy statements on health care priorities - Scottish Health Authorities Priorities for the Eighties (SHAPE) in 1980 and Scottish Health Authorities Review of Priorities for the Eighties and Nineties (SHARPEN) in 1988 (Scottish Home and Health Department 1988) both stressed the commitment to community care. SHARPEN stressed the needs of people with dementia and encouraged further development of community services particularly for the elderly.

2.2.4 SUMMARY

In this section the organisation of the NHS in Scotland at the time of this study has been summarised. The next chapter provides a brief overview of the financing the NHS.

2.3 FINANCING THE NATIONAL HEALTH SERVICE

When this study was conducted public expenditure in the UK amounted to over 40% of the Gross Domestic Product (GDP). Within this percentage, central government's share was in the region of 75% with local authorities being responsible for most of the remaining 25% (NAHAT NHS Handbook 1991). Most of the money for the NHS was derived from three main sources (Figure-2.3.1). The amount of expenditure from general taxation was agreed each year for the following three years through the Public Expenditure Survey.

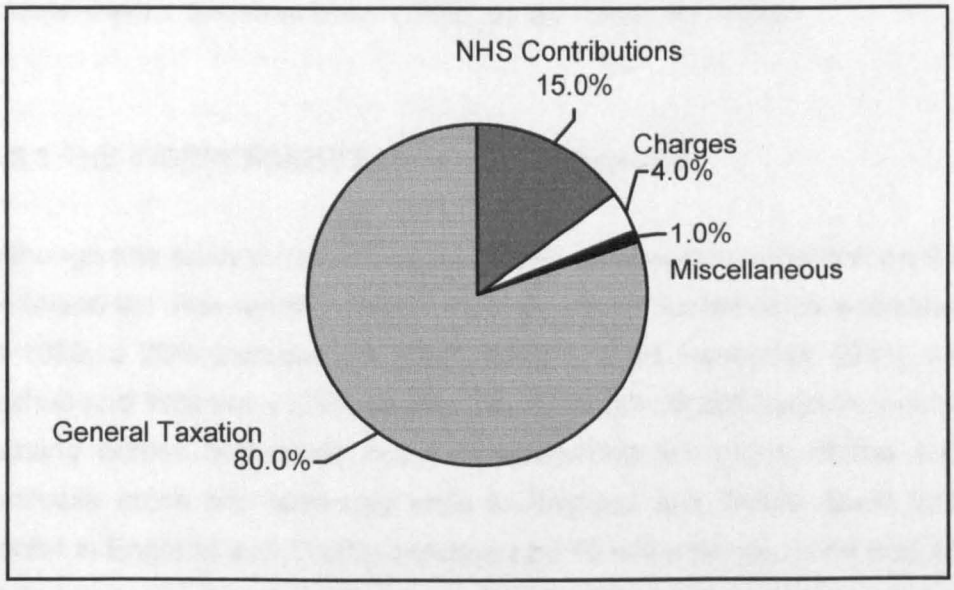


Figure-2.3.1: Sources of NHS finance, Great Britain, 1990-91

Source: Ham (1992), Health Policy in Britain, MacMillan

According to Levitt & Wall (1992) over the years the amount of money spent on the NHS has risen substantially. Within the UK the resources allocated to health can also be compared with the allocations to other public services (Table:2.3.1 over). The UK general government expenditure totalled £227.5 billion in 1991 (Central Statistical Office 1993), an increase of 6% on 1990.

Table: 2.3.1 UK general government expenditure in 1991

FUNCTION	1991 (£b)	%
Social security	73.9	32.48
Health	30.9	13.58
Education	29.5	12.97
Defence	27.3	12.0
Public Order and Safety	12.8	5.63
Other	53.1	23.34
Total Expenditure	227.5	100.00

Source: Central Statistical Office (1993), Social Trends, 23, HMSO

2.3.1 THE INDEPENDENT SECTOR AND THE NHS

Although this study's concern was the NHS, it is worth noting that on the broadest definition the independent health care supply amounted to an estimated £6,535m in 1989, a 20% increase on 1988 (NAHAT NHS Handbook 1991). As Thomas, Nicholl and Williams (1988) reported in 1985 the 52,886 beds in private long-stay nursing homes and acute hospitals accounted for 13.2% of the 400,886 total available acute and long-stay beds in England and Wales. Beds in the private sector in England and Wales increased by 19.4% between 1984 and 1985. It was stated that any change in the size or composition of the private sector would have implications for the pool of experienced qualified nurse manpower available to the NHS. It was also reported that there was a concern about the loss of NHS-created nursing skills to the private sector (Thomas *et al* 1988).

A key factor in the development of the private sector was the spread of private medical insurance. It was the main engine of growth for private acute health care, about 70% of which claimed to be insurance-funded. At the end of 1989 there were an estimated 3,430,000 medical insurance policy holders in the UK. Including dependants an estimated 7,240,000 people were covered by private medical insurance (NHS Handbook 1991, p:211). The main reason giving for choosing insurance was to ensure immediate medical attention, whether for elective or essential surgery (Smith 1991).

The three major medical insurance agencies in the UK during the early 1990s were BUPA (the British United Provident Association), WPA (Western Provident Association), and PPP (Private Patients Plan). BUPA also runs hospitals (Levitt & Wall 1992). In mid-1990 there were 216 independent acute medical/surgical hospitals throughout the UK with a total of about 10,900 beds -running at about 60% occupancy- this compares with 373,000 beds in NHS hospitals at a similar time. There were another 1900 acute psychiatric beds, 90,000 private nursing places and 140,000 private residential home places. In addition 17% of all elective surgical operations in Britain were carried out in the independent sector (Smith 1991).

In the independent hospital sector there were three groups with more than 1,000 beds each; AMI Health Care Group, BUPA Health Services and Nuffield Hospitals. Together they accounted for about 35% of independent hospital revenue (NHS Handbook 1991). Movement of skilled nursing staff into the independent sector was an important issue.

In one study, Thomas *et al* (1988) investigated 2,165 qualified nurses in eight NHS DHAs and 72 private sector institutions in England and Wales. The aim of the study was to measure the skills which moved between these sectors and to estimate the likely impact on NHS nursing services of any future growth in the private sector. Data were collected over a year period commencing in January 1985. A stratified random sample was used for sampling. In the study it was found that the estimated net loss of NHS qualified nursing staff to the private sector in 1985 was 1,098. This represents an average of 5.5 nurses per DHA in England and Wales. They argued that numerically that may not have represented a serious loss to the NHS. However, the authors showed that private acute hospitals selectively attracted recruits from specific groups within the NHS workforce, in particular nurses under 30 years of age with specialist skills such as theatre nursing, renal nursing, intensive care and oncology where NHS nurses were already in short supply (Thomas *et al* 1988).

2.3.2 SUMMARY

In this section the main sources of NHS finance has been outlined. Also the importance of the independent sector within the context of health care provision is

discussed. In the next section the history of nursing and the Salmon Report are discussed.

2.4 NURSING -BEFORE AND AFTER THE COMING OF THE NHS

2.4.1 INTRODUCTION

Nurses are the largest professional group within the NHS comprising approximately half of total staff. The proportion of nursing staff who are qualified was 61% in 1989. The nursing profession in the UK is regulated by five statutory bodies -the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC) and four national boards, for England, Scotland, Wales and Northern Ireland (NAHAT NHS Handbook 1991).

The statutory bodies came into existence under the Nurses, Midwives and Health Visitors Act, 1979 (NHS Handbook 1991). In 1992 a new Nurses, Midwives and Health Visitors Bill was given royal assent which was designed to amend the 1979 Act (Hand 1992). The UKCC is responsible for maintaining a single professional register of all qualified nurses, midwives and health visitors as well as for general policies on professional education and development and conduct. The national bodies are the examining bodies for the nursing profession (NHS Handbook 1991).

Although nursing has been recognised as 'women's work' by Beardshaw & Robinson (1990), approximately 10% of nursing staff in NHS hospitals are men. The percentage is much higher in psychiatric hospitals, and rather lower in general hospitals and in the community. According to September 1991 figures there were 75,068 nursing staff in Scotland (Scottish Health Statistics 1992). The distribution of all Nursing staff in Scotland by location, qualification status and grade is shown in Table-2.4.1 over.

Table:2.4.1 All nursing staff in Scotland by location, qualification status and grade in 1991

NURSING STAFF	NUMBER
Nursing Management	**287**
Teachers	**890**
Hospital Staff	**65943**
Qualified	35228
Registered	25130
Enrolled	10098
In Training	9891
Unqualified	20824
Other Staff	**7687**
Blood Transfusion Staff	**261**
Total	75068

Source: Scottish Health Statistics 1992, Information & Statistics Division, 1992.

2.4.2 HISTORY OF NURSING

Before 1860 there were both the voluntary hospitals and the Poor Law establishments. Within the Poor Law there were workhouses which sheltered the poor, the sick and the aged. Both the voluntary hospitals and the workhouses were administered by a male steward or master and a female matron (White 1986). In the workhouses, nearly all the nursing of the sick paupers was done by such able-bodied paupers as happened to be available (Abel Smith 1960, p:4). Voluntary hospital nurses were either the ward maids or the sisters. The sisters were responsible to the doctor whose patients were admitted to 'his' ward (White 1986, p:50). Although there had been religious orders which dedicated themselves to the service of the sick, according to Abel Smith (1960) 'historically the antecedents of the nursing profession were domestic servants'.

The matron's duties for all female staff were those of recruitment, discipline, feeding and payment and issuing supplies to the wards for nursing and domestic purposes. With all the responsibilities of household management left largely to the matron, there was little time left for the supervision of the nurses and it was not

thought that any special training or experience were required to nurse the sick. Nor was it the matron's duty to teach the nurses. The nurses of this period are roundly condemned by nursing writers and the time is described as a 'dark ages' (Abel-Smith 1960, p:9).

As Levitt & Wall (1992) point out, in the mid-nineteenth century attitudes began to change and the idea of nursing as a vocation began to emerge. The Nightingale Training School at St Thomas was set up in 1860 and many others followed. The missionary effect of Florence Nightingale's nurses led fairly rapidly to the appointment of certificated nurses as matrons in the voluntary hospitals by the late 1880s. The appointment of trained matrons effected a considerable change in the administration of the hospitals. In the Poor Law establishments, trained matrons were also appointed slowly but their title was 'superintendent of nurses' (White 1986).

Levitt & Wall (1992) stress that statutory registration of nurses trained to an approved standard involved a long and complicated struggle. After 1919 the Nursing Registration Acts with the establishment the General Nursing Council (GNC) as the registering authority, the matter was resolved. The Nurses Act (1949) incorporated male nurses into the main register but not until the Sex Discrimination Act (1975) were men allowed to train as midwives.

Some believe that the role of matron began to change after the coming of the NHS. Gradually she handed over most of the domestic duties to the hospital administrator. Matrons suffered a major loss of status when they were no longer invited to attend the meetings of hospital management committees as there was no post for a Group Matron. They were relegated to the second tier of control in the Group (White 1986; Dimmock 1985). White (1986), claimed that:

> *"The loss of control of their non-nursing departments was a major reduction in the authority of the matrons... this alteration in the power base had considerable reverberations over the course of the next decades" (White 1986, p:52).*

As the Salmon Report on Nursing Management noted 'while the status of matrons in former local authority hospitals generally improved, in many voluntary hospitals it declined' (Ministry of Health Scottish Home and Health Department 1966).

2.4.3 THE REPORT OF THE COMMITTEE ON SENIOR NURSING STAFF STRUCTURE (THE SALMON REPORT)

In 1963 the apparent decline in the status of nursing and shortage of trained nurses (Levitt & Wall 1992), and the chronic shortage of applicants for nursing administration posts (Carpenter 1977), prompted the government to set up a review of the profession under the chairmanship of B. Salmon. His report was published in 1966. This Committee recommended a division between managers and practitioners through the abolition of nurse matrons and their replacement by a hierarchy of nurse managers (Allsop 1984). According to Rafferty (1992) the model suggested by Salmon, which was based partly on the industrial model, was intended 'both to modernise nursing management to fit the new environments of the district general hospitals and to achieve a more efficient use of labour' (Rafferty 1992, p:80).

Salmon's proposals also aimed to open to nursing an extended career hierarchy, and to establish the nursing profession as an equal partner in hospital management with the medical profession and lay administrators (Bellaby & Oribabor 1980; Dimmock 1985). It was also suggested that nursing management should be relieved of control over services which did not require specialist nursing knowledge. As outlined by Rafferty (1992), the Report proposed three tiers of administration:

> *"The top level managers were responsible with the making of the policy (the CNO); middle management was responsible for translating plans into operational programs for a particular sector, using as well as managerial expertise (principal and senior nursing officers); and the practical delivery of nursing -execution of policy and plans- remained with the first line nurse, nursing officer, charge nurse or sister and staff nurse" (Rafferty 1992, p:80).*

There was also to be a division between nurse managers and nurse teachers with the higher-ranking posts going to the former (Allsop 1984).

The recommendations of the Report were accepted and it was agreed that sixteen pilot schemes should be set up and evaluated. However, in 1968 the DHSS took the decision to implement the Report's recommendations throughout the NHS. Following the Report, CNOs were appointed who were to be responsible for the

nursing services in each group of hospitals. The Mayston Committee (1969) was set up to apply the Salmon principles to the community services (Leathard 1990).

Many nurses and administrators welcomed the Salmon proposals, thinking that these would help to develop greater professional status. The Report established the professional head of nursing as an equal with her other administrative and medical colleagues and gave them considerable power and opportunity to manage resources at a senior levels (White 1986; West 1992). But Young (1986) believed that in the past nursing and its managers were not successful and management in nursing had created a bureaucracy that had failed to create thinking/adaptive people. He also argued that nurses did not always seize the opportunities given by the Salmon Report. He said:

> *"We reinforced the bureaucracy by pursuing a model of middle management that failed to grasp the real, positive intentions of a well thought through report. Most nursing officers, have lost, if they ever had, credibility among their staff as 'clinical experts" (Young 1986).*

Other administrators and doctors, however, were slightly more cynical or scornful of the idea of nurses as managers (Levitt & Wall 1992). West (1992) claimed that some key administrators resented the loss of their 'dominant position' and did not welcome the introduction of the Salmon Report at all (West 1992).

Dimmock (1985) believed that the Salmon Report and all that followed were double edged. He maintained that:

> *"It enabled the profession to establish itself as an equal partner in tripartitism. But in doing so it encouraged nurses to become over-concerned with the management of nursing alone and to develop managerial system which appeared almost entirely self-contained. But a general manager's job consists of four principal aspects: domain, agenda, network and own skills. Events of the last 20 or so years have reduced the nursing profession's ability to claim significant experience in these critical aspects" (Dimmock 1985).*

Leathard (1990) argued that some nurses saw the post-Salmon in-service management courses as a pitfall. The basic problem was that nurses had limited training in management skills. White (1986) also stressed lack of managerial knowledge of nurses. She maintained;

> *"...by 1974 a new generation of senior managers was emerging but their training was still deficient; nurses knew nothing of social policy, demography, employment law...; they continued to react to policy made by administrators and doctors; on a national basis they were no more successful in winning a part in policy making" (White 1986).*

The abolition of nurse matrons was seen by some nurses as the 'loss of a post with a lot of power' (Meates 1989; Andrews 1990; Davidson & Cole 1991) and loss of a clear and well defined career structure in nursing (Meates 1989). It was argued that the matron not only had responsibility but authority to carry out her clear, well defined role. She was the top nurse manager on the hospital management committee and she had the power when changes or developments were planned (Meates 1989). Dean (1993) also stated that 'until the 1970s every hospital had its matron, many of whom were first class general managers and leaders'. Andrews (1990) said that:

> *"The matron of the stereotype was a woman who was very powerful, but ingratiating and fawning towards the consultant. In throwing over this image we lost the consultant's teamaid, but we also lost the powerful nurse" (Andrews 1990).*

As opposed to this belief Robinson argued that, as quoted in Davidson & Cole (1991), matrons had the power, but that was because 'it was in the doctors' interests to have them in that position. In reality, they were still very much under their thumb'. Mostly the matrons did not make any contribution to advance nursing in research, education or clinical practice (Davidson & Cole 1991). In regard to the matron's power Kitching (1993) also agreed that 'the matron's power was more symbolic than functional and her control and dominance was predominantly over women within the context of a male dominated hierarchical health care system'.

The Salmon Report was seen by Carpenter (1977) to be an implicit critique of female authority. Carpenter maintained that:

> *"Female nurses were viewed almost as inherently unable to exercise administrative skills. In the past men could not be expected to possess the 'qualities 'of a good nurse, or if they did, were often considered effeminate. Salmon transformed the image of 'men' in nursing and men were considered tougher material for management" (Carpenter 1987, p:181).*

Therefore, the proposals of the Salmon Report provided more opportunity for male nurses because they possessed the characteristics that would enable them to move up the hierarchy more quickly (Carpenter 1977). Carpenter set out these features:

> *"They were more likely to stay longer in the service, to work full-time, to wish to escape low pay and perhaps a feeling of marginality in the clinical situation and to have greater geographical mobility than their female competitors" (Carpenter 1977, p:180).*

In fact the September 1991 statistics supported Carpenter's opinion: In Scotland there were 187 female nurses and 100 male nurses in nursing management in the NHS. In other words nearly one in third of the managerial posts were taken by male nurses, yet they constituted only 10% of the profession in the UK as a whole (Scottish Health Statistics 1992).

2.4.4 SUMMARY AND CONCLUSION

In this chapter a brief history and development of the NHS in the United Kingdom and particularly in Scotland have been provided. The establishment and the structure of the NHS have been summarised. The reorganisations of the NHS in 1974 and in 1982 and the problems followed the reorganisations have been described.

As noted earlier in Chapter I, this study aimed five research questions which were:

1) What are the demographic and educational features of nurses in management?
2) What is the current management training(s) and/or management education and how has this training contributed to the job of nurses in management?
3) What are the main job responsibilities, and skills, knowledge and qualities necessary for nurses in management?
4) How do nurses in management perceive the 1990 NHS Reforms and their effects on their job?
5) What is the view of nurses in management regarding their present and future role within the NHS in Scotland?

Therefore this chapter has included detailed literature review regarding the position of nursing management after Griffiths and after the NHS (1990) Reforms in detail. It has summarised the reactions of different professionals particularly nurses and doctors' to these changes. In this chapter the need for formal training in management and better preparation of nurses in management for their managerial roles was also emphasised.

In this chapter the organisation of the NHS in the UK and particularly in Scotland have been described and differences between the countries in terms of the structural organisation have been briefly provided. This chapter has also included the sources of NHS finance briefly and and provided an overview about the independent sector and the NHS. In this chapter the numbers of all nursing staff in Scotland and the importance of the nurses as a workforce within the NHS have been emphasised. The Salmon Report and its effects to nursing profession and nursing management have also been discussed.

CHAPTER III

MATERIALS - METHODS

3.0 Overall Research Design

This study was conducted in two stages, the first being a postal questionnaire followed by a volunteer sub-sample of semi-structured interviews as indicated by the questionnaire. The design of the study was descriptive in accordance with the primary aim of exploring the role of nurses in management within the NHS in Scotland. Data were obtained using a questionnaire, composed of both open and closed questions, and the responses were then used to develop a semi-structured interview schedule. In this study data were linked as shown by Miles and Huberman (1994 p:41). Following an extensive literature search on the topic a series of informal exploratory discussions were held with experienced nurses in management. This led to the development of the questionnaire, whose findings were then used to develop a semi-structured interview schedule based on the emergent issues.

In this chapter, the overall design of the questionnaire is described along with the construction of the interview schedule and the conduct of the interviews. It should be noted that literature pertaining to the methods is integrated in this chapter.

3.1 PART I THE QUESTIONNAIRE

3.1.1 Study Sites

Time, financial and manpower constraints meant that this study could not include all possible specialities or sizes of hospitals. The researcher had no secretarial support and had therefore to carry out the study alone including data collection and analysis. Therefore a set of exclusion criteria concerning study sites was established which were as follows:

- all specialist units, hospitals and departments e.g. urology, Ear, Nose & Throat, radiology;
- all maternity and children's units, hospitals and departments;
- all Accidents & Emergency, theatre, anaesthesia departments (if not attached to a general hospital);
- all hospitals with 50 beds or less.

It was also decided that all purchasing units (Health Boards) should be excluded. However Chief Area Nursing Officers' (CANOs) views regarding the role of nurses in management were included to provide insight into the study. Sisters/charge nurses were excluded owing to special developments in their roles and it was thought that a detailed study of their role was outside the scope of this project and should be carried out independently.

3.1.2 Samples

The possibility of including nurses in management working in England was examined. However owing to constraints of time, money and manpower this was not considered to be feasible.

In order to identify all Directors of Nursing Services (DNSs), or equivalent, at provider level throughout Scotland, the 1992-93 Hospital and Health Services Year Book, and a list provided by the MDG (Management Development Group), Edinburgh, were used. In addition a number of telephone calls to some organisations (e.g. hospitals, health centres) were made to confirm details and fill in gaps or sometimes to elicit the information for this purpose. In the light of the exclusion criteria, it was found that there were 51 DNSs (the most senior nurse in the organisation) or equivalent who met the inclusion criteria of the study. In order to have a database for the study a detailed notebook was compiled including the hospital size, names, titles, work places, addresses and telephone numbers of all these nurses. In order to be included in a study sample the participants had to meet the following criteria:

- be a Director of Nursing Services (DNS), or equivalent, at provider level throughout Scotland;
- be a nurse above sister/charge nurse level who had a management remit in the organisation i.e., nurse managers, operational managers, business managers.
- work in a provider organisation - DMUs and NHS Trusts over 50 beds

3.1.2.1 Access to Sample

The first communication with these nurses concerning this study took the form of a letter, introducing the researchers, outlining the scope of the project and

requesting that they supply their Senior Nurse Managers' (SNMs) names, titles, addresses and clinical setting (Appendix I.1). They were also invited to take part in the study.

At this early stage it was realised that the title 'Senior Nurse Managers' was misleading and there were difficulties encountered in defining who qualified as a SNM. Owing to the NHS (1990) reforms many NHS organisations had gone through major structural changes and therefore were changing job titles accordingly. For example one DNS stated that they had no SNM in the hospital but there were some nurses who were previously SNMs but they were working under different titles i.e. Directorate Nurse Manager. Since all nurses were to be included above sister/charge nurse level who had a management remit in the organisation, a second letter was sent to all 51 DNSs and explained the information needed. In this second letter it was decided to use the term 'nurses in management' instead of SNM. The term 'nurse manager' or 'nursing manager' was to be avoided since the study was not concerned solely with managers of nurses; the study covered a wider perspective. Consequently a total of 48 DNSs (94%) supplied the necessary information and access for the study. Responses provided the details of potential participants' availability. The 48 letters were then carefully examined to determine the eligible subjects which eventually provided 284 names.

In conclusion all nurses in management working in hospitals and the community, (provider organisations- DMUs and NHS Trusts) in Scotland, with the exception of those excluded as stated earlier in 3.1.1, were invited to participate in the study. They included:

15 CANOs or equivalent (Purchasing level)
48 DNSs or equivalent
221 other nurses in management i.e., all nurse managers, operational managers, business managers.

3.1.3 Questionnaire Design

In designing this study it was recognised that interviews would have yielded a rich source of data from which to examine the issues identified in the research questions. However, as there was a lack of research into the role of nurses in management within the NHS, it was decided that a questionnaire would provide a

more comprehensive range of data. Interviews would then be utilised in the next stage of the research to explore in greater depth the issues raised by the respondents who completed the questionnaire. Therefore it was thought that the best way to capture and analyse the data, in the first stage of this study, was to design and construct a postal, self-administered questionnaire.

The questionnaire was the main data collection tool and questionnaire items were derived from two sources. A literature review on the role of nurse manager/ director (or nursing manager) (Bowman (1980); King Edward's Hospital Fund for London (1981); Applin (1984); Read (1984); Barnett (1988); Robinson, Strong & Elkan (1989); Beardshaw & Robinson (1990); Owens & Glennerster (1990); Audit Commission (1991); NHSME (1992); Watt (1992); (Balogh & Bond (1992): and informal discussions with nurses in management including a deputy CANO, two DNSs and some other nurse managers and researchers from different institutions in the UK. Several meetings held with a senior statistician at Glasgow University were also helpful in constructing the questionnaire. The aim of the questionnaire was to collect mainly quantitative and some qualitative information about the role of nurses in management in Scotland.

3.1.4 Advantages of the Questionnaire

Reasons for using a questionnaire in the first stage of the study were that it required less time to administer; the absence of an interviewer ensured that there was no interviewer bias; it allowed a much wider geographical area to be covered; data collection and processing were not expensive; and vast amounts of information could be gathered easily (Polit & Hungler 1991; Oppenheim 1992). Waltz, Strickland & Lenz (1991) argue that the questionnaire is also time efficient and convenient for the respondent who is able to plan the self administration time, pace, and setting independently. They also discuss that its impersonal and standardised format assures that all respondents are exposed to uniform stimuli and this feature increases reliability. The questionnaire also offers anonymity, a feature that is believed to increase the validity of the response (Waltz *et al* 1991).

3.1.5 Disadvantages of the Questionnaire

According to Polit and Hungler (1993) the most serious weakness of the questionnaire is the question of validity and accuracy of the questions. They argue that researchers have no alternative but to assume that most of their respondents have been frank. It is difficult to ensure that respondents feel or act the way they say they do but the investigator has no alternative but to trust the information that respondents provide. Oppenheim (1992) lists the main disadvantages of the postal questionnaire as follows:

a. generally low response rates, and consequent biases;
b. no opportunity to correct misunderstandings or to probe, or to offer explanations, or help;
c. no check on incomplete responses, incomplete questionnaires or the passing on of the questionnaires to others.

3.1.6 Why Not Observation?

The possibility of using observation techniques for this study was also examined. However as discussed by Polit & Hungler (1993) information about feelings, values, opinions can sometimes be inferred through observation but people's actions do not always tell us about their state of mind. Behaviours can be observed directly but only if the subject is willing to manifest them publicly. The main concern of this study was to elicit the respondents' views, feelings and opinions regarding the role of nurses in management. Therefore it was decided that observation techniques would not be suitable for this study.

3.1.7 Pre-Pilot Study

The benefits of performing pre-pilot work with a convenience sample was examined. It was decided that 20 second year Master of Nursing students in Glasgow University's Department of Nursing and Midwifery Studies could be approached to take part in this study. The rationale for the use of these students was mainly that many of them had already had some kind of management experience in their work life and some were studying to improve their management prospects in their work place. Having received permission from the Head of

Department to carry out pre-pilot work, the study was introduced to the students by the researcher and their consent to participate in the study was sought. Subsequently the pre-pilot work was conducted in January 1994 to test the accuracy of the wording of questions and to determine the approximate length of time necessary to complete the questionnaire.

Of the 20 students approached, five completed the questionnaire. Common comments were about the length of the questionnaire which was thought to be too long. Although this was also a concern for the researcher it was decided that the questionnaire should be sufficiently comprehensive to be able to cover all the issues regarding the role of nurses in management. During a meeting to discuss the content of the questionnaire, an experienced DNS was asked to comment on the length on the questionnaire. She said 'I think it is in the right length. If you want to do something worthwhile you have to ask these questions. I do not feel that this is a very long questionnaire'. The length of the questionnaire was also discussed/debated in details with both supervisors of this study, as a balance between response rate and comprehensiveness. However in the light of the comments received during this pre-pilot the number of questions was reduced and several questions were altered or reworded.

3.1.8 Pilot Study

A pilot study is defined as a small-scale version of the major study (Polit & Hungler 1993). It is developed similarly to the proposed study, using similar subjects, the same setting, and the same data collection and analysis techniques (Burns & Grove 1993). Polit & Hungler (1993) suggest that the effects of unforeseen problems in a project may be so severe that the study has to be stopped. Therefore, wherever possible a pilot study should be carried out.

3.1.8.1 Aims of the Pilot Study

The aims of the pilot study were:

1. to test the accuracy of the wording in the questionnaire (e.g. nurses in management);
2. to test whether the questions asked produced the type of information expected (appropriateness of the responses);

3. to test the response rate;
4. to test the questionnaire format e.g. adequacy of spaces for answers for open questions, appropriateness of the brackets beside each item for closed questions;
5. to test whether any section(s) or question(s) in the questionnaire were difficult to understand or to complete.

3.1.8.2 Pilot Sample

The questionnaire was piloted with 28 nurses in management, 10.0% of the number of subjects to be used in the main study. Respondents were chosen randomly from the letters provided by the 48 DNSs (or the most senior nurse in the organisation). As noted earlier in section 3.1.2 there were 51 DNSs or equivalent who met the inclusion criteria of the study throughout Scotland and of them 48 DNSs supplied the necessary information and access for the study. However in order to avoid losing participants in the main study, subjects of the pilot study were selected from speciality units/departments (e.g. maternity and children's units) which did not meet the inclusion criteria of the study. Participants of the pilot were not included in the main study.

3.1.8.3 Conduct of the Pilot

The questionnaires were mailed to 28 participants with a covering letter explaining the study. They were assured that all information given would be treated confidentially. However, as the questionnaires contained a code number at the bottom of the first page to identify those questionnaires that had been returned, the questionnaires were not anonymous. Therefore respondents were assured that their anonymity would be protected.

The pilot study was conducted between 10-31 March 1994.

3.1.8.4 Findings From the Pilot

Accuracy of wording:
It was understood that the wording of the questions was accurate.

Appropriateness of the responses:

The questions were answered as expected and the data seemed to be what were required.

Response rate:

The response rate was 42.9% (12 out of 28). It was decided that this figure was not a satisfactory result and special care should be taken to increase the response rate in the main study.

Questionnaire format:

Another aim was to test the adequacy of spaces for answers for open questions. It was found that for several questions (e.g. questions 25, 30, 34) respondents either used the back page to complete their answers or tried to write with small letters which made the deciphering process difficult. Therefore in main study more spaces were provided for these questions. There was no problem with the appropriateness of the brackets.

Completion of the questionnaire:

The last aim was to test if there were any difficulties in completion of the questionnaire. Two of the respondents stated that it was a very time-consuming questionnaire and for question 27, about potential job functions of the respondents, one respondent stated that 'not everything can be seen as a regular occurrence' and the other subject said that 'statements were dependent on area of work and policies, some could have had several responses'. As these were the only negative comments it was decided to keep question 27 in the main study.

To increase the content validity and to ensure the inclusion of any important information the respondents were asked, if they had commissioned this investigation, what else would they like to ask of 'Nurses in management'? Five subjects stated their opinion as follows:

> *"What other disciplines do you have responsibility for?"*
> *"What senior nurse support they have e.g. do they have a clinical co-ordinator"?*
> *"What is job satisfaction"?*
> *"Aspects of communication systems within the nursing service"*
> *"Balance between nursing and business"*

Apart from the first suggestion it was decided that they were not directly relevant to this research. The first suggestion was reworded and used in the main study.

In conclusion, three open questions ('what is the least important element of your job'; 'how much do you depend on others (e.g. your supervisor) when doing your job' and 'what is the approximate size of the budget which you are responsible for') were taken out owing to inconsistency of the answers. One open question was changed to closed and was reworded ('how would you describe the preparation you received for your present position?'). Two statements from question 27 ('preparing nursing budget' and 'recruitment of nursing staff') were taken out, and one question to the first page was added ('what was the title of your previous job?').

Finally the last four questions regarding the evaluation of the questionnaire itself ('How completely do you feel this questionnaire has addressed the various aspects of your job?'; 'if you had commissioned this investigation what else would you like to ask to nurses in management'; 'please indicate any section(s) or question(s) which were difficult to understand/complete' and the time needed to complete the questionnaire) were not included in the main study. It was decided that the changes in the questionnaire were not substantial, and therefore it did not require re-piloting.

According to the results of both the pre-pilot and the pilot study the approximate time required to complete the questionnaire was between 45-60 minutes.

3.1.9 Main Study

In the light of the findings of the pilot study, the final version of the questionnaire consisted of 6 major parts (Appendix I.2):

1) demographic data and professional and educational qualifications
2) management preparation and its contribution to the work
3) job responsibilities, potential job functions and skills, knowledge and qualities (SKQ) necessary for the job
4) role-job changes and the respondents' views on the NHS (1990) reforms
5) subjects' perspectives regarding their present and future roles
6) views on relationships with managers and subordinates.

1) Demographic data and professional / educational qualifications:

Although Oppenheim (1992) suggests that only a novice starts to design a questionnaire by asking personal information, it was thought that it would be easier for the respondents to answer this kind of question and therefore they would be encouraged to carry on with the rest of the questionnaire. In the questionnaire the first section consisted of ten questions regarding demographic and educational information. These data were collected;

a) to provide background for a comparative analysis of the sample and
b) to present a profile of the subjects' personal characteristics in terms of variation within the groups including age, gender, marital status, professional and educational (academic) status.

To be able to classify/characterise the sample, clinical or managerial grade and titles of current position (including name of directorate or speciality) were requested. Length of time in current position and title of previous job were included as an indicator of experience. Hospital size was asked to confirm eligibility for the study.

2) Management preparation

In the second section subjects were asked firstly whether they had had any management training and if 'yes' what was the qualification and when had they obtained it. Questions 13 and 14 were asked to enable assessment of the usefulness of management training attained by the subjects. It was thought that the effectiveness of management training would affect the way that their responsibilities (related to management) were carried out. Question 15 sought to identify subjects' views on the level of management education that was needed to perform their work satisfactorily. The next question sought to answer whether management experience was required to perform the respondent's job and if so what sort of experience. The following two questions were about the formal job orientation of the respondents.

3) Job responsibilities, potential job functions and skills, knowledge, qualities (SKQ) necessary for the job

The aim of the third section was to determine the nature of the post in terms of the responsibilities carried out by the respondents. It was thought that there should be

common elements of job content despite the differences between each individual Trust and the services which they provided. Therefore participants were asked to define their main job purpose and main job responsibilities.

In order to determine whether respondents spent their time solely with their tasks they were asked if they perform any task(s) that could be done by someone else. Subjects were also asked to indicate how they defined the nature of their job or role and to what extent they could use independent judgement regarding their work.

It was thought that having and controlling a nursing budget was an important issue in terms of possessing power in the organisation. Therefore subjects were asked to state if they had a nursing budget responsibility and if so how much control they exercised over the budget.

In this section there were two other questions; the first question requested respondents to list the necessary skills, knowledge and qualities (SKQ) that nurses in management should have to be able to perform their work satisfactorily. The second question (question 26) asked respondents to state their opinion about whether nurses in management currently had these SKQ.

Unfortunately questions regarding potential job functions proved to be unsuccessful in defining the respondents' responsibilities owing to the low response rate. Given the design and complexity of these questions there was concern about the potential response rate. These questions was piloted and as noted earlier in section 3.1.8.4, only two respondents gave negative comments on these questions therefore it was decided to keep the questions in the main study. However in the main study there were many comments from the respondents which indicated that the wording and the accuracy of the items were questionable. Therefore the data obtained from these questions are presented in Appendix II.9 but not included in the presentation of findings.

4) Role-job changes and respondents' views on the NHS (1990) reforms

This section commenced by asking the respondent whether one had to be a nurse to be able to carry out his/her job. This was asked because the recent trend had been to replace the nurse manager with other professionals. Questions 29-30 aimed to define the role changes (if any) which the respondents had encountered

within the last three years in relation to their responsibilities, relationships with their colleagues and their work climate. The aim of the next question was to identify the respondents' view on the issue of role transition from Senior Nurse Manager (SNM) to Business, Locality or Service Manager.

In order to elicit the respondents' views on the NHS (1990) reforms and its effects on their job, a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree' was utilised and it consisted of 15 items.

5) Subjects' perspectives regarding their present and future roles

In this section there were two parts. The first part consisted of three questions, the first of which was about their views on their success in their job . The second was related to their opinion on the role of nurses in management and the last question asked participants to identify the main constraints (if any) that limited them from doing their job effectively.

In the second part respondents were requested to state their opinion on their own potential career developments and the future roles of nurses in management.

6) Views on relationships with managers and subordinates

The last section consisted of nine mainly closed questions, seeking to describe the nature of the relationships of the respondents with managers and subordinates.

Further comments and invitation to interview

At the end of the questionnaire respondents were asked to add any further comments on the role of nurses in management. Finally they were invited to participate in a face to face interview and space was provided for name, address and telephone number if they wish to be interviewed.

3.1.10 Response Rate and Procedure to Enhance Response Rate

The survey was carried out by post between 16 May and 22 July 1994. One of the major concerns in carrying out a study with a postal questionnaire is a low response rate. In this study to increase the response rate the following strategy was followed:

1. Two different meetings in Edinburgh, with the DNSs (18 March 1994) and CANOs (29 April 1994) were attended to introduce and discuss the study, and to have the contributions of both groups. The researcher had the opportunity to present the study briefly. The Supervisors also attended these meetings to increase the authority of the study. Feedback from both groups was encouraging.

2. The questionnaires were mailed in packs to 284 nurses in management. Envelopes were addressed to the subject personally. Each pack included;

   a) a covering letter encouraging participation in the study ;
      In the letter,
      - all subjects were personally addressed
      - the researchers and the study were introduced and the term 'nurses in management' was explained; (all nurses, above sister/charge nurse level, who have a management remit in the organisation)
      - how the respondent had been selected was explained
      - confidentiality and anonymity were assured
      - each letter was individually signed by the researcher and the supervisors

   b) the questionnaire itself; (the questionnaire was printed on white paper)
   c) an addressed and postage paid return envelope.

These three items were also put into a green transparent file as it was felt that this would help to attract the attention of the subjects and prevent the contents from becoming lost on a desk.

3. Reminders: Two reminder letters were sent to all respondents as the questionnaire was anonymous (in the main study as opposed to pilot, there was no ID number on the questionnaires). As noted earlier (3.1.9) only those who indicated their willingness to be interviewed, and therefore supplied their names, were not sent further reminders. It was found that the first recall letter was highly effective in increasing the overall response rate (from 42.1% to 57.7%).

In this study the overall response rate was 64.4% with a usable response rate of 55.6%. As presented in Appendix I.3 in total there were twenty five unusable

questionnaires. Of them seventeen people returned the questionnaire back to the researcher and indicated that they had no time for completing it. There were two late responses and six questionnaires were completed by people who did not meet the inclusion criteria. The details of the response rate are shown in Appendix I.3.

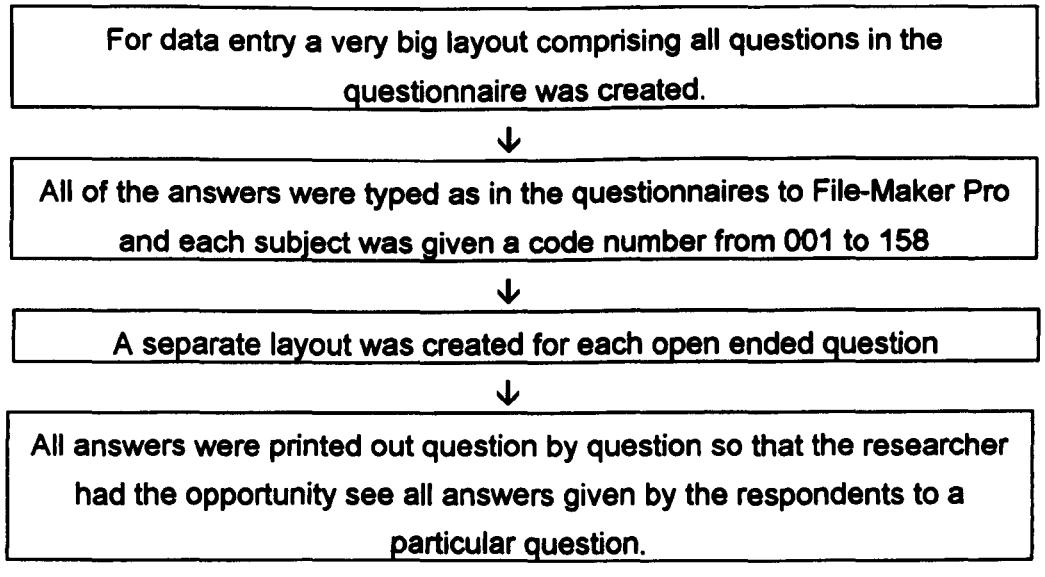
3.2 Data Analysis

Analysis was carried out in three stages. First, a computer package, File-Maker Pro, was utilised to store and code all the questionnaire data. Then for each open question content analysis was performed and categories were constructed. Third, non-parametric statistics (Chi Square and Kolmogorov-Smirnov Z tests) were used to analyse the data following statistical advice.

3.2.1 File-Maker Pro

The use of File-Maker Pro is summarised in the diagram 1 below.

Diagram 1: The use of File-Maker Pro



3.2.2 Category Construction

The following steps were applied to all questions in order to create categories and to carry out content analysis of the open questions in the questionnaire and in the interviews.

Step 1

All answers to a particular question were read. In the first reading the aim was to gain familiarity with the content. During this reading, notes were made on general themes beside the answer. Leaving the right margin wide made this possible. Dey (1993 p:113) suggests that 'in practice there is no need to develop a complete category set in advance of categorising the data'. Therefore in this study the categories devised were based on the themes as they appeared in the data. Development of the categorical scheme proceeded inductively, deriving categories from the data themselves by identifying clusters of similar data through a data shuffling-and-sorting procedure, as described by Glaser & Strauss (1967).

Step 2

A second reading aimed to create broad categories to describe all aspects of the content, bearing in mind that categories are the key to content analysis, must reflect the purpose of the research, must be exhaustive and must be mutually exclusive (Mostyn 1985).

Separate blank sheets were used to write down categories. At this stage it should be noted that the researcher had to utilise two different 'recording units' according to the type of question. For example for some questions a 'word' was the recording unit and in this case it was possible to do a word search using File-Maker Pro as in the case of question 25a (what kind of skills nurses in management have to be able to perform their job satisfactorily) where a word for instance 'communication', was used to search and organise the text responses.

On the other hand in question number 34 (How do you see the role of nurses in management at present?) 'theme' was the recording unit and such questions were more labour intensive. For example three responses to question 34 were as follows;

"In a very strong position, with the development of the clinical directorate structure the senior nurses' knowledge and experience is being recognised and utilised".
"They have a key role to play in the new NHS but they must be prepared to broaden their horizon"
"I feel it is a strong role, no one else could do this job at present and be effective"

These responses were listed under the headings of:

1 Strong position
2 Development of the clinical directorate structure is good for senior nurses.
3 Senior nurses' knowledge and experience is being recognised and utilised
4 Key role in the NHS but must broaden their horizon
5 Strong role
6 Nurses are effective in this job.

Step 3

The list of categories, which could be as large as 50-60 categories for each question, was examined again and grouped together under higher-order headings. The process of 'collapsing' as described by Burnard (1991) was applied. In this 'funnelling' process many initial categories were generated and then these were distilled down to a smaller number.

Step 4

The list of categories were worked through and repetitious or similar headings were abandoned to reduce the number of categories. Since it is important to define the categories as fully and as clearly possible (Wilson 1989) typical responses from the data were written down under each category to illustrate the properties a response should have if it is to be coded into a particular category. To define the categories explicitly, a clear coding instruction was also written down i.e. include any data which relates to the clinical directorate structure. At this point it should be noted that a colleague helped the researcher to construct the categories for question 25 a, b, c.

Step 5

All answers were re-read alongside the final list of categories to see if the categories covered all aspects of the text. Alterations were made when necessary.

Step 6

This step involved pretesting the categorical scheme by applying it to a small portion of the content to be analysed. As cited by Waltz *et al* (1991), Fowler (1986) recommends pretesting the coding scheme with 10 or 20 data sets. In this study pretesting was done with 20 randomly selected questionnaires. Each answer to a particular question was coded to File-Maker Pro according to the list of categories. This software allowed the researcher to see, on one PC screen, the response as it was in the questionnaire, respondent number and the category labels in their short forms so that she could read the response, decide under which category this response could go and then put '1' in the relevant category field. This procedure was carried out until all answers were coded.

Step 7

To assess the intercoder reliability (Waltz *et al* 1991) two colleagues were requested to read the responses to open questions, generate category systems and code them into the computer independently (a brief training on File - Maker Pro was given to both colleagues). At the end of this step some categories in a number of questions (14, 19, 20, 34, 37) were redefined and some minor alterations made in other questions. Two other colleagues were asked to repeat the same procedure for the above five questions. There seemed to be good level of agreement between the coders.

Step 8

The data were coded into the computer according to the developed category scheme. The 'find' mode of the package was used in order to identify the frequency of response for each category.

3.2.2.1 Content analysis of open questions

Mostyn (1985) states that one way for systematically making sense out of data obtained from open ended questions is content analysis. Weber (1994) also asserts that content analysis can be used for coding open ended questions in surveys. In this study a method of analysing semi-structured, open ended data described by Mostyn (1985), Wilson (1989), Burnard (1991), Waltz *et al* (1991), Dey (1993), and Weber (1994), was adopted to carry out content analysis of both open questions in the questionnaire and the interview data.

According to Krippendorff (1980 p:21) 'Content analysis is a research technique for making replicable and valid inferences from data to their context'. Polit & Hungler (1991 p:514) describe it as 'a method for quantifying the content of narrative communications in a systematic and objective fashion'. The purpose of content analysis of open ended material is to understand the meaning of the communication.

3.2.2.2 Advantages and disadvantages of content analysis

This technique allows use of existing information; categorical schemes are developed after data are collected and thus do not constrain or bias the data (Waltz *et al* 1991). However content analysis has several disadvantages. First the procedure is very time-consuming and labour intensive; second there is a risk of subjectivity since judgement is required in order to interpret the meaning of another's communication (Waltz *et al* 1991); and third there is no generally useful and agreed upon classification system for categorising and comparing diverse material (Polit & Hungler 1991).

3.2.2.3 Validity and reliability

The validity of a research insrument refers to the degree to which an instrument measures what it is supposed to be measuring (Polit & Hungler 1991). To ensure content validity of the questionnaire, as noted earlier in section 3.1.3, its construction followed a systematic review of literature and informal discussions with nurses in management. The questionnaire items were first drafted in accordance with the study aims. Following comments from the research supervisors, nurse managers and a senior statistician the questionnaire was pre-piloted with 20 Master of Nursing students. In the light of the comments received from this pre-pilot the questionnaire items were changed in several questions.

The questionnaire was further validated by means of a pilot survey of 28 randomly selected nurses in management. In the pilot study to increase the content validity and to ensure the inclusion of any important information the respondents were also asked, if they had commissioned this investigation, what else would they like to ask of 'Nurses in management'?. In addition in the main study, as opposed to

the pilot, the questionnaire was anonymous, which is believed to increase the validity of the response and the response rate (Waltz *et al* 1991).

Reliability of an instrument is usually carried out by using the procedures of test-retest reliability. In this study the questionnaires were not repeated, owing to limited resources.

As cited by Weber (1994:259) Krippendorff (1980) suggested three types of reliability that are relevant to content analysis:
a) stability: it is described as 'the extent to which the results of content classification are invariant over time' and it can be determined when the same content is coded more than once by the same coder. In the study the content of the questionnaires were coded several times by the researcher.

b) reproducibility (intercoder reliability): It is 'the extent to which content classification produces the same results when the same text is coded by more than one coder'. It measures the consistency of shared understandings held by two or more coders. In the study several colleagues were requested to code a number of questions as mentioned above.

c) accuracy: It refers to 'the extent to which the classification of text corresponds to a standard or norm'. This form of reliability is not pertinent to this study since standard coding was not established.

3.2.3 Statistical Analysis

SPSS for Windows was used for the statistical analysis of the data. In this study tables of the frequencies and percentages were calculated. In general the Pearson Chi-square test was applied to discover if there were significant relationships between variables and/or categories. As relevant to the nature of the data Fisher's Exact p test (two tailed), and Kolmogorov-Smirnov Z test were used in the comparison of subgroups of the tables. Yates correction was made where necessary. The level of significance was set at p=0.01 since a probablity of 0.01 gives more confidence in the results.

The Pearson Chi-square test is a non-parametric test of statistical significance used to assess whether a relationship exists between two nominal level variables

and is used when there are categories of data and hypotheses about the proportion of cases that fall into the various categories, as when a contingency table has been created (Polit & Hungler 1993). Having determined if there were differences between the groups it was necessary to calculate in what direction the difference lay. This was determined by using χ^2 tests for two independent samples.

The Kolmogorov-Smirnov Z is a non-parametric test of whether two samples come from the same distribution. It is sensitive to any type of difference in the two distributions. This test compares the two cumulative distributions and focuses on the largest difference between the two distributions. Statistical analysis was conducted by the researcher with additional statistical support provided by the University of Glasgow and the University of Cumhuriyet.

3.3 PART II THE INTERVIEWS

Following an initial analysis of the questionnaire, the semi-structured interview schedule was constructed. Each question concerned a matter raised in the questionnaire. The selection of issues raised by respondents was done by reviewing all their responses and selecting a number of issues which they clearly thought were important. The aim of the interviews was to clarify and to enrich the key issues that had emerged from the questionnaire data.

An interview can be described as a face to face verbal communication between the researcher and the subject, during which information is provided to the researcher (Burns & Grove 1993). Interviewing can be structured, semi-structured, or unstructured.

For the second stage of this study, a semi structured interview was selected as the mean of data collection for two reasons. First it is well suited for the exploration of the perceptions, views and opinions of the respondents regarding different issues. Semi-structured interviews also enable probing for more information and clarification of the answers. Second, the subjects who agreed to be interviewed had various educational, managerial and personal backgrounds and therefore this ruled out the use of a standardised interview schedule.

In structured interviews all subjects are asked to respond to exactly the same questions, in exactly the same order and to have the same set of options for their responses (Polit & Hungler 1991). In contrast in a semi-structured or focused interview the interviewer may move freely from one topic area to another and allow the respondent's cues to help determine the flow of the interview. Although an interviewer who uses this kind of interview has a list of areas or questions to be covered with each respondent, the way in which questions are phrased and the order in which they are asked are left to the discretion of the interviewer and may be changed to fit the characteristics of each respondent (Waltz *et al* 1991). In this process the function of the interviewer is to encourage participants to talk freely about all of the topics on the list (Polit & Hungler 1991).

3.3.1 Ethical Considerations

Prior to the audio taped interviews, the purpose of the study and the consent of the subject was clarified verbally with each participant and participants' questions were answered. A written explanation about the interview was also provided a week before the interview. None of the participants asked any questions, or expressed any concern regarding audio tape recording or about anonymity. Nevertheless, once more they were all assured that no names would be disclosed at any stage of the research and the content and responses at the interview will be treated in strict confidence. Also they were reminded that all tapes would be destroyed after the research had been completed in accordance with the Data Protection Act (1984).

Following the interviews three of the participants expressed interest in the results of the study and hoped to see them.

3.3.2 Interview Sample and Exclusion Criteria

At the end of the questionnaire, respondents were asked to indicate if they wished to be interviewed for this study. A total of 75 subjects out of 158 (47.5%) indicated their willingness to be interviewed and supplied their names and contact addresses.

In terms of manpower, cost, time and expense it was decided that it would be very difficult to cover all Scotland. Therefore 16 subjects in the Scottish Islands and Highlands were excluded. However it was thought that interviewees should be representative of all groups (i.e. position level, sex) in the study. In January 1995, a letter was sent to the remaining 59 respondents requesting their participation in an interview between 22 February and 31 March 1995 (Appendix I.4). Forty seven subjects out of 59, (79.7%) replied providing several possible interview dates. By 12th February, 32 arrangements out of 47 had been completed. Arrangements for the remaining 15 subjects could not be made for miscellaneous reasons explained below.

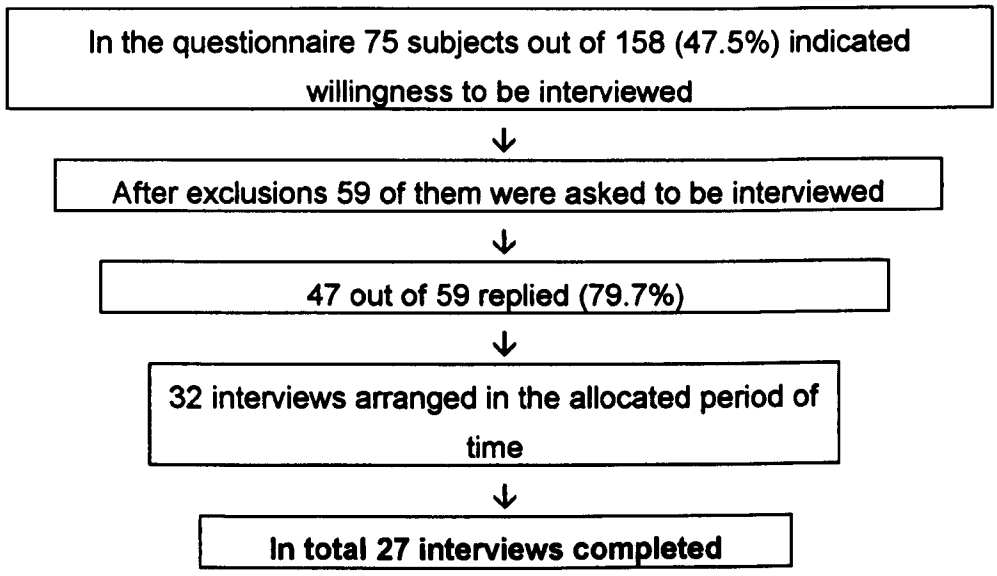
- 8 returned their slip in March well after the February 12, cut-off date for response.
- 3 changed their job to the private sector
- 1 appeared to have given a wrong address
- 1 was on maternity leave
- 2 apologised and said they had no time for the interview.

By the end of March 1995 the researcher had completed 27 interviews. A further 5 arrangements were cancelled owing to the following reasons:

- 3 subjects cancelled their appointments
- 1 subject forgot her appointment (When I went to Dundee she was not in her office and I was told that she was off that day)
- 1 subject's daughter had a serious car accident (When I went to Aberdeen I was told that the subject had to leave owing to the accident).

All interviews were confirmed in writing stating the time and the place of the interview in addition to other explanations such as ethical considerations (Appendix I.5). A summary of interview process is provided in diagram 2 over.

Diagram 2 . A brief explanation of interview process



A formula was used to calculate whether 27 respondents were representative when the total sample of 75 participants were considered. It was found that sample of 27 interviewees were representative of 75 interviewees.

3.3.3 Advantages and Disadvantages of the Interview

Because of its diversity, the interview is a very useful instrument. It allows the researcher to explore a topic in considerable depth and detail. It is well suited to elicit an individual's opinions, attitudes and beliefs. There is a higher response rate to interviews than to questionnaires and it is flexible. In interviewing it is possible to identify and clarify any misunderstanding. It ensures that the desired respondent is the one from whom data are obtained (Waltz *et al* 1991; Burns & Grove 1993). On the other hand interviewing requires much more time and money than questionnaires. The interviews themselves may be quite time-consuming, especially if travel is required. Therefore the sample size is usually limited (Waltz *et al* 1991; Burns & Grove 1993). In this study another limitation with the interviews was that some respondents said that they had 20-25 minutes although the interview had been arranged to take about 45 minutes at least two weeks

previously. Hastily arranged Trust meetings curtailed interview time for two respondents.

3.3.4 Pilot Study

The interview schedule was piloted with three subjects who completed the questionnaire but who had changed their job and entered the private sector subsequently. The aims of piloting this schedule were:

a) to test if the respondent could understand the questions in terms of wording;
b) to test whether the audio tape recorder produced the desired quality so audio tapes could be transcribed without difficulty;
c) to test the researcher's interviewing skills.

At the end of this small scale pilot study there was no substantive problem with the interview schedule, audio tape recording and the researcher's interviewing skills. In conclusion although this pilot study did not indicate substantial changes to the interview schedule, it was a valuable experience for the researcher whose native language was not English.

3.3.5 Main Study:

3.3.5.1 Interview Schedule

Interviews started with a standard introduction and focused on a schedule (Appendix I.6) which included six sections, each investigating a different area. They were as follows.

Section I: Titles of the respondents
This was an introductory section to the interview and included two questions regarding the variety of job titles identified by the subjects who had completed the questionnaire.

Section II: The role of nurses in management
In this section interviewees were asked to state their opinion on the role of nurses in management at different management levels. In addition participants were

asked to comment on two findings, elicited from the questionnaire, to enrich the data.

Section III: NHS Changes

This section was about the NHS (1990) changes, and its effects. Also, in the questionnaire it was understood that many nurses in management felt removed from the clinical environment. The subjects were asked if they agreed with this view and whether maintaining clinical expertise was important.

Section IV: Preparation for the Job

This section consisted of four questions about management training. For example, each was asked if first and/or middle line management courses were sufficient preparation for nurses in management, what kind of management preparation should nurses in management receive and whether the respondents were happy with their management preparations in terms of management training and experience.

Section V: Strength and weaknesses

The aim of this question was to identify perceived strengths and weaknesses of the nurses in management.

Section VI: Recent changes and anything else to comment?

This section intended to find out if there had been any changes, in terms of role, job responsibilities and the organisation, since the participant had completed the questionnaire. Finally each interview session was concluded with a comment question (if they had anything else to say). This question allowed each participant to state her/his opinion freely and to ensure that the researcher had not missed any important aspects of the job not already mentioned in the interview.

3.3.6 Conduct of the interviews

At the beginning of the interview the researcher introduced herself (name, job, university) to the subject and a short informal conversation took place usually about the questionnaire that the respondent completed 6-7 months previously, and about some personal information concerning the researcher herself. The interview session commenced with a standard introduction that included following headings:

- thanked for agreeing to be interviewed;
- reviewed the study very briefly and the aim of the interview;
- emphasised the confidentiality of the interview and the data;
- reminded that it would be audio tape recorded and take approximately 45 minutes;
- reminded how they were chosen for the interview.

All interviews, except one, were conducted at the interviewees' place of work. They were carried out in a suitable room that was quiet and without interruptions. The use of a semi-structured schedule allowed the researcher to change the order of the questions when necessary. For example when talking about the NHS (1990) changes, if the subject focused on the management preparation of nurses in management, then questions regarding this issue were asked. This helped to create more flexible and spontaneous communication between the researcher and the interviewee. The interviews took between 25-50 minutes depending on the interviewee's time.

According to Barriball and While (1994) the use of audio tapes provides a detailed insight into the performance of both the respondents and the researcher. Also access to the nuances of the interactions between respondent and interviewer help validate the accuracy and completeness of the information collected. In addition audio tape recording reduces the potential for interviewer error by, for example, recording data incorrectly.

3.3.7 Analysis of the Interview Data

When undertaking content analysis with the interview data the same procedure as used for the analysis of the questionnaire survey analysis was used. However owing to the number of respondents, it was decided that it was inappropriate to evaluate the interview data numerically.

3.3.7.1 Reliability and Validity

As noted earlier reliability of an instrument is usually carried out for structured interviews using the procedures of test-retest reliability in which the same

respondent is interviewed more than once using the same schedule and the results are compared. In this study as a semi-structured interview schedule was used and interviews were not repeated, a reliability assessment was omitted.

In relation to validity two issues should be assessed. First the validity of the interview itself and second validity of the self reported information. According to Hutchinson & Wilson (1992), 'valid interview data are those that accurately portray what the investigator is attempting to study'. They note five categories of validity threats: interview questions that are not relevant to the research purpose; timing of interviews; interviewer behaviour; problematic respondent behaviour and recording problems.

In this study interview questions were derived from the questionnaire data itself and therefore the questions were relevant to the purpose of the study. In relation to the timing of interviews, as noted earlier, all interviews were confirmed in writing stating the time and the place of the interview at least two weeks before the interviews. During the interviews the researcher did not encounter any problematic respondent behaviour and recording problems.

As noted by Barriball and While (1994) it is impossible to always control or plan the research. However interviewer friendliness, approach and manner towards subjects can help to improve the validity of the data. Also careful design of the interviews and wording of the questions can enhance the validity of the data (Waltz *et al* 1991). To ensure validity of the interviews several meetings held with the research supervisors and comments obtained from colleagues. Also a small-scale pilot study was carried out with three subjects.

In terms of the self-report information there are several ways to assess the validity. For example during the interview the researcher can observe whether the respondent is disturbed by certain questions and if so this may be taken into account in interpreting the data. In this study the researcher did not observe any untoward disturbances experienced by the interviewee. The other way to assess the validity is to note if there were any inconsistencies in the responses and if so these should carefully be called to the respondent's attention and clarified (Waltz *et al* 1991).

3.4 Summary and Conclusion

In this chapter the overall research design is defined in two parts. The use of two methods - one for the questionnaires and the other for the interviews is explained. The value of the pilot study for the questionnaire has also been explained. The following were identified as methodological weaknesses of this study:

a) there was no pre-existing valid and reliable questionnaire.

b) If resources had allowed, it might have been more useful to begin with an in-depth interview approach and move to a questionnaire; then interview again. However it is not clear whether this approach or the one adopted in this study would have been the most successful considering the workload of nurse managers.

c) In the questionnaire there were some questions that did not produce usable results despite piloting i.e. questions about the potential job responsibilities of the subjects. Also at the end of the study it was felt that there were several questions which could have been omitted or presented in alternative ways in order to secure better quality data.

In the next chapter researcher's notes on the presentation of the findings will be given first and then the findings of the study will be presented.

CHAPTER IV

THE FINDINGS

PART I THE QUESTIONNAIRE

Researcher's notes on the presentation of the findings

In the presentation of the findings, the convention is as follows.

1. The distribution of the answers to each question is provided at the beginning of the section related to the question. Cross tabulations were then made in accordance with the relationships found.

2. If the distribution of the cross tabulated answers added to 100.0%, the findings were presented in frequencies together with percentages and the results of the statistical analysis are provided at the bottom of the table regardless of the results of statistical analysis.

3. When the totals of the answers did not add to 100.0%, the percentages were not included in the table. In each row if the overall result of the statistical analysis was significant p values are presented, otherwise when statistical analysis did not produce any significant difference 'NS' was used to denote 'not significant'.

4. In all cross tabulations when evidence of an overall significant difference was found, the level of significance for relevant sub-groups is provided to show where the effect occurred. For convenience, the result of other sub-groups (where no significant differences were found) are not presented.

5. When a cross tabulation was done with a variable e.g. current position, age, gender by categories of any open question, the most frequently reported answers were included in the tables. It was assumed that 10.0% of the total sample (that is 16 subjects) would be sufficient for the cross tabulation. For example a total of 13 different categories were derived from question number 19 (main job purposes of the subjects). In order to show how the categories were constructed, first all categories were provided at the beginning of the related section. In the second table only cross tabulations of nine categories are presented because the number of subjects who talked about 10th, 11th, 12th and 13th categories were under 10.0% of the total sample.

6. In presentation of the distributions of answers to open questions, categories were constructed as described above and examples which represented the category most accurately were listed where necessary.

7. When the variable 'current position' was used in cross tabulations the groups were referred with abbreviations of FLMs for 'First Line Managers', MMs for 'Middle Managers', and SMs for 'Senior Managers'.

8. The response rate for each question was different and therefore the percentages in each table or graph refer to the total of the respondents who replied to a particular question. In all Tables 'N' refers to the total numbers of all the subjects who replied to a particular question and 'n' refers to the percentage (%) of total. The details of the overall response rate for the questionnaire are presented in Appendix I.3. It should be noted that subjects completing the 'other' option were always asked for an explanation and their responses were also categorised according to the content.

The order of presentation of the findings are based on the questionnaire and interview schedule.

4.0 PART I THE QUESTIONNAIRE

4.1 DEMOGRAPHIC CHARACTERISTICS

4.1.1 Age, sex and marital status

In this study, 38.0% (n=60) of all the respondents were in the 40-49 age group, 67.7% (n=107) were female and the majority of the subjects were married. There was no respondent below 30.

Table-4.1.1: Distribution of age, sex and marital status of all the respondents (N=158)

Age Band	**n**	**%**
30-39	45	29.1
40-49	60	38.0
50 or +	52	32.9
Sex		
Male	51	32.3
Female	107	67.7
Marital Status		
Single	38	24.0
Married	99	62.7
Widowed	5	3.2
Separated or Divorced	16	10.1

4.1.2 Sex and age

Table-4.1.2 shows the differences in proportion of male and female respondents in each age group. A total of 17.6% (n=9) of males were in the >49 age group, compared with 40.2% (n=43) of females. The overall differences were statistically significant. Almost half of the male respondents were in the 40 to 49 age group.

Table-4.1.2: Male and female age profiles (N=158)

	AGE BAND							
	30-39 (n=46)		40-49 (n=60)		50+ (n=52)		Total (n=158)	
SEX	n	%	n	%	n	%	n	%
Female	28	26.2	36	33.6	43	40.2	107	100.0
Male	18	35.3	24	47.1	9	17.6	51	100.0

	χ^2	df	p
Overall:	7.96	2	0.019

4.1.3 Sex and marital status

Overall the majority of the respondents (62.7%, n=99) were married and 24.1% (n=38) were single. However in total, a much higher proportion of females was single: 33.6% (n=36) of the women compared with 3.9% (n=2) of the men. This relationship was statistically significant. It should be noted that in order to carry out statistical analysis widowed and separated/divorced categories were combined together and therefore degree of freedom equals to two (Table-4.1.3).

Table-4.1.3: Female and male profiles by marital status (N=158)

	MARITAL STATUS									
	Single (n=38)		Married (n=99)		Widowed (n=5)		Separated/ Divorced (n=16)		Total (n=158)	
SEX	n	%	n	%	n	%	n	%	n	%
Female	36	33.6	55	51.4	4	3.7	12	11.2	107	100.0
Male	2	3.9	44	86.3	1	2.0	4	7.8	51	100.0

	χ^2	df	p
Overall:	20.1	2	0.000
Single v Married	17.2	1	0.000

4.1.4 Current position

When respondents were asked to state their current job title, it was found that there were 44 different job titles used by the subjects and therefore it was difficult to categorise respondents' current position into a management level. A study by Disken et al (1995) set an example which helped to define the categories. The person whom respondents reported to was the main criterion but in the event of uncertainty, respondents' grade and job responsibilities were taken into account. The following classification was developed for use in this study.

Senior Managers (SMs): Those who are directly and managerially responsible to a *top manager i.e.* Chief Executive; Unit or Board General Manager; for example- **Chief Area Nursing Officers (CANOs), Directors of Nursing Services (DNSs) Directors of Nursing & Quality (DN&Q) and its equivalent.**

Middle Managers (MMs): Those who are directly and managerially responsible to a *senior manager i.e.* DNSs, DN&Q, Clinical Director; for example- **Locality Managers, Nursing Services Managers, Care Group Managers, Business Managers, Clinical Services Managers.**

First Line Managers (FLMs): Those who are directly and managerially responsible to a *middle manager i.e.* Nursing Services Manager; for example- **Clinical Nurse Managers, Clinical Co-ordinators.**

It should be noted that in many instances although the term 'first line managers' describes sisters and charge nurses, in this study this term refers to nurses who are above sister/charge nurse level. All titles used by the nurses in management are provided in Appendix II.1. Table-4.1.4 provides the distribution of all respondents according to the above classification.

Table-4.1.4 Classification of current position of all the subjects (N=158)

CURRENT POSITION	n	%
First Line Managers (FLMs) e.g. Clinical Nurse Managers, Clinical Co-ordinators	45	28.5
Middle Managers (MMs) e.g. Nursing Services Managers, Clinical Services Managers	84	53.2
Senior Managers (SMs) e.g. CANOs, DNSs, DN&Q	29	18.3

4.1.5 Age groups and current position

As can be seen from Table-4.1.5, 48.3% (n=14) of the senior managers and 42.2% (n=19) of first line managers were in the 40-49 age group. Middle managers were equally distributed in all age groups. There was no significant relationship between current position and age group of the respondents.

Table - 4.1.5: Age groups by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
AGE BAND	n	%	n	%	n	%	n	%
30-39	13	28.9	28	33.3	5	17.2	46	29.1
40-49	19	42.2	27	32.1	14	48.3	60	38.0
50 or +	13	28.9	29	34.5	10	34.5	52	32.9

	χ^2	df	p
Overall:	4.0	4	0.406

4.1.6 Sex and current position

There was no significant difference between sex and current position of the respondents (Table-4.1.6).

Table- 4.1.6: Sex by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
SEX	n	%	n	%	n	%	n	%
Female	31	68.9	59	70.2	17	58.6	107	67.7
Male	14	31.1	25	29.8	12	41.4	51	32.3

	χ^2	df	p
Overall:	1.4	2	0.504

4.1.7 Marital status and current position

There were no significant differences between the subjects' marital status and the current position (Table-4.1.7). However a cross tabulation of marital status by sex and current position (Appendix II.2) showed that in total 91.7% (n=11) of the males who were at the senior manager level were married compared with 35.3% (n=6) of the females. A total of 58.8% (n=10) of females in senior positions were single and there was no single male respondent holding a senior managerial position.

It should be noted that in order to carry out statistical analysis 'widowed' and 'separated/divorced' categories were combined together in Table-4.1.7 below therefore degree of freedom equals to four.

Table-4.1.7: Marital status by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
MARITAL STATUS	n	%	n	%	n	%	n	%
Single	10	22.2	18	21.4	10	34.5	38	24.1
Married	29	64.4	53	63.1	17	58.6	99	62.7
Widowed	2	4.4	3	3.6	0	0	5	3.2
Separated/Divorced	4	8.9	10	11.9	2	6.9	16	10.1
		χ^2		df		p		
Overall:		2.9		4		0.573		

4.1.8 Clinical / managerial grade

Respondents were asked to specify their clinical or managerial grade. Approximately half of the respondents (52.9%, n=81) were on a managerial grade, 33.3% (n=51) of the subjects were on 'I' grade. When grade was cross tabulated with current position it was found that 96.3% (n=26) of the senior managers and 64.2% (n=52) of all middle managers were on a managerial grade. First line managers were either on nursing grade H or grade I. In total 5 (3.2%) respondents did not answer this question.

4.1.9 Clinical settings

When asked to specify clinical setting, in total 19 (12.0%) respondents did not provide any answer to this question. The clinical settings of the remaining 139 respondents were grouped according to the type of the speciality. For example respondents who work with the community, elderly and mentally ill were classified as 'Group A', 45.3% (n=63) of the respondents were working in this group. All senior managers responded to this question and the majority of them (93.1%, n=27) were grouped into the 'not applicable' category, as they were either responsible for the whole hospital (e.g. DNSs) or were working at health boards (e.g. CANOs). Details of the clinical settings of the participants are provided in Table-4.1.8.

Table-4.1.8: Clinical settings of the respondents (N=139)

CLINICAL SETTINGS	n	%
Group A (Community, Elderly, Mental Health, Psychiatry)	63	45.3
Group B (Acute Medical & Surgical Departments)	43	30.9
Others (Directorate of Planning & Contract, Department of Nursing & Quality Assurance)	6	4.3
Not Applicable (including, CANOs and DNSs who are responsible for the whole organisation)	27	19.4
Total	139	100.0

4.1.10 Time in job

In total the majority of the respondents (77.8%, n=123) had been working in their present post for less than four years (Figure-4.1.1). The length of time in present post may illustrate the degree of change which nurses in management had undergone since the NHS (1990) Reforms.

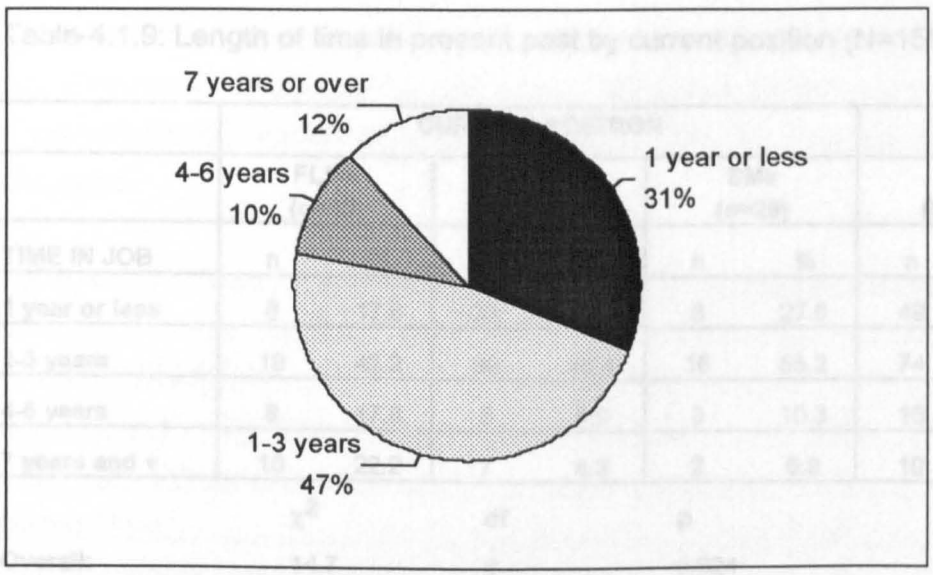


Figure-4.1.1: Length of time of all the respondents in current position (N=158)

4.1.11 Time in job and current position

There was no significant difference between the managers in respect of length of time in current position as can be seen in Table-4.1.9. However a majority of middle managers (85.7%, n=72) had been in their present post for less than three years compared with 60.0% (n=27) of first line managers.

Table-4.1.9: Length of time in present post by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
TIME IN JOB	n	%	n	%	n	%	n	%
1 year or less	8	17.8	33	39.3	8	27.6	49	31.0
1-3 years	19	42.2	39	46.4	16	55.2	74	46.9
4-6 years	8	17.8	5	6.0	3	10.3	16	10.1
7 years and +	10	22.2	7	8.3	2	6.9	19	12.0
	χ^2		df		p			
Overall:	14.7		6		0.024			

4.1.12 Previous job titles

In the questionnaire respondents were asked to state their previous job titles. As can be seen from Table-4.1.10 below approximately one in five of respondents (21.5%, n=34) had worked as 'Clinical Nurse Manager' or 'Clinical Services Manager'.

The 'others' category included respondents who had been working in different jobs e.g. Community Adviser, Principal Officer, Resource Management Co-ordinator, Health Manager, Project Manager, Personnel and Training Manager, Hospital Manager.

Table-4.1.10: Distribution of previous job titles of all the respondents (N=158)

PREVIOUS JOB TITLES	n	%
Clinical Nurse Manager / Clinical Services Manager	34	21.5
Senior Nurse Manager / Nurse Manager	32	20.3
Nursing Officer	25	15.8
Director of Nursing Services / Chief Area Nursing Officer	25	15.8
Sister / Charge Nurse	21	13.3
Health Visitor / District Nurse / Midwife	8	5.1
Others e.g. Community Adviser, Principal Officer, Hospital Manager	13	8.2
Total	158	100.0

When previous job titles were cross tabulated with the current position, it was found that 31.1% (n=14) of the first line managers' previous job titles were sister/charge nurse. A total of 58.6% (n=17) of the senior managers had been DNSs/CANOs and mostly they had retained their position at senior level. Respondents who had a title of Clinical Nurse Manager, Clinical Services Manager, Sister, HV/ District Nurse previously, were now working largely either at first line management level or middle management level. Detailed distribution of previous job titles of all the respondents by current position is provided in Appendix II.3.

4.1.13 Hospital size

Respondents were asked to give the number of beds in the hospital where they were working. A total of 94.9% (n=150) of all the respondents answered this question. As can be seen from Table-4.1.11, 44.0% (n=66) of the respondents were working relatively small hospitals, less than 450 beds.

Table-4.1.11: Hospital size (N=150)

HOSPITAL SIZE	n	%
50-249 Beds	26	17.3
250-449 Beds	40	26.7
450-649 Beds	26	17.3
650 & Over	27	18.0
Community	31	20.7
Total	150	100.0

4.2 PROFESSIONAL AND ACADEMIC QUALIFICATIONS

This section provides information about professional and academic characteristics of the respondents. It includes the views of the nurses in management on the training/education qualification that they had obtained. It also summarises the findings of two questions regarding previous experience required for the job and formal orientation for the present post.

4.2.1 Professional qualifications

When asked to indicate what professional nursing qualifications were held, all respondents gave responses. An overwhelming majority of the respondents (89.9%, n=142) had a RGN qualification. As one might expect a higher proportion of males were RMN (68.6%, n=35) compared with 14.0% (n=15) of the women. A total of 31, (19.6%) respondents had only a RGN qualification, 4.4% (n=7) had only a RMN qualification. Most of the respondents held two or more professional qualifications; for example there were 15 (9.5%) respondents who held both a RGN and RMN qualification. It should be noted that as expected, given the exclusion criteria, there were only five RSCN in the study (Appendix II.4).

4.2.2 Possession of a degree qualification and current position

Respondents were asked to state if they had a degree qualification. Overall approximately one in four of subjects (23.4%, n=37) had a degree, but a much higher proportion (51.7%, n=15) of the senior managers possessed a degree. Whilst there was no significant difference between first line and middle managers, a significant difference occurred between senior managers and the other managers where possession of a degree qualification was concerned (Table-4.2.1).

Table-4.2.1: Distribution of possession of a degree qualification of all the subjects by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
DO YOU HAVE A DEGREE?	n	%	n	%	n	%	n	%
Yes	5	11.1	17	20.2	15	51.7	37	23.4
No	40	88.9	67	79.8	14	48.3	121	76.6

	χ^2	df	p
Overall:	17.2	2	0.000
FLMs v SMs	15.8	1	0.000
MMs v SMs	9.03	1	0.003

4.2.3 Degree qualifications and age groups

There was no significant difference between age groups and having a degree qualification as can be seen in Table-4.2.2. However it was found that there was a tendency for the younger age group to have a degree qualification. In total 37.0% (n=17) of those under 40 years of age had a degree. The least qualified group was the 50+ age group with 86.5% (n=45) having no degree.

Table-4.2.2: Possession of a degree qualification by age groups (N=158)

	AGE BAND							
	30-39 (n=46)		40-49 (n=60)		50+ (n=52)		Total (N=158)	
DO YOU HAVE A DEGREE?	n	%	n	%	n	%	n	%
Yes	17	37.0	13	21.7	7	13.5	37	23.4
No	29	63.0	47	78.3	45	86.5	121	76.6

	χ^2	df	p
Overall:	7.7	2	0.022

4.2.4 Degree qualifications and sex

In total 37 (23.4%) respondents had a degree. Of these 25.2% (n=27) of the females and 19.6% (n=10) of male had degree level education. The relationship between sex and possession of a degree was not significant.

Table-4.2.3: Possession of a degree by sex (N=158)

	Sex					
	Female (n=107)		Male (n=51)		Total (N=158)	
DO YOU HAVE A DEGREE?	n	%	n	%	n	%
Yes	27	25.2	10	19.6	37	23.4
No	80	74.8	41	80.4	121	76.6

	χ^2	df	p
Overall:	0.6	1	0.435

4.2.5 Type of the degree and sex

Respondents were asked to specify the degree qualification which they held. Of the female respondents 37.0% (n=10) had a BA degree compared with 20.0% (n=2) of the men. Of the 158 respondents, 16 (10.1%) held a master's degree. Of those 10 (62.5%) were women. However as can be seen in Table-4.2.4 the relationship between sex and type of the degree was not statistically significant. The difference was also not significant when these degrees were compared as undergraduate (BA & BSc) and postgraduate degrees (MSc & PhD).

Table-4.2.4: Type of the degree by sex (N=37)*

	SEX		
TYPE OF THE DEGREE	Female (n=27)	Male (n=10)	
BA	10	2	NS**
BSc	8	4	NS**
MSc	10	6	NS**
PhD	2	0	NS**

*Some respondents had more than one degree

**Fisher's exact p, two tailed

4.2.6 Management training/education

Respondents were asked whether they had any management training/education. A total of 128 (81.0%) respondents said 'yes' to this question. However when the type of the training/education was considered (Table-4.2.5) more than half of the people who had a management training qualification (59.4%, n=76), indicated that they had attended first and middle line management courses and a variety of short term (1-7 days) courses. These courses were not counted as formal management training. When this kind of training was excluded as formal management training, it was found that in total 76 (48.1%) respondents had a formal management training qualification(s). For example a Certificate in Health Service Management. It should be noted that 24 respondents had another 'formal management qualification' in addition to their first line and/or middle line management training courses .

Of the total number (158), 19.0% had not received any management training including first and middle line management and other short term courses. Detailed distribution of management training qualifications of the respondents is presented in Table-4.2.5 over.

Table-4.2.5: Qualification(s) of management training and/or education of the respondents (N=128)*

TYPE OF MANAGEMENT TRAINING	n	%
First & Middle Line Management Courses and various level short term (1-7 days) courses / in house courses	76	59.4
Various Certificates or equivalent i.e. Certificate in Health Service Management; Certificate in Health Economics, Certificate in Nursing Administration; Certificate in Professional Management; Certificate in Decision Making	40	31.3
Various Diplomas i.e. Diploma in Management Studies; Diploma in Professional Studies ; Diploma in Health Services Management; Diploma in Personnel Management; Diploma in Business Administration; Diploma in Counselling	21	16.4
Various Degrees i.e. MBA (Master of Business Administration); MSc in Public Sector Management, MSc in Nursing Administration, MSc in Health Economics; BSc in Management of Health services	16	12.5
Miscellaneous i.e. DMS; PACE Programme; Foundation Business Studies; Rainbow; Open University Effective Manager; MESOL	10	7.8

*Totals do not add to 100.0% as some respondents may have had more than one qualification

4.2.7 Management training and current position

There was a significant difference between having management training and the level of this current position. As can be seen in Table-4.2.6, 72.4% (n=21) of the senior managers had a formal management qualification (certificate, diploma, or degree), compared with 24.4% (n=11) of the first line managers.

If all first and middle line management courses and short courses are considered as formal management training, 96.6% (n=28) of senior managers and 73.3% (n=33) of first line managers had management training. In other words the more senior the position, the more likely the individual was to have had management training (Table-4.2.6 below excludes first & middle line management courses and short term courses).

Table-4.2.6: Distribution of having a formal management qualification by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (n=158)	
DO YOU HAVE A MANAGEMENT QUALIFICATION	n	%	n	%	n	%	n	%
Yes	11	24.4	44	52.4	21	72.4	76	48.1
No	34	75.6	40	47.6	8	27.6	82	51.9

Overall:	χ^2	**df**	**p**
	15.6	2	0.000
FLMs v MMs	8.24	1	0.004
FLMs v SMs	14.6	1	0.000

4.2.8 Type of management training and current position

There was a significant difference between first line and middle managers in terms of attending first and middle line management courses and other short term courses. Senior managers were more likely to have a degree qualification in management than first line managers. Almost all of the managers who had miscellaneous management training, such as MESOL (Management Education Syllabus and Open Learning), were middle managers. The detailed distribution of the type of the management training/education obtained by the respondents is presented in Table-4.2.7.

Table-4.2.7: Distribution of the type of management training by current position (N=128)*

	CURRENT POSITION					
TYPE OF MANAGEMENT TRAINING	**FLMs (n=33)**	**MMs (n=67)**	**SMs (n=28)**	χ^2	**df**	**p**
First & Middle Line and other short term courses	27	32	17	**Overall:** 10.7 FLMs v MMs 5.3	2 1	0.005 0.002
Various Certificates	7	22	11		NS	
Various Diplomas	3	13	5		NS	
Various Degrees	2	7	7		NS**	
Miscellaneous	0	9	1		NS**	

*Some respondents had more than one qualification

** Fisher's exact p, two tailed

4.2.9 Management training/education and sex

In total there were 107 female and 51 male subjects. Of those 85 (79.4%) women and 43 (84.3%) men said that they had had management training. As can be seen in Table-4.2.8 management training by sex showed that there was no significant difference between male and female respondents in terms of having management training.

Table-4.2.8: Distribution of management training by sex (N=128)*

TYPE OF MANAGEMENT TRAINING	SEX		χ^2
	Male (n=43)	Female (n=85)	
First & Middle Line & other short term courses	25	51	NS
Various Certificates	18	22	NS
Various Diplomas	5	16	NS
Various Degrees	3	13	NS
Miscellaneous	0	10	NS**

*Some respondents had more than one qualification

**Fisher's exact p, two tailed

4.2.10 Year of management training/education

In the questionnaire an attempt was made to find out whether respondents had taken up their current post before or after their management training. For this question 30 (19.0%) respondents were taken into the 'not applicable' category as they had indicated that they did not have any management training at all. In total 61 subjects did not provide any answer to this question, and 67 (52.3%) respondents gave the information on year of the study of any management training/education. Of these 44.8% (n=30) of participants did their management training between 1992-94 as can be seen in Table-4.2.9 below.

Table-4.2.9: Year of study of any management training/education (N=67)*

YEARS	n	%
1992-94	30	44.8
1989-91	18	26.9
1986-88	18	26.9
1983-85	18	26.9
1980-82	7	10.4
1969-79	18	26.9

*Totals do not add to 100.0% as some respondents may have studied at different periods

4.2.11 Contribution of the management training/education

Those who had management training (N=128) were asked to indicate the extent to which management training had contributed to their job. A total of 51.6% (n=66) of those with management qualification(s) selected the option 'a lot', whilst 41.4% (n=53) of this group chose the 'some' option, and eight (6.6%) subjects selected 'not much'. Only one respondent said that his/her management training did not help to his/her job at all. Detailed cross tabulation of the contribution of management training to respondent's job by type of management training and current position is provided in Appendix II.5. In total there were seven senior managers who had a degree qualification and all of them thought that their degree qualification had contributed to their job 'a lot' (Appendix II.5).

4.2.12 How management training helped the respondents' job?

In the questionnaire respondents were asked to state in what way their management training had helped them. As can be seen from Table-4.2.10 there was a variety of responses to this question which were categorised under six main headings.

In total seven respondents did not provide any answer to this question. A further 31 (19.6%) respondents were in the 'not applicable' category as 30 had indicated that they did not have any management training, and one respondent stated that her/his training had not been helpful at all. A total of 120 (75.9%) respondents explained the way which their training helped them in their job. Of those who gave an answer to this question, 43.3% (n=52) stated that the management training that they had had helped them to develop various managerial skills and abilities and 29.2% (n=35) thought that their management training helped them in gaining theoretical knowledge, understanding of management concepts and theories.

It is interesting to note that only 10.8% (n=13) of the subjects with management training exposure indicated that their training had prepared them for management of change. Again only 5.8% (n=7) of the respondents mentioned that management training had helped them in gaining an understanding of the NHS. The findings of this question are presented in Table-4.2.10 over.

Table-4.2.10: In what way has your management training helped you in your job?* (N=120)

	n	%
Helped in developing managerial skills & abilities e.g. Decision making; Communication; Quality Assurance; Team building; Leadership; Budget management; Objective setting; Time management; Marketing; Counselling; Business Planning; Interviewing	52	43.3
Helped in gaining theoretical knowledge, understanding of management concepts and theories e.g. Supplied information which was helpful in practical terms; Assisted with understanding managerial concepts; Presented a formalised and structured approach; In depth understanding of management and business issues	35	29.2
Self awareness, self control & confidence (self growth-development) e.g. Confidence to make management decision; Deeper understanding of the role; More objective thinking; Improved overall performance; Greater insight into problems connected with nursing; Now have a more strategic viewpoint	25	20.8
Manpower / Personnel management, planning e.g. Personnel management; Manpower planning; Sickness control; Recruitment; Management of staff; Performance appraisal	22	18.3
Management of change (Process & structure) e.g. Preparation for management of change; Adaptation to frequent change within the NHS; Preparation for the transition from professional nurse to nurse manager / business + general manager; Preparation for the changes as a result of Trust status	13	10.8
Understanding the NHS & the organisation e.g. Understanding the politics of NHS; Understanding the business aspects of running the NHS; Understanding of the NHS and how it works.	7	5.8
Miscellaneous e.g. Rainbow useful in most aspects of my job; On the job training has been very beneficial	20	16.7

*Totals do not add to 100.0% as some respondents provided more than one answer

4.2.13 Level of management education needed for the job

The respondents were asked to give their opinion on the level of management training/education needed to be able to perform their work satisfactorily. All the subjects provided an answer to this question. As can be seen in Table-4.2.11, on the job training was reported by the majority of the respondents (78.5%, n=124). A total of 104 (65.8%) nurses in management emphasised that degree level education in management was necessary in order to carry out their job satisfactorily. It is interesting that only 17.1% (n=27) of the participants believed that 'a degree qualification in nursing' is needed to do their job satisfactorily. A total of 74 (46.8%) respondents ticked both degree in management and on the job training at the same time.

Table-4.2.11: In your opinion what level of management education is needed to be able to perform your work satisfactorily? (N=158)*

	n	%
On the job training	124	78.5
Degree in Management	104	65.8
Degree in Nursing	27	17.1
Relevant education / training with the job e.g. a diploma, a certificate	20	12.7
Experience	12	7.6
Others e.g. Personnel & Labour relation; Business planning; Use of technology; Management development study; Personnel management; Counselling; Diploma in Management; Human resource Management	16	10.1

* Totals do not add to 100.0% as many subjects ticked more than one answer

For this question, when each option (e.g. 'on the job training', 'degree in management', 'degree in nursing') was cross tabulated with age groups, there were no significant differences between the groups of managers.

4.2.14 Level of training needed for the job and current position

Respondents were asked to state their opinion about the level of management training that was needed to be able to perform their work satisfactorily. As can be seen in Table-4.2.12, middle and senior managers were in general agreement over what level of management education was needed to perform their work satisfactorily. The majority of them believed a degree in management was needed alongside of 'on the job training'. However there were significant differences between first line managers and the other two groups of managers about the level of management experience needed to perform the job satisfactorily.

Table-4.2.12: Level of management training that was needed to be able to perform respondents' work satisfactorily by current position (N=158)*

	CURRENT POSITION						
LEVEL OF TRAINING	**FLMs (n=45)**	**MMs (n=84)**	**SMs (n=29)**		χ^2	**df**	**p**
On the job training	39	65	20				NS
Degree in Management	21	60	23	**Overall:**	10.9	2	0.005
				FLMs v MMs	6.7	1	0.009
Degree in Nursing	7	14	6				NS
Relevant training	4	15	1				NS
Experience	12	0	0	FLMs v MMs	21.6	1	0.000
				FLMs v SMs			0.002**
Others	6	9	1				NS

*Some respondents ticked more than one option

**Fisher's exact p, two tailed

4.2.15 Is previous experience in management necessary?

Respondents were asked to give their opinion about whether previous experience in management was required for a person to be able to do their job. Only two subjects did not give a response to this question and 14 (9.0%) respondents indicated that previous experience in management was not required to be able to do their job. The remaining 142 (89.9%) respondents said that previous experience was required for their jobs.

In another question they were requested to indicate the sort of experience which was required for their job. Of the 142 respondents 92.3% (n=131) gave an answer to this question. Personnel/human resource management and a nursing management experience at ward level were the most frequently reported requirements by nurses in management. The detailed analysis of the answers is given in Table-4.2.13 below.

Table-4.2.13: Experience required for the job (N=142)*

	n	%
Personnel/people/manpower/human resource management experience e.g. Management of staff; handling personnel issues; allocation of staff	52	36.6
Ward/clinical nurse management experience e.g. middle line management experience; nursing experience at ward level	46	32.4
General management experience e.g. Business and strategic planning; marketing; negotiating; contracting; audit; General management	43	30.3
Resource management including budget management	33	23.2
Managerial Skills, Knowledge and Abilities (SKA) e.g. team building; communication; interpersonal skills; negotiating skills; leadership	29	20.4
Change management	11	7.7
Various training experiences e.g. Management training; budget/finance training; on the job training	11	7.7
Miscellaneous To 'act up' with person of similar experience.	1	0.7
No Answer	11	7.7

*Totals do not add to 100.0% as some respondents provided more than one answer

4.2.16 Orientation to the job

Respondents were asked to indicate whether they received a formal orientation to prepare them for their present position. The majority of the respondents indicated that they had not received any orientation (60.1%, n=95). In another question, when asked to comment on the orientation they received, the overwhelming majority (88.9%, n=56) of those who did receive an orientation thought that their orientation was either 'good' or 'adequate' (Figure 4.2.1). However, when the total sample (N=158) was considered, it could be argued that only 35.4% (n=56) of all respondents felt their orientation to be 'adequate' or 'good'.

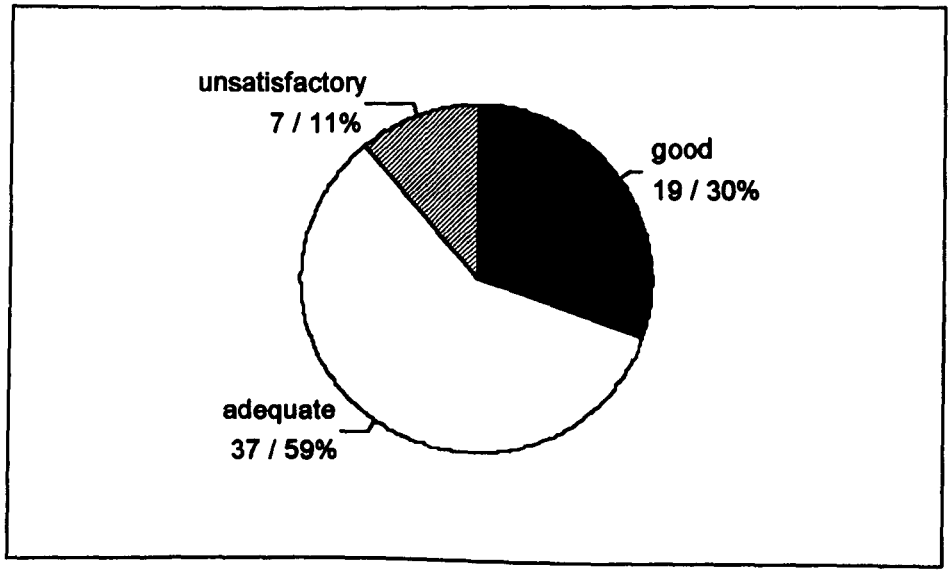


Figure-4.2.1: Views of the respondents who received an orientation (N=63)

There was no significant difference between the managers in terms of receiving an orientation (χ^2=0.7, df=2, p=0.706). However the cross tabulation of the question by current position showed that all of the senior managers who had an orientation (n=12) were happy with the orientation they received. In total 20 first line managers, out of 45, received an orientation and of those 4 (20.0%) indicated that their orientation was 'unsatisfactory'.

There was no significant relationship between the age band and use of orientation (χ^2=0.6, df=4, p=0.634).

4.3 JOB RESPONSIBILITIES AND SKILLS, KNOWLEDGE & QUALITIES (SKQ) NECESSARY FOR THE JOB

4.3.1 Main job purpose(s) or objective(s)

Respondents were asked to describe the main purpose(s) or objective(s) of their job. All subjects answered this question and various statements were identified (Table-4.3.1). Human resource management was the most frequently reported component of the job (35.4%, n=56). Two other components, delivery of nursing services, and management and development of hospital services, were also frequently described by the respondents. It is interesting to note that change management was identified by only five respondents and they were placed in the 'miscellaneous' category as the number was so small.

Table-4.3.1: Main job purpose(s) or objective(s) of all the subjects (N=158)*

	n	%
Human resource Management e.g. To maintain staffing levels; development of staff; supporting and empowering staff; maintain agreed nursing skill mix, recruitment and selection; ensure all wards and departments have sufficient nurses for workload, personnel management; orientation of newly appointed staff	56	35.4
To ensure delivery of quality nursing services e.g. Providing a quality service to patients; to maintain and develop a high standard of care for the patients; to ensure a quality and comprehensive health service is provided to the people	49	31.0
Management and development of directorate/unit/hospital services e.g. To participate and contribute effectively to the overall management of the directorate; to manage the day to day running of the elderly care hospital; to manage, and develop the acute services within the unit	46	29.1
Management of nursing services e.g. To manage nursing services within an allocated budget; organisation and management of the nursing services within the directorate; control the operational management and co-ordinate the nursing services	35	22.2

continued on the next page

	n	%
Professional / managerial leadership e.g. To provide managerial and professional leadership; to provide advice, encouragement and professional leadership to nursing staff	34	21.5
Corporate responsibilities e.g. To contribute to the strategic and corporate management of the Unit; marketing the service; negotiating achievable contracts with purchasers and monitoring contract compliance; strategic planning; producing, developing, implementing business plans	30	19.0
Quality assurance/standards/audit e.g. to implement a system of quality assurance within nursing department; management of the quality assurance process; Oversee nursing standards	28	17.7
Budget/financial responsibilities e.g. To monitor and manage the budget; efficient management of nursing budget	25	15.8
Advisory roles e.g. To act as supervisor and advisor in all nursing issues; provision of nursing advice to staff / Unit Executive / Trust Board	19	12.0
Communication/liaison/networking e.g. To communicate information to the second level management teams; liaise with other professions and those providing support services	12	7.6
Multidisciplinary roles e.g. Management of multidisciplinary work-force; to lead and direct a multidisciplinary group of professionals including paramedics	9	5.7
Act as a: director, manager, member of trust board	7	4.4
Miscellaneous e.g. Implementing change and change management; managing a downsizing service; managing hotel services; executive contribution to the Board's purchasing requirements	12	7.6

*Totals do not add to 100.0% as some respondents provided more than one answer

4.3.2 Main job purpose(s) and current position

In Table-4.3.2 the most frequently identified job components were cross tabulated with current position. It was found that significantly more first line managers were concerned with human resource management than the other two groups whilst senior managers were more concerned with corporate management issues, quality assurance, and advisory roles than the remaining two groups. There were no significant differences between the three groups in terms of assigning other statements as main job objectives.

Table 4.3.2: Distribution of frequently reported main job components and current position (N=158)*

	CURRENT POSITION					
	FLMs (n=45)	**MMs (n=84)**	**SMs (n=29)**		χ^2	**df**	**p**
Human resource management	27	26	3	**Overall:**	20.5	2	0.000
				FLMs v SMs			0.000**
				FLMs v MMs	9.05	1	0.003
Delivery of quality nursing services	15	30	4				NS
Management and development of services	14	25	7				NS
Management of nursing services	8	21	6				NS
Leadership	11	14	9				NS
Corporate responsibilities	1	19	10	**Overall:**	13.5	2	0.001
				FLMs v SMs			0.000**
				FLMs v MMs	7.8	1	0.005
Quality assurance	1	11	16	**Overall:**	36.5	2	0.000
				FLMs v SMs			0.000**
				MMs v SMs	18.7	1	0.000
Budget / financial responsibilities	5	18	2				NS
Advisory roles	6	3	10	**Overall:**	19.6	2	0.000
				MMs v SMs	17.3	1	0.000

*Some respondents provided more than one answer

**Fisher's exact p, two tailed

4.3.3 Main job responsibilities

Respondents were asked to list up to five items which they considered as their main responsibilities. Each respondent provided at least three responsibilities and in total 12 subjects listed more than five items. For this question only the first five items were analysed. Overall a variety of responsibilities were identified, in total 708 items. In this question, apart from the last two categories, the groupings used for the previous question were used again since the contents of the responses were naturally similar, but there was a need to add two other categories which were teaching responsibilities and change management.

As can be seen in Table-4.3.3, as in the previous question, human resource management was again the most frequently reported main job responsibility of the respondents. Quality assurance and budget responsibilities were reported by approximately half of the subjects.

Table-4.3.3: Main job responsibilities of all the respondents (N=158)*

	n	%
Human resource Management	96	60.8
Quality Assurance / Audit /Standards	79	50.0
Budget	76	48.1
Communication / liaison	54	34.2
Management of directorate / unit / hospital services	53	33.5
Identifying training needs of the staff / training and teaching	48	30.4
Ensuring delivery of quality nursing services	44	27.8
Corporate responsibilities	37	23.4
Professional / managerial leadership	36	22.8
Management of nursing services	33	20.9
Advisory roles	30	19.0
Management of change	24	15.2
Miscellaneous e.g. Research; dealing with statistics; representation of the organisation/ nursing; statutory requirements of UKCC; management of college of nursing	13	8.2

* Totals do not add 100.0% since respondents provided more than one answer

4.3.4 Main job responsibilities and current position

When main job responsibilities were cross tabulated with current position it was found that the results were quite similar to the findings presented previously (Table 4.3.2). Significant differences occurred between the groups for human resource management, quality assurance/standards, corporate responsibilities, advisory roles, and change management as main responsibilities (Table 4.3.4).

Table-4.3.4: Distribution of main job responsibilities by current position (N=158)*

	CURRENT POSITION						
	FLMs (n=45)	**MMs (n=84)**	**SMs (n=29)**		χ^2	**df**	**p**
Human resource management	34	53	9	**Overall:**	15.1	2	0.001
				FLMs v SMs	12.6	1	0.000
				MMs v SMs	7.7	1	0.005
Quality assurance / audit/ standards	19	38	22	**Overall:**	9.6	2	0.008
				FLMs v SMs	6.8	1	0.009
				MMs v SMs	6.9	1	0.008
Financial responsibilities	18	49	9				NS
Communication / liaison	19	29	6				NS
Management of unit / hospital services	14	30	9				NS
Identifying training needs and training and teaching	17	24	7				NS
Ensuring delivery of quality nursing services	13	28	3				NS
Corporate responsibilities	3	15	19	**Overall:**	37.1	2	0.000
				FLMs v SMs			0.000**
				MMs v SMs	21.1	1	0.000
Professional / managerial leadership	7	17	12				NS
Management of nursing services	7	20	6				NS
Advisory roles	4	10	16	**Overall:**	30.4	2	0.000
				FLMs v SMs			0.000**
				MMs v SMs	20.4	1	0.000
Management of change	14	8	2	**Overall:**	12.5	2	0.002
				FLMs v MMs	8.2	1	0.004

*Respondents provided more than one answer ** Fisher's exact p, two tailed

4.3.5 What task do you do at present which you think should be performed by someone else?

Respondents were asked if they did any task that should be done by someone else. The response rate for this question was 78.5% and 34 respondents did not provide any information. Table-4.3.5 shows the distribution of the answers of the 124 subjects. Of the subjects who provided an answer, 50.0% (n=62) stated that some clerical and administrative work should be done by others, 21.8% (n=27) stated that there was no task that should be done by someone else. A further 10 (8.1%) respondents gave miscellaneous answers to this question.

Table-4.3.5: Tasks that should be done by others (N=124)*

	n	%
Clerical and administrative issues e.g. Collection of statistical data; chasing up equipment; keeping sickness / absence cards up to date; filing	62	50.0
None	27	21.8
Secretarial jobs e.g. Answering telephones; writing minutes; photocopying	21	16.9
Personnel - manpower issues e.g. Staff allocation on a daily basis; administering recruitment	17	13.7
Miscellaneous Pharmacy control; health & safety issues; hotel management	10	8.1

*Totals do not add to 100.0% as some respondents provided more than one answer

When this question was cross tabulated with current position it was found that a majority of the first line managers (61.5%, n=24) and half of the middle managers (n=33) indicated that their clerical and/or administrative task(s) should be done by others. In total 19 (65.5%) senior managers replied to this question, of these nine said that they had no task that should be done by others. This might show that first line managers and middle managers were more engaged with clerical and/or administrative task(s) than senior managers.

4.3.6 Clarity on the nature of their role and freedom to use own judgement

Respondents were asked to indicate to what extent they were clear on the nature of their job/role. The response rate for this question was 100.0%. Overall almost all respondents (94.3%, n=149) said that they were 'very clear' and 'fairly clear' about the nature of their role. In total nine (5.7%) subjects chose the 'not very clear' option and they were asked to explain their answer if they were not very clear on the nature of their job/role. Some examples of the answers of these nine managers are given below.

> *"The organisation is undergoing a lot of changes and structures have not stable enough yet and there is much policy confusion".*
> *"A role confusion between the Head Office roles and divisional roles which leads lack of role clarity, responsibility and authority".*
> *"Change recently is purchaser/provider; now too many people involved; no clear guidelines".*
> *"I was appointed, and then left very much to my own devices".*
> *"As this is a new Trust, the role of the service manager within the service management team has not yet been adequately defined".*

Respondents were also asked to indicate whether they had 'enough freedom to use their own judgement about their work'. Again the response rate for this question was 100.0% and almost all of the subjects indicated that they had either 'a lot' or 'some' freedom to use their own judgement about their work. In total only seven (4.4%) participants ticked the 'not much' option in this question and again they were requested to explain their answer. Some of the examples of the responses from these seven subjects are given below.

> *"A somewhat dictatorial senior management system based on fear and mistrust does not lend itself to any degree of autonomy".*
> *"Control of budget still remains tightly controlled by the unit team, although they may say differently".*
> *"To some extent I have a lot of freedom but there is all too often a high degree of accountability without the complementary responsibility. i.e. you are often given no/little choice of how things are done".*

The cross tabulation of these two questions by current position showed that in terms of 'role clarity' there was no relationship between the three groups (χ^2=2.5 df=4, p=0.652).

In terms of 'using one's own judgement about his/her work', senior managers were more likely to be independent enough to use their judgement than first line managers. It should be noted that in order to perform statistical analysis, the 'some' and 'not much' options were combined Table-4.3.6.

In both questions there were no senior managers who chose either the option 'not very clear' or the 'not much' option.

Table-4.3.6: Freedom to use judgement by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (n=158)	
EXTENT OF USING JUDGEMENT	n	%	n	%	n	%	n	%
A lot	22	48.9	49	58.3	24	82.8	95	60.1
Some	21	46.7	30	35.7	5	17.2	56	35.4
Not much	2	4.4	5	6.0	0	0	7	4.4
Overall	χ^2		**df**		**p**			
	8.7		2		0.013			

4.3.7 Responsibility for a nursing budget and current position

Respondents were asked if they were responsible for a nursing budget. It was found that in total 108 (68.4%) subjects had a budget responsibility. When this question was cross tabulated with current position, a significant difference occurred between the managers. As can be seen in Table-4.3.7, middle managers were more likely to have a budget responsibility compared with the other two groups of managers.

Table-4.3.7: Responsibility for a nursing budget and current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (n=158)	
ARE YOU RESPONSIBLE FOR A BUDGET?	n	%	n	%	n	%	n	%
Yes	24	53.3	69	82.1	15	51.7	108	68.4
No	21	46.7	15	17.9	14	48.3	50	31.6

Overall:	χ^2	**df**	**p**
	15.8	2	0.000
FLMs v MMs	12.1	1	0.001
MMs v SMs	8.92	1	0.003

There were no significant differences between sex (χ^2= 1.1, df=1, p=0.295) and age groups (χ^2= 0.3, df=2, p=0.853) and having a budget responsibility.

4.3.8 Control over a budget and current position

Those respondents who had a budget were requested to indicate how much control they had over their own budget. In total 25.0% (n=27) of the subjects stated that they had complete control over a budget. Comparison of those who indicated that they had a nursing budget and current position showed that there were significant differences between first line managers and the remaining two groups in terms of having control over the budget. It should be noted that in order to carry out statistical analysis 'completely' and 'very much', and 'fairly' and 'a little' options were combined together. Table-4.3.8 provides the details.

Table-4.3.8: The extent of control over a budget and current position (N=108)

	CURRENT POSITION							
	FLMs (n=24)		MMs (n=69)		SMs (n=15)		Total (n=108)	
EXTENT OF THE CONTROL	n	%	n	%	n	%	n	%
Completely	5	20.8	13	18.8	9	60.0	27	25.0
Very much	5	20.8	37	53.6	6	40.0	48	44.4
Fairly	5	20.8	12	17.4	0	0	17	15.7
A little	9	37.5	7	10.1	0	0	16	14.8

	χ^2	df	p
Overall	15.6	2	0.001
FLMs v MMs	7.38	1	0.006
FLMs v SMs	13.7	1	0.000*(Fisher's exact p two tailed)

4.3.9 Skills, knowledge and qualities (SKQ) necessary to perform the job satisfactorily

Respondents were asked their opinion on the kind of skills, knowledge and qualities that nurses in management should have to be able to do their job satisfactorily. In the questionnaire these three items were asked separately as subheadings and the analysis of the items was carried out separately. Again owing to the number of varied responses given to these three items, it was difficult to establish a system to categorise the responses. To increase the internal validity a clinical psychologist was requested to construct the categories from the raw data independently.

It was found that in terms of 'skills', communication came out as number one (52.3%, n=80) followed by 'interpersonal skills' and 'leadership'. Change management and decision making skills were reported by a small proportion of the respondents 11.1% (n=17) and 10.5% (n=16) respectively.

With regard to the 'knowledge' that was required to be able to perform the job satisfactorily, there was no real consensus among the responses on this matter; for instance, clinical knowledge or knowledge of the area working in, was reported most frequently by 36.6% (n=56) of the respondents. The importance of human resource management knowledge and nursing knowledge was also cited by the subjects.

The most common 'qualities' were those of leadership and motivation, cited by an equal number of the respondents (34.9%, n=52). The detailed findings of this question comprising all three issues (skills, knowledge and qualities) are presented in three different tables in Appendix II.6, II.7 and II.8.

When respondents were asked if they possessed the skills, knowledge and qualities they had listed in the previous question, 151 (95.6%) subjects responded. Of these 50.3% (n=76) ticked 'some' and 43.7% (n=66) ticked 'many' options. Only four (2.6%) respondents believed that 'almost all' nurses in management possessed the skills, knowledge and qualities they had listed. When this question was cross tabulated with current position, there were no significant differences between the groups of managers (χ^2= 3.8, df= 6, p=0.698).

4.3.10 Potential job responsibilities of the subjects

In total 23 items were asked to determine the potential job functions of the respondents (question number 27 in the questionnaire, Appendix II.9). The respondents were asked to state how frequently they 'actually' and 'ideally' carry out given responsibilities. In the pilot study, although two subjects indicated that there were some difficulties in completing these questions, it was decided with supervisors that they should be asked in the main study to try and gain adequate information on these items.

Although the response rate for the 'actually' situation was satisfactory, in the second situation, 'ideally', it was not. In addition there were many respondents who either ticked more than one option, when they were asked to indicate only one response, or gave explanations without specifying an option. Therefore it was thought that these questions were an unsuccessful attempt to determine the potential job functions of the subjects. Because of the great variability in the way respondents replied to this question detailed analysis was not carried out. However the responses are presented in Appendix II.9.

As can be seen in Appendix II.9, in total there were 23 potential job functions identified. In the ideal situation respondents wanted to do 20 functions more often than they did actually. For instance, (statement number 17), 68 subjects (73.9%) said that ideally, they would more often 'initiate facilitate and participate in nursing research'. However in the questionnaire when the respondents were asked to define their main job responsibilities (Table-4.3.3) only five (3.2%) respondents defined research process as one of their main job responsibilities. Similarly 57 subjects (65.5%) indicated that ideally, they would more often 'participate and present up-to-date educational programs' (statement number 16).

4.4 ROLE CHANGES AND RESPONDENTS' VIEWS ON THE NHS (1990) REFORMS

4.4.1 Do you have to be a nurse to be able to carry out your job?

Respondents were asked to indicate if they thought one had to be a nurse to be able to carry out their job. As expected, a total of 82.3% (n=130) of all the respondents said 'yes' to this question but 28 respondents indicated that one did not have to be a nurse for their job. The cross tabulation of this question by current position showed that almost all first line managers (86.7%, n=39) and senior managers (93.1%, n=27) and a majority of middle managers (76.2%, n=64) agreed that it was necessary to be a nurse for their job.

In the next question all respondents were asked to explain their answers. The following categorisation was defined for this question. As can be seen in Table-4.4.1 all explanations for 'yes' and 'no' were grouped in one table. This was owing to some respondents' overlapping answers. For example a 'contract manager' indicated that she/he did not have to be a nurse for the job but she/he explained that:

> *"My nursing background is beneficial, and gives me credibility, however general management skills are the vital skills of contract management, not a nursing qualification".*

Another respondent ticked the 'no' option but she/he said:

> *"To be a nurse is a definite advantage when dealing with nursing and medical staff. You have to be seen as an expert and to solve a problem you must understand the problem".*

In both cases their responses were coded into the 'a nursing background is an advantage' category. In the main question 28 respondents indicated that one did not have to be a nurse for their job, of these 14 indicated that one did not have to be a nurse, other people could have done the job and 12 believed that one did not have to be a nurse for their job but a nursing background was advantageous. These 12 subjects' answers were coded in the third category in Table-4.4.1 over. In the main question a further eight subjects ticked the 'yes' option, however when

they asked to explain their answers they said that one did not have to be a nurse for their job but a nursing background was advantageous. Therefore these answers were also coded to the third category in Table-4.4.1 below. Nine subjects did not provide any explanation although they answered the main question either 'yes' or 'no'. Detailed analysis of this question is given in Table-4.4.1 below.

Table-4.4.1: Why do you have to be a nurse (or otherwise) (N=158)*

	n	%
To understand the professional issues/clinical practice	41	25.9
Human resource management e.g. Recruitment of nursing staff should be carried out by a nurse; to understand requirement for proper allocation of staff; to effectively manage manpower	20	12.7
I don't have to be a nurse but a nursing background is advantageous	20	12.7
To understand patient care	17	10.8
Management of nursing requires a nurse, nurses should be managed by nurses	15	9.5
No, I don't have to be a nurse, other non -nurses could do my job	14	8.9
To understand staff's problems / needs	12	7.6
Professional leadership	12	7.6
To make appropriate decisions	11	7.0
It gives credibility	10	6.3
A non-nurse; would have difficulty in doing my job, would not understand the job, would be unable to see things or to address professional issues	9	5.7
Yes, I have to be a nurse but some aspect of the job could be done by someone else	8	5.1
Statutory requirements	13	8.2
Miscellaneous e.g. "My role is a dual role nurse manager and service manager. If the post holder was not a nurse the Trust would require to employ two people"; "It is more important to understand the organisation and manage people rather than the professional qualifications"	7	4.4
No answer	9	5.7

* Totals do not add 100.0% since some respondents provided more than one answer

4.4.2 Recent job changes in relation to responsibilities, relationships and work climate

Respondents were asked if their job had changed within the last three years and if so how. An overwhelming majority (n=152, 96.2%) stated that their job had changed within the last three years and of those 78.9% (n=120) said that their job was 'highly' changed and 29 (19.1%) respondents stated that their job had changed 'moderately'. The cross tabulation of this question by current position showed that 67.4% (n=29) of first line managers, 81.3% (n=65) of middle managers and 89.7% (n=26) of senior managers felt their job had changed 'highly'. However this was not statistically significant (χ^2=6.6, df=4, p=0.161).

In the next question the 152 respondents were asked to describe how their job altered in relation to their professional responsibilities, formal relationships with colleagues and everyday work climate. A detailed distribution of the answers of the subjects about these three questions is provided in Appendices II.10, II.11 and II.12. The following three subheadings examine the relationships between the current position of the respondents and described changes in role; that is changes in professional responsibilities, changes in formal relationships and changes in everyday work climate.

4.4.2a: Changes in professional responsibilities

In relation to professional responsibilities, 61 (40.1%) respondents stated that their responsibilities had increased and widened to other areas and they now had wider roles in multi-disciplinary work. In total 27 (17.8%) subjects reported that they were no longer managerially responsible for nurses and/or nursing services and an equal number of respondents said that they now had more corporate responsibilities. A total of 19 (12.5%) subjects stated that there were no real changes in their professional responsibilities (Appendix II.10).

In Table-4.4.2a, the most commonly reported statements were cross tabulated with current position. Overall there were no significant differences between the groups although first line managers were more likely to have had increased responsibilities compared with middle and senior managers; 44.4% (n=20), 38.1% (n=32) and 31.0% (n=9) respectively. A total of 34.5% (n=10) of senior managers and 12.5% (n=10) of middle managers said that they were no longer managerially responsible for nursing or for nurses. A total of 20.9% (n=9) of first line managers and 17.2% (n=5) of senior managers stated that they were now more involved in corporate issues. In total 15.0% (n=12) of middle managers said that their responsibilities had not changed.

Table-4.4.2a: Job changes in responsibilities by current position (N=152)*

	CURRENT POSITION			
	FLMs (n=43)	MMs (n=80)	SMs (n=29)	χ^2
Wider-increased responsibilities	20	32	9	NS
No longer responsible for nursing/nurses	7	10	10	NS
Involvement in corporate issues	9	13	5	NS
No real change	5	12	2	NS

*Some respondents provided more than one answer

4.4.2b: Changes in formal relationships

In relation to formal relationships, a total of 31 (20.4%) respondents reported that there had been no change in their relationships with colleagues within the last three years. Twenty nine (19.1%) subjects said that their relationships were always good with others. The third most frequently reported answer was about the increased relationships with other disciplines after the NHS (1990) Reforms. In total 24 (15.8%) respondents stated that they have had more relationships with other disciplines, and were more involved in discussion with other disciplines. In regard to the fourth category there were 19 (12.5%) nurses in management who thought that their relationships with their colleagues had become more isolated or distanced and there was a lack of communication. Detailed analysis of the findings about how the respondents' relationships changed after the NHS (1990) Reforms is provided in Appendix II.11.

When these most frequently reported answers were cross tabulated with current position, overall no significant differences occurred between the groups. However, 20.9% (n=9) of first line managers stated that there was no change in their relationships, compare with 13.8% (n=4) of senior managers. Again 20.9% (n=9) of first line managers believed that their relationships with colleagues had changed negatively (Table-4.4.2b).

Table-4.4.2b: Job changes in formal relationships by current position (N=152)*

	CURRENT POSITION			
	FLMs (n=43)	MMs (n=80)	SMs (n=29)	χ^2
No change	9	18	4	NS
Good relationships	10	15	4	NS
More multi disciplinary relations	4	14	6	NS
Negative change	9	8	2	NS

*Some respondents provided more than one answer

4.4.2c: Changes in everyday work climate

When respondents were asked to describe how their everyday work climate had changed within the last three years, 48 (31.6%) subjects said that they were now busier than ever before, there was more paper work, more meetings and not enough time to achieve targets. In total 27.0% (n=41) gave negative emotional statements and 19.1% (n=29) of the respondents again stressed that their responsibilities had increased and/or widened (Appendix II.12).

As can be seen from Table-4.4.2c once more these commonly reported statements were cross tabulated with current position. Although there were no significant differences between the groups, first line managers were more likely to complain about increasing work volume, paper work and a busier environment compared with senior managers. Once again first line managers gave more negative views than middle and senior managers.

Table-4.4.2c: Job changes in work climate by current position (N=152)*

	CURRENT POSITION			
	FLMs (n=43)	**MMs (n=80)**	**SMs (n=29)**	χ^2
Increased work volume and not enough time	16	27	5	NS
Negative statements	15	23	3	NS
Wider / increased responsibilities	6	14	9	NS
No longer have direct line management responsibilities	8	7	6	NS

*Some respondents provided more than one answer

4.4.3 Views of the subjects on the issue of SNM's becoming business, service or locality managers

Respondents were asked to comment on the issue of senior nurse managers (SNMs) becoming business, service or locality managers as a result of the introduction of a clinical directorate structure. Only four respondents did not answer this question; of these two were in middle and, the other two in senior manager positions. Of the respondents 26.6% (n=41) felt that this was a positive development that could lead to an improvement in services. Also that was a chance for nurses to demonstrate their ability to manage at a different level.

The second most commonly reported view was concerned with the training needs of the people who would take up these roles. A total of 30 (19.5%) respondents said that becoming business, service or locality managers would be a good experience for nurses. However nurses entering to this field would need additional preparation in areas such as finance, business planning and statistical analysis.

There were 19 (12.3%) nurses in management who saw the 1990 NHS changes from a negative perspective. They claimed that the clinical directorate structure was a mechanism to weaken nursing's voice and there was no evidence to show a more efficient and improved service under a clinical director. Also they said that nurses were forced to choose these roles. Appendix II.13, provides the detailed answers which were categorised into 10 main headings.

The relationship between the subjects' views on this issue and their current position is shown in Table-4.4.3 over. More than half of the senior managers reported a positive view compared with 18.3% (n=15) of middle managers and this was statistically significant. Of the 27 senior managers only one stated a negative view and 22.2% (n=6) stressed the need for preparation for the business, service or locality manager's roles. It should be noted that only most frequently reported answers to this question were cross tabulated with current position in Table-4.4.3 over.

Table-4.4.3: Views of the subjects on the issue of role changes of SNM's by current position (N=154)

	CURRENT POSITION						
	FLMs (n=45)	**MMs (n=82)**	**SMs (n=27)**		χ^2	**df**	**p**
Positive View	12	15	14	**Overall:**	11.7	2	0.003
				MMs v SMs	10.1	1	0.002
OK, but they need training/preparation	8	16	6				NS
Negative view	7	11	1				NS

*Some respondents provided more than one answer

4.4.4 Views of the subjects on the NHS Reforms

In order to elicit the respondents' views on the NHS (1990) Reforms and their effect on their job, a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree' was utilised for 15 separate statements. Table-4.4.4 over, presents a summary of the findings of these statements. Here only four tables where significant relationships between the current position and statements occurred are presented. Cross tabulation of the remaining statements by current position are provided in Appendix II.14. It should be noted that for convenience in statistical analysis, 'strongly agree' and 'agree', and 'strongly disagree' and 'disagree' categories were combined together in all cross tabulations of these 15 statements by current position.

As can be seen in Table-4.4.4 over page 187, 59 subjects (39.9%) felt that the NHS (1990) Reforms had strengthened their professional role within the organisation. An equally large proportion felt otherwise. More than half of the respondents (54.3%, n=83) believed that in recent years nurses had been involved in a higher level of decision taking in the organisation as a whole. There was a general tendency to agree that (70.6%) in recent years relationships in nursing had been changing from hierarchical to facilitative. However as can be seen in section 4.6.3, only 3.8% (n=6) of all the respondents saw their relationships with their subordinates as 'hierarchical' and 14.9% (n=23) participants stated that their relationships with their managers was hierarchical.

Opinion was divided on the proposition that 'the NHS Reforms are generally a threat, not an opportunity for nurses'. While just over half of the respondents (52.2%) tended to disagree, more than one in every four subjects (26.8%) believed that the Reforms were generally a threat for nurses. Similarly just over half of the respondents (51.0%) tended to disagree that NHS Reforms had resulted in a loss of power and status for nurses. However 34.0% agreed with this proposition. The majority of the respondents (74.4%) stated that expectations of the nurse manager's role had been increased in recent years. There was also widespread agreement (85.1%) about the statement 'my leadership and advisory role to nurses has become more important'. Almost all of the respondents (95.5%) agreed that their responsibilities regarding quality assurance issues had increased. In total 57.1% of the subjects tended to agree that 'the directorate structure has the potential to provide a supportive environment to promote highly successful nursing practice' but a high proportion (28.2%) remained uncertain. Again opinion was divided about the statement whether 'the subjects had equal status with medical staff in terms of management activities'. While more than half (54.2%) tended to agree they did have equal status, 33.4% stated the opposite. A majority of the subjects (87.6%) stated that they were (at the time of the study), more aware of political developments than before. Almost two in every three subjects felt that their strategic roles had increased within the organisation, and that a higher degree in nursing management was a necessary preparation for nurse managers. In total 44.5% of the subjects stated that they had enough resource to do their job satisfactorily and finally a vast majority (91.5%) believed that nurse directors should have business management skills. The details of these findings are presented in Table-4.4.4 over.

As can be seen in Table-4.4.4 over, in general there was a high level of uncertainty in these statements. With such a high percentage of respondents remaining uncertain it is difficult to establish whether this uncertainty was indicative of the effect of the changes in the NHS at the time of this study or merely indecision on the part of respondents.

Table-4.4.4: The views of the respondents on the NHS (1990) Reforms

	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree		Total	
STATEMENTS	n	%	n	%	n	%	n	%	n	%	n	%
1. The NHS Reforms have strengthened my professional role within the organisation.	9	6.1	50	33.8	30	20.3	54	36.5	5	3.4	148	100.0
2. In recent years nurses have become involved in a higher level of decision making for the organisation as a whole.	13	8.5	70	45.8	25	16.3	41	26.8	4	2.6	153	100.0
3. In terms of relationships, nursing structure has been changing from hierarchical to facilitative (more flexible).	22	14.4	86	56.2	18	11.8	25	16.3	2	1.3	153	100.0
4. The NHS Reforms are generally a threat, not an opportunity for nurses.	9	5.9	32	20.9	32	20.9	68	44.4	12	7.8	153	100.0
5. The NHS Reforms mean 'a loss of power & status' for nurses.	11	7.2	41	26.8	23	15.0	72	47.1	6	3.9	153	100.0
6. Expectations of Nurse Manager's role have increased in recent years.	44	28.8	85	55.6	12	7.8	10	6.5	2	1.3	153	100.0
7. My leadership & advisory role to nurses has become more important.	50	32.5	81	52.6	12	7.8	11	7.1	0	0	154	100.0

continued on the next page

	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree		Total	
STATEMENTS	n	%	n	%	n	%	n	%	n	%	n	%
8. My responsibilities regarding quality assurance issues has increased	66	42.9	81	52.6	3	1.9	4	2.6	0	0	154	100.0
9. The directorate structure has the potential to provide a supportive environment to promote highly successful nursing practice.	28	18.8	57	38.3	42	28.2	19	12.8	3	2.0	149	100.0
10. I have an equal status with medical staff in terms of management activities in the organisation where I work.	23	15.0	60	39.2	19	12.4	43	28.1	8	5.2	153	100.0
11. I am now more aware of political developments than before.	45	29.4	89	58.2	2	1.3	16	10.5	1	0.1	153	100.0
12. My strategic roles have been increasing within the organisation.	30	19.4	84	54.2	21	13.5	20	12.9	0	0	155	100.0
13. Higher degree education (e.g. MSc, MN) in nursing management or in administration is necessary preparation for nurse managers.	24	15.7	74	48.4	25	16.3	25	16.3	5	3.3	153	100.0
14. I have enough organisational resource to do my job satisfactorily.	5	3.3	63	41.2	21	13.7	58	37.9	6	3.9	153	100.0
15. Nurse Directors should have business management skills & knowledge.	49	31.8	92	59.7	8	5.2	5	3.2	0	0	154	100.0

4.4.4a Structure of nursing and current position

Respondents were asked to state their views about the structure of nursing. As can be seen Table 4.4.4a, the majority of subjects (70.6%, n=108) agreed with the statement 'In terms of relationships, nursing structure has been changing from hierarchical to facilitative (more flexible)'. However 31.8% of first line managers compared with 3.8% of senior managers disagreed with this statement. In total 16.9% of middle managers compared with 4.5% of first line managers were uncertain about this statement. Table-4.4.4a provides the detailed findings. As noted previously in section 4.4.4, for convenience in statistical analysis, 'strongly agree' and 'agree', and 'strongly disagree' and 'disagree' categories were combined together in Table-4.4.4a.

Table-4.4.4a: 'In terms of relationships, nursing structure has been changing from hierarchical to facilitative (more flexible)' (N=153)

	Current Position							
	FLMs (n=44)		MMs (n=83)		SMs (n=26)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	3	6.8	11	13.3	8	30.8	22	14.4
Agree	25	56.8	46	55.4	15	57.7	86	56.2
Uncertain	2	4.5	14	16.9	2	7.7	18	11.8
Disagree	12	27.3	12	14.5	1	3.8	25	16.3
Strongly Disagree	2	4.5	0	0	0	0	2	1.3

	χ^2	df	p
Overall:	14.0	4	0.008

(FLMs v SMs) for agree and disagree p=0.006 (Fisher exact p, two tailed)

4.4.4b NHS (1990) Reforms and nurses

In another statement, subjects were asked to indicate whether they saw the NHS (1990) Reforms as a threat to nurses. In terms of agreement there were significant differences between first line managers and both middle and senior managers. A total of 37.8% (n=17) first line managers agreed with the statement 'the NHS (1990) Reforms are generally a threat, not an opportunity for nurses' compared with 15.9% (n=13) of middle managers and 7.7% (n=2) of senior managers. In addition the majority of senior managers (76.9%, n=20) disagreed that the NHS (1990) Reforms were generally a threat for nurses, compared with 37.8% (n=17) of first line managers. In total 20.9% of the respondents were uncertain about the proposition. Table-4.4.4b below provides the details. It should be noted that for convenience in statistical analysis, 'strongly agree' and 'agree', and 'strongly disagree' and 'disagree' categories were combined together in Table-4.4.4b.

Table-4.4.4b: 'The NHS (1990) Reforms are generally a threat, not an opportunity for nurses' (N=153)

	Current Position							
	FLMs (n=45)		MMs (n=82)		SMs (n=26)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	4	8.9	4	4.9	1	3.8	9	5.9
Agree	17	37.8	13	15.9	2	7.7	32	20.9
Uncertain	7	15.6	22	26.8	3	11.5	32	20.9
Disagree	14	31.1	38	46.3	16	61.5	68	44.4
Strongly Disagree	3	6.7	5	6.1	4	15.4	12	7.8

	χ^2	df	p
Overall:	17.9	4	0.001
FLMs v MMs	9.47	2	0.009
FLMs v SMs	11.1	2	0.004

(FLMs v MMs for agree and disagree χ^2=6.6, df=1, p=0.008)

(FLMs v SMs for agree and disagree p=0.001 Fisher exact p, two tailed)

4.4.4c Equal status with medical staff

Respondents were asked if they had equal status with medical staff in terms of management activities in the organisation. As can be seen in Table-4.4.4c, 81.4% (n=22) of senior managers agreed that they had equal status with medical staff in the organisation compared with 34.1% (n=15) first line managers. In terms of being uncertain about this statement, first line managers were more likely to be uncertain than middle and senior managers. Overall 40.9% (n=18) of first line managers thought that they did not have equal status with medical staff in the organisation compared with 35.3% (n=29) of middle managers and 14.8% (n=4) of senior managers. Again it should be noted that for convenience in statistical analysis, 'strongly agree' and 'agree', and 'strongly disagree' and 'disagree' categories were combined together in Table-4.4.4c.

Table-4.4.4c: 'I have an equal status with medical staff in terms of management activities in the organisation where I work' (N=153)

	Current Position							
	FLMs (n=44)		MMs (n=82)		SMs (n=27)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	3	6.8	11	13.4	9	33.3	23	15.0
Agree	12	27.3	35	42.7	13	48.1	60	39.2
Uncertain	11	25.0	7	8.5	1	3.7	19	12.4
Disagree	17	38.6	23	28.0	3	11.1	43	28.1
Strongly Disagree	1	2.3	6	7.3	1	3.7	8	5.2

	χ^2	df	p
Overall:	18.9	4	0.001
FLMs v SMs	15.4	2	0.000

(FLMs v SMs for agree and disagree p=0.003 Fisher exact p, two tailed)

(FLMs v SMs for agree and uncertain p=0.002 Fisher exact p, two tailed)

4.4.4d Increased strategic roles

In response to this question the majority of respondents (73.6%, n=114) agreed that their strategic roles had been increasing within the organisation. While 26 senior managers out of 27 (96.3%) believed that their strategic roles had been increasing within the organisation, only 55.5% (n=25) of first line managers felt similarly. Indeed a high proportion of first line managers were uncertain. No participant strongly disagreed with this proposition. It should be noted that for convenience in statistical analysis, 'strongly agree' and 'agree' categories were combined together in Table-4.4.4d.

Table-4.4.4d: 'My strategic roles have increased within the organisation' (N=155)

	Current Position							
	FLMs (n=45)		MMs (n=83)		SMs (n=27)		Total (N=155)	
	n	%	n	%	n	%	n	%
Strongly Agree	1	2.2	15	18.1	14	51.9	30	19.4
Agree	24	53.3	48	57.8	12	44.4	84	54.2
Uncertain	9	20.0	11	13.3	1	3.7	21	13.5
Disagree	11	24.4	9	10.8	0	.0	20	12.9

	χ^2	df	p
Overall:	15.7	4	0.004
FLMs v SMs	KS Z=1.674		0.007

(FLMs v SMs for agree and disagree p=0.002 Fisher exact p, two tailed)

4.5 THE VIEW OF THE SUBJECTS ON THEIR PRESENT & FUTURE ROLES

4.5.1 Feeling successful as a nurse manager since the NHS 1990 Reforms?

Respondents were asked if they felt successful as a nurse manager from the beginning of the 1990 Reforms. Of the subjects, 155 managers rated their success from 'very successful' to 'not very successful'. As can be seen in Figure-4.5.1 almost half (49.7%, n=77) saw themselves as 'fairly successful'.

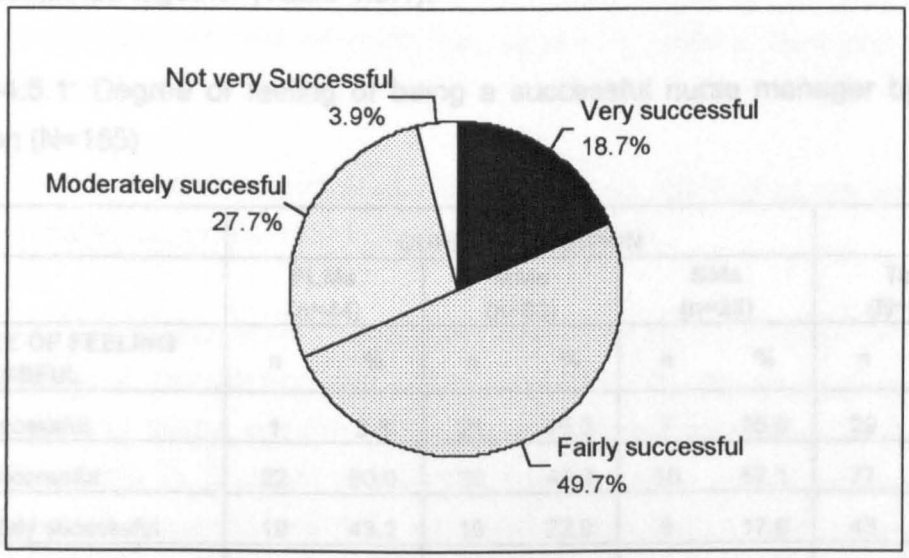


Figure-4.5.1: 'Do you feel yourself a successful nurse manager?' (N=155)

4.5.2 Feeling of being a successful manager by current position

In order to see if there was any relationship between feeling of being a successful manager and current position, a cross tabulation was performed. A significant difference occurred between the first line and middle managers when the level of success was considered. There was only one first line manager who felt that she/he was very successful from the beginning of the 1990 NHS Reforms compared with 25.3% of middle managers. It should be noted that in order to carry out statistical analysis 'moderately successful' and 'not very successful' categories were combined together (Table-4.5.1).

Table-4.5.1: Degree of feeling of being a successful nurse manager by current position (N=155)

	CURRENT POSITION							
	FLMs (n=44)		MMs (n=83)		SMs (n=28)		Total (N=155)	
DEGREE OF FEELING SUCCESSFUL	n	%	n	%	n	%	n	%
Very successful	1	2.3	21	25.3	7	25.0	29	18.7
Fairly successful	22	50.0	39	47.0	16	57.1	77	49 .7
Moderately successful	19	43.2	19	22.9	5	17.9	43	27.7
Not very successful	2	4.5	4	4.8	0	0	6	3.9

	χ^2	df	p
Overall:	15.0	4	0.005
FLMs v MMs	12.2	2	0.002

4.5.3 Reasons for feeling successful or otherwise

Respondents were again asked to explain why they felt that they were a successful manager. The explanations were grouped into two different tables. Table-4.5.2 over, summarises the answer of 106 (68.4 %) subjects who, as managers, described themselves as either 'very' or 'fairly' successful. In total, 29 (27.4%) respondents indicated that they were successful managers because they initiated and implemented changes in their organisations and improved services. Approximately one in four subjects (22.6%, n=24) considered themselves successful since they were able to cope with constant changes. In total 8 (7.5%) respondents explained that although they were successful in their jobs they did not see themselves as a 'nurse manager'.

Overall only 12 respondents did not explain why they felt themselves as either a 'very' or a 'fairly' successful manager.

The answers of 49 people who considered themselves as 'moderately' or 'not very' successful were categorised into eight headings. Of these respondents 12 subjects (24.5%) stated that they felt themselves either 'moderately' or 'not very' successful owing to constant changes within the NHS. An equal number of subjects (n=12) explained that their roles were new for them and therefore they were at a learning stage, and they needed time to evaluate their success or otherwise. The detailed findings are presented in Appendix II.15.

Table-4.5.2: The explanations of the subjects who felt that they were either 'very' or 'fairly' successful (N=106)*

	n	%
Initiated - implemented changes / developed - improved services	29	27.4
Coping with the changes	24	22.6
Able to fulfil / adapt the new role	11	10.4
I have managed to keep my job	11	10.4
Confirmed by the managers verbally	10	9.4
Got promotion	10	9.4
I do my job well	8	7.5
Involved in various corporate roles i.e. contracting process, decision making, multidisciplinary team management	8	7.5
I am no longer a nurse manager / do not see myself as a nurse manager	8	7.5
Achievement of objectives	7	6.6
I am a respected person	6	5.7
No problem has occurred	4	3.8
Miscellaneous e.g. I can only be as successful as the system and resource allow; generally I have achieved a great deal of success both in and for nursing. However the 1990 Reforms appear in many instances are distancing nursing, and in some cases, devaluing nursing	7	6.6
No Answer	12	11.3

* Totals do not add 100.0% as some respondents provided more than one answer.

4.5.4 The role of nurses in management at present

Respondents were asked how they saw the role of nurses in management at that time. A total of 148 subjects answered this question. As can be seen from Table-4.5.3 below, almost half of the managers (45.9%, n=68) perceived their role negatively, with twice as many expressing negative views as opposed to positive views. Approximately one in six of subjects stressed that the role had been changing owing to NHS (1990) Reforms. In total 10 subjects did not provide any answer to this question.

Table-4.5.3: The view of the respondents on the role of nurses in management at present (N=148)*

	n	%
Negative view e.g. Threatened; the role is diminishing; many nurses feel unable to enter the business world of the NHS now feel threatened by the push to employ people from industry to manage the service.	68	45.9
Positive view e.g. In a very strong position, with the development of the clinical directorate structure, the senior nurses' knowledge and experience is being recognised and utilised; it is at least as important as involving medical staff in management; nurses need to be involved in management in order to ensure business decisions are not taken without the impact on patient care etc. having first been examined	32	21.6
Changing e.g. Changing dramatically; period of immense change with development still to take place.	26	17.6
Suggestions e.g. Should be working into more general management position; need to be more active in business management; should grasp the opportunities given; nurses need to work hard at explaining the unique contribution nurses make; nurses need to have confidence in what nurses do and need to be flexible and adaptable	21	14.2
Need preparation e.g. Nurses in management are essential but training in business matters for nurses is necessary; nurses should gain management training and have a specific role to play in the delivery of patients' care	17	11.5

continued on the next page

	n	%
Wider roles in other areas e.g. Changing to be broader and more responsible for wider areas e.g. quality assurance; working as part of the corporate team; the role has expanded greatly	15	10.1
Negative unless... e.g. Potentially very shaky. Nurses have got to broaden their perspectives beyond the micro level of one patient, or a ward of patients and start to think on a macro level. Without broadening their perspective, they are in danger of being obliterated.	9	6.1
The ward sister is taking a much wider managerial role	4	2.7
Miscellaneous Very difficult to answer; the nature of the role is very variable depending on directorate, location,	9	6.1

*Totals do not add to 100.0% as some respondents provided more than one response

Comparisons of the most commonly reported statements regarding the subjects' view on the role of nurses in management by current position, sex and by age groups showed no significant differences.

4.5.5 Main constrains that limit the subjects' ability to do their job effectively

In the questionnaire respondents were asked to identify, if any, the main constraints that limited them from doing their job as effectively as they would like. Again there were a variety of responses, subsequently grouped into 17 main headings. Mostly lack of time, lack of resource, and lack of information and communication were identified as major constraints. Table-4.5.4 presents the findings. A total of 16 respondents did not answer this question.

Table-4.5.4: Main constraints that limit the subjects from doing their job as effectively as they want (N=142)*

	n	%
Lack of time	46	32.4
Lack of resource	32	22.5
Lack of information and communication	23	16.2
Lack of understanding / lack of proper support by others & more senior staff	21	14.8
Increased work volume	18	12.7
Lack of autonomy / accountability	18	12.7
Lack of secretarial support / increased paper work / number of meetings	17	12.0
Lack of clear role / strategy definition / uncertainty	16	11.3
Rapid change / changing environment	15	10.6
Lack of education / training / skills	13	9.2
Low morale / stress	11	7.7
Old practices; old tradition; old people	9	6.3
Clinical directorate structure, number of tiers of management	8	5.6
None	7	4.9
Other disciplines / other departments	5	3.5
Political issues	4	2.8
Hospital closure / downsizing	3	2.1
Miscellaneous	8	5.6

*Totals do not add to 100.0% since some respondents identified more than one barrier.

Cross tabulation of the nine commonly reported limitations by current position showed no significant difference (Appendix II.16).

4.5.6 Future career developments

Respondents were asked how they would like their career to change/develop in the future. Of the respondents, 91.1% (N=144) responded and of those who answered the question 18.1% (n=26) wanted to expand their current role. In total 24 subjects (16.7%) expected their next career step to be a move into a general management role within the NHS and of these 24 only 4 (2.7%) subjects wanted to become a Chief Executive. Eight respondents wanted to leave NHS or nursing. The findings are presented in Table-4.5.5.

Table-4.5.5: Future career developments of the respondents (N=144)*

	n	%
Expanded roles within existing job e.g. I enjoy my job I feel I have made progress and hopefully will continue to do so. I will develop my career with keeping up to date with current issues.	26	18.1
General Management Roles / More Managerial Roles e.g. would like to move into the Trust/ Executive structure; be prepared to be a clinical director; general management roles before becoming executive director of nursing; will continue to develop and prepare myself for chief executive post after proving myself as a competent executive nurse on board	24	16.7
Don't wish to change-develop further/ wish to stay in the same position	20	13.9
Corporate Issues More participation in business and strategic planning and contracting; expand role to total quality co-ordinator covering all services; to gain more business experience and move into a business Manager role; further develop knowledge in marketing, contracting, information systems	18	12.5
Retirement	17	11.8
Career in nursing management From Unit Nurse to Trust Executive Nurse Director; development of skills and competencies within a more senior nursing management	17	11.8
Take further training / education in various areas e.g. management, computer, finance	10	6.9
Wish to be back in clinical work	9	6.3
Leave the NHS/ nursing	8	5.6
Uncertain	7	4.9
Wish to work in community setting	5	3.5

*Totals do not add to 100.0% as respondents provided more than one answer

4.5.7 Future career developments and current position

Further breakdown of the previous answer showed that a significant difference occurred between first line managers and the remaining two groups of managers only in terms of selecting general management roles as future career changes (χ^2=11.5, df=2, p=0.003). It was found that 23.7% (n=18) of middle managers and 22.2% (n=6) of senior managers wanted to move to more general management roles within the NHS. There was no first line manager who wish to take roles in general management. There were no significant differences for the remaining options between the managers. The cross tabulation of the respondents' future career development options by current position is given in Appendix II.17.

4.5.8 Future career options and age groups

When subjects' future career options were cross tabulated by age group (Table-4.5.6) it was found that there were significant differences between the 50+ age group and the other two groups in terms of selecting general management roles and retirement as future career options. While the younger age groups wanted to be in general management roles, as might be expected, the 50+ age group did not wish to develop or to change their job. Instead they preferred to retire in the near future. Those who were in the 30-39 age group stated that they would like to develop their career in nursing management.

Table-4.5.6: Future career developments by age groups (N=144)*

	AGE GROUPS					
	30-39 (n=44)	40-49 (n=54)	50+ (n=46)	χ^2	df	p
Expanded roles within existing job	8	9	8			NS
General Management Roles / More Managerial Roles	12	11	1	**Overall:** 11.1	2	0.004
				30-39 v 50+		0.001**
				40-49 v 50+		0.005**
Don't wish to change/ wish to stay in the same position	1	8	11			NS
Corporate issues	7	6	5			NS
Retirement	0	1	16	**Overall:** 34.3	2	0.000
				30-39 v 50+		0.000**
				40-49 v 50+		0.000**
Career in nursing management	10	5	2			NS

*Some respondents provided more than one answer

** Fisher's exact p, two tailed

4.5.9 Future roles

When asked to express their views on the future role of nurses in management an equal number of subjects (n=31) stated positive and negative views. It should be noted that in Table-4.5.7, respondents who only said 'general management roles' were compressed into the third category ('roles in general management') and those who gave additional information such as business management were coded into the fourth category (business involvement and combined roles in management). In total 13 (8.2%) respondents did not give any answer to this question. Table-4.5.7 summarises the findings.

Table-4.5.7: The view of the respondents on the role of nurses in management in the future (N=144)*

	n	%
Positive View e.g. Effective Nurse Executive Directors on trust boards; as an active member of he management team	31	21.4
Negative View e.g. The role is disappearing; precarious for a lot of people; don't see a future for nurses in management; it will be gradually reduced to non existence and we have allowed it to happen; as a very subservient role	31	21.4
Roles in General Management e.g. I see nurses in management developing as general managers; there is nothing to stop nurses becoming clinical director, chief executive	24	16.6
Business involvement (corporate roles) and combined roles in management Nurse manager + Business Manager; involvement in contracting; strategic planning; budgeting; negotiating	23	15.9
Suggestions We must make ourselves valuable at board level; nurses should be in CE jobs; nurses need to be involved in at all levels of hospital management.	21	14.5
Negative view unless... At present situation we are all being taken over and If we don't educate, motivate senior staff we will be overtaken completely; non existent if we are not careful; diminishing unless we don't stand for our profession; unless we are trained in management skills we will be overshadow by people who have the skills.	14	9.7

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	n	%
In order to survive and be successful need better preparation, skills / education / training	14	9.7
There will be no nurses in management above ward sister level. Charge nurses taking on more managerial responsibilities	10	6.9
Advisory roles	7	4.9
Up to us / depend on our abilities	5	3.4
Unsure, do not know	4	2.8
Miscellaneous Majority will become clinical specialists, depends on the political agenda	7	4.9

*Totals do not add to 100.0% as respondents provided more than one answer

Cross tabulation of the most commonly reported statements regarding the subjects' views on the future role of nurses in management by current position showed no significant differences. However 30.0% (n=12) of first line managers stated negative views compared with only two of senior managers. In total 34.6% (n=9) of senior managers stated that nurses in management would take general management roles in the future as compared with 10.0% (n=4) of first line managers.

4.6 VIEWS ON RELATIONSHIPS WITH MANAGERS AND SUBORDINATES

4.6.1 Title of the person whom the respondents managerially report to

All respondents answered this question. A clinical director was the most commonly reported to person at 25.9% (n=41) followed by a DNS or equivalent and Unit General Manager/Chief Executive (Table-4.6.1). It might be useful to restate that this question was used to classify the respondents' current job titles into a management level. A cross tabulation of the people whom the respondents reported to by current position is provided in Appendix II.18.

Table-4.6.1: The job title of the person to whom the respondents managerially report to (N=158)

	n	%
Clinical Director	41	25.9
Director of Nursing Services or equal	30	19.0
Unit General Manager (UGM) / Chief Executive (CE)	24	15.2
Care Group Manager	13	8.2
Clinical Services Manager	13	8.2
Sector General Manager	12	7.6
Board General Manager	6	3.8
Business Manager	6	3.8
Nursing Services Manager	4	2.5
Others e.g. Hospital Manager; Director of Patient Services	9	5.7
Total	158	100.0

4.6.2 Contact with managers and subordinates

On a three point scale from 'too much' to 'not enough', respondents were asked to state how much contact they had with their manager and with their subordinates. As can be seen from Table-4.6.2 the majority of the respondents stated that their contact with managers and subordinates was 'enough'.

Table-4.6.2: Extent of the contact with the managers and subordinates

	Contact with managers (N=155)		**Contact with subordinates (N=153)**	
	n	%	n	%
Too much	1	0.6	2	1.3
Enough	128	82.6	105	68.6
Not enough	26	16.8	44	28.8
Don't have any subordinates	0	0	2	1.3

When further cross tabulations were performed with current position, no significant differences occurred between the managers in terms of the extent of their contact both with their managers (χ^2=5.3, df=2, p=0.072) and subordinates (χ^2=5.0, df=2, p=0.083). In total 90.9% (n=40) of first line managers, 75.6% (n=62) of middle managers and 89.7% (n=26) of senior managers said that their contact with their managers was 'enough'. On the other hand nearly half of first line managers (42.9%, n=18) thought that their contact with their subordinates was 'not enough', compared with 23.2% (n=19) of middle managers and 24.1% (n=7) of senior managers.

It should be noted that when statistical analysis was performed for both questions the 'too much' and 'don't have any subordinates' options was omitted because of very small numbers.

4.6.3 Perception of relationships by managers and subordinates

Respondents were asked to describe how they perceived their relationships with their managers and subordinates. As can be seen from Table-4.6.3, the majority of the respondents saw them either as a 'colleague' or in a 'supportive' role. Overall 23 (14.9%) participants stated that their relationship with their managers was hierarchical. Four respondents did not provide any answer to the question of 'how do you perceive your relationship with your managers'. Table-4.6.3 below presents the findings of two questions together.

Table-4.6.3: Perceptions of the respondents of their relationships with the managers and subordinates*

	Relationship with manager (N=154)	**Relationship with subordinates (N=158)**
Colleague	79	95
Supportive	73	102
Peer group	17	10
Role mentor	18	44
Hierarchical	23	6
Do not have any subordinates	0	2

*Totals do not add to 100.0% as some respondents provided more than one answer

To see if there was any significant differences between the respondents' perceptions of their relationships with their managers and subordinates further cross tabulations for each category with current position were carried out. No significant differences were found between the managers. However 11 out of 45 first line managers (24.4%) stated that their relationships with their managers were hierarchical, compared with 8.6% (n=7) of middle managers and 17.9% (n=5) of senior managers. The majority of all managers saw their relationships with their subordinates as being as a 'colleague' or as a 'supportive' role.

4.6.4 Self perception and perception of others

As can be seen in Table-4.6.4 nearly one in seven respondents (14.1%, n=22) saw themselves as being only a manager, while almost one in three (31.4%, n=49) were perceived as 'a manager' by others. Only four subjects indicated that they felt themselves to be different either as a nurse teacher - an educator, or as a corporate member of the board - a policy maker. Of these four, two subjects indicated that the perceptions of others were the same. However one subject, who probably felt undervalued, said that in the organisation where she worked she was perceived by others as 'a subordinate, spare, all things and nothing'. As can be seen in Table-4.6.4 the majority of all respondents saw themselves as both 'a nurse' and 'a manager' as did the people they worked with.

Table-4.6.4: Self perception and perception of others

	Do you feel yourself as to be... (N=156)		How are you perceived by others? (N=156)	
	n	%	n	%
A nurse	1	0.6	7	4.5
A manager	22	14.1	49	31.4
Both	129	82.7	97	62.2
Others	4	2.6	3	1.9

The cross tabulation of these two questions by current position showed that only one middle manager saw herself as a nurse, almost all first line managers (93.3%, n=42) stated that they saw themselves both as a nurse and a manager compared with 78.3% (n=65) of middle managers and 78.6% (n=22) of senior managers. However this was not statistically significant (χ^2=7.7, df=2, p=0.022). Similarly 66.7% (n=30) of first line managers, 57.8% (n=48) of middle managers and 67.9% (n=19) of senior managers said that they were perceived by others within the organisation where they worked, both as 'a nurse' and 'a manager'. Again the difference was not significant (χ^2=1.8, df=2, p=0.402).

It should be noted that when statistical analysis was performed in both questions 'a nurse' and 'other' options were omitted.

4.6.5 Membership of hospital/unit management team and current position

Respondents were asked to indicate whether they were a member of the hospital, unit, or board management team. Overall the majority (77.2%, n=122) said 'no' to this question. However, as one might expect, senior managers were more likely to be a member of the management team compared with the other two groups, as it was a statutory requirement that all Trusts have a nursing director at Board level. Table -4.6.5 below presents the findings.

Table-4.6.5: Membership of hospital/unit management team by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (n=158)	
MEMBER OF THE MANAGEMENT TEAM	n	%	n	%	n	%	n	%
Yes	1	2.2	11	13.1	24	82.8	36	22.8
No	44	97.8	73	86.9	5	17.2	122	77.2

	χ^2	df	p
Overall:	74.6	2	0.000
FLMs v SMs			0.000 (Fisher's exact p, two tailed)
MMs v SMs	45.7	1	0.000

4.6.6 Membership of the management team and possession of a degree

There was no significant difference between being a member of the management team and having a degree qualification. However as can be seen in Table-4.6.6 respondents with a degree were more likely to be found in the management teams.

Table-4.6.6: Membership of the management team and possession of a degree (N=158)

	DO YOU HAVE A DEGREE?					
	Yes (n=37)		No (n=121)		Total (158)	
MEMBER OF THE MANAGEMENT TEAM	n	%	n	%	n	%
Yes	13	35.1	23	19.0	36	22.8
No	24	64.9	98	81.0	122	77.2

	χ^2	df	p
Overall:	3.3	1	0.068

Similarly there were no significant differences between sex (χ^2=0.02, df=1, p=0.878) and age groups (χ^2=5.8, df=2, p=0.560) and being a member of the hospital/board management team.

4.6.7 Supervision and current position

Respondents were asked to state the number of staff they supervised. In total 146 (92.4%) respondents answered this question. Approximately 1/3 of subjects indicated that they supervised between 101-250 staff. When this question was compared with their current position (Table-4.6.7), it was found that there were significant differences between the managers and the number of people they supervised. While a majority of middle managers (61.0%) supervised between 101 and over staff, 77.8% of senior managers supervised between 0-50 staff.

Table-4.6.7: Number of staff respondents supervised by current position (N=146)

	CURRENT POSITION							
	FLMs (n=42)		MMs (n=77)		SMs (n=27)		Total (N=146)	
	n	%	n	%	n	%	n	%
0-50	7	16.7	22	28.6	21	77.8	50	34.2
51-100	12	28.6	8	10.4	0	0	20	13.7
101-250	19	45.2	27	35.1	1	3.7	47	32.2
251 and over	4	9.5	20	25.9	5	18.5	29	19.9

	χ^2	df	p
Overall:	43.5	6	0.000
FLMs v SMs	33.6	3	0.000
MMs v SMs	22.3	3	0.000

4.6.8 Staff responsibility

When asked to identify what staff group(s) they were responsible for, as one might expect the majority of subjects stated 'nursing'. The details of this question by current position are provided in Table-4.6.8.

Table-4.6.8: Staff groups for whom the respondents were responsible (N=144)*

	n	%
Nurses	122	84.7
Secretarial & administrative	37	25.7
Medical	14	9.7
Quality Assurance & Audit	14	9.7
Paramedics	11	7.6
Hotel services	10	6.9
All therapists	9	6.3
All staff in the department / hospital	8	5.6
All technicians	6	4.2
Miscellaneous e.g. Hairdressing, chaplain, dieticians	6	4.2

*Totals do not add to 100.0% as respondents might be responsible for more than one group

4.7 Comments of the respondents

At the end of the questionnaire, respondents were asked to add any further comments regarding the study. In total 45 (28.5%) managers supplied a comment and their responses were grouped into seven main headings. Unedited examples of these comments are provided in Appendix II.19. In total ten subjects provided various suggestions in order to be successful in management and in nursing. For instance one subject stated that:

> *"Nurses need to pull together clear rational information to negotiate with and not rely on emotive issues. As a profession we need to 'pull together' better".*

Seven subjects stated that nurses in management should have 'wide vision' and various skills and abilities such as change management skills, business management skills. Five respondents gave negative views or descriptions about the role of the nurses in management and of these, four were first line managers. For example one first line manager said that:

> *"I do not think nurses in management are seen as very necessary any longer and it is only a matter of time until the "nursing' element is removed".*

Only three respondents stated positive views about the role of nurses in management. They mainly believed that nurses are important for patient care and nurse managers are able to provide a wide range of input into management.

4.8 Summary and Conclusion

It should be noted that the size of the study was relatively small and therefore there is a low level of generalisability. Nevertheless the outcomes of this study are interesting and provide some indicators of respondents' views and opinions and also provide quantitative information on the issues addressed in the research questions. It should also be noted that the sample frame was in fact a total sample of individuals in Scotland meeting specific inclusion criteria.

The following were identified as the key findings of the study:

- The job titles of the respondents varied enormously according to the institutions and/or the job of the subjects. In total there were 44 different job titles used by the 158 nurses in management.
- It was easier for women to achieve senior positions if they were single, and yet the converse was true for the men. It was found that female nurses in management were better qualified academically than males.
- It was identified that the majority of nurses in management thought that their management training was insufficient to do their job satisfactorily. In addition there was poor preparation of managers for NHS changes.
- In general there was no consensus between respondents in terms of both the role of nurses in management and the NHS (1990) Reforms.
- In general there was a trend for senior managers to be more positive than first line managers and middle managers in terms of defining the role of nurses in management and the NHS Reforms at the time of this study and in the future.
- The job content of the subjects had altered considerably after the NHS 1990 Reforms with greater responsibility and more multi-disciplinary work.
- There was no consensus between subjects in terms of the merit of the clinical directorate structure. However respondents emphasised that nurses who wanted to enter this field would need additional preparation in finance and business planning. It was also stressed that the personality of the clinical director was the most important factor which affected the position of the nurse within the directorate.
- First line managers and middle managers were more concerned with traditional nurse manager responsibilities while senior managers were more involved with corporate management issues and advisory roles to others.
- Communication, interpersonal skills and leadership skills were the most frequently reported skills that nurses in management should have to do their job satisfactorily.

In the next chapter findings from the interviews will be presented.

CHAPTER V

THE FINDINGS

PART II INTERVIEWS

5.0. PART II INTERVIEWS

In this section the findings of 27 interviews are presented. The presentation order follows the same order as in the interview schedule.

5.1 CURRENT JOB TITLES OF THE RESPONDENTS

It was thought that to start with a neutral question would make an comfortable beginning for the interview. From the analysis of the questionnaires it was found that there were 44 different titles used by the 158 respondents. Therefore interviews began by asking the interviewee's opinion regarding the number of titles which had been gathered from 158 nurses in management.

Most of the interviewees agreed that the development of trust status and the way in which the Health Service had evolved were the main reasons for the variety of titles within a relatively small group. Interviewees indicated that as Trusts developed, each had decided its own structure and each had decided on different types of structures i.e. directorate, care group structures, and titles for their employees.

The other reason for the many different titles was that nurses had taken on a variety of roles in areas such as quality assurance, budgeting and the use of resources. Some of them were responsible for nurses as well as other professional groups. Although all nurses who participated in the study had a nursing background, some of the new roles did not require an individual to have a nursing background. For example a community services manager said;

> *"I think I said in my questionnaire response that I did not see myself as a Nurse Manager, I was actually a general manager and that is an example of somebody who comes from a nursing background, but has actually moved slightly to one side or up. The fact that I am from a nursing background and it is of secondary importance, I am not doing my job as a nurse".*

It was emphasised that in many cases the titles reflected the nature of the job. As one respondent said 'people want to emphasise the most important function of their job'. However several participants indicated that there was concern regarding the number of different titles. It was thought that in some cases there was

uncertainty and a lack of clarity about the titles which were used by nurses in management. A Care Group Manager said;

> *"I don't know if they do clearly convey to people what the role actually is now. Many of these roles will be professional roles, whereas many will be managerial roles as well. I think it is very confusing for the staff and I don't suppose the public have any idea at all".*

A few interviewees emphasised that although the titles were new, the jobs did not change significantly. The reason for having different titles was only the result of reorganisation in the NHS. One respondent said that:

> *"I have changed my title I do not know how many times throughout my career because whenever they reorganise the Service they want to attach different titles to them. Sometimes the jobs did not change significantly, but they seemed to think that if they changed the title that looked as though they had reorganised. Now that we have gone into Trust set-ups that the Trusts are now beginning to experiment with different hybrid posts. They have different compositions within the post, therefore you get this huge range of titles. It is a symptom of the process of change that we have gone through and it would have happened anyway. If you looked at the job description of all of these you may find there is not that significant difference".*

When they were asked to explain if the job content and the responsibilities varied according to title, all participants agreed that they varied according to the level of responsibility rather than the title. It was also stated that nurses in the most senior positions had a larger span of control and responsibility than other nurses in management. As emphasised by one of Director of Nursing & Quality:

> *"Each executive nurse in a trust has slightly different job content and I think that's reflected perhaps in the title, some are Directors of Nursing, some are Directors of Nursing and Quality, some are Directors of Planning which include nursing as well. It probably tries to reflect the job content although it is very difficult to do that just within one title".*

However as far as other groups were concerned (nurses between DN&Q and Ward Sisters) there was a consensus between all interviewees. They agreed, that despite the different titles, the role and responsibilities were in fact quite similar,

and even the same in many areas. However they stated that the responsibilities had increased greatly. For example one respondent expressed his/her opinion as:

> *"It's just that people in the various Trusts have decided to have a different name. My name prior to the November was Service Manager, now I'm still doing the same kind of duties but because its a bigger remit, they decided to change it to Operations Manager. No real reason for it. In my case, there's no difference. I'm doing exactly the same job as I did prior to getting this one but it is much much bigger".*

5.2 THE ROLE OF NURSES IN MANAGEMENT

As was mentioned by almost all interviewees, there was much going on within the NHS, not just within nursing. The whole way of delivering care and delivering services was changing. Inevitably changes, especially introduction of the trust status to the hospitals and the split between purchaser and provider units, had an important impact on the role of nurse manager/nurses in management. Some participants believed that in Scotland, the NHS (1990) changes had not been as radical as they had been in England.

Some of the participants emphasised the difficulty of coping/managing the constant changes. For instance one Clinical Services Manager said:

> *"Looking at the present position in the health service, it is like trying to hit a moving target the whole time because what is right now may not necessarily be right in a year's time if they once again change the structure".*

In general terms, when interviewees were asked to give their opinion on the role of nurses in management within the NHS, some argued that they were in a strong position because they understood the objectives of the organisation and they understood the outcomes that they were trying to achieve; they had good organisational ability; they had good communication skills and they had a major contribution to make to the management of the Health Services. Nurses in management were now being drawn into a business area, which had not existed before, where they were setting and monitoring contracts, setting objectives and standards and negotiating developments. In summary they now had more

strategic roles within the NHS. One of the Operations Managers who supported this positive approach said:

> *"...in previous years nurses did not have a clear management role. They managed people but I don't think they had a full management role. They never had budget responsibility, they never had accountability for strategic or operational issues and they only dealt with nurses. I don't think that was management role. Nurses in management now, like myself, have got the corporate role. We are responsible, and more importantly accountable, for a much wider remit than we ever had before and it covers everything from multi-disciplinary management right down to budget control, ...it is a corporate role. We've never had that before".*

A number of people expressed concern about the role of middle and first line managers. They argued that in most areas nurses were now managerially responsible to a non-nurse at middle and first line management level and this would/might create serious problems in the future.

5.2.1 The role of first line managers (sisters/charge nurses)

Although it was not an aim of this project, many respondents emphasised the changing role of charge nurses. They stated that one of the most important changes in the NHS was the devolvement of direct day to day management decisions as far down the line as possible, for example clinical re-grading in 1988. In practice this meant that Charge Nurses/Sisters or 'Ward Managers' at ward level had become more responsible for managerial issues. For instance, in many places they now had 24 hour responsibility; they were accountable for their budget, they were responsible for their own staff and their performance appraisal. It was argued that although the middle and senior management level had lost much power, this had been partly compensated at Charge Nurse (CN) level. CNs had much more power than they had previously, and now a far louder voice than they ever did in the past. In many cases, participants thought that CNs have key roles within the health service. However it was suggested that they should also be supported and prepared for their new and difficult roles.

Some interviewees believed that CNs were not yet ready to take over a variety of management responsibilities and detach or remove themselves from clinical 'hands on' commitments. It was felt that their managerial and clinical

responsibilities should be balanced, and they should be supported by middle line nurse management. However it was recognised by a CANO that there were some difficulties in providing support to G Grade nurses during this transitional period, as middle line management had been 'stripped out' to a large extent.

There was no consensus as far as the interviewees' opinions and feelings were concerned regarding the increasing responsibilities of the Charge Nurses. Some managers, especially people who are at a senior management position i.e. CANO, DN&Q, saw this as a 'good thing'; others i.e. Clinical Nurse Managers, felt that the profession had lost its credibility, power and voice since nurses 'allowed' the line management structure to be taken away. Some said that they did not have as clear a line of communication as they had had before. An experienced Clinical Services Manager who worked in a clinical directorate structure, said:

> *"If you concentrate on my role as a nurse, who do I relate to? ...our Director of Nursing & Quality has no line management at all over me now, but she is there for professional issues and I think that line between professional issues and management issues is a very grey area. At what point do I bring professional issues to her, or do I take it to the Clinical Director".*

In the interviews all respondents agreed that having no clear promotional system or structure in nursing created problems. It was seen that to take an executive role or to be a DN within the Trust was a 'big jump' for any charge nurse. Nevertheless, as suggested by a DN&Q, roles in general management gave them opportunities to move their career up if they were able to take those opportunities.

5.2.2 The role of middle managers (nurses between sisters and DNs)

In terms of middle nursing management, all of the interviewees agreed that the number of middle managers within the NHS had been reduced, diminished or dismantled, and many of the posts that used to be held by nurses were now taken on by other professionals. It was suggested that there was a move away from the kind of single line management structure according to discipline, into the multi-disciplinary approach. Some participants stressed that they no longer had middle management tiers between CNs level and DN level whereas there were previously two or more tiers in between these two levels. To illustrate the reduction, an Operations Manager said that:

> *"In this hospital, ten years ago, there were 27 Nursing Officers, there are now four and they are not called Nursing Officers".*

On the other hand it was agreed that the activities having a direct relationship to nursing (i.e. scheduling of staff, recording of wage information) had diminished because nursing administration duties were being devolved either down the line to nurses, or being taken over by other departments. In spite of this the amount of work that needed to be done had increased. Nurses at middle management positions had now more responsibilities than ever before in other areas - such as being responsible for other disciplines. Some interviewees said that many nurses had now taken over a non-nursing post in general management i.e. a business manager role. A combined nurse/business manager role was described as a powerful job. Some interviewees thought that both the role and the number of middle managers had diminished while a Clinical Services Manager said the role was constantly under threat:

> *"When Trusts first came into being existing post holders were slotted into the new structure. Maybe the title just did not quite fit what their experience to date had been, but they slotted them in anyway. Now, as time goes past, they are looking at those posts again and if the individual post holder has not fully developed their own role and satisfied their expectations then these people are being replaced. So, Trusts have been in now for a few years, they are going back and looking at these individuals and seeing if they are actually fulfilling the role they were intended to fulfil and in a lot of cases they are deciding that they do not and nurses are losing out".*

It was suggested that there was a whole new area of business that had appeared in the Health Service with the purchaser/provider split, and nurses should take up/apply for these roles otherwise many organisations would appoint non-nurse managers. Some senior respondents who were in general management roles blamed nurses for being reluctant or for not having enough confidence to apply for these posts. It was believed that nurses could and should transfer their skills from nursing into other jobs.

As far as the issue of 'whether there is a need for middle managers' was concerned, some participants believed that there was a great difference/gap between charge nurses and executive level nurses and therefore middle

managers were needed. They thought that charge nurses should have someone to refer to who understood clinical care and they needed an advisor on professional issues. Others argued that was not necessary to have a middle management tier in nursing as ward managers had broad roles in management.

5.2.3 The role of senior managers

The interviewees agreed that the role of senior managers, for example DN&Qs was perceived as that of 'professional leader' and advisor to other nurses in the organisation, as they did not have management responsibility for the profession.

Interviewees argued that at the purchaser level (Health Board) there was now a 'Nurse Advisor' as opposed to the traditional CANO role. Usually they were also involved in 'quality' issues. Their main responsibility was now to advise the purchaser on nursing issues. In effect the relationship between CANO and individual Directors of Nursing (or their equivalent) had changed. They did not have line responsibility over nurses and the nature of the relationship was more consultative rather than hierarchical. Some interviewees stressed that at the Health Board level there was still a nursing voice but probably not as strong as it had been in the past.

In terms of the senior management level in nursing, 'senior managers' argued that they now had a bigger remit than they did in the past. They were involved in strategic planning issues and they had professional leadership roles and they believed that usually their role/position was perceived as 'strong'.

It was interesting to note that only a few interviewees (n=3) confirmed that they were not happy with the NHS (1990) changes but many stated the opposite and said that they were happy with the changes but their colleagues were 'crying'.

5.2.4 Views of the interviewees on the negative perception of the role of nurses in management

According to our survey findings many nurses in management perceived their role negatively e.g. undervalued, under stress or uncertain. For this question almost all interviewees stated that this finding was a fairly accurate reflection of how people

felt generally. However it was emphasised that the scope of these negative feelings depended on the individual. Interviewees who were either at a more senior level or with general management responsibilities, usually saw their role from a positive perspective but they also confirmed that their colleagues had negative feelings.

A Community Services Manager who thought her nursing background was of secondary importance for her job, believed that most first and middle line managers had negative perspectives on their job. She said:

> *"... these findings may reflect the fact that these people are the ones probably most affected by change in the last years, ...I would imagine that the majority were at the first and middle management level before they turned into these new jobs, and they probably see their past role changing quite a lot and they either feel anxious about taking on a new role, or feel they are not equipped to do so, or they have not been given sufficient training, or support, and probably a perceived lack of control. Before they may have seen themselves as being in control, with changes in the organisation they probably now see that they are in many instances need to be accountable to people who are non nurses. I do not see myself in that way and that is why I am conscious that I may not be a typical manager".*

In the interview many participants agreed that nurses in management felt negatively. As described by the participants the reasons for perceiving the role negatively can be summarised as follows:

- In most places the middle management tier in nursing had gone and the number of nurse managers reduced. Administrative responsibilities had either been devolved to the Charge Nurse level or been taken over by other departments/professionals. In effect, in some places nurses were being replaced by non-nurses.

- Owing to the 'business environment' of the NHS, people had started to discuss 'whether they need a nurse to manage nursing services'. This question caused a great deal of distress and uncertainty, and elicited a fear of redundancy. Their voice was not felt to be valuable and their jobs were under threat because all the time they heard that they were not needed in the Trust.

- Owing to the 'flattening of the hierarchical nursing structure' there were no promotional prospects. They were either having to go to general management jobs which required additional skills, abilities, training, or stay in 'hands on' jobs.

- For many nurses in management recent hospital closures or bed cuts and constant changes meant the danger of unemployment and/or uncertainty and therefore less job security.

> *"To be realistic, I do not think there is one member of the NHS employees who has not felt under threat since 1979!. .. People see this continual change of the management structure and they are not sure if they are going to fit in".*

- Trust management began to see nurse managers as an expensive resource and in some places this perception led to employment of other people who were cheaper to employ than nurses.

- Nurses in management did not have the skills, abilities and competence to fulfil the new roles that were expected from them. They were not prepared for the change. Most people who reached management, reached it through years of practical work without any academic preparation for being a manager yet on the job training was valued.

- Traditional nurse training, compared to other professionals within the Health Service, was an academically junior qualification and people suffered from that in terms of the expectations that were placed on managers, such as preparing reports and stating cases. They were disadvantaged academically.

- Perception of others - A CANO said:

> *"All Directors of Nursing Services for example, are Executive Members of their Trust Boards, but that is compulsory and I do not think that many Unit or Chief Executives want that in many instances. There are only six CANOs that are Executive Directors of Boards out of 15 and I think that is a reflection on how we are perceived, that we do not always automatically get the top seat at the table".*

- The people at the top of the organisation (Trust management) did not recognise or appreciate the skills of nurses in management, and they undervalued nurses/nursing. Not all the trusts' management supported nurses in their roles.

- Responsibilities had increased but this had not been recognised in a financial way. Many middle nurse managers earned less than a charge nurse on the ward.

All participants agreed that not only nurses but also each NHS employee felt under stress owing to increased work volume, short deadlines and the speed of change. Many of the interviewees reported that they had to take work home. Also other factors such as not having the necessary qualification for the job contributed to feelings of stress.

In the interviews not all the subjects expressed negative feelings. In fact some interviewees blamed/accused nurses themselves and believed that nurses who felt negatively had not moved forward with the changes and their individual performance was low or they were not good at their job. The most common advice/suggestion given, especially by Senior Managers, was:

> *"Feeling negative does not help. We have to get up and fight. Nurses should see the reality that this is a business area. If you do your job well you will be recognised by the Trust management. But for this you have to be aware of your skills, have to recognise your own worth because we have lots of contributions to make the health services better; broaden your skills into business area; take additional training in business management and take risks if necessary and be prepared go to general management roles, (these are opportunities and nurses are in a better position to take them), if not there will be so many people to take on these roles because although it is an advantage to be a nurse, the posts do not require one to be a nurse".*

It was suggested that each individual had to have a positive input to what they were doing so that they were valued. A DN&Q believed that 'the job is what you make it and you get the respect that you deserve'.

Again a DNS's thoughts supported the people quoted above.

> *"I think there's always times when you feel all those bad things. But it's up to the individual to be able to show their value to the organisation, nurses have to be a lot more proactive. We've seen changes coming in the distance and in the main a lot of nurses buried their heads in the sand and waited for the change to happen and then be caught up in this negative response to it. We have to start planning our*

future. It is up to the individual to be able to self motivate, to be able to get satisfaction from the job, to make sure they carved a niche within the organisation so they become a valuable member of it. If people are feeling undervalued then they've got to ask themselves what part they play in that organisation and they've got to get the recognition for the job they do and make sure that they sell themselves. It is about self belief and self awareness and having credibility with your colleagues which is very important and having recognition that you are a professional in your own right and you should be able to speak with authority about a number of subjects which a lot of other people actually can't do because they haven't had the experience that you've had, so it is having confidence in yourself, it doesn't always work in practice because some days you do feel that you're under stress but in the main it is up to you to be able to do something about it".

5.2.5 Views of the interviewees about the statement: 'unless nurses in management increase their managerial skills their role will be taken over by other professionals'

The majority of interviewees agreed with the above statement. They argued that while being a nurse might be an advantage, nurses should not rely just on their nursing qualification to take them into a management position. Once again it was suggested that nurses in management, especially nurses at middle management levels, should broaden their managerial skills and grasp the opportunities given. An interviewee who had general management responsibilities said:

"Nurses have less influence and less control than they did in the past. At present the medical profession has a very strong influence and a lot of power but nurses have the opportunities as well and if we do not stand up and say we can do it, someone else will do it but the changes that have taken place in the NHS over the last wee while have been fairly fundamental and if nursing is not careful it will have lost out. ...who knows, it may cease to be a profession... because there are many people who would see nursing as a very expensive resource, who are looking for ways of delivering care but not necessarily with nurses as we know it and I think that is a distinct threat to the future, to nursing".

When a CANO was asked if he agreed with the statement of 'unless nurses in management increase their managerial skills their role will be taken over by other professionals' he said:

"Definitely, there is no doubt about that. Many of them cannot formulate, draft a report with a beginning, a middle and an end".

Some of the respondents said that they were aware of their lack of managerial skills, preparation and training for their job. A couple of interviewees thought that this finding was very defensive and it showed how much nurses undervalued themselves. An Operations Manager said:

"I do not think any other professional can show the ability to manage a group of nurses the way I can manage, I have over 500 staff. I doubt very much that an occupational therapist has ever been faced with more than 10 in their time, I don't think they stand any hope of doing it and I've never seen any evidence of them being able to achieve it".

Some believed that, for the present Director of Nursing (or equivalent) posts were secure because it was a statutory requirement to have a nurse on the Trust Board. They believed however that the role of ward managers and nurse middle managers was under threat.

5.3 NHS CHANGES

5.3.1 The effects of the recent NHS changes on subjects' personal work and nursing management

Respondents were asked to describe the effects of the changes on their personal work. Almost all managers again emphasised that their workload had increased dramatically and now there was more paper work to do, more meetings to attend, more work to take home, shorter deadlines, and inevitably there were more pressures and stress as well. Others indicated that they spent less time working on nursing issues because there were so many new components to their job like quality assurance and contracting. They said that in essence they were probably less aware than they used to be to everything that was happening on the shop floor.

Some interviewees said that they had become more politically aware, and NHS changes heightened their awareness of what was going on in the political arena.

People who were in senior management positions argued that the NHS (1990) reforms had changed their career and had given them the opportunity to work as an Executive Director which they would not have had otherwise. In addition there were new opportunities to influence the way in which patient care was provided. Nevertheless they said that they worked under more pressure to perform effectively in their role. One DN&Q said:

> *"We need to make sure that they see the value of having a Nurse on the Board we have got to work very hard at ensuring our position on the Board is safeguarded and the only way we can do that is make sure we are fully committed to the Trust Board and that we are able to put papers forward, able to talk to different issues and then people will say yes they deserve their place on the Trust Board, not because of Government edict of how a Trust should be set up but because they are a valuable member of the Trust Board so that puts pressure on you in terms of the job".*

Some of the middle managers i.e. operations managers, said that they were much more accountable than they had been before and they had taken on tasks that they had never envisaged that they would take on when they came into the NHS as a staff nurse. A Care Group Manager indicated that before the changes he was a Clinical Nurse Manager who only managed the nurses in a unit but now, after Trust status, he was responsible for all disciplines, including the doctors, in his care group. However he also added that, like many others, he had been on a steep learning curve for the last year and a half.

A few interviewees stated that because their staff were having problems coping with the constant changes and uncertainties, they had become 'a sponge' for the staff who 'gave' them their problems and worries. They also explained that the instability and uncertainty of the Health Services had affected themselves as well. An interviewee summarised his feelings as:

> *"Any time that things do not go may be 100% to plan you begin to wonder, well is this going to be held against me. ...they will always keep on organising and every re-organisation has its casualties and you wonder if next time round, if things are not going too well, for that particular week, you wonder if you will be the next casualty in the next re-organisation".*

A Clinical Services Manager pointed out that she did not like/approve the competition between the hospitals which affected her relationships negatively with other colleagues. She said:

> *"I find that totally alien to the whole philosophy of caring for patients. We shouldn't be in competition with other hospitals for patients. If I take out the nearest competitor which is X Infirmary, we used to have a very good relationship with the Nurse Managers there and used to exchange ideas, but now you are looked upon as a competitor and there is not this flow of ideas going on".*

A nurse manager who worked within a directorate stressed the importance of being appreciated by other people, particularly by senior management:

> *"Previously, when things moved so slowly the centralised administration was always to blame. Now that they have devolved these responsibilities down to individual directorate level then it is the middle manager, i.e. myself, who would be seen to be at fault for something not moving as quickly as it should be, that affects your own feeling of self-worth as well, If somebody is always on the phone and saying, what is happening to this and why hasn't this progressed, you begin to feel inadequate yourself for it not progressing, but when you have time to sit down and think about it realistically, you realise you are doing a good job, you realise things are moving as quickly as they possibly can, and it is the individual who is asking you all these things that really has the problem - does not understand the full process".*

5.3.2 Views on the Clinical Directorate Structure

Regarding this question there was a consensus amongst all interviewees. They thought that in theory it was a good idea to involve doctors in management but in practice it very much depended on the individual clinical director.

Some nurse managers who had been working in clinical directorates expressed anger and negative feelings towards the medical profession and to government policy. They believed that doctors did not work as a team; that doctors had not been trained to manage; and that doctors were chosen for these posts just because it was 'politically correct' to do so. However interestingly all interviewees

stated that they had been 'lucky' because they had a 'good' clinical director in their directorates.

> *"A Clinical Director has a very essential part to play in delivery of a service and if you've got a sensible clinical director you can take the service beyond all its dreams but if you get an idiot for a clinical director because of his academic seniority, its just a waste of time, especially if they're not recognising what their actual management role is. I have sensible clinical director with a good academic background, he's got management ability but he's still tied up in his colleagues and what his colleagues' reactions will be".*

Some believed that clinical director posts automatically went to the consultants, many of whom were not necessarily the best people but they got the position on the basis of their professional background and their influence. Interviewees thought that there were no reasons why nurses could not become clinical directors. In this matter a few participants blamed/accused nurses of not being assertive and willing to take leading roles. A DN&Q said:

> *"I am trying to get nurses to lead Community Mental Health Teams, but they will not do it and they keep perpetually reinforcing the Doctor/Nurse stereotype by saying - you are a consultant, you should lead. I think this is an issue of the occupational confidence of nurses because we have never actually valued nurses as independent practitioners, we have always demanded subservience and obedience, and we have always required them to play homage to traditional values .*

An interesting comment on the introduction of the clinical directorate structure came from a Senior Nurse Manager who argued that nurses were not allowed to take clinical director posts:

> *"It is politically correct to get the Clinicians on board and the way to do that is to appoint them Clinical Director, but is it appropriate that these clinicians that have not been managers, that have no management skills are allowed to manage? There is no reason why a nurse cannot be a Clinical Director, but they will not allow us to go for the jobs. I think is grossly unfair and undermines the position of nurses which demoralises us in so much as we have formal management qualifications, a Consultant has not perhaps".*

One Clinical Services Manager's explanation about why she did not apply for a clinical director post was also notable:

> *"Some people say to me - why have you not gone higher? To be totally honest with you, when my first Clinical Director went on to higher things he wanted me to take over the Directorship. I said no, the whole point of introducing Clinical Directors is to bring doctors on board. Although I did not have any problem in taking on that role in dealing with the Directorate management but I knew that the consultants would fight me at every turn and it had to be one of them that did it".*

Some interviewees thought that, although the philosophy behind the structure was good, they had not seen any good examples in practice yet, but they also stressed that the changes needed time to evolve and be evaluated.

When interviewees were asked to state their opinion on the role or position of nurse manager within a clinical directorate structure, again they stressed that the personality of the clinical director was the most important factor which affected the position of the nurse within the directorate. Some managers thought that the directorate structure pulled medical and nursing staff together and there was far more communication between these two professions regarding the management of an area, providing people with a sense of identity. They now began to work together for one particular service (team work), whereas they used to work either for themselves or for their own ward. It was emphasised also that the role or position of the nurse manager within a directorate very much depended on the nurse managers themselves. They had to influence and negotiate if they wanted a high profile.

Some believed that people who were nurse managers previously continued to be Nurse Managers and they basically did the same job that they had done before. However now, in the organisation, they were seen as being subservient to the Clinical Director as they did not control a budget. They said 'if you do not control the budget you do not have control of the resources'.

A Clinical Nurse Manager who clearly felt undervalued argued that the clinical directorate structure was imposed on nurses. He said:

> *"Nobody actually asks what our opinion is. People will say at the top of the organisation that opinion was sought, but no-one really wants to know what I think*

as a nurse manager and how much influence that carries. People do not feel that they are being consulted or that their skills are being recognised and it is almost a lip service that is being paid. The only other point I would make is that nurses are historically never happy and they will always want more of this and more of that at an emotional level. Nurses are terrible ones for moaning anyway".

In the interviews managers were asked to give their opinion about one of the survey findings regarding ambivalent feelings about clinical directorate structures. Interviewees were asked if they thought that this was because nurses usually become managerially responsible to the Clinical Director. Responses to this question were grouped under three headings.

- Those who agreed that nurses did not like being managed by a doctor. It was pointed out that nurses had struggled for a long time to be recognised as a unique and separate profession and it was perceived sometimes that they had moved the structure back to 'Matron' who reported to the Chief Doctor who had all the power and the budget.

- Those who indicated that they did not have any problem with a member of the medical staff being their direct line manager but they believed that the personality of the Clinical Director affected the interpretation and implementation of the job. They said 'depends on the clinical director and your view and personality; if you are working as a team, as equals, then it should not be a problem'.

- Those who argued that being responsible to a doctor or another profession was not an important issue as it did not matter since the traditional barriers between the professions were being broken down. They suggested that nurses were resistant to change and they wanted 'the good old days'.

5.3.3 Views of the participants on the issue of maintaining clinical expertise

In the interviews, although all the subjects agreed that nurses in management (people above charge nurse level) were becoming distanced from clinical practice and although remaining and/or having clinical knowledge was important, nevertheless not all of them thought that maintaining clinical expertise an important issue for them.

Senior level participants said that they now had a bigger remit than they had had in the past and it was impossible or unnecessary to be involved in 'hands on' clinical tasks since there was other work to be done in the managerial arena such as attending meetings, contracting and negotiating services. Some interviewees thought that strategic expertise was more important than retaining clinical expertise at their stage. A DN&Q said:

> *"I don't think it is important for me to retain any clinical expertise. I believe that within my organisation I'm surrounded by clinical experts. They're the ward managers or the nurses who deliver care on the ward or the clinical nurse specialist. If I need to know anything about a particular subject then I've got a whole range of people I can go to ask for advice and opinions on, I can't be a jack of all trades and master of none. It would be unfair to think that I should have any clinical expertise, I can have strategic expertise in terms of looking where nursing and midwifery is going in the future and make sure I'm as up to date as possible in terms of changes within nursing and the political agenda for nursing but in terms of the clinical expertise I don't feel that I need that".*

On the other hand a few subjects stressed that the maintenance of clinical knowledge and expertise was required to be able to lead the professional aspects of the role and to have credibility in the eyes of their staff. One Care Group Manager said:

> *"It is important to retain clinical expertise and knowledge in order for staff to have faith in you, that you actually know what you are talking about and in that sense are representing them and that the managerial decisions that you take have taken into account all the scenarios and all their needs as well".*

A number of subjects claimed that senior nurses, especially at very high levels, i.e. DNs and CANOs, were removed from the clinical environment and therefore did not know what was happening.

5.4 PREPARATION FOR THE JOB

5.4.1 Management preparation

First the interviewees were informed that in this study, the majority of the respondents had attended first and/or middle line management courses. Then they were asked to state their opinion as to whether they thought that this level of management training was sufficient for the job when considering this entire group of nurses. As a second question they were requested to give their opinion on the kind of management preparation that nurses in management should receive. Generally interviewees suggested that first and middle line management courses were definitely not enough as far as the level of responsibility of this group of nurses in management was concerned. A majority of the managers emphasised that these courses usually provided a very elementary introduction to the topic and generally they found them unsatisfactory and inappropriate in terms of length and content of the courses.

It was pointed out that these courses comprised two to three weeks of short, sharp talks on a variety of subjects which could not prepare anyone for the job of a Manager in the NHS at that time. A few people said that their first and middle line management courses taught them nothing and sometimes they were just undertaken by everybody within the organisation regardless of individual management training needs. It was also agreed that management training courses should be taken before moving into management areas. One interviewee described these courses as 'cosmetic' and said that 'in many other organisations, unlike the NHS, you would have to prove your competence before you actually moved on'.

Many interviewees agreed that there were different requirements at different levels of management. In addition everybody's individual needs and experience should be taken into account. However it was suggested that the level of management training for nurses who were above charge nurse level should be at least at diploma level, and it should include business planning, budgeting and contracting issues. A degree level training e.g. MBA was the most popular training programme which was recommended by some of the respondents. A DN&Q's thoughts provided a good example in terms of reflecting many other interviewees' beliefs. She said:

"At the nurse manager level we are looking at a much more strategic approach to management and not just the hands-on day to day stuff, but being able to take that overview of a larger area and move forward with operational plans and meet contractual requirements. The Managers who have moved into Business Management obviously need to take account of some sort of business training and many of them do MBA. At my level I think most of us have got one if not two degrees and if we do not have two degrees most of us are working towards some sort of Masters Degree, but it is to do with being strategic and developing leadership skills".

Some of the participants emphasised that they were aware of their lack of training or preparation for their job. The following example expresses the feelings of this group of interviewees:

"Prior to coming into this type of job I was a Senior Nurse and I dealt only with nurses, I didn't carry full budget responsibility. In this post I manage all disciplines including doctors and that's a whole new remit for me. On top of that I am accountable for budgets. I have no training in that apart from my previous experience which was limited. I did attend short courses set up by the Trust to look at specific areas of management but I don't believe for a moment it was enough. I've been in this type of situation for coming on three years now, I really have had to struggle tremendously with it and I had to learn on the job and I made mistakes, no tragic mistakes luckily but I did make mistakes. ...I honestly believe deep down and I know it seems contradictory to my particular position but I really believe that nurses coming into this level of management, multi-disciplinary and real accountability for budget should undertake a recognised management degree course, without a doubt".

A couple of interviewees said that management training for nurses should start at the beginning of nursing training because they believed that, to some extent, all nurses had a role to play in management whether it was at ward level or whether they were going to progress further into a management role outwith the clinical field. It was suggested that management had to be an integrated part of nurse development and it should not be seen as 'when you get to a certain stage in your career then you undertake management training'. Furthermore they suggested that management training or preparation should be an ongoing activity according to the level of responsibility, the speciality in which someone wanted to develop her/his skills, and the training needs of people. A few managers said that first

and/or middle line management courses might have been sufficient in the past but in order to survive in the Health Service, today's managers required more up to date preparation. The importance of mentorship and on the job training was also emphasised by a number of interviewees.

5.4.2 Orientation to the job

Interviewees were asked if they knew what they were going to be doing before starting their job. Only four interviewees out of 27 said that they 'knew the job', and that they had had a good job description and a very good orientation before starting their job. The remainder of the interviewees indicated that they either did not know anything about the job or they had had very rough ideas about what the job involved. Inevitably some had experienced highly difficult or 'dreadful' months (as it was described by some) as a result of the stress, and anxiety in a new job.

A number of respondents emphasised that the job was a new experience for everybody in the organisation, nobody knew what it was about and they had to develop the job and the job description themselves. In order to explain this view a subject's answer is given below:

> *"It was a whole new experience and new structure. ...people at headquarters had drawn up what they thought was the job description. Some of it I understood, some of it I felt kind of wary about, so I wasn't entirely clear, but then neither were they because it was a kind of trial, and as the months progressed and the job became more defined by experience then the job description had to be altered quite a bit, so I suppose your original question was did you know what you were coming into, no I didn't, not really".*

5.4.3 Subjects' preparations for the job in term of management training that they received and their clinical/managerial experience

Generally interviewees said that they did not feel they were well prepared for their jobs but it was thought that some people who had had a formal management training felt more comfortable than others. It was understood that the need for management education or the value of having a management training qualification

was highly appreciated by nurses in management. A subject who had no management training expressed his/her feelings as:

> *"I've had thirty years now of a whole variety of areas in nursing. I was a teacher, I was a Senior Manager, I came up through the ranks so I've an understanding of the thing but I still feel I really needed further management training in the kind of degree courses that are being offered now. Not only because they open up your eyes to a whole variety of things and you're trained properly by people who know what they are talking about but you've also got the opportunity to come out of the situation, reflect on it and be able to plan strategically a lot better than you're doing at the moment. I think my life experience has stood me well".*

Many of the respondents emphasised, that in terms of clinical/managerial experience, they felt they did not have any problems as they had come through a traditional nursing rank. However, in terms of the new components of the jobs (business planning, contracting etc.), they had learned it on the job as time progressed. In this question, again respondents emphasised that they were no longer a clinical expert as they did not do clinical 'hands on work' but also they felt that it was not a necessary component of the job because they were paid to do the 'management job'. Some interviewees made a sort of confession about how they felt that they were not capable of doing some components of the job. Some described their feelings as 'a nightmare'. An interviewee said:

> *"Basically, it was a nightmare at first because right I was a Senior Practitioner, and I was in charge of the District Nurses in my locality, but I had someone at my level above who took all the decisions, but took my advice on clinical matters. One day I went for an interview for this job. Got it. Came into work, my boss, the Clinical Services Manager, came up and gave me a list of bits and pieces. Prior to that I had had a word with the previous incumbent and she told me in about 1 hour what she did. I had no support in the first six months. I was very much left to my own devices, so it was a big struggle up until I would say two months ago... I can now relax at my desk but I was not prepared and did not get any induction, and am glad that is confidential.*

Some subjects stated that they had had a very steep learning curve since coming into post. The speed of the NHS changes was mentioned by a Patient Services Manager. He said that he was not prepared for the job, but it was nobody's fault

since the changes were so rapid and the time scale had been so acute. One Clinical Nurse Manager emphasised the importance of having management preparation during nursing training. He said:

> *"Nobody prepares you for promotion in the NHS - one day you are a student, the next you are a Staff Nurse; and the next you are a Charge Nurse. You are the same person and nobody in the past would have invested in major training or performance appraisal so that you were actually developing as you went along in a planned way. So, nobody got prepared in any sort of structured way or planned educational way. I think it is slightly improving now with PREP and a commitment to providing a quality service, but we have still got a long way to go in comparison to other disciplines and other professions".*

Another respondent who thought that she was well prepared for her job through her nursing career also stressed the importance of management preparation during nursing training She said:

> *"I think nurses should be prepared for management throughout their career, it has to start within their training because at the end of the day to some extent all nurses have a role to play in management whether its at ward or department level or whether they're going to progress further into a management role outwith the clinical field so I think management has to be an integrated part of nurse development, it shouldn't just be seen as when you get to a certain stage in your career then you undertake nurse or management training, it has to be worked in at a very early stage because you have to prepare people to be staff nurses which has a management content, certainly we have to prepare people to be ward sisters because I think thats a very important management role even though its clinical based and then if the progress after that I think it has to be a continuing part of their development and education".*

One interviewee who did not have any formal management training said that she was fortunate to have very good people in senior management. She said that her preparation was 'on the job training' and 'working alongside experience' that she had gained.

5.5 STRENGTHS AND WEAKNESSES OF NURSES IN MANAGEMENT

Interviewees were asked to identify strengths and weaknesses of nurses in management. In this study it was found that being the largest group in the NHS was the most commonly mentioned strength of nurses working in management roles. They said that they had the experience of managing a large group of people and had communication with a wide range of people.

Having come up through the ranks was also identified as an important strength of this group of nurses. Some people said that coming up through the ranks meant they had a wide range of experience in the clinical area and therefore they had an understanding or an insight of what was happening on the shop floor. They felt this gave them 'credibility' in the eyes of charge nurses at ward level.

On the other hand with the current changes within the NHS, the traditional hierarchical structure had been removed and there were fewer promotion opportunities for those nurses who wished to progress within a nursing career. To become an Executive Nurse in a Trust from the charge nurse level was described as a 'big jump'.

Strengths and weaknesses which were listed by the interviewees are summarised below:

Strengths

- Being part of the biggest workforce within the health sector;
- Coming up through the ranks (i.e. staff nurse, charge nurse, NO, SNO);
- Possession of a wide range clinical expertise and skills; including ability to make decisions and good communication skills;
- High standards and high levels of motivation.

Weaknesses

- Nothing professionally to prepare nurses to be managers; not being trained for the job (neither nursing training nor the traditional promotion system were adequate); not having a formal management qualification; or having only a narrow management training;
- Lack of business management knowledge, having never really considered picking up skills outwith the traditional professional hierarchy;

- Lack of flexibility;
- Lack of confidence and often looking for other people to blame;
- Unassertive (as they are a female dominated profession);
- Being traditional ('we undersell ourselves'); don't want to look forward; mainly negative about the future; lack of adaptability to change;
- Lack of ability to take/seize the opportunities. e.g. not applying for CE posts;
- Ambivalence about new roles which were both an opportunity but also stressful;
- Allowing people to diminish nursing posts (don't collectively come together and do something positive);
- Too far removed from the clinical side (we sit in an office all day);
- Too many different jobs and not knowing where nursing stands.

5.6 RECENT IMPORTANT CHANGES IN THE JOB

As a last question respondents were asked to describe the important changes (if any) that had happened over the last seven months in terms of their role and organisation.

The most noticeable change was the job title changes of the interviewees that had happened within seven-eight months (between July 1994 - February 1995); six out of 27 had changed their job title within the existing post, one has become a Clinical Director. This might be an indication of constant change in the NHS. The new and former titles of the subjects are given below:

Former	NHS (1990) Reforms
Nursing Services Manager	Senior Nurse Manager
Service Manager	Operations Manager
Contract Manager	Community Services Manager
Contract Manager	Patient Services Manager
Senior Nurse Manager	Locality Manager
Director of Nursing & Quality	Clinical Director
Nursing Services Manager	Nursing Services Manager/Business Manager

For this question there was no consensus between the answers. Some emphasised that the year 1994 was probably the most traumatic and difficult year for everybody since gaining Trust status, but during 1995 the changes were settling down. However it was declared that there had been a number of redundancies in the organisation owing to downsizing of the services. A couple of interviewees said that their organisation would become a Trust on 1 April 1995. Therefore within the last seven months there had not been significant changes. In general participants stressed the importance and the impact of the movement from hospitals to community/primary care in their job. Once again respondents said that some of their management responsibilities related to clinical settings devolved to charge nurse level and their managerial responsibilities/roles had increased. Some believed that the NHS (1990) changes had been continuing and they would never cease.

5. 7 COMMENTS OF THE INTERVIEWEES

In the interview all the managers were given the opportunity to express their feelings and thoughts on the aspects of their work that they felt had not been mentioned in the interview, or if there was anything else that they wanted to tell the researcher.

The interviewees were asked to answer this in order to give the opportunity to express themselves freely. In total five interviewees felt that they had covered everything and there was nothing they could think of that they had not looked at that was vitally important. Three of them were interested in the findings of the study and asked to have a copy of the findings once the study had finished. Others (19 people) gave a comment either about various aspects of their personal job or their thoughts on nurses in management. Examples of these comments are provided in Appendix II.20.

CHAPTER VI

DISCUSSION OF THE FINDINGS

6.1 Research Questions

In order to identify the emerging role of nurse managers / nurses in management this descriptive study aimed to answer the following five research questions:

1. What are the demographic and educational features of nurses in management?
2. What is the current management training(s) and/or management education and how has this training contributed to the job of nurses in management?
3. What are the main job responsibilities, and skills, knowledge and qualities necessary for nurses in management?
4. How do nurses in management perceive the 1990 NHS Reforms and their effects on their job?
5. What is the view of nurses in management regarding their present and future role within the NHS in Scotland?

6.2 Introduction

This study was carried out to answer the above research questions. The following section discusses the findings to these questions using both questionnaire and interview data.

As noted earlier in Section 2.1.12 the literature pertaining to the role of nurses in management was largely based on anecdote or government reports. There had been a little small scale research, carried out specifically in Scotland usually based on interviews and workshops. In other words, there was no comprehensive work in the nursing management field carried out in Scotland at the time of the study. However there were a few UK research studies, which therefore, included Scotland's nurse and/or non-nurse managers.

6.2.1 Key messages from the study

Given the complexity of the study and the wealth of detail provided, it was agreed to identify key messages and use these to frame the discussion. The criteria used in the presentation of the key messages were whether the finding(s) were important, unexpected, interesting or represented trends.

Important findings:

- It was identified that the majority of nurses in management thought that their management training was insufficient to do their job satisfactorily.

- The job content of the subjects had altered considerably after the NHS 1990 Reforms with greater responsibility and more multi-disciplinary work.

- There was no consensus between subjects in terms of the merit of the clinical directorate structure. However respondents emphasised that nurses who wanted to enter this field would need additional preparation in finance and business planning.

- Communication, interpersonal skills and leadership skills were the most frequently reported skills that nurses in management should have to do their job satisfactorily.

Unexpected findings:

- In general there was no consensus between respondents in terms of both the role of nurses in management and the NHS (1990) Reforms.

- Change management was not identified often either as a job responsibility or as a skill needed to do their work and not included in curriculum.

Findings that represented trend:

- First line managers and middle managers were more concerned with traditional nurse manager responsibilities while senior managers were more involved with corporate management issues and advisory roles to others.

- In general there was a trend for senior managers to be more positive than first line managers and middle managers in terms of defining the role of nurses in management and the NHS Reforms at the time of this study and in the future.

- It was easier for women to achieve senior positions if they were single, and yet the converse was true for the men.

Interesting finding:

- The job titles of the respondents varied enormously according to the institutions and/or the job of the subjects. In total there were 44 different job titles used by the 158 nurses in management.

6.3 Main Discussion

Given the size and the complexity of the data the key messages from the study were identified to organise and facilitate the discussion. The presentation order of the discussion of the findings is based on the questionnaire (Appendix I.2).

6.3.1 DEMOGRAPHIC CHARACTERISTICS

6.3.1.1 Age, sex, marital status and current position

In this study, a high proportion of females were single: 34% of the women compared with 4% of the men. A total of 58.8% of females in senior positions were single and there was no single male respondent holding a senior managerial position supporting the findings of Hutt (1986), Robinson *et al* (1989), Ong (1993) and Ball *et al* (1995).

A total of 18% of males were in the 50+ age group compared with 40% of females. Almost half of the male respondents were in the 40 to 49 age group. These findings might suggest that male senior managers tended to have a faster career progression than female senior managers. Previous research indicated that female senior nurses were more likely to have taken a career break than the men (Ball *et al* 1995) possibly to have or to raise children. Family or partner commitments and also time spent in gaining further specialist qualifications at an early career stage could be another explanation. It was also argued that in the British culture, opportunities for women at a senior level are generally more restricted than for men (Balogh and Bond 1992). As Ong (1993) noted, most women managers in the NHS gain a professional qualification and move up their disciplinary career ladder before going into general management.

In total 59% of the senior managers were females. Based on this finding females appeared to be better represented in senior nursing posts than found by previous research (Hutt 1986; Disken *et al* 1987; Robinson *et al* 1989; Wyatt *et al* 1994). But as noted earlier, women comprise 89% of the NHS nursing workforce and accounted for 68% of all the respondents in this study. Therefore it is clear that the proportion of women in management decreases as seniority increases. According to previous research in the NHS, women are under-represented, especially in more senior management levels. Disken *et al's* (1987) study on Unit General Managers (UGMs) showed that 82.7% of UGMs were men while in Hutt's (1986) study nearly half of the chief officers were male. Owens and Glennerster (1990) noted that nearly half of all the managerial posts in the NHS were taken by male nurses. Wyatt *et al's* (1994) study comprised 657 top managers in the NHS in all kinds of NHS organisations and found that 21% of the top managers were women. In Wyatt *et al's* study 9% of all the top managers were nurses and of these just over half of the nurses were women. Based on the finding of this present study it could be argued that the trend is changing in women's favour slightly.

In this study, as noted earlier, there were 44 different job titles used by the 158 respondents. In the CCP survey by Ball *et al* (1995) and the previous *One Year On* (NHSME 1992) study it was found also that the job titles used by nurse managers and Nurse Executive Directors varied enormously. In Robinson *et al's* (1989) study there were 31 titles used by 159 Chief Nurse Advisers. When the changes in the health care system as well as the nursing profession are considered, this finding is not surprising. As the interviewees of this study stressed, the development of trust status and the way in which the Health Service had evolved, were the main reasons for the variety of titles within a relatively small group. It may also have been that nurses had taken on a variety of roles in areas such as quality assurance, budgeting and the use of resource. Some of them were responsible for nurses as well as other professional groups and could not have a title which reflected nursing only. Also in many cases the titles reflected the nature of the job. It can be argued that traditional titles such as directors of nursing were generally self-explanatory and patients understood them. However the variety of titles as identified in this study may have indicated a lack of clarity, with possible confusion for the public and for some staff as well. One of the Clinical Services Managers at the present study said that:

> *"The role content and responsibilities vary from title to title and I think the title can be very confusing. For instance, you can go to one organisation and the Director of*

> *Nursing will be quite clearly the Chief Nurse at the top of the tree in terms of nursing. You go to another organisation and you may have quite a few Directors of Nursing because they are in charge of a Directorate. I do not know if they do clearly convey to people what the role actually is now. Many of these roles will be professional roles, whereas many will be managerial roles as well. I think it is very confusing for the staff and I do not suppose the public have any idea at all".*

It might be that the variety of titles was 'simply' a staging to more defined titles in the future. Nevertheless many might feel that a nurse within a hospital should be easily identifiable owing to the importance of recognising their duties if they are in a traditional nursing role.

6.3.1.2 Time in job and current position

It was found that most respondents were quite new to their present job in terms of length of time in post. The creation of NHS Trusts and changes in commissioning organisations had affected nurses, and the length of time in present post may illustrate the degree of change which nurses in management had undergone since the NHS (1990) Reforms. In Ball *et al*'s (1995) study, similar to this study's findings, it was found that 68% of the respondents had been in their current post for two years or less. It can be argued that this mobility might have management and cost implications.

6.3.2 PROFESSIONAL AND ACADEMIC QUALIFICATIONS

6.3.2.1 Management training and current position and sex

It was identified that the management training of the respondents was insufficient to do their job satisfactorily. The majority stated a higher degree level of education in management along with on the job training was a necessary preparation for nurse managers. Also in the interview it was stressed that narrow management training was one of the weaknesses of nurses in management. Hewison (1994) believed that nurses were ill prepared to take on the role of manager. In this present study in general interviewees also agreed that they were not well prepared managerially for their jobs. The need for management education, or the value of having a management training or of gaining managerial skills, was stressed by the

subjects. In this study there was a tendency for the men to be better qualified managerially than the females.

In the present study, in total there were 16 subjects (10%) who held a degree in management and 76 respondents (48%) had a formal management training qualification(s). In Robinson *et al's* (1989) study 13.8% of the subjects held formal management qualifications. In Forrest's study in 1983, 90% had received management training. However in Forrest's study first line, middle line and top line management courses were counted as formal management training. On the basis of the findings of this present study it can be argued that there has been an increasing trend to undertake formal management training, as nurses are increasingly responsible not only for nursing issues but also other areas such as business planning, negotiating and marketing. Also the structure of the NHS has been changing and therefore in the new era more skilled and managerially better prepared nurses are needed. Hempstead (1992) believed that there was a crises of confidence in nurse management and leadership. To be well prepared and confident, nurse managers need the requisite knowledge, skills and experience which can be provided by training and/or sound continuing education programmes that will help them to perform effectively. Cole (1993) suggested that training programmes, if they are to improve skills, should focus on three distinct areas; technical, human and conceptual. Technical refers to the employee's understanding and ability to use the specific methods, processes, procedures, and techniques required to perform the tasks which make up the job. Human skills refer to the employee's ability to work effectively as a group member and to motivate and to lead others. Finally Conceptual skills refer to the employee's understanding of the functioning of the organisation as a whole. In fact in this present study the interviewees identified that one of the weaknesses of nurses in management was that a lack of management preparation for the job. One of the reasons for the increasing trend in undertaking formal management training among nurses in management, might be increased self-awareness of nurses on this issue. An Operation Manager's response in the interview supports this view. He said:

> *"I've had thirty years now of a whole variety of areas in nursing. I obviously came up through the ranks so I've an understanding of the thing but I still feel I really needed further management in the kind of degree courses that are being offered now. Not only because they open up your eyes to a whole variety of things and you're trained properly by people who know what they are talking about but you've*

also got the opportunity to come out of the situation, reflect on it and be able to plan strategically a lot better than you're doing at the moment".

In Ball *et al*'s (1995) study it was found that the men were better qualified managerially than the women, but the women were better qualified academically than the men, with 44% of females having a bachelor's degree or higher compared to 40% of the men. In this present study there was a tendency that the men were better managerially qualified than the females. In total 84% of the men had undertaken management training compare with 79% of females. Therefore this study's findings support Ball *et al's* work.

A total of 76% of the respondents explained the way in which their management training helped them in their job. Of these 43% stated that the management training that they had had, helped them to develop various managerial skills and abilities such as decision making, communication and leadership.

Only 11% of the subjects with management training experience indicated that their training had prepared them for management of change. Again only 6% of the respondents mentioned that management training had helped them in gaining an understanding of the NHS. The reason for this could be, as stressed by some interviewees, that first and middle line management courses were usually a very elementary introduction to the topic and generally the courses were unsatisfactory and inappropriate in terms of length and content. According to Kelly (1990) they were not effective. In the present study it was found that occasionally these courses were undertaken by everybody within the organisation regardless of individual management training needs and experience. It was also agreed that management training courses should be taken before moving into management areas. In the present study, 52% of the subjects gave the information on the year of their management training. Of these 45% did their management training between 1992-94. As reported earlier in Balogh and Bond's study (1992), it was found that there was a clear tendency for managers first to be promoted from within the system and later to receive training for a job which by then they were already doing: A total of 83% of the respondents felt that they had tended to receive training for their post after taking it up, rather than beforehand. Present study's findings support Balogh and Bond's study. Henderson (1990) reported that many health service staff had picked up their management skills haphazardly and there were few opportunities for systematic management training, and even fewer for recognising such training in the form of a management qualification. As

emphasised by the respondents of this present study, It can be argued that management training courses should be taken before moving into management roles.

6.3.2.2 Level of management training/education and experience needed for the job and current position

The majority of the respondents believed that a degree in management was needed alongside 'on the job training', to be able to perform their work satisfactorily.

In the Thwaites Report (1977) it was argued that there was no one management job or one type of manager, but that there were quite different types of management jobs; different levels of management involve different tasks and skills and managers occupy their time in widely differing ways. Also Thwaites noted that the setting of the managerial job was important therefore it was pointless to generalise about either the nature of the managerial job or the training needed for management. In the report it was stated that:

> *"As for management training, it should be clear that we do not seek to impose any one pattern of provision, training format, or curriculum. But, many of the training elements are common although different combinations and permutations are possible. We have ...noted the argument that the need for technical, human and conceptual skills varies between levels of management, but this is a matter of emphasis and of achieving appropriate mixes of skills. In designing curricula for management courses, we would argue that the elements include such subjects as policy analysis, organisational analysis, personnel management, financial administration, information sciences, and contextual studies (King Edward's Hospital Fund for London 1977, p:27).*

In another report (King Edward's Hospital Fund for London 1981) the preparation of senior nurse managers in the NHS was examined and a variety of approaches were suggested for the preparation of top nurse managers including self-appraisal, peer group discussion, short subject-specific courses and formal courses at advanced diploma or Master's level which may be unidisciplinary or multi-professional. In this present study there was no evidence that the Thwaites recommendations on a planned career structure was in place or under

consideration by NHS nurse managers. In the present study generally interviewees said that they did not feel they were well prepared for their jobs. However they stressed that they had had a very steep learning curve, had prepared and developed themselves as they were in the job. An interviewee said:

> *"Most people who reached management jobs reached it through years of practical work without any academic preparation for being a manager at all. I had proved myself by having some many years work as a Staff Nurse, so many years work as a Charge Nurse, etc. It was based on experience and you may have subsequently have gained some management qualification, but that did usually happened after you got the post - you are manager now, you had better learn something about it. Nobody was actually prepared to be a manager and I think there has always been a feeling of insecurity. So, do I well prepared for my job, to be quite honest no. ...Many of them were quite alien to me.*

As it was suggested in the '*A Vision for the Future*' (NHSME 1993) nurses might require higher degrees in order to obtain leadership positions within the NHS, but 'the success of professional leaders will depend not only on their personal preparation and capacity but the commitment of all tiers in the service to provide support and encouragement' (NHSME 1993, p:14). In line with these suggestions it can be argued that management preparation and/or training of nurses in management should be based on an individual's needs and the nature of the job. In addition management training for nurses should start at the beginning of nursing training because to some extent, all nurses had a role to play in management whether it was at ward level or whether they were going to progress further into a management role outwith the clinical field. Also it can be suggested that management had to be an integrated part of nurse development and management training or preparation should be an ongoing activity according to the level of responsibility, the speciality in which someone wanted to develop her/his skills, and the training needs of people.

6.3.3 JOB RESPONSIBILITIES AND SKILLS, KNOWLEDGE & QUALITIES (SKQ) NECESSARY FOR THE JOB

6.3.3.1 Main job responsibilities and current position

As noted before, significantly more first line managers and middle managers were concerned with more traditional nursing roles such as human resource management. On the other hand senior nurse managers were more concerned with quality assurance, audit, standards, corporate responsibilities and advisory roles than the other two groups.

In the CCP survey (Ball *et al* 1995) on Senior Nurses, 21 Nurse Executive Directors (NEDs) were interviewed and three main headings were discussed as main responsibilities of NEDs. They were as a board member making a corporate contribution and giving nursing advice; as a professional head of nursing offering leadership and practice development; and as a key person influencing quality assurance. It was found that all the NEDs saw themselves as having a corporate advisory role; also that the NED roles varied quite considerably, although there were a number of common components. However the authors stated that the amount of variation between the interviewees seemed less than was found in the *One Year On* (NHSME 1992) study.

In another study (NHS Executive & Newchurch & Company 1995), nurse directors and Chief Executives were asked to rate the top five of a list of 22 activities in relation to the question of 'where does the Nurse Director (ND) add particular value to the operation of the Trust Board?'. Both groups listed strategic development, clinical practice development, and quality assurance as the three key areas in which NDs brought value to the Trust Board. It was also shown that the role and function of the nurse director varied between Trusts. According to that study, only 26% (n=66) of nurse directors directly managed all of their nursing services, and nurse directors had a very wide and varied management remit including quality assurance, management of medical and dental staff, audit and human resource. In terms of job responsibilities, when the findings of this present study are compared to previous studies, it can be argued that senior managers in this study had quite similar job components to NEDs. The differences in terms of the job responsibilities found in the previous studies and in this study, could be owing to the nature of the sample, since this study's subjects were grouped into

first line managers, middle managers and senior nurse managers and they were not only NEDs.

In this study, 68% of the subjects had a budget responsibility and middle managers were significantly more likely to have a budget responsibility compared with the other two groups of managers. However when the extent of the control over the budget was investigated, it was found that only 25% of the respondents who had a budget felt that they had 'complete' control over it. During the interview process some interviewees emphasised the importance of having a budget and argued that 'if you do not control the budget you do not have control of the resources'. In this study reasons of why the majority of the managers did not have complete control over their budget were not determined. However it can be argued that nurse managers lack management power within the organisation where they work, given that only 23% of all respondents were member of their hospital, unit or board team. Therefore it can be suggested that the managerial power of nurses in management should be enhanced and they should have effective budgeting skills to be able to control their budget and resources effectively.

6.3.3.2 Clarity on the nature of their job and freedom to use own judgement

Overall almost all respondents said that they were 'very clear' or 'fairly clear' about the nature of their role. Again almost all of the subjects indicated that they had either 'a lot' or 'some' freedom to use their own judgement about their work. When the speed and the nature of the changes taking place in the NHS and the time spent on the current job were considered, it can be argued that these answers were unexpected. The reason for these findings may be in part owing to a lack of clarity in the question itself. In Ball *et al*'s study (1995) job descriptions for advertised NED and equivalent posts were obtained as another way of exploring the roles of NEDs. In Ball *et al's* study it was found that the language used to describe the NED job was vague and it was not possible to gain a clear understanding of what the job entailed. The authors emphasised that 'in general it was unclear what the post-holder was supposed to do, what decisions they were to make and who was accountable to them and for which activities' (Ball *et al* 1995 p:68). Similarly, in this present study 60% of the respondents indicated that they had not received any orientation before starting their present post. When the total sample was considered 35% of all respondents felt their orientation to be 'adequate' or 'good'. Also in the interview it was found that only four interviewees

out of 27 said that they 'knew the job' and that they had had a good job description and a very good orientation before starting their job. A number of respondents emphasised that the job was a new experience for everybody in the organisation, and they had to develop the job and the job description themselves. Inevitably some had experienced highly difficult or 'dreadful' months as a result of the stress, and anxiety in a new job. In line with these findings it can be suggested that a comprehensive and clear job descriptions should be provided to the potential employees before starting their job. In addition managers should receive a reasonable orientation in order to minimise stress and anxiety experienced at the beginning of the new job. The value of having a good job description and a reasonable orientation was emphasised by an interviewee. She said:

> *"I think I was fairly well prepared to my job. We had a good job description at the time and we had a reasonable orientation. The orientation involved brainstorming sessions as to what we felt we needed in the job, and really by going through what we felt the needs of the job were and discussing it with our colleagues and discussing it with the human resources, we developed an awareness of what the job was going to involve and therefore I do not think there have been any major surprises".*

6.3.3.3 Skills, knowledge and qualities (SKQ) necessary to perform the job satisfactorily

In total 52% (n=80) of the respondents thought that nurses in management should have communication skills, 'interpersonal skills' and 'leadership' to be able to do their job satisfactorily. In 1981, as reported earlier, King Edward's Hospital Fund for London (1981) published a report and identified the knowledge and skills required by top nurse managers. They were leadership skills, interpersonal skills, appraisal and counselling, communication, analytical skills and abilities, planning skills, manpower planning, budgeting, and resource allocation.

Katz (cited in King Edward's Hospital Fund for London 1977) argued that there were three basic categories of skills for managers: technical, human and conceptual. Technical skills of a manager imply proficiency in methods, processes, procedures, or techniques. Thwaites' report also included in this category such skills as costing, investment appraisal, project control, automatic data processing, organisation and methods and operational research applications. Human skill

meant a manager's ability to work effectively as a group member and to build co-operative effort with the team s(he) leads. The conceptual skill of the manager referred to their ability to see the enterprise as a whole. This involves an understanding of how a manager's part in the organisation relates to other parts and to the total organisation. Managers also must have a strategic sense, and as they are the co-ordinators and integrators, they should also possess the spark of creativity and innovativeness.

In Everson-Bytes & Fosbinder's (1994) study it was found that the first and most critical competency was communication. The other competencies that were identified were leadership, problem solving, staff development and the understanding that health care is changing. In the present study although communication and leadership were identified by the subjects, problem solving and change management skills were reported only by a small proportion of the respondents. On the other hand as presented in Chapter IV, Table-4.5.2, half of the respondents (n=53) who saw themselves as successful managers from the beginning of the 1990 Reforms explained that they were successful because they were either initiated/implemented changes or able to cope with the changes. Therefore despite not being reported overtly it can be argued that they demonstrated the change management skill but perhaps difficult to identify it as necessary skill to perform the job satisfactorily.

In Balogh and Bond's (1992) study the participants listed a range of skills that they thought management development courses ought to cover. They were human resource management, interpersonal skills, planning techniques, budget management, quality improvement programmes, understanding the organisational structure, communication and leadership skills, personal skills. In this study similar skills were described which nurses in management should possess to be able to the job satisfactorily. It can be argued that any management course to prepare nurses for their current roles should cover these areas and it is unclear why so many NHS courses had failed to do so given earlier reports and the impact of MBAs generally. It might be argued that dealing with lowest common denominator; and/or course content had not caught up with current thinking; and/or monolithic NHS.

In the *One Year On* study (NHSME 1992) respondents (N=24) were asked 'to do your job effectively, in which areas do you feel you would like to develop improved knowledge and skill'?. The areas needing knowledge and skill development were

primarily marketing, political and negotiating skills, policy analysis, contracting and financial management. In the areas of problem solving, change management, people management, and team working, the respondents reported that they needed these skills and they had them.

In this study negotiating skills, political awareness, contracting and change management skills were not often mentioned by the subjects. It could be argued that these findings were again unexpected since during the course of this study there had been a massive amount of change within the NHS with a more business orientation. Also in the literature especially change management skill have been identified as the key skills that nurses in management should have (Antrobus & Whitby 1994; Andrews 1994; Mulholland 1994; Bradshaw 1995). Andrews (1994) said that:

> *"Managing change is fundamental to the management of people. The NHS is now feeling the effect of the constant process of change which has become central to our society. Health service managers must be skilled at managing the effect of change, both on staff and on themselves. It is one skill to survive and prosper in a changing situation" (Andrews 1994).*

Bradshaw (1995) believed that the new era 'requires nurse managers to be active initiators of change who exert a strong personal presence in and controlling influence over the clinical environment'. The reason why the subjects of this present study did not often mention political awareness, negotiating, contracting and change management skills as necessary for their job could be that they may not to be aware of the importance of these skills. It was identified that this area should be examined further.

Although there was some similarities in terms of the 'skills' needed by the nurse managers between the *One Year On study* (1992) and this study, there were a number of reasons why the respondents of these two studies provided different priorities for these skills. First, the nature of sample of this study covered a range of nurses in management from clinical nurse managers to DNSs. In the NHSME study only NEDs were the subjects. Secondly the wording and the content of questions were not the same. For example in the present study respondents were not asked specifically to identify necessary skills for themselves. It might have been better to use 'you' instead of 'nurses in management' as the subject of the question. Moreover the way that the data were analysed differed. Finally the pace

of the changes was slower in Scotland that in England and therefore at the time of the study, respondents may not have had the same exposure to the business culture as in England and therefore the respondents of these two studies provided different priorities for these skills.

In this study only 35% of the subjects stated that leadership skills were a necessity for their roles. The importance of leadership in nursing is widely discussed in the literature (O'Donnell-Imle 1991; NHSME 1992; NHSME 1993; Rafferty 1993). According to Rafferty (1993) 'leadership (is) portrayed as essential to the management of the workforce in the increasingly complex environment in which the NHS subsisted'. Lorentzon (1992) also emphasised that strong leadership and the importance of leadership training are clearly crucial at times of radical change. She believed that 'nurses in the late twentieth century in the UK and elsewhere must grasp the nettle of effective leadership in order to exert the professional and managerial influence which is necessary for promotion of patient welfare and for furthering the broader aims of health service systems throughout the world' (Lorentzon 1992). It is clear that given the findings from this study and research from elsewhere, more emphasis should be placed on the importance of developing leaderships skills alongside other managerial skills for nurses in management. Hunt (1992) believed that historically, the culture of nursing does not encourage the development of leaders, as the traditional role of nurses has been to follow. Kitching (1993) stated that 'nurse education or its socialisation process never prepared nurses for leadership roles'. It was believed that leadership in British nursing had long been neglected by nurses and policy makers (Rafferty 1993; Naish 1995). Rafferty (1993, p:26) stated that 'the legacy of this neglect is now being felt as nurses struggle to establish an identity and role for themselves in the changing environment of the NHS'. According to Hempstead (1992) 'nurses was becoming powerless and divided within itself and therefore unable to sustain strong leaders'. It can be argued that without strong leaders nursing would remain powerless and divided. It can also be argued that unless enough nurses give careful thought to developing their full potential, nursing might continue to be seen as a profession which habitually resists change and scorns opportunity. Furthermore, unless more nurses recognise and realise their leadership potential, they are unlikely to meet the demand for the numerous positions of influence available.

It is accepted that today's NHS needs strong and effective nursing leadership (Hunt 1992; Kitching 1993; Rafferty 1993). Hunt suggested that:

> *"If we want nursing to be recognised as being as important as we know it is, if we want nursing to adapt to and meet the challenges of the 1990s and the next century, then we have to have nurse leaders with not only the vision but the ability to make things happen so that the vision is achieved (Hunt 1992).*

In the present study the importance of leadership was also emphasised by the respondents. For instance an interviewee said that

> *"You cannot be a manager unless you have appropriate leadership abilities. How can you manage staff if you are not a good role model, that if you cannot control staff, that you cannot participate as part of a team, but at the same time distance yourself. You need to have the proper ability as a leader to motivate staff as well as demonstrate how well motivated you are. Changes do not happen easily and there will always be some form of conflict every time a new change is introduced and in order to implement those changes you definitely need to have good leadership skills".*

In a study of Chief Nursing Officers, Hutt (1986) identified a wide variety of personal characteristics and skills which were necessary to do the job of a chief nursing officer well. Some of these personal characteristics and skills identified in the study were the ability to think quickly, enjoy a challenge, inject enthusiasm, encourage team sprit, take criticism, delegate; being positive, tough, sensitive, tolerant, a good listener, assertive, open-minded, firm, articulate, a good communicator; and be able to understand in broad context nursing, research, budget, statistics, people, planning, staff development; having credibility, judgement, political awareness, professional knowledge, and a sense of humour. She concluded that although some of the characteristics were difficult to inculcate either by training or career development, many could be taught and most could be improved with the right training or leadership. Similar characteristics were also identified in this study suggesting that managers' thoughts on this issue had not changed much over the years. Nevertheless Hutt believed that 'whatever happens to the chief officer role in the future these characteristics would be needed in nurse management and those responsible for training and career development should consider how best they can be identified and encouraged' (Hutt 1986).

6.3.4 ROLE CHANGES AND RESPONDENTS' VIEWS ON THE NHS (1990) REFORMS

6.3.4.1 The need to be a nurse

As expected, the majority of the respondents (82%) thought that one had to be a nurse to be able to carry out their job. Overall 26% of the respondents explained that they had to be a nurse to understand the professional issues involved and /or clinical practice. In the CCP survey (N=478) by Ball *et al* (1995) it was found that a nursing qualification was a formal requirement for the vast majority of the jobs in the DoH (96%), the RHA (90%), and units (95%), whereas just over half of those working in commissioning (53%) said this was the case. Wright (1993) stated that

> *"Good managers/leaders are made not born. Managers who are also nurses can bring great benefits to the wider organisation. The strength of having a nursing background and of having actually cared for patients as well as knowing how the organisation works, is a tremendous asset to health care. When this is combined with an effective management and leadership style, then there is great potential for nurses to exert authority and take a much bigger role in the management of health services" (Wright 1993).*

In another small study reported by the King Edward's Hospital Fund for London (1981) 30 nurses were asked to give their opinion as to whether a top nursing manager at district level and above needed to be a nurse. Eighty percent of respondents of this study (King Edward's Hospital Fund for London 1981) believed that a top nursing manager needed to be a nurse. Reasons for this belief were sought and were classified into five main categories, with examples from each. They were:

> *"a) requires knowledge and understanding of nursing needs: non-nursing people do not understand the peculiarity of the nursing profession;*
> *b) requires awareness of problems in nursing: only a nurse can understand the problems current in nursing;*
> *c) requires experience in nursing: has been through the system and therefore experienced all aspects;*
> *d) necessary for career prospects in nursing; provide career prospects for nursing;*

e) professional autonomy: if the top manager is not a nurse it will put back professional progress 60 years" (King Edward's Hospital Fund for London 1981, p:14).

It was found that the above reasons given both in King Edward's Hospital Fund for London's study (1981) and Ball *et al's* (1995) study were quite similar to the present study's findings which were presented in Table-4.4.1 in Chapter IV. These findings might suggest that one had to be a nurse to be able to carry out a nurse manager's job.

6.3.4.2 Job Changes in relation to responsibilities, relationships, work climate, and views of the subjects on the NHS (1990) Reforms and the clinical directorate structure

In this study 79% said that their job was greatly changed. Mostly respondents stated that their responsibilities had increased and widened to other areas and there was not enough time to achieve the targets. As presented in Table-4.5.4, approximately one in three subjects identified that 'lack of time' was the main constraint that limit the subjects from doing their job as effectively as they want.

As noted earlier in Chapter II, in a study carried out in Scotland with nurse managers by Edmonstone & Havergal (1992), it was stated that communication at Trust / DMU level seemed extremely fragmented (even fractured) with rumour and counter-rumour rife. Relationships with staff changed fundamentally and only a minority of participants reported feeling excited and challenged by the new relationships with staff. It was also found that, as in this study, the pace and amount of work had increased significantly to hectic levels.

In this present study although the working hours of the subjects were not examined explicitly the previous research findings (Wyatt *et al* 1994; Ball *et al* 1995; Disken *et al* 1995) showed that NHS managers work too many hours and the intensity of work increased over the last decade. Within organisations, increased work volume and not enough time to achieve targets might be a source of stress, reducing effectiveness and undermining the morale of the organisation. Outside the work place, it may contribute to strained family relationships. It can be suggested that, as an organisation with a key role in promoting a health nation, the NHS should lead in finding ways to reduce hours of work and promote working

patterns which allow a better balance between professional and personal lives. It can be suggested that there should be much greater flexibility in working patterns without compromising good management.

In the *One Year On* study NEDs (N=24) were asked to describe any job changes since they had been in the post. The most common response was that the focus of the role had shifted from a nursing concentration to corporate issues, such as strategy, capital, business planning and financial issues. Respondents felt that they had become involved in a higher level of decision making for the organisation and were participating in determining the shared direction for the Trust. In this study similarly 54% of the subjects tended to agree with the statement 'in recent years nurses have become involved in a higher level of decision making for the organisation as a whole'. Again in line with the *One Year On Study*, the majority of the respondents in this study tended to agree that their strategic roles had increased within the organisation.

In the *One Year On study* it emerged that NEDs (N=24) had moved from being perceived as a 'nurse hand maiden' to a full participating member of the board with equal status to the medical staff (NHSME 1992). However as opposed to the views of NEDs, in Edmonstone & Havergal's study (1992) it was argued that clinical directorates created ambivalent feelings within nurses who were concerned with 'subservience' to doctors and a possible return to the 'handmaiden' role. Morris-Thompson (1994) also stated that in many clinical directorates medical doctors were appointed as the clinical directors and nurses took the title of 'adviser'. According to her this title emphasised a 'subservient' role. In the present study while 27% of the subjects felt positive about the introduction of the clinical directorate structure while 12% respondents felt negative.

In this study views of the respondents on the role or position of nurse manager within a clinical directorate structure were investigated further in the interview stage with 27 subjects. In general the findings obtained from the questionnaire on this issue were endorsed by the interviewees. They thought that in theory it was a good idea to involve doctors in management but in practice the personality of the clinical director was the most important factor which affected the position of the nurse within the directorate. From the literature (Rye 1991; Hancock 1993; Wall 1994; Morris-Thompson 1994) and from the findings of this present study, it was evident that doctors were filling most of the clinical directors role and as stressed by some interviewees clinical directorates was seen as the prerogative of doctors.

However Kitching (1993) believed that nurses needed to demonstrate their contribution in clinical directorates and adopt a less tribalistic approach if their true worth was to be recognised.

The reason why the respondents of these three studies stated different feelings may have been the sample itself. In *One Year One* study the sample comprised only NEDs, but Edmonstone & Havergal's study and the present study were carried out with nurse managers at different levels. In the present study the sample covered all groups from clinical nurse managers to NEDs, and therefore yielded both negative and positive views on this issue.

6.3.5 THE VIEW OF THE SUBJECTS ON THEIR PRESENT & FUTURE ROLES

6.3.5.1 The role of nurses in management at present

Nearly half of the respondents perceived the role of nurses in management negatively. Also some suggestions had been offered such as 'nurses need to be more active in business management and nurses should work in more general management positions'. In general first line managers tended to agree that the NHS (1990) Reforms were a threat. According to Hempstead (1992) negative attitudes remained a barrier to progress in some areas and this could be illustrated by the number of respondents who continued to see the Reforms as a threat rather than an opportunity, meaning loss of status and power for nurses. Antrobus & Whitby (1994) stated that 'historically, nurse education has tended to be didactic. This may be why nurses can respond in a reactive or negative way when faced with change or major uncertainty'.

In the interview, when talking about the changes within the NHS, a Nursing Services Manager said:

> *"Nurses are historically never happy and nurses will always want more of this and more of that at an emotional level. Nurses are terrible ones for moaning anyway".*

In fact in this study first line managers generally tended to be more negative about the Reforms and the role of nurses in management than the rest. This was evident in both qualitative and quantitative responses. The following findings might explain the reason for this tendency. Overall 76% did not have a formal management

qualifications; 88.9% did not have a degree, 98% were not a member of their management team. However nearly half had the freedom to use their own judgement about their work; just over half felt that they were 'fairly' or 'very successful' after the Reforms; 66% felt that they did not have equal status with the medical staff in the organisation, and although more than half had a budget, of these only 42% had 'complete' or 'very much' control over their budget. They felt their positions were not secure. It could be argued that they felt more disadvantaged than they were; but also they may have felt that they had some educational disadvantage. They certainly felt an inequality of status compare to medicine. Rafferty (1993, p:26) believed that 'intellectually, nurses have been historically disadvantaged. Like many other predominantly female occupations, nurses have largely been excluded from the educational institutions and resources which distribute the prestigious social and economic rewards in our society'. The feeling of these people, that the nurse's role is inferior to medicine, might hinder them in their strategic management role and many aspects of NHS organisational culture and employment practice also might work against them.

Senior managers generally were more positive, hopeful and confident because they were more likely to be well prepared for their job in terms of management qualifications (72% had a formal management qualification); more than half had a degree; 83% were a member of their management team; they were more likely to use their own judgement about their work (83%); 82% felt that they were 'fairly' or 'very successful' after the Reforms; 81% had equal status with the medical staff in the organisation. 52% had a budget, and of those all had complete or very much control over their budget. They generally had a secure position, as it was a statutory requirement that all Trusts have a nursing director at Board level. As a group their level of education and perceived status, as well as autonomy, made them feel secure, independent and responsible. It may also be the case that these individuals were senior managers precisely because they inherently possessed leadership characteristics which were only enhanced by their more senior position and hence became like a self-fulfilling prophecy.

Middle managers were generally tended to be in the "middle". 20% had a degree, 52% had formal management qualification, 13% were a member of their management team; 72% felt that they were 'fairly' or 'very successful' after the Reforms; 56% had equal status with the medical staff in the organisation; 94% had the freedom to use their own judgement about their work; 82% had budget responsibility, of those 72% had complete or very much control over their budget;

their number had been reduced or dismantled but many had taken over roles in general management.

According to Batehup (1992) 'if nursing is to take some large leaps forward and become a real force in current and future health care, then it is imperative that it becomes innovative and dynamic, quick to respond change and take initiatives'.

6.3.5.2 Future career changes

Overall 17% of the subjects expected their next career step to be into a more general management role within the NHS. As can be expected a third of the 50+ age group wanted to retire in the near future. Overall 14% wished to stay in the same position. However Ball (1995) stated that 'with current organisational structure, non-nursing posts are frequently the only ones available above ward manager. It is no longer possible to move upwards without moving outside nursing. Senior nurse posts have become less common, so moving upwards inevitably means taking up more generalist posts, such as business manager or service manager'. Therefore nurses should get more general management experience at an early stage in their career if they want to reach an executive position e.g. Nurse Executive Director.

In the CCP survey by Ball *et al* (1995) it was found that 17% (n=77) of the senior nurses planned to retire, 23% expected their next career step to be a move into a general management role within the NHS, with most of these (16%, n=65) wanting to work as a CE of either a Trust or a commissioning body. Approximately 13% of the subjects were uncertain about their next career step. In the *One Year On* study (N=24) there was a high level of uncertainty over future career options among NEDs interviewed (NHSME 1992). In this study the level of uncertainty regarding the career development of the subjects, was quite low with only seven (5%) subjects being uncertain.

Huntington (1993) argued that in order to have a role in purchasing and in general management nurses should have 'the interest, capacity and above all the will to perform it'. She said that in Trusts, nurses spoke of becoming more corporate, yet top of the list of their perceived achievements was 'keeping the profile and credibility of nursing high within the trust' and 'changing nursing practice and culture'. This study confirms her judgement. Only four respondents wanted to

become a CE. According to Batehup (1992) 'the potential for nurses acquiring positions in general management needs to be promoted. Nurses must see this as a legitimate role for nurses, and until nurses believe this they cannot expect others to do so'. As presented in Chapter IV, Table-4.5.5, overall 22% of the respondents either wanted to retire or leave the NHS or were uncertain about their next career steps. Based on these findings it can be suggested that individuals should take more responsibility for developing and managing their own careers and the NHS, as an organisation, should provide support and encouragement for their staff. In addition the NHS need to plan actively to attract and retain skilled staff for its managerial posts.

6.3.5.3 The future role of nurses in management

Respondents were more positive about the future role of nurses in management. The majority stated that nurses in management would assume roles in general management, and nurses would be effective NEDs on Trusts boards and would take on more business and corporate roles. However in this study only 17% of the subjects wanted to take up general management roles in the future. There were no first line managers who wished to take roles in general management. Therefore the question of 'then who is going to be in there' is raised in this study.

In the *One Year On* study respondents were asked their views on the future role of the NEDs. It was found that most of the comments and suggestions related to the national initiatives. It was envisaged that general management responsibilities outside direct nursing management would increase in importance and emphasis in the future. Also it was suggested that nurses must be encouraged to view nursing within the broader health care context, and to appreciate the influence which they had over wider issues. The need to develop nurses for management and ultimately the NED role, expanding beyond a limited professional remit was also emphasised. In addition it was stated that nurse managers should participate in general management training and development on a multi-disciplinary basis (NHSME 1992).

In the CCP survey, (Ball *et al* 1995) as noted previously, the 21 NEDs interviewed, expressed curiosity about the way in which their own job compared to others. They felt very isolated in the competitive environment in which Trusts operated and felt they needed to ensure that the benefits of competition did not eradicate useful

collaboration. The CCP survey findings strengthened the need for units and the NHS as a whole to take succession planning for these roles seriously. Similar to the CCP survey, in this study a third of the subjects were aged 50 years or older. It can be argued that retirement was likely to make a considerable impact on turnover on nurses in management. Moreover only 32% of the respondents planned to stay in the same position or expand the roles within the existing job

6.3.6 Limitations of the Study

The following were identified as strengths and weaknesses of this study.

Weaknesses:

1. The researcher's initial lack of familiarity with Scotland and the NHS meant that there was considerable preparatory work to be done prior to commencing the main study.

2. The resources (time, money and manpower) for the study were limited.

3. There is a possibility of bias in those interviewed. Firstly they volunteered (47.5). Secondly appointments were made within restricted period of time and thus those available might not have been typical off all those in the original sample.

Strengths:

1. The study included a comprehensive review of the literature as it affected Scotland and the UK. It also confirmed the worrying lack of emprical literature.

2. In this study a mixed method approach was used (a substantial questionnaire and interview) providing rich data.

3. The response rate (overall 64.4%) was good for a study conducted by a research student without any support from governmental institutions.

4. This study was conducted in a rigorous manner with attention paid to validity and reliability.

6.3.7 Summary

Inevitably changes, especially the introduction of trust status and the split between purchasers and provider units, had an important impact on the role of nurse manager/nurses in management. In this chapter the key messages of the study have been discussed. Also strengths and weaknesses of this study have been identified.

CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

Conclusions and Recommendations

The findings of this study suggest that in order to meet the demands of the competitive NHS, nurses in management should broaden their horizon, be positive and take proper management training (preferably a degree in management i.e. MBA) that would meet their individual needs. It is widely suggested that nurses have a major contribution to make to the management of the Health Services and they have the potential to be effective managers (Hewison 1994). However in this study it was found that there was a lack of management preparation for nurses for their managerial roles. Previous literature (Kelly 1990; Walker 1993; Hewison 1994) also support this finding. However there is a very important distinction to be made between this study which uniquely provides real data and is a baseline compared to most of the earlier studies which were largely based on opinion. Both the benchmark study and prevalent opinion agree that nurses in management should be prepared managerially for their roles, and encouraged to grasp the opportunities that exist.

As stressed throughout this study traditional nursing roles and management structure are disappearing. Nurses are being replaced by new roles which require nurses, from clinician to executive level, to operate with vision and creativity in order to lead services effectively. Nurses in these new leadership roles need to acquire the skills necessary to develop nursing to achieve best practice. Batehup (1992) stated that especially the role of the senior nurse requires a wide range of skills, combining some traditional management skills including planning, organising, co-ordinating, budgeting, with less traditional skills such as problem solving, change management skills. In her paper on leadership Rafferty (1993) concluded that:

> *"Nurse leaders need not only the imagination but the political, practical and intellectual skills to take nursing forward. They must seize the initiative and promote a radical agenda to ensure that the key positions in nursing are filled by people with the calibre that the health service and the profession so urgently needs" (Rafferty 1993, p:27).*

Preparing nurses to lead nursing requires educational programmes that will enable the integration of theory with practice, assist participants to acquire skills to plan strategically and, most importantly, manage change (Antrobus & Whitby 1994). It was suggested that nurses must embrace and develop management aspects of

their role to secure a future, and more importantly, enhance patient care (Hewison 1994). Nurses need structured management development linked with professional and clinical courses (Kelly 1990) to support this process. It can be argued that proper education/training can produce more self confident nurses who are not afraid to take their seat at the top table, enabling them to make a creative contribution to the planning, delivery and evaluation of health care (Robinson *et al* 1989). There is a clear need that first line managers especially should be supported and encouraged by their senior managers, and arguably also by policy makers, to take up roles in general management.

Although Griffiths recommendations represented a particular landmark in the curtailment of nursing autonomy (Bradshaw 1995) and with the introduction of general managers nursing became decreasingly managed by nurses it was accepted that the clinical directorate structure and in general the (1990) NHS Reforms could offer opportunities for nurses. It was suggested that there was a whole new area of business that had appeared in the Health Service with the purchaser/provider split, and nurses should have the confidence to take up/apply for these roles, otherwise many organisations would appoint non-nurse managers. In this study the respondents believed that in fact nurses are in a strong position because they understand patients; they have good organisational ability; they are generally good communicators and they are comfortable working in teams which are multi-disciplinary. Therefore nurse managers could make significant improvements to services for patients by working strategically and they can achieve strategic changes in their organisations by using their power and authority as nurses, and ensuring they have a visible presence as managers with a strategic view. It was believed that 'managers who are also nurses can bring great benefits to the wider organisation' (Wright 1993).

This study's findings support previous research on gender issues. It can be argued that women have always been under-represented in managerial posts within the NHS (Hutt 1986; Disken, Dixon and Halpern 1987; Robinson *et al* 1989; Wyatt *et al* 1994). According to Wright (1993) 'within the health care system women and nursing remain essentially suppressed'. This may continue to be the case unless more women decide to take a management career track. However it might be argued that for women it is a more difficult choice, because of the difficulty in ensuring adequate domestic and social support.

Based on this study's findings it can be suggested that especially first line managers and middle managers need leadership qualities, as their responsibilities and roles increase and widen to other areas with little time and resource to achieve targets. Hunt (1992) emphasised that 'to fit in with expectations and trends in other work situations, potential leaders will need to be well educated, that is graduates, and demonstrate an involvement in continuing education and professional development'. Kitching (1993) believed that 'to survive nursing needs to be innovative, dynamic, quick to respond and take initiative. ...nurse leadership is about creating and communicating a vision, motivating staff and making things happen'. However according to Wright (1993) 'to inspire and motivate staff is no easy task if managers have not been offered training and development or do not get support from their managers, or the wider organisation'.

It has been clearly understood that there are two groups of nurses. That is, senior managers who are successful, independent, self confident and strong and first line managers who are negative, felt undervalued, and weak. These groups of managers could be examined further. It was believed that negative view may be interpreted as an abandonment and betrayal of nursing or an example of management at its worst. However a positive view would demonstrate and release the abilities, talent and creativity of nursing to contribute to the debate on objective setting, contract planning and delivering a quality service at all levels of the health services (Hempstead 1992).

Nurse managers need to understand their organisational history and the environmental and management changes that have shaped their current roles so that they might work to develop in directions that might serve their own needs and those of the patients they care for even more effectively in today's NHS. Rye (1992) suggested that nurse managers should support their staff but not control them, have the capability of ensuring innovation in clinical practice, and should be able to monitor standards of nursing care objectively and manage resources efficiently and effectively if they want to survive in the future. The increasing voice of the public and of consumerism in the NHS can only increase demand in a field where there are likely to be finite resources. It can be suggested that nurses in management need to evaluate critically the effectiveness of the profession, and balance personal development between professional nursing matters and broader health issues otherwise the myth that nurses were unable or unfit for senior management position would persist.

It was accepted that the challenges facing the health care system at the time of this study were perhaps some of the toughest ever experienced in the NHS. Staff empowered to innovate will not only be desirable, but also essential for the survival of the organisation. Nurse managers need to feel that they are in control of what they perceive as professional and managerial issues if they are to be able to implement change with confidence. With globally rising health care costs McClosky *et al* (1994) concluded that no delivery system can afford not to invest in nursing management innovation and the evaluation of such interventions.

It can be suggested that nurses in management have to be part of the corporate strategy, and must have a wider view. They also need to be articulate and confident leaders, giving direction and contributing fully at board level. In this study only 22.8% of all the respondents were a member of the hospital, unit or board management team. Bradshaw (1995) believed that 'the old maxim focused on conformity, caution and the avoidance of mistakes. The new one concerns dynamic leadership, business sense and the achievement of results'.

Based on the findings of this present study it was suggested that individuals should take more responsibility for shaping their own careers and the NHS, as an organisation, should provide support, encouragement and counselling for their staff.

Finally it can be argued that it is a fast moving competitive world and therefore the NHS will continue to change. It will not stop. Therefore the ability to manage change is an essential skill for all managers (Mulholland 1994). However this study's findings might suggest that there is a lack of awareness of the importance of this skill. In order to survive in the future nurse managers and leaders must learn to steer the profession through these changes and keep nurses at the forefront of such change. They should also constantly review working practices and be proactive in implementing changes as and when necessary. It was believed that nursing leaders are ideally positioned to influence changes and to play a major role in facilitating the changes.

More research is required to provide a basis for planning how best to utilise the role of the nurses in management in preparing the next generation of nurse managers. The role of nurses in management is undoubtedly complex and important. Whilst recognising the limitations described in the previous chapter, this

study provides a base from which to develop further studies into the role of nurses in management. Also time constraints limited the analysis of this extensive data base to the use of univariable methods. Some further work using a multivariate approach might add a few further pointers to help design future studies.

APPENDICES

Appendix I

(Appendices Relating to the Method Chapter)

Appendix I.1: First letter to the DNSs regarding the study

17 December 1993

Dear

I am currently working as a research student in the Department of Nursing Studies at Glasgow University. I am being supervised by Professor L Smith and Dr R P Knill-Jones.

We are going to carry out a study regarding the role of Senior Nurse Managers within the NHS in Scotland. The aims of the proposed study are as follows;

a. To investigate the present responsibilities of the nurse managers
b. To identify the management preparation, including management education of nurse managers
c. To describe the formal relationships of the nurse managers with their subordinate and/ or their managers.
d. To find out the effects of the NHS reforms on the work of Senior Nurse Managers

The method which will be used in the study are a postal questionnaire to all subjects and an interview with selected nurse managers who wish to participate in the research project.

This research will be a part of a doctoral thesis and the results of the thesis may be published in a professional journal. A summary of the results will be disseminated to all health boards in Scotland at the end of the study.

We would therefore be grateful if you could supply us with the names, titles, places of work and department or clinical settings if relevant, of the Senior Nurse Managers who are working in your Unit/Hospital.

Thank you very much for your help.

Yours sincerely

Mrs H Ulusoy

Professor L N Smith, BScN, MEd, PhD

Appendix I.2: Research Questionnaire

16 May 1994

Dear

We would be grateful if you would agree to participate in a study concerning the role of the nurses in management within the NHS in Scotland.

You were chosen from a list provided by the Senior Nurse Management. CANOs, Director of Nursing Services, Unit Nurse Managers and other nurses who are working in a management capacity have been asked to participate in this study.

The main aim of this study is to identify your job responsibilities, your management training and experience, and formal relationships at work. We are also interested in finding out your perceptions about NHS reforms and their effects. We are expecting that the study will provide a valuable insight into the changing NHS.

A SAE has been provided for the return of the questionnaire. We would be grateful if you could complete and return it to us by 6 June 1994. If you have any questions regarding this project please do not hesitate to contact H Ulusoy at 041 339 8855 extension 8368.

All information will be treated confidentially and each individual will have their anonymity protected.

If you are willing to be interviewed, at a later date, about issues raised by the questionnaires, please complete the question at the end of the questionnaire.

Thank you very much for your help and time which is greatly appreciated.

Yours sincerely

Professor L N Smith
Head of Department
University of Glasgow
Dept.of Nursing Studies

Dr R P Knill-Jones
Director of Management Education for Clinicians & Senior Lecturer in Epidemiology, University of Glasgow
Dept. of Public Health

Mrs H Ulusoy
Doctoral Student
Uni. of Glasgow
Dept. of Nursing Studies

YOUR ANSWERS TO THESE QUESTIONS ARE CONFIDENTIAL & ANONYMOUS

I. DEMOGRAPHIC DATA & PROFESSIONAL/EDUCATIONAL QUALIFICATIONS

The following questions are about your personal details. Please tick the appropriate box and give details if necessary.

1. Please tick your age category

29 or below	[ ] 1	40 - 49	[ ] 3
30 - 39	[ ] 2	50 or above	[ ] 4

2. Are you;

Female [ ] Male [ ]

3. Are you;

Single	[ ] 1	Widowed	[ ] 3
Married	[ ] 2	Separated or divorced	[ ] 4

4. What is your clinical or managerial grade ?

Grade I	[ ] 1	Managerial (please specify)	[ ] 3
Grade H	[ ] 2	Other (please specify).....	[ ] 4

5.What is the title of your present position (including, name of directorate or clinical speciality).

6. How long have you worked in your present position?

1 year or less	[ ] 1	4 - 6 years	[ ] 3
1 - 3 years	[ ] 2	7 years and over	[ ] 4

7. What is the title of your previous post?

8. What is the number of beds of the hospital where you have been working?

50 - 249	[ ] 1	650 and over	[ ] 4
250 - 449	[ ] 2	Community	[ ] 5
450 - 649	[ ] 3		

9. Would you please indicate your professional qualification(s)?

RGN	[ ] 1	RMHN	[ ] 5
RM	[ ] 2	HV	[ ] 6
RSCN	[ ] 3	DN	[ ] 7
RMN	[ ] 4	Other (please specify)	[ ] 8

10. Please tick whether you have a degree.

Yes [ ] No [ ]

If YES please specify your degree(s)

II. MANAGEMENT PREPARATION

11. Please tick whether you have had any management training/ education?

Yes [ ] (If YES please go on to Q 12)
No [ ] (If NO please go on to Q 15)

12. Please indicate the qualification(s) and year(s) of study of any management training / education.

13. Please indicate in what extent your management training/education made a contribution to your job?

A lot	[ ] 1	Not much	[ ] 3
Some	[ ] 2	None at all	[ ] 4 (please go on to Q 15)

14. In what way has your management training/education helped you in your job?

15. In your opinion, what level of management education is needed to be able to perform your work satisfactorily? Please tick as many as necessary.

Degree in Nursing	[ ] 1	On the job training	[ ] 3
Degree in management	[ ] 2	Other (please specify)	[ ] 4

16. Is previous experience in management required for a person to be able to perform your job?

Yes [ ] No [ ]

If YES, please specify what sort of experience is required?

17. Did you receive a formal orientation to prepare you for your present position?

Yes [ ] (If **YES** please go on to Q 18)
No [ ] (If **NO** please go on to Q 19)

18. In the light of your experience, please tick whether your orientation was:

Good	Adequate	Unsatisfactory
[ ] 1	[ ] 2	[ ] 3

III. JOB RESPONSIBILITIES

19. How do you describe the main purpose(s) or objective(s) of your job?

20. Would you please list up to 5 items which you consider are your main responsibilities. Please be as specific as possible.

1.

2.

3.

4.

5.

21. What task(s), if any, do you do at present which you think should be performed by someone else.

22. Would you please indicate to what extent you are clear on the nature of your job / role?

Very Clear	[ ] 1	Not Very Clear	[ ] 3
Fairly Clear	[ ] 2	Other (Please specify)	[ ] 4

If your answer is 3 or 4 would you please explain your answer.

23. Do you have enough freedom to use your own judgement about your work?

A Lot	[ ] 1	Not Much	[ ] 3
Some	[ ] 2	None At All	[ ] 4

If your answer is 3 or 4 would you please explain your answer.

24. Are you responsible for a nursing budget?

Yes [ ] No [ ]

If **YES**, would you please indicate how much control do you have over own budget?

Completely	[ ] 1	Fairly	[ ] 3
Very much	[ ] 2	A little	[ ] 4

25. In your opinion, what kind of skills, knowledge and qualities should *"Nurses in Management "* have to be able to perform their job satisfactorily. Would you please list them?

SKILLS:

KNOWLEDGE:

QUALITIES:

26. Do you think that "*Nurses in Management* " currently have these skills, knowledge and qualities which you listed on the previous question?

Almost all	[ ] 1	Some	[ ] 3
Many	[ ] 2	A Few	[ ] 4

27. The following questions are about your potential job function. Please tick, how frequently you carry out, actually, each of the following. In the ideal situation would you do this activity more often or less often.

	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
1.Formulating policies & procedures about nursing services.											
2. Establishing, implementing & evaluating nursing appraisal systems.											
3. Monitoring departmental productivity & effectiveness.											
4. Monitoring & developing hospital/unit objectives with non-nursing managers.											
5. Monitoring & reviewing objectives with nurse managers regularly.											
6. Determining & maintaining appropriate staffing levels in the area you are responsible for.											
7. Obtaining, deploying and developing resources.											

continued on the next page

	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
8. Providing leadership, motivation and support to staff working in the nursing services.											
9. Initiating changes & promoting innovations in nursing services.											
10. Representing nursing on all official matters.											
11. Participating in negotiations on behalf of the organisation.											
12. Establishing & maintaining proper nursing audit systems.											
13. Determining the long and short- term objectives for nursing services.											
14. Identifying the educational/ training needs of nursing staff.											
15. Establishing a system for communication within the area you are responsible for.											

continued on the next page

	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
16. Participating & presenting up-to-date educational programs.											
17. Initiating, facilitating & participating in nursing research.											
18. Developing & evaluating management information systems for the nursing services.											
19. Orienting & assisting the development of nursing staff/managers.											
20. Providing & controlling the ward based nursing services.											
21. Establishing relationships with non-nursing management.											
22. Teaching & informing of nursing staff relevant legislation & NHS regulations.											
23. Co-ordinating different disciplines.											

PLEASE ADD ANY FURTHER RESPONSIBILITIES THAT ARE NOT ADDRESSED IN ABOVE STATEMENTS

IV. ROLE-JOB CHANGES & THE NHS REFORMS

28. In your opinion, do you have to be a nurse to be able to carry out your job?
Yes [ ] No [ ]

Would you please explain your above answer.

29. Has your role changed within the last 3 years?
Yes [ ] No [ ] (If NO, please go on to Q 31)

If YES, please indicate the degree to which your job has changed.

little changed	moderately changed	highly changed
[ ] 1	[ ] 2	[ ] 3

30. Would you please describe how your role has changed in relation to:

a. Your professional responsibilities

b. Your formal relationship with colleagues

c. Your everyday work climate

31 As a result of the Clinical Directorates many Senior Nurse Managers have become business, service or locality managers. What do you think about this role change?

32. Below are a number of statements. Please indicate to what extent you agree/ disagree.

	Strongly Agree 1	Agree 2	Uncertain 3	Disagree 4	Strongly Disagree 5
1. The NHS reforms have strengthened my professional role within the organisation.					
2. In recent years nurses have become involved in a higher level of decision making for the organisation as a whole.					
3. In terms of relationships, nursing structure has been changing from hierarchical (bureaucratic) to facilitative (more flexible).					
4. The NHS reforms are generally a threat, not an opportunity for nurses.					
5. The NHS reforms mean "a loss of power and status" for nurses.					
6. Expectations of the nurse manager's role have increased in recent years.					
7. My leadership and advisory role to nurses and others has become more important.					
8. My responsibilities regarding quality assurance issues has increased.					
9. The directorate structure has the potential to provide a supportive environment to promote highly successful nursing practice.					
10. I have an equal status with the medical staff in terms of management activities in the organisation where I work.					
11. I am now more aware of political developments than before.					
12. My strategic roles have been increasing within the organisation.					
13. Higher degree education (eg. MN, MSc) in nursing management or in administration is necessary preparation of nurse managers.					
14. I have enough organisational resources to do my job satisfactorily.					
15. Nurse Directors should have business management skills and knowledge.					

V. PRESENT AND FUTURE ROLES

33. Do you feel yourself to be a successful nurse manager since the beginning of the reforms?

Very successful	[ ] 1	Moderately successful	[ ] 3
Fairly successful	[ ] 2	Not very successful	[ ] 4

Would you please explain your above response?

34. How do you see the role of the *"Nurses in Management"* at present?

35. Please identify, if any, the main constraints that limit you from doing your job as effectively as you would like?

36. How would you like to change /develop your career in the future?

37. How do you see the role of the "*Nurses in Management* " in the future?

VI. RELATIONSHIPS

38. Would you please state the job title of the person you report to?

39. Please tick how much contact you have with your manager?

too much [ ] 1 enough [ ] 2 not enough [ ] 3

40. Please tick how much contact you have with your subordinates?

too much [ ] 1 enough [ ] 2 not enough [ ] 3

41. How do you perceive your relationship with your manager?

Peer group	[ ] 1	Role mentor	[ ] 4
Professional colleague	[ ] 2	Hierarchical	[ ] 5
Supportive	[ ] 3	Other (please specify)	[ ] 6

42. How do you perceive your relationship with your subordinates?

Peer group	[ ] 1	Role mentor	[ ] 4
Professional colleague	[ ] 2	Hierarchical	[ ] 5
Supportive	[ ] 3	Other (please specify)	[ ] 6

43. Do you see yourself as

a nurse	[ ] 1	both	[ ] 3
a manager	[ ] 2	other (please specify)	[ ] 4

44. How do you think you are perceived by others within the organisation where you work?

a nurse	[ ] 1	both	[ ] 3
a manager	[ ] 2	other(please specify)	[ ] 4

45. Please tick whether you are a Board Member of Hospital management team?

Yes [ ] No [ ]

46.What staff group(s) are you responsible? (Including other professional groups).

47. Please add any further comment which you feel may be helpful in helping us to understand the role of the *"Nurses in Management"* (Please use the back page if necessary).

Please indicate whether you are willing to participate in a face to face interview later.

Yes [ ] No [ ]

If Yes, would you please give your address and telephone number.

THANK YOU VERY MUCH FOR YOUR HELP AND TIME.

Appendix I.3: Response Rate (for questionnaire survey)

Questionnaires mailed out	284
Questionnaires returned	183
Non-participants (those who returned the questionnaire back to the researcher and said that they had no time for completing the questionnaire)	17
Late responses (questionnaires received well after the cut-off date for response)	2
Completed by people who did not meet the inclusion criteria	6
Questionnaires available for analysis	158
Overall response rate	**64.4%**
Usable response rate (183-25=158)	**55.6 %**

Appendix I.4: Invitation letter to the interview

27 January 1995

Dear

THE ROLE OF NURSES IN MANAGEMENT WITHIN THE NHS IN SCOTLAND

As you may remember you completed a questionnaire some 6-7 months ago on 'Nurses in Management'. In the questionnaire you indicated that you were willing to be interviewed. Thank you for agreeing to be interviewed. Having examined the questionnaire responses we are now ready to go ahead with the interviews.

It is expected that interview will take approximately 30-40 minutes and will be tape recorded.

The content and responses at the interview will be treated in strict confidence and used only by the researchers as part of the data collection for the study. All tapes will be destroyed after the research is completed in accordance with the Data Protection Act (1984).

In general the discussion will be about issues that have arisen from the responses to the questionnaires.

I would be grateful if you would still agree to see me and if so would you please complete the attached form and return it to me with the enclosed SAE by **12 February 1995.**

Once again thank you very much for your help and interest in this study, and agreeing to be interviewed.

Yours sincerely

Hatice Ulusoy (Mrs)

Name: _____

Job Title: _____

Address: _____

_____

_____

_____

Tel Number:_____

(If possible, please indicate the best time to telephone)

Interviews will be held at <u>your place of work</u> unless you state otherwise.

Is it possible for you to arrange a place to be interviewed which will ensure privacy? (Please tick)

YES [ ] NO [ ]

Could you please list <u>several dates</u> indicating which is the most convenient for you to be interviewed between 22 February and 31 March 1995 inclusive.

Once I have received your proposed interview dates, I will telephone to confirm the date, time and place of interview. All interviews will be confirmed in writing.

February 1995

	AM	PM
Thursday 16		
Friday 17		
Monday 20		
Tuesday 21		
Wednesday 22		
Thursday 23		
Friday 24		
Monday 27		
Tuesday 28		

March 1995

	AM	PM
Wednesday 1		
Thursday 2		
Friday 3		
Monday 6		
Tuesday 7		
Wednesday 8		
Thursday 9		
Friday 10		
Monday 13		
Tuesday 14		
Wednesday 15		
Thursday 16		
Friday 17		
Monday 20		
Tuesday 21		
Wednesday 22		
Thursday 23		
Friday 24		
Monday 27		
Tuesday 28		
Wednesday 29		
Thursday 30		
Friday 31		

THANK YOU VERY MUCH

Appendix I.5 Confirmation letter for the interview

16 February 1995

Dear

THE ROLE OF NURSES IN MANAGEMENT WITHIN THE NHS IN SCOTLAND

Thank you very much for agreeing to be interviewed regarding the above study.

As we have arranged on the telephone with you/your secretary the interview will be held at your place of work on

.....

I would be grateful if you could arrange a room suitable for the interview (Quiet and without interruptions).

It is expected that interview will take approximately 45 minutes and will be tape recorded. The content and responses at the interview will be treated in strict confidence. All tapes will be destroyed after the research is completed in accordance with the Data Protection Act (1984). In general the discussion will be about issues that have arisen from the responses to the questionnaires.

Once again thank you very much for your help and interest in this study, and agreeing to be interviewed.

I look forward to meet you on the date given above.

Yours sincerely

Hatice Ulusoy (Mrs)
Research Student
Dept. of Nursing Studies

Appendix I.6 Interview Schedule

First of all I would like to thank you for agreeing to be interviewed and your previous help with the questionnaire. I am doing this interview as a follow up to the questionnaire you filled in some time ago, so that I can obtain more detailed information.

I will be tape recording the interview since I can't take shorthand. However the tape is for my use only and will be destroyed after I have used it.

This interview will take approximately 45 minutes and will be strictly confidential However the results of the study might be published in a journal but your name will never be disclosed.

The title of the study is THE ROLE OF NURSES IN MANAGEMENT WITHIN THE NHS IN SCOTLAND. The word "nurses in management" refers to the all nurses who have a management role in the organisation where they work.. Now, I would like to show you this paper to explain what I mean by Nurses in Management (Show the current job titles which used by the respondents)

I TITLE OF THE RESPONDENTS

We found that there were a number of different titles to identify this group of nurses in management (for example nursing services manager, business manager, locality manager, service manager, contract manager, DNS, Executive Director of Nursing)

1) Why do you think there are so many different job titles to identify this group of nurses in management

2) Do you think that the job content and responsibilities vary according to job title?

II THE ROLE OF NURSES IN MANAGEMENT

Now I would like to ask your opinion about the role of nurses in management. We could say that mainly there are 3 or 4 level of nurse managers.

First line managers (Sisters and Charge nurses)
Middle managers
Senior managers and top managers

3) We know that first line managers are taking on more managerial responsibilities. How about Middle and Senior Nurse Managers. What is the role of this group of nurses within the NHS ?

4) According to our survey findings many nurses in management perceive their role negatively, (with twice as many expressing negative views as opposed to positive views). In general they feel undervalued, under stress uncertain etc. What do you think about that. Why they feel in that way?

5) Again in the questionnaire many people argued that unless nurses in management increase their managerial skills their role will be taken over by other professionals. Do you agree with this opinion? (Would you please explain it)

III NHS CHANGES

Now I would like to ask you a few questions about the NHS changes.

6) What is going on within the NHS in terms of nursing management and / or nurses in management? (What is happening)

7 What are the effects of the recent NHS changes on your work?

8) What do you think about the introduction of the Clinical Directorate structure? (In the Questionnaire it has been understood that participants have ambivalent feelings about the introduction of the Clinical Directorate (or equivalent) structures, do you think that this is because nurses usually become managerially responsible to the clinical director).

9) Some nurses believe that nurses in management are becoming more removed from the clinical environment.

a. Do you agree with this statement,
b. Do you think that maintaining some clinical expertise is an important issue and why?

IV PREPARATION FOR THE JOB

10) In the Questionnaire the majority of people said that they had attended first and/or middle line management courses. Do you think that this level of management training is sufficient for the job? (Considering the whole of this group of nurses, show the acetate)

11) In your opinion, what kind of management preparation should nurses in management receive?

12) Did you know what you were going to be doing? (before starting your job)
(Only 31% were happy with the orientation that they received)

13) In summary do you feel that you were well prepared for your present job in terms of

a: management training / that you received (if the interviewee had any)
b: clinical and/or managerial experience

V STRENGTH & WEAKNESSES

14) Now I would like to ask your opinion regarding the strength and weaknesses of nurses in management. Would you please tell me, what are the strengths and weaknesses of this group of nurses in management?

VI RECENT CHANGES

As you know approximately 7-8 months has gone since you filled the questionnaire. Now I would like to talk about possible changes which may have happened during that period.

15) What important changes have happened in last 7-8 months?
    a) in terms of your role and job responsibilities
    b) in terms of your organisation

Are there any important aspects of your work that you feel have not been mentioned in this interview? (Is there anything else that you want to tell me?)

THANK YOU VERY MUCH FOR YOUR HELP AND TIME

Appendix II

(Appendices Relating to the Findings Chapter)

Appendix II.1 Current job titles of all the respondents (N=158)

JOB TITLES	n
First Line Managers (n=45)	
Clinical Nurse Manager	15
Clinical Co-ordinator	3
Senior Nurse	6
Acting SNM/Acting Nursing Services Manager	3
Clinical Manager	2
Night Duty Co-ordinator	5
Senior Practitioner Nursing	8
Nursing Practice Development Officer	1
Clinical Section Manager	2
Middle Managers (n=84)	
Nursing Services Manager	15
Clinical Services Manager	11
Nurse Manager	11
Senior Nurse Manager	10
Service Manager	7
Locality Manager/Locality Nurse Manager	5
Business Manager	4
Operational Manager	4
Directorate Nurse Manager/ Directorate Manager	4
Deputy Director of Nursing and Patient Services	1
Care Group Manager	3
Quality Assurance Manager	1
Assistant Director of Nursing	1
Contracts Manager/Contracts & Marketing Manager	3
Service / Business Manager / Site Manager	1
Divisional Nurse Manager	1
Principal Nurse	1
Quality Co-ordinator / Senior Nurse	1
Senior Managers (n=29)	
Director of Quality / Chief Area Nursing Officer	2
Director of Contracts and Standards / Chief Area Nursing Officer	2
Director of Nursing & Human Resources	1
Chief Nursing Adviser & Director of Quality	2
Unit Nurse / Director of Quality Assurance	1
Director of Professional Services & Quality	1
Director of Planning & Quality	2
Nurse Director	1
Director of Strategic Planning /Nursing & Quality	1
Director of Nursing & Quality Assurance	8
Director of Nursing	2
Director of Nursing Quality & Community Services	1
Divisional General Manager	1
Executive Director of Nursing & Quality Assurance	1
Director of Nursing Services	1
Hospital Manager	1
Matron	1
Total	**158**

Appendix II.2: Marital status by sex and current position (N=158)

	SEX											
	Female (n=107)						Male (n=51)					
	CURRENT POSITION						CURRENT POSITION					
	FLMs (n=31)		MMs (n=59)		SMs (n=17)		FLMs (n=14)		MMs (n=25)		SMs (n=12)	
Marital Status	n	%	n	%	n	%	n	%	n	%	n	%
Single	9	29.0	17	28.8	10	58.8	1	7.1	1	4.0	0	0
Married	18	58.0	31	52.5	6	35.3	11	78.6	22	88.0	11	91.7
Widowed	2	6.5	2	3.4	0	0	0	0	1	4.0	0	0
Separated/Divorced	2	6.5	9	15.3	1	5.9	2	14.3	1	4.0	1	8.3

Appendix II.3: Previous job titles by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total (N=158)	
PREVIOUS JOB TITLES	n	%	n	%	n	%	n	%
Clinical Nurse Manager / Clinical Services Manager	9	20.0	24	28.6	1	3.4	34	21.5
Senior Nurse Manager / Nurse Manager	5	11.1	22	26.2	5	17.2	32	20.3
Nursing Officer	10	22.2	12	14.3	3	3.4	25	15.8
Director of Nursing Services / Chief Area Nursing Officer	1	2.2	7	8.3	17	58.6	25	15.8
Sister / Charge Nurse	14	31.1	7	8.3	0	0	21	13.3
Health Visitor / District Nurse / Midwife	4	8.9	4	4.8	0	0	8	5.1
Others e.g. Community Adviser, Principal Officer, Hospital Manager	2	4.4	8	9.5	3	10.3	13	8.2

Appendix II.4: Distribution of professional qualifications of all the respondents by sex (N=158)*

	SEX					
	Female (n=107)		Male (n=51)		Total (N=158)	
QUALIFICATIONS	n	%	n	%	n	%
RGN (Registered General Nurse)	103	96.3	39	76.5	142	89.9
RM (Registered Midwife)	40	37.4	2	3.9	42	26.6
RSCN (Registered Sick Children's Nurse)	5	4.7	0	0	5	3.2
RNMH (Registered Nurse in Mental Handicap)	2	1.9	6	11.8	8	5.1
RMN (Registered Mental Nurse)	15	14.0	35	68.6	50	31.6
HV (Health Visitor)	21	19.6	0	0	21	13.3
DN (District Nurse)	18	16.8	3	5.9	21	13.3
Various Certificates & Diplomas e.g. Orthopaedic Nursing Certificate; Certificate of Intensive Care Nursing; Diploma in Professional Studies; Diploma Nursing Tropical Diseases	19	17.8	7	13.7	26	16.5
Teaching Qualifications e.g. CNT (Clinical Nurse Tutor); FWT (Field Work Teacher) RNT (Registered Nurse Tutor)	6	5.6	1	2.0	7	4.4
Other e.g.RFN (Registered Fever Nurse); CPN (Community Psychiatric Nurse); ENB (English National Board speciality qualifications)	12	11.2	2	3.9	14	8.9

*Totals do not add to 100.0% as some respondents had more than one qualification

Appendix II.5: Contribution of management training to respondent's job by type of management training and current position*

	Various Certificates			Various Degrees			Various Diploma			First & Middle Courses & Other Short Courses		
	CURRENT POSITION			CURRENT POSITION			CURRENT POSITION			CURRENT POSITION		
	FLMs (n=7)	MMs (n=22)	SMs (n=11)	FLMs (n=2)	MMs (n=7)	SMs (n=7)	FLMs (n=3)	MMs (n=13)	SMs (n=5)	FLMs (n=27)	MMs (n=32)	SMs (n=16)
A lot	3	13	7	0	5	7	3	9	3	9	16	10
%	42.9	59.1	63.6	0	71.4	100.0	100.0	69.2	60.0	33.3	50.0	62.5
Some	4	8	4	1	2	0	0	4	2	15	11	6
%	57.1	36.4	36.4	50.0	28.6	0	0	30.8	40.0	55.6	34.4	37.5
Not Much	0	1	0	1	0	0	0	0	0	2	5	0
%	0	4.5	0	50	0	0	0	0	0	7.4	15.6	0
None	0	0	0	0	0	0	0	0	0	1	0	0
%	0	0	0	0	0	0	0	0	0	3.7	0	0

*Some respondents had more than one qualification

Appendix II.6: Kind of skills 'nurses in management' have to be able to perform their job satisfactorily? (N=153)*.

	n	%
Communication	80	52.3
Interpersonal Skills e.g. People skills; approachability; tact; diplomacy; conflict handling; empathy; persuasion; manipulation; optimism; integration; listening; literacy; good speaker	60	39.2
Leadership Motivator; team building; advocacy; adaptability	52	34.0
Human resource management People Management; interview; teaching; management training skills	48	31.4
Clinical-Practical-Nursing Skills / Counselling Skills	43	28.1
Negotiating	39	25.5
Planning	36	23.5
Problem solving Analytical skills; objective setting; creative/forward/strategic thinking; political awareness; ability to apply theory to practice	28	18.3
Personal Attributes / characteristics Stress management, innovative; credibility; tenacity; self awareness; updating skills; common sense; reliability; conscientiousness; commitment; perseverance; good judgement; visionary; assertiveness; fairness; literacy; articulate; enthusiasm; sensitivity; focus	28	18.3
Budget / financial skills	25	16.3
Organisational skills	22	14.4
Change management	17	11.1
Decision making	16	10.5
Miscellaneous Numeracy / IT/ mathematics / computer	12	7.8

*Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.7: Kind of knowledge 'nurses in management' have to be able to perform their job satisfactorily? (N=153)*.

	n	%
Clinical knowledge / knowledge of the area working in	56	36.6
Human resource management	45	29.4
Professional / nursing knowledge; nursing background	44	28.8
Finance or budget knowledge	41	26.8
Knowledge of the NHS/ Health Services Knowledge	37	24.2
Managerial knowledge; management theories; management techniques; principles of management; management tools and strategies	36	23.5
Business and business strategies knowledge; planning, contracting, marketing knowledge	21	13.7
Management training, education	16	10.5
Experience	13	8.5
Political awareness knowledge	13	8.5
Quality assurance / audit	12	7.8
IT & research knowledge	12	7.8
Change management	11	7.2
Organisational knowledge; understanding organisation	10	6.5
Miscellaneous e.g. Legal issues; psychology; problem solving; knowledge of different disciplines; a vision of the future; knowledge of sociology	14	9.2

*Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.8: Kind of qualities 'nurses in management' have to be able to perform their job satisfactorily? (N=153)*.

	n	%
Leadership	52	34.9
Motivation, commitment, enthusiasm, clear thinking, vision	52	34.9
Good listener, understanding, empathy, sensitivity	47	31.5
Communication, articulate, tact, diplomacy, negotiator	45	30.2
Fairness, integrity, reliability, honesty	40	26.8
Good personality, sense of humour, calm temperament	35	23.5
Adaptable to change, flexibility, open minded	34	22.8
Decisiveness, confidence, assertiveness	34	22.8
Approachable	25	16.8
Professionalism	24	16.1
Human resource management	18	12.1
Sound judgement, common sense	18	12.1
Patience	15	10.1
Physical fitness, stamina, energy	12	8.1
Miscellaneous Being consistent, people person	8	5.4

*Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.9: Potential job functions

The following questions are about your potential job function. Please tick, how frequently you carry out, actually, each of the following. In the ideal situation would you do this activity more often or less often.

	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
1.Formulating policies & procedures about nursing services.	5	18	64	32	16	12	147	54	19	38	111
%	3.4	12.2	43.5	21.8	10.9	8.2	100.0	48.6	17.1	34.2	100.0
2. Establishing, implementing & evaluating nursing appraisal systems.	5	8	14	26	67	27	147	57	16	36	109
%	3.4	5.4	9.5	17.7	45.6	18.4	100.0	52.3	14.7	33.0	100.0
3. Monitoring departmental productivity & effectiveness.	27	25	68	11	9	8	148	39	11	42	92
%	18.2	16.9	45.9	7.4	6.1	5.4	100.0	42.4	12.0	45.7	100.0
4. Monitoring & developing hospital/unit objectives with non-nursing managers.	4	20	38	21	24	39	146	54	11	38	103
%	2.7	13.7	26.0	14.4	16.4	26.7	100.0	52.4	10.7	36.9	100.0

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	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
5. Monitoring & reviewing objectives with nurse managers regularly.	5	16	49	21	35	15	141	57	5	43	105
%	3.5	11.3	34.8	14.9	24.8	10.6	100.0	54.3	4.8	41.0	100.0
6. Determining & maintaining appropriate staffing levels in the area you are responsible for.	64	24	35	7	12	7	149	9	34	47	90
%	43.0	16.1	23.5	4.7	8.1	4.7	100.0	10.0	37.8	52.2	100.0
7. Obtaining, deploying and developing resources.	47	35	34	8	15	5	144	16	26	39	81
%	32.6	24.3	23.6	5.6	10.4	3.5	100.0	19.8	32.1	48.1	100.0
8. Providing leadership, motivation and support to staff working in the nursing services.	126	11	12	2	0	2	153	17	7	50	74
%	82.4	7.2	7.8	1.3	0	1.3	100.0	23.0	9.5	67.6	100.0
9. Initiating changes & promoting innovations in nursing services.	37	34	45	18	4	4	142	33	7	37	77
%	26.1	23.9	31.7	12.7	2.8	2.8	100.0	42.9	9.1	48.1	100.0

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	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
10. Representing nursing on all official matters.	56	35	24	9	5	18	147	27	11	40	78
	38.1	23.8	16.3	6.1	3.4	12.2	100.0	34.6	14.1	51.3	100.0
11. Participating in negotiations on behalf of the organisation.	19	16	43	19	12	32	141	37	8	42	87
%	13.5	11.3	30.5	13.5	8.5	22.7	100.0	42.5	9.2	48.3	100.0
12. Establishing & maintaining proper nursing audit systems.	8	17	48	41	15	15	144	44	12	37	93
	5.6	11.8	33.3	28.5	10.4	10.4	100.0	47.3	12.9	39.8	100.0
13. Determining the long and short- term objectives for nursing services.	8	6	40	35	45	16	150	50	4	35	89
%	5.3	4.0	26.7	23.3	30.0	10.7	100.0	56.2	4.5	39.3	100.0
14. Identifying the educational/ training needs of nursing staff.	7	23	51	22	41	5	149	45	8	36	89
	4.7	15.4	34.2	14.8	27.5	3.4	100.0	50.6	9.0	40.4	100.0

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	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
15. Establishing a system for communication within the area you are responsible for.	30	39	43	13	9	4	138	24	4	43	71
%	21.7	28.3	31.2	9.4	6.5	2.9	100.0	33.8	5.6	60.6	100.0
16. Participating & presenting up-to-date educational programs.	1	9	46	41	19	23	139	57	3	27	87
%	0.7	6.5	33.1	29.5	13.7	16.5	100.0	65.5	3.4	31.0	100.0
17. Initiating, facilitating & participating in nursing research.	2	7	13	19	48	41	130	68	1	23	92
%	1.5	5.4	10.0	14.6	36.9	31.5	100.0	73.9	1.1	25.0	100.0
18. Developing & evaluating management information systems for the nursing services.	3	19	30	21	27	38	138	46	5	34	85
%	2.2	13.8	21.7	15.2	19.6	27.5	100.0	54.1	5.9	40.0	100.0
19. Orienting & assisting the development of nursing staff/managers.	9	16	25	19	18	38	125	32	3	47	82
%	7.2	12.8	20.0	151.2	14.4	30.4	100.0	39.0	3.7	57.3	100.0

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	ACTUALLY							IDEALLY			
	Daily	Weekly	Monthly	Quarterly	Yearly	Never	Total	More Often	Less Often	Not Applicable	Total
20. Providing & controlling the ward based nursing services.	48	16	14	3	4	37	122	6	9	59	74
%	39.3	13.1	11.5	2.5	3.3	30.3	100.0	8.1	12.2	79.7	100.0
21. Establishing relationships with non-nursing management.	87	29	24	3	1	1	145	22	5	40	67
%	60.0	20.0	16.6	2.1	0.7	0.7	100.0	32.8	7.5	59.7	100.0
22. Teaching & informing of nursing staff relevant legislation & NHS regulations.	17	30	56	22	1	15	141	26	10	36	72
%	12.1	21.3	39.7	15.6	0.7	10.6	100.0	36.1	13.9	50.0	100.0
23. Co-ordinating different disciplines.	45	19	30	12	0	31	137	22	9	42	73
%	32.8	13.9	21.9	8.8	0	22.6	100.0	30.1	12.3	57.5	100.0

Appendix II.10: Job changes in relation to the 'professional responsibilities' (N=152)

	n	%
Wider - Increased Responsibilities Wider roles in multidisciplinary work (responsible for other disciplines); responsible for a much wider area/ staff/ wider nursing group	61	40.1
Less or no longer responsible for nursing and/or nurses, no longer in line management Less involvement with operational issues; no longer responsible of a unit/no involvement in clinical decisions; less professional responsibility	27	17.8
Corporate responsibilities: More involvement in decision making; quality; audit; standard setting; contracts; finance & business	27	17.8
No real change / less change / unchanged mostly	19	12.5
Role become more advisory	11	7.2
Totally different post within last 3 years	11	7.2
Responsibilities are being devolved to others	7	4.6
More accountability but less autonomy/ authority Accountable for everything and everyone but do not have real authority to deal with important issues i.e. budget, sickness, discipline	5	3.3
Now responsible for or report to a non-nurse	4	2.6
Miscellaneous e.g. more difficult to uphold these responsibilities as the influence of business managers are more apparent; require to keep myself up to date on UKCC changes regarding PREP + P2000 training; much more innovative	17	11.2
No answer	3	2.0

* Totals do not equate to100.0% as some respondents gave more than one answer

Appendix II.11: Job changes in relation to 'formal relationships' with colleagues (N=152)

	n	%
No Change	31	20.4
Good relationships	29	19.1
More relationships with other disciplines work and corporate responsibilities More involved with discussion with other disciplines; now corporately responsible for all Trust activities in conjunction with other Board members; more involved and integrated with Trust Board management, clinical directors and heads of departments, and much less with nursing colleagues.	24	15.8
Negative Change Relationships have become more isolated; less team work; lack of communication; more distanced; more remote	19	12.5
Relationships have become more formal A more formal business like relationships with colleagues	11	7.2
Changes due to clinical directorate structure e.g. Clinical Directorates not a good concept. Doctors managing nurses does not work. Reorganisation has made relations with colleagues more remote and the division to directorates has caused isolation	10	6.6
Less line management relationships with nurses, less relationship with nurses	9	5.9
Advisory roles- relationship	6	3.9
Conflicting roles/ confused roles & expectations I feel there is still some confusion with other departments, who is responsible for what.	4	2.6
New post	3	2.0
Miscellaneous e.g. Expected to have all the answers; becoming more distant from patient and grass root level; my colleagues and I are all in the process of change so it is difficult to make a judgement; I am now responsible for managing staff that I previously reported to;. much more competitive; I have had to become aware of maintaining objectivity when dealing with colleagues.	11	7.2
No Answer	11	7.2

* Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.12: Job changes in relation to the 'everyday work climate' (N=152)

	n	%
Increased work volume and not enough time e.g. busy busier environment; longer working hours; not enough time to achieve targets, deadlines; more meetings / office work / paperwork	48	31.6
Negative Statements e.g. more pressure; more stress; less job satisfaction; uncertainties; low moral; frustration; no clear guidelines what is expected; lack of support; Feelings of distrust by staff towards management	41	27.0
Wider / increased responsibilities More general management roles; responsible for other disciplines not only nursing; now responsible for quality issues / budget-business plans / resources	29	19.1
No longer have direct line management responsibilities e.g. less clinically involved; less contact with staff	21	13.8
Changing / change management	19	12.5
Positive statements e.g. more hectic; frenetic-frantic; exciting; challenging stimulating; gratifying; satisfactory; enjoy doing the job	12	7.9
No change / less change / unchanged mostly	10	6.6
Finance/ business / money oriented	10	6.6
Doctors in management, reporting to a doctor	3	2.0
Miscellaneous More questioning attitude of other clinical nurse managers over decisions which are made; much more formal work climate where everything is put in writing; far too bureaucratic; proliferation of all departments unnecessary. nurse management very poorly represented at senior level; little change day to day in relation to staff under nursing's jurisdiction but less autonomy and more people at the top to be consulted before plans can be implemented or decisions made	11	7.2
No answer	9	6.0

* Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.13: Views of the respondents on the issue of SNMs becoming business, service or locality managers in a clinical directorate structure (N=154)*

	n	%
Positive View e.g. Can only lead to an improvement in the service; with control of budget and business matters the nurse manager is able to prioritise use of funds and facilities; a chance for nurses to work in a multidisciplinary team sharing a complete picture of patient services and not just a ward picture; the development of the changes is positive and an opportunity for nurses to demonstrate their ability to manage / operate at a variety of levels	41	26.6
It is OK but they need training/ preparation for the role e.g. Nurses are in a unique position to undertake this role because of previous experience and acquired skill. However nurses entering into this arena need additional preparation in areas such as finance , business planning, statistical analysis	30	19.5
Negative view e.g. No evidence that I can see to highlight a more efficient and improved service under a clinical director; It unfortunately is a situation which is forced in rather than chosen by nurses; Once again nurses are seen in a sub servant role to doctors; this is a mechanism to weaken nursing's voice	19	12.3
Suggestions e.g. If we do not take up these roles administrators with no nursing background will be in these roles and nurses will have no career moves beyond 'H' grade in the future; ability to transfer skills should be encouraged; We have to act as change agents therefore need to be flexible;. this role change can work with training and support.	13	8.4
Nurses are in a good position to take these roles/they have the skills & abilities for these posts e.g. Nurses are well equipped to assume these roles; nurses are extremely capable managers with a range of skills	13	8.4

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	n	%
Nurses are not equipped for these roles e.g. It is essential that nurses put themselves forward for these roles but many are ill prepared for the increased responsibility; many SNMs are not equipped for the changes in their role given that they are nurse trained and not management trained; some have no management training and therefore do not carry out the job properly; negotiating service contracts is not a nursing task.	10	6.5
Natural progression due to NHS changes	9	5.8
Depends on - up to the individual	7	4.5
Distant from patient care/clinical work	11	7.1
Miscellaneous It is difficult to argue about money when you are looking at it from both sides of the coin but the plus side is more multidisciplinary communication It is very much expected that you change with the role, and that the negotiations which proceed the change are enough to enable you to adopt to this change, or adopt the change		

*Totals do not equate to 100.0% as some respondents gave more than one answer

Appendix II.14: Cross tabulations of the views of the respondents on the NHS (1990) reforms by current position

"The NHS reforms have strengthened my professional role within the organisation" (N=148)

	Current Position							
	FLMs (n=43)		MMs (n=79)		SMs (n=26)		Total (N=148)	
	n	%	n	%	n	%	n	%
Strongly Agree	1	2.3	3	3.8	5	19.2	9	6.1
Agree	11	25.6	28	35.4	11	42.3	50	33.8
Uncertain	10	23.3	17	21.5	3	11.5	30	20.3
Disagree	19	44.2	28	35.4	7	26.9	54	36.5
Strongly Disagree	2	4.7	3	3.8	0	0	5	3.4

"In recent years nurses have become involved in a higher level of decision making for the organisation as a whole" (N=153)

	Current Position							
	FLMs (n=45)		MMs (n=81)		SMs (n=27)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	3	6.7	4	4.9	6	22.2	13	8.5
Agree	21	46.7	37	45.7	12	44.4	70	45.8
Uncertain	6	13.3	13	16.0	6	22.2	25	16.3
Disagree	13	28.9	25	30.9	3	11.1	41	26.8
Strongly Disagree	2	4.4	2	2.5	0	0	4	2.6

"The NHS reforms mean 'a loss of power & status' for nurses" (N=153)

	Current Position							
	FLMs (n=45)		MMs (n=82)		SMs (n=26)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	6	13.3	4	4.9	1	3.8	11	7.2
Agree	13	28.9	24	29.3	4	15.4	41	26.8
Uncertain	6	13.3	14	17.1	3	11.5	23	15.0
Disagree	19	42.2	38	46.3	15	57.7	72	47.1
Strongly Disagree	1	2.2	2	2.4	3	11.5	6	3.9

"Expectations of Nurse Manager's role have increased in recent years" (N=153)

	Current Position							
	FLMs (n=44)		MMs (n=82)		SMs (n=27)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	16	36.4	21	25.6	7	25.9	44	28.8
Agree	21	47.7	48	58.5	16	59.3	85	55.6
Uncertain	4	9.1	7	8.5	1	3.7	12	7.8
Disagree	3	6.8	5	6.1	2	7.4	10	6.5
Strongly Disagree	0	0	1	1.2	1	3.7	2	1.3

"My leadership & advisory role to nurses has become more important" (N=154)

	Current Position							
	FLMs (n=45)		MMs (n=82)		SMs (n=27)		Total (N=154)	
	n	%	n	%	n	%	n	%
Strongly Agree	12	26.7	27	32.9	11	40.7	50	32.5
Agree	26	57.8	40	48.8	15	55.6	81	52.6
Uncertain	5	11.1	6	7.3	1	3.7	12	7.8
Disagree	2	4.4	9	11.0	0	0	11	7.1

"My responsibilities regarding quality assurance issues has increased" (N=154)

	Current Position							
	FLMs (n=45)		MMs (n=82)		SMs (n=27)		Total (N=154)	
	n	%	n	%	n	%	n	%
Strongly Agree	14	31.1	38	46.3	14	51.9	66	42.9
Agree	28	62.2	40	48.8	13	48.1	81	52.6
Uncertain	1	2.2	2	2.4	0	0	3	1.9
Disagree	2	4.4	2	2.4	0	0	4	2.6

"The directorate structure has the potential to provide a supportive environment to promote highly successful nursing practice" (N=149)

	Current Position							
	FLMs (n=43)		MMs (n=81)		SMs (n=25)		Total (N=149)	
	n	%	n	%	n	%	n	%
Strongly Agree	5	11.6	18	22.2	5	20.0	28	18.8
Agree	17	39.5	30	37.0	10	40.0	57	38.3
Uncertain	16	37.2	22	27.2	4	16.0	42	28.2
Disagree	5	11.6	9	11.1	5	20.0	19	12.8
Strongly Disagree	0	0	2	2.5	1	4.0	3	2.0

"I am now more aware of political developments than before" (N=153)

	Current Position							
	FLMs (n=45)		MMs (n=82)		SMs (n=26)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	9	20.0	26	31.7	10	38.5	45	29.4
Agree	30	66.7	47	57.3	12	46.2	89	58.2
Uncertain	1	2.2	1	1.2	0	0	2	1.3
Disagree	5	11.1	7	8.5	4	15.4	16	10.5
Strongly Disagree	0	0	1	1.2	0	0	1	0.7

"Higher degree education (e.g. MSc, MN) in nursing management or in administration is necessary preparation for nurse managers" (N=153)

	Current Position							
	FLMs (n=44)		MMs (n=82)		SMs (n=27)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	6	13.6	9	11.0	9	33.3	24	15.7
Agree	14	31.8	49	59.8	11	40.7	74	48.4
Uncertain	13	29.5	8	9.8	4	14.8	25	16.3
Disagree	9	20.5	14	17.1	2	7.4	25	16.3
Strongly Disagree	2	4.5	2	2.4	1	3.7	5	3.3

"I have enough organisational resources to do my job satisfactorily" (N=153)

	Current Position							
	FLMs (n=45)		MMs (n=81)		SMs (n=27)		Total (N=153)	
	n	%	n	%	n	%	n	%
Strongly Agree	1	2.2	3	3.7	1	3.7	5	3.3
Agree	20	44.4	28	34.6	15	55.6	63	41.2
Uncertain	8	17.8	11	13.6	2	7.4	21	13.7
Disagree	14	31.1	37	45.7	7	25.9	58	37.9
Strongly Disagree	2	4.4	2	2.5	2	7.4	6	3.9

"Nurse Directors should have business management skills & knowledge" (N=154)

	Current Position							
	FLMs (n=45)		MMs (n=83)		SMs (n=26)		Total (N=154)	
	n	%	n	%	n	%	n	%
Strongly Agree	10	22.2	28	33.7	11	42.3	49	31.8
Agree	27	60.0	51	61.4	14	53.8	92	59.7
Uncertain	5	11.1	2	2.4	1	3.8	8	5.2
Disagree	3	6.7	2	2.4	0	0	5	3.2

Appendix II.15: Why the subjects felt that they were either 'moderately' or 'not very' successful (N=49)*

	n	%
Constant changes	12	24.5
New job / difficult to measure - judge e.g. As this is a new role for me I am still very much at a learning stage & will need time to evaluate any success at otherwise; very difficult to judge how well you perform.	12	24.5
Increased workload; lack of time	9	18.4
Lack of Resources	7	14.3
Central control	5	10.2
Lack of support	4	8.2
Uncertainty	3	6.1
Lack of education / preparation for the role	3	6.1
Miscellaneous e.g. It is disheartening. Patients are lost in the equations of budgets and other statistics; I sometimes feel I am hitting my head of a brick wall.	4	8.2

*Totals do not add to 100.0% as some respondents may have more than one answer

Appendix II.16: Commonly reported limitations by current position (N=142)

	CURRENT POSITION			
	FLMs (n=40)	MMs (n=76)	SMs (n=26)	X^2
Lack of time	12	21	13	NS
Lack of resources	11	18	3	NS
Lack of information & communication	7	15	1	NS
Lack of understanding / lack of proper support by others	6	9	6	NS
Increased work volume	7	6	5	NS
Lack of autonomy / accountability	4	13	1	NS
Lack of secretarial support / increased paper work / number of meetings	5	10	2	NS
Lack of clear role / strategy definition / uncertainty	4	9	3	NS
Rapid change / changing environment	4	6	5	NS

*Totals do not add to 100.0% as some respondents may have more than one answer

Appendix II.17: Future career developments by current position (N=144)

	CURRENT POSITION					
	FLMs (n=41)	MMs (n=76)	SMs (n=27)	X^2	df	p
Expanded roles within existing job	6	14	6			NS
General Management Roles / More Managerial Roles	0	18	6	11.5	2	0.003
Don't wish to change/ wish to stay in the same position	7	8	5			NS
Corporate Issues	5	11	2			NS
Retirement	5	9	3			NS
Career in nursing management	6	7	4			NS

Appendix II.18: The job title of the person whom the respondents reported to by current position (N=158)

	CURRENT POSITION							
	FLMs (n=45)		MMs (n=84)		SMs (n=29)		Total* (N=158)	
	n	%	n	%	n	%	n	%
Clinical Director	6	13.3	35	41.7	0	0	41	25.9
DNSs or equal	12	26.7	18	21.4	0	0	30	19.0
UGM / CE	1	2.2	0	0	23	79.3	24	15.2
Care Group Manager	13	28.9	0	0	0	0	13	8.2
Clinical Services Manager	1	2.2	12	14.3	0	0	13	8.2
Sector General Manager	1	2.2	11	13.1	0	0	12	7.6
Board General Manager	0	0	0	0	6	20.7	6	3.8
Business Manager	5	11.1	1	1.2	0	0	6	3.8
Nursing Services Manager	4	8.9	0	0	0	0	4	2.5
Others	2	4.4	7	8.3	0	0	9	5.7

Appendix II.19: Comments of the respondents regarding the questionnaire

"Please add any further comment which you feel may be helpful in helping us to understand the role of "nurses in management" and the factors which are important for its success"

1 Skills / abilities requirements for the role / for the success

"The ability to switch quickly from one major issue to another and they need to be confident about representing the value of nursing at Board level."

"We need to be able to manage change and need to understand the culture and develop an environment for learning within the organisation. We need to understand the pressures people work under if we want to be successful".

"Successful nurses in management should have a 'wide vision', flexibility of role, not be constrained by traditional roles. Be prepared to expand knowledge + skills".

"Nurses must understand the requirement to be responsive and adaptable to change but must not lose the focus on nursing".

"Nurses must be more assertive or they are going to lose their voice. We are too passive, which historically has been to the patients' benefit, but as a profession we stand to be swamped by business managers and doctors, with 'token' nurse representation at the top".

"I personally feel nurses require negotiation skills, numeracy skills, marketing skills, change management skills, business awareness skill to ensure 'new nursing' people see us as competent, successful individuals".

2 Positive view / positive description of the role of nurses in management

"Nurses in management are important because they understand the assessment of care needs, they take a leading role in identifying areas where standards require to be set and monitored and also participate in the development of nursing practice. They are important for patient care".

"Nurse managers can provide a wide range of input into management. They can help ensure an efficient and effective service delivery in climates of financial constraint. They have the ability to analyse information effectively and use it in contributing to health planning and policy development. They can also interpret the potential impact of corporate activities on client care".

"Strategic planning is another area in which they can contribute due to new understanding and co-ordination of services designed to meet patient/client needs"

3 Need for educational preparation / practical experience for the role

"Theoretical preparation essential (in management studies) with ability to apply this into practice".

"Planned practical experience with a mentor"

"Proper preparation and education / training is necessary"

4 Negative view or negative description of the role

"Most nurses are in management at the moment because of the structure requires at least one senior post, not because boards feel that they have a positive contribution to make".

"I do not think nurses in management are seen as very necessary any longer and it is only a matter of time until the ' nursing ' element is removed".

"Withdrawal of administrators has led to vast increase in non-nursing oriented workload"

"I feel that at 45 years old I am one of the last of the old school, and although I have spent a great deal of (my own) time and money in attempting to keep up with and adapt to the changes the next generation will have to be even more 'Jack of all trade' as well as nurses".

"It has been my experience that nurse managers in the Health Service lack proper management qualifications and are so entrenched in an authoritative, hierarchical line management structure, that they are incapable of adapting today's' style. Young, properly educated nurse managers are our only hope. People who can adapt to todays' style of management."

5 Suggestions

"Since the establishment of nurse managers in directorate manager type posts the gap between charge nurses and the next step up has widened. We need to provide a mechanism to enable them wishing to progress to bridge that gap".

"Being a nurse does not mean you can succeed in management. In my opinion to survive in management you require to be a manager first and nursing as an add on useful experience but you must be a competent manager above all else, or all credibility is lost".

"We have to understand the business principles related to health care and ensure our professional values and principles continue to have an impact on changes / developments by grasping management opportunities".

"Must be able to stand back and realise that there is a difference between nursing and managing".

"As in all management some have better skills than others. Nursing is no different so it is essential to recognise the nurses with potential in management by encouraging management training early in their careers".

"Nurses need to pull together clear rational information to negotiate with and not rely on emotive issues. As a profession we need to 'pull together' better".

"We need to be more attuned to pro actively managing change"

"As a group we must be determined to succeed. Patient care must remain the priority in all issues. Quality through excellent practice should be the philosophy"

"They have a breath of vision. Must understand public services the whole concept"

"I feel that boards should have a better professional representation on their, because currently they are more dictatorial and totally finance oriented rather than people or care oriented".

6 Support needs from others

"This role generally requires more support than is given at present"

"I certainly feel this is a time when we need more support from professional bodies i.e. RCN"

7 Miscellaneous

"Nurses' training curriculum has to incorporate aspects of clinical nursing management, personnel and assertiveness. Management module should be more intensively pursued and be more realistic to help cope in the future".

"A change of government policy".

"Medical staff need to accept nurses in management as responsible, capable and intelligent people".

"I believe I do my job very satisfactorily but would have been able to do it more easily I believe if I had had formal management training / education".

"Stability within the structure and a good supporting network"

Appendix II.20: Comments of the interviewees regarding the interview and/or the study

"There is something wrong with the nursing profession, with its structure and its leadership and I think that is reflected in the nurses in management titles. We lack direction, we lack leadership at the very top to take the nursing profession forward. There is a great deal of unhappiness in the nursing profession whether it is in management or otherwise, There are a lot of changes that are making people feel very uncomfortable or devalued throughout the work environment and it is not necessarily financial... It would be naive to think that the people in Scotland wanted Trusts, they were imposed. Unlike the old system where people came up through the organisation to the top, we now have younger people coming in from the outside and taking over very senior positions. Nobody knows these people and that is uncomfortable, whereas before you knew the Director of Nursing or the Personnel Manager, because they had come up through the system and everything was fairly comfortable. ... Trust hospitals and general management didn't invent the NHS, they didn't invent nursing, they didn't invent corporate image. They are only building on the skills and expertise that people have laid down over 20/30/40/50 years and some recognition of that would be appreciated, but there is this suggestion that is continually coming round that everything that was being done before was wrong and the people at the top of the organisation know better.

I am 39 years old and I have done 22/23 years in the Health Service in Lothian and it is not arrogance when I say I do not need a 24 year old Human Resource Manager or Business Manager of the Trust to come along and tell me how to do my job. I am not saying I am perfect, but I know how this hospital works, I know my speciality. I do not need them coming along and telling me that what I have been doing for the last 20 years was wrong and that they can do it better. I am not saying that things cannot improve, or that things cannot develop, but you have to recognise people's worth. ...People need to be recognised and valued, their skills need to be appreciated and we have lost that at the moment. Managers have lost it, ward based nurses have lost it and there is a lot of lip service being paid and that is not going to get better overnight. I do not see the people at the top of the organisation taking it on board. That is not to say that everybody at the top of the organisation is bad" (A Clinical Nurse Manager).

"Everyone looking back to the key issues, the budgetary issues, the strategic issues and the business planning issues - for me they are all fine, but the most important thing is managing people and people forget that and the only way we can achieve these three other things is through proper management of people. We are gathering all these other sort of skills, like marketing skills and we have got to be very careful that we do not loose our good inter-personal skills, because we are very good with people" (A Nurse/Business Manager).

"I think there is a very large teaching component from us as managers. We are always educating our staff in the fact that we are developing the role of Ward Sisters. If my job is not there in the future and the Ward Managers are going to be, it will be the Ward Managers and the Clinical Director and clearly a Director of Nursing somewhere, at support level and this tier of folk is missing. It is probably because we have done a good job training up the Ward Manager and I think we have got to remember that for all the changes it is the Senior Managers that passed on perhaps by teaching. Not by teaching in a classroom situation, but by discussion and explanation, keeping the Ward Sister right, advising and giving support and allowing them to develop themselves. That is a big part of our job and ensuring that they get the support that is required because it is very stressful for everybody in the NHS and I would say that the Ward Sisters are under a lot of pressure, therefore a lot of stress and certainly need a lot of support" (A Senior Nurse Manager).

"I think that one of the things that I would mention is the support that you would expect from your Trust Management. We have probably talked about that all the way through in a sense, but I think that some nurses are left to flounder. People are expected to take on these new roles and I am very much aware that nursing has been devolved down and down and down. The Trust Board in all hospitals have to recognise that nurses were not trained to take on general management roles, whereas the general managers have maybe done Business Administration at University or worked in very general businesses which maybe some nurses cannot relate to patients and patient care. ...You cannot possible influence people in change if you have not quite accepted it yourself. I think that nurses have always found it difficult to discuss personal issues or controversial issues with the Director of Nursing, because the Director of Nursing has in the past been seen as this kind of ogre sitting at the top of the tree and I think we need to get rid of that altogether. I feel that nurses should be heard they have an awful lot to offer in

management, but the Trust Management have to listen and provide the support to help nurses through these changes into the very much the role of general management. I feel quite lucky because I think ours have. We are valued and always when you go to our Trust Management always they will give you support. You do not feel that you are, a nuisance or inadequate because they make you feel like that. They are very supportive of our role" (A Directorate Nurse Manager).

"My feeling is that for whatever reason in middle management in nursing has not worked. I think we need to do something about it and we need to give nursing back to more senior people, but may be not in a management role. ...if we did break down some of the roles or some of the activities that we see our managers do we would probably find very little nursing and we need to do something about that. We need to give nursing back to the nurses, because there is a big need for that as well. There is a big need to improve the standards and improve the guidance and support that other nurses need and I do not think that these structures tend to do that kind of thing, especially at the middle management role. I think that these added on quality, planning and contracts is no bad thing. ...nurses are in a good position to inform the quality process and inform the contracting process, but there what we need to do is think well what is the nursing part of their job, what is expected of them as a nurse and that needs to be a professional advisor and that is it. They are not managing nursing they are a professional advisor to nursing, but what they are dealing with are quality and contracting from a nursing perspective. I do not know if it works that way if that is how it actually works, or whether they have said you will continue to manage these services, but we want you to take on this responsibility as well. I suspect that is what happens in a lot of places, but it maybe should not happen that way" (A Nursing Services Manager).

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The role of nurses in management within the National Health Service in Scotland

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The introduction of an internal market in health care in 1991 was the most radical change to the National Health Service (NHS) since its inception. The consequent NHS changes and reforms have had a profound impact on nursing management and inevitably on nurses in management at a personal level. This paper reports on the initial findings of a study of 158 nurses in management within the NHS in Scotland and addresses their demographic features and their management training/education pattern. It was found that the majority of respondents (77.8%) were working in their current position less than 4 years. There was a significant relationship between marital status and gender and current position ($P<0.05$). A total of 58.8% of women in senior positions were single, on the other hand there was no single male respondent at a senior manager position. In total, 37 nurses in management (23.4%) had a degree qualification and there was a relationship between having a degree, age and current position. Overall, approximately half of the respondents had a formal management training qualification and only 10.1% (16 subjects) had a degree level management education. However, a large proportion (65.8%) of nurses in management believe that degree level education in management is required to be able to perform their work satisfactorily.

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Introduction

The National Health Service (NHS) has undergone a period of major changes/reforms which began with the recommendations of the Salmon Report (MHSHHD 1966), continued with the implementation of the Griffiths proposals (DHSS, The NHS Management Inquiry 1983) and accelerated with the implementation of the White Paper 'Working for Patients' (DoH 1989) and the NHS & Community Care Act (DoH 1990). The central elements of the reforms were the introduction of a split between purchasers and providers and the creation of competition between NHS Trust hospitals for available business. It was thought that 'competition between providers of health care would not only improve patients' choice but also give health authorities and hospitals more incentive to work efficiently and become more flexible and adaptable to a discerning market' (Levitt & Wall 1992: p. 35).

In the NHS efficient management, including that of nursing services is vital. Wright (1993) argues that nurses have the greatest influence on how resources are spent on

patients and nurses can affect the quality of patient care more significantly than any other single professional group. He believes that 'whether nurses manage their work well, or whether they manage themselves well will determine whether patient care is good or bad'. Therefore, there is a need to examine the role of nurses in management through formal research studies.

Selected literature review

The need for sound management in nursing is very clear; nurses are the biggest, single group of health care employees in both the public and private sectors. As a result, their wages bill consumes 36% of total revenue expenditure of the NHS. This is more than three times as much as the next largest group, doctors (Thomson & Marshall 1993). Nurses also occupy a large proportion of the individuals with management roles in the NHS. In a recent study of top managers in the NHS, Wyatt, Disken and Dixon (1994) found that 9% of all top managers in the NHS in the UK had a nursing background. The third report of this project also showed that, in England, 24% of the managers had a nursing background (Disken, Wyatt & Dixon 1995).

There is a vast amount of American literature regarding the role of nurse managers. However, in the UK, there are few results of empirical studies. Instead much of the literature pertaining to the role of nurses in management and their management training is based largely on opinion. For example, Rye (1992) believes that as NHS Trust hospitals increase in number, two roles are pivotal and not under threat: the executive nursing director and ward sister/charge nurse. However, the senior nurse role lacks clarity in many organizations (Rye 1992) and in many instances lines of professional accountability are also becoming blurred or non-existent (Hewison 1994). Like Rye, Calvert-Simms (1993) argues that due to NHS reforms, the nurse manager's role has become unclear. She also believes that 'since the majority of the present nurse managers lack expertise in the crucial areas of business management, their career opportunities can (and will) be limited'.

It is widely recognized that the reforms created a variety of roles for senior nurses working above ward sister/charge nurse level. According to Bradshaw (1995) in many instances, in order to reduce the costs of the health budget the number of senior nursing posts were reduced. Senior nurses have been removed from formal management structures and new roles in advisory, support, and quality assurance have been created under the control of a general manager who often has little knowledge of the context in which nursing work is conducted. Rye (1992) says that 'all too frequently, these staff posts were used as a mechanism for slotting in displaced nurse managers when restructuring takes place. Again, Bradshaw (1995) argues that 'for a small minority of nurses who have retained or assumed significant senior leadership responsibilities the task has changed rapidly from one of administration to one where the exercise of the principles of managerial control have become paramount'.

Historically, nurses' basic education has not prepared them to be managers. As a general rule, nurses were promoted to supervisory roles because of their clinical expertise (Forrest 1983). Mangan (1993) notes that in the past there was a straightforward career progression in nursing. Now many of the old certainties have disappeared and like other nurses, nurse managers' jobs are coming under threat.

Some argue that nursing's identity and independence is in jeopardy as the profession comes increasingly under the control of General Managers (Bradshaw 1995). Nevertheless, it is widely accepted that reforms pose a significant challenge for nurse managers (Hennessy & Gilligan 1994) and there are considerable career development opportunities for those nurses who are able and prepared to contribute in multidisciplinary teams to meet the modern health services requirements (Walker 1993).

In one report it was argued that 'the Salmon Report and the associated Mayston Report on Community Services commented on the problem of the incoherence of nursing administration and these comments led to radical reforms both in the management structure of the profession and in the preparation of nurses for managerial responsibilities' (King Edward's Hospital Fund for London 1981: p. 3).

In the Salmon Report it was stated that: 'we are aware that these changes we recommend cannot be implemented unless nurses are educated to the job we describe. Accordingly we have proposed a broad scheme of systematic education and training for promotion upwards through first-line to top management, with accent upon progressively increasing managerial skills' (Ministry of Health SHHD 1966: p. 9, para 1.19). The Report defined three levels of management training for nurses, on a national scale: senior, middle and first line management. However, according to Kelly (1990) those courses were not very effective and often 'uni-disciplinary and rather mechanistic' and course teachers were very different in age, experience and profession (King Edward's Hospital Fund for London 1977: p. 34). The other problem regarding the post Salmon management courses identified by Beardshaw and Robinson (1990) was that 'the training used industrial and business models which nurses found of limited relevance to their work'.

The need for formal training in management and better preparation of senior nurses for their managerial roles has been emphasized by many nurse authors, writing from a management perspective and governmental reports following the Salmon Report (Ministry of Health SHHD 1966; King Edward's Hospital Fund for London 1977 (Thwaites Report), King Edward's Hospital Fund for London 1981; Forrest 1983; Rowden 1987; Barnett 1988; Balogh & Bond 1992; Watt 1992).

Recently, due to the changing health care environment, it is also widely recognized that senior nurses and nurse managers should increase and/or learn new managerial skills, knowledge and abilities such as business management skills if nursing is to do more than survive in the new NHS (O'Donnell-Imle 1991; Schroeder 1993). Bradshaw (1995) says that:

> 'for former nurse administrators, resource usage was a secondary consideration. In the new era efficient resource utilization is the salient concern to the nurse management and this primary task demands a high level of financial literacy, a thorough understanding of business planning and a sound working knowledge of contracting processes and procedures'.

Neither traditional nurse training nor higher education diplomas included these subjects. Rowden (1987) points out that 'in basic nursing training, the emphasis is placed on the acquisition of clinical skills, which is fostered as the individual moves through the profession'. In a report it was argued that 'the traditional development and career advancement of nurses had been pursued on a narrow professional front, so that nurses have not been exposed to broader health care management issues and to opportunities to develop their business management skills' (SWTRHA 1992: p. 6). Therefore those who want to be effective managers in the NHS should consider taking formal management education/training which will give them an appropriate perspective. Nurse Managers in the UK are now charged to operate the rules of commercial competition (Bradshaw 1995) and to achieve profit, to do this efficiently, they need to be trained.

According to Watt (1992) the changes and demand for more effective management in the NHS require a review of managerial training of nurses in management. Nurse managers, like other members of the executive group, should make an equal and effective contribution to the planning of health services. One key issue for nursing management has been described as 'To contribute effectively to health services manpower and policy development as a key member of the multi-disciplinary team within the general management framework' (SHHD 1990: para 5.2.4). It is argued that nurse managers need preparation for this level of participation. In the case of Nurse Executive Director posts it was emphasized that there is a need to develop nurses for management 'expanding beyond a limited professional remit' (NHS Management Executive 1992: p. 23).

In order to identify the emerging role of nurse managers/nurses in management and their management training pattern the following research questions were derived for a descriptive, empirical study.

1 What are the demographic and educational features of this group? (e.g. marital status, professional and academic qualifications).
2 What is the current management training(s) and/or management education of nurses in management?
3 What are the main job responsibilities of nurses in management?
4 How do nurses in management perceive the NHS reforms and its effects on their job?
5 What is the view of nurses in management regarding their present and future role within the NHS in Scotland?
6 How do nurses in management see their relationships with their subordinates and managers within the organization where they work?

The aim of this paper is to present the study's findings about the first two questions, and to clarify the nature of existing patterns of management education and training of nurses in management who participated in the study. Further papers will report the findings about questions 3–6.

Method

The target population of the study comprised all nurses who have a management capacity in the organization. Therefore the term 'nurses in management' instead of nurse manager or nursing managers was used deliberately to identify the respondents. We avoided the term 'nurse manager' since we were not solely concerned with managers of nurses; the study covered a wider perspective.

Study design

A descriptive study was carried out to collect both quantitative and qualitative data in two stages from nurses in management working within the NHS in Scotland. The data collection tools were an extensive postal questionnaire to all subjects, which incorporated a covering letter explaining the study, and later interviews with a stratified sub-sample of participants who indicated at questionnaire their willingness to be interviewed.

Sample

Time constraints meant that this study could not include all possible specialities or sizes of hospital. Therefore, a set of exclusion criteria were established which were: all speciality units, hospitals and departments, e.g. urology, ENT, radiology; all maternity and children units, hospitals and departments; all A&E, theatre, anaesthesia departments (if not attached to a general department); and all hospitals with 50 beds or less.

It was also decided that all purchasing units (Health Boards) should be excluded but it was thought that CANOs' views regarding the role of nurses in management would give a valuable insight to the study. All nurses in management working in hospitals and community, with the exception of the above exclusion criteria, were invited to participate in the study. In effect larger hospitals and most acute specialities were included in the study.

The 1993 Hospitals and Health Services Year Book and a list provided by Management Development Group file were used to identify all Directors of Nursing or equivalent within the NHS in Scotland. In the light of above criteria, it was found that there were 51 Directors of Nursing (the most senior nurse in the organization) or equivalent who met the inclusion criteria of the study. A letter was then sent to all Directors of Nursing requesting them to supply the names, addresses and clinical settings of their nurses in management. A total of 48 Directors of Nursing (94%) supplied the necessary information and access for the study. The 48 letters were then carefully examined to determine the eligible subjects which eventually provided 284 names.

Stage I

The main data collection tool was the questionnaire and it was developed through reviewing the literature and from informal discussions with some nurses in management in Scotland.

Stage II

The second stage of the data collection was conducting one to one, semi-structured, tape recorded interviews with 27 subjects who had indicated a willingness to be interviewed for the study. The aim of the interviews was to clarify and enrich the key issues that had emerged from the questionnaire data. For example, from the questionnaire data it was found that the majority of the respondents had attended first and/or middle line management courses at some point of their career. In the interview, respondents were asked to give their opinion about what kind of management training and/or education should nurses in management receive? The interviews also aimed to enhance the validity of the questionnaire (e.g. they were asked to explain the role of nurses in management in detail). The interviews were conducted in February and March 1995.

Data collection

Stage I—Questionnaire

Questionnaire design A draft questionnaire was piloted first with 20 Master of Nursing students in Glasgow University's Department of Nursing and Midwifery Studies. Common comments were about the length of the questionnaire which initially was thought to be too long. Having done the necessary revisions, the questionnaire was again piloted with 25 nurses in management to test the adequacy of the questions. The questionnaire was revised in the light of the comments received during this pilot study and the final version covered six major parts that addressed the research questions previously identified.

Distribution of questionnaire and response rate The questionnaire was mailed to 284 nurses in management. Respondents also received a personally addressed covering letter, explaining the study, and a postage paid return envelope. In the study the population included CANOs, Directors of Nursing Services (or their equivalent) and all nurses having a management role in the organization, i.e. business managers. The questionnaire took 45 minutes—1 hour to complete and consisted of both open and closed questions regarding issues related to the role of nurses in management. Two follow-up letters were sent to all respondents since the questionnaire was anonymous. The survey was carried out by post between 16 May and 22 July 1994. The overall response rate was 64.4 % with a usable response rate of 55.6 %. The details of the response rate are shown in Table 1.

Table 1
Response rate

Questionnaires mailed out	284
Questionnaires returned	183
Non-participants	17
Late responses	2
Completed by people who did not meet the inclusion criteria	6
Questionnaires available for analysis	158
Overall response rate:	64.4%
Usable response rate: (183–25 = 158)	55.6%

Data analysis

A computer package, File Maker-Pro, was used to store and code the questionnaire data and to categorize the open questions. The SPSS for Windows 2 package is currently being used for the statistical analysis of the questionnaires. In this study the level of significance was set at $P=0.05$.

It was difficult to categorize respondents' current position into a management level. This was due to the variety and number of different titles used by the respondents (Appendix 1). A recent study (Disken *et al.* 1995) set an example which helped to define the categories. The person whom respondents report to was the main criterion but in the event of uncertainty, respondents' grade and job responsibilities were taken into account. The following classification was developed for use in this study.

Senior Managers: Those who are directly and managerially responsible to a *top manager*, i.e. Chief Executive /Unit or Board General Manager for example, CANOs, Director of Nursing & Quality (DN&Q).

Middle Managers: Those who are directly and managerially responsible to a *senior manager*, i.e. DN&Q, Clinical Director for example Locality Managers, Nursing Services Managers, Care Group Managers, Business Managers, Clinical Services Managers.

First Line Managers: Those who are directly and managerially responsible to a *middle manager*, i.e. Nursing Services Manager for example Clinical Nurse Managers, Clinical Co-ordinators (In many instances although the term 'first line managers' describes sisters and charge nurses, in this study 'first line managers' means nurses who are above sister/charge nurse level).

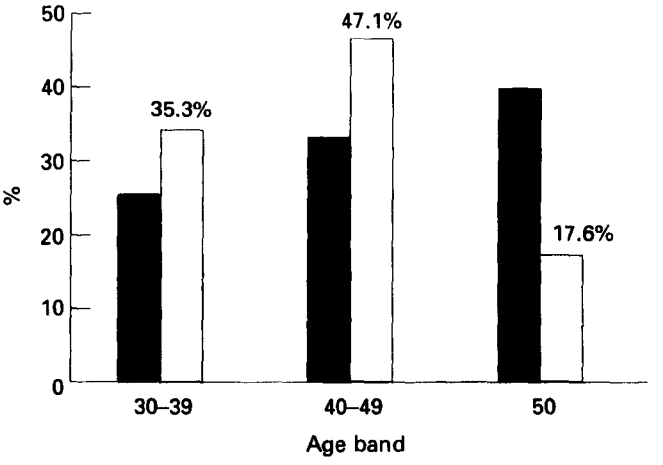

Figure 1
Male and female age profiles. ■, female; □, male.

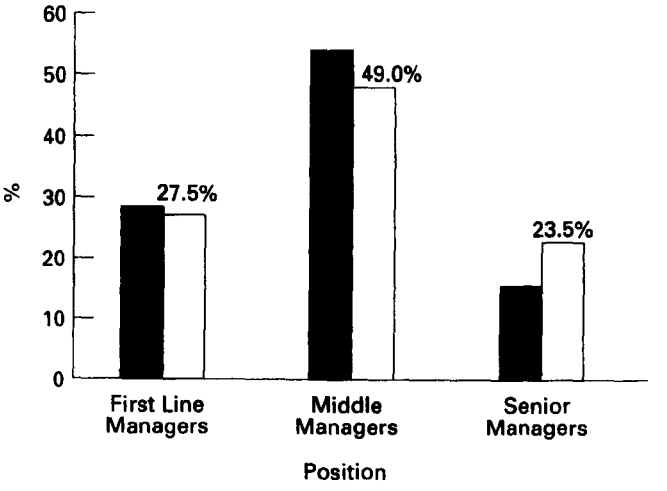

Figure 2
Gender by position. ■, female; □, male.

Findings and discussion

Figure 1 shows the differences in proportion of male and female respondents in each age group ($P<0.05$, χ^2 test). A total of 17.6% of males were in the 50+ age group, compared with 40.2% of females. Almost half of the male respondents were in the 40–49 age group. As can be seen from Figure 2, 23.5% of male respondents were in senior position compared with 15.9% of the women. However, using χ^2 test this was not statistically significant. According to previous research findings in the NHS, women are under-represented, especially in more senior management levels (Hutt 1986; Robinson, Strong & Elkan 1989; Wyatt *et al.* 1994).

There was no significant relationship between current position and age group of the respondents ($P>0.05$). However, almost half of (48.3%) senior managers were in the 40–49 age group. These findings might suggest that male senior managers tended to have a faster career progression than female senior managers. Hutt's (1986) study supports our findings.

Table 2, shows the marital status of the respondents by gender and position. Overall the majority (62.7%) of the respondents were married, but in total, a much higher proportion of females were single: 33.6% of the women compared with 3.9% of the men ($P<0.05$) (Fig. 3). As can be seen from Table 2, 91.7% of the male who were at the senior manager level were married compared with 35.3% of the females. A total of 58.8% of females in senior positions were single. There was no single male respondent holding a senior manager position.

It was found that most respondents were quite new to their present job in terms of working period. A total of 77.8% of nurses in management have been working in their current position less than 4 years. The post which

Table 2
Current position by gender and marital status

Marital status	*Gender*					
	Female (n = 107)			*Male (n = 51)*		
	First Line Managers n = *31*	*Middle Managers* n = *59*	*Senior Managers* n = *17*	*First Line Managers* n = *14*	*Middle Managers* n = *25*	*Senior Managers* n = *12*
Single (F36; M2)	29.0%	28.8%	58.8%	7.1%	4.0%	
Married (F55; M44)	58.0%	52.5%	35.3%	78.6%	88.0%	91.7%
Widowed (F4; M1)	6.5%	3.4%			4.0%	
Separated/divorced (F12; M4)	6.5%	15.3%	5.9%	14.3%	4.0%	8.3%

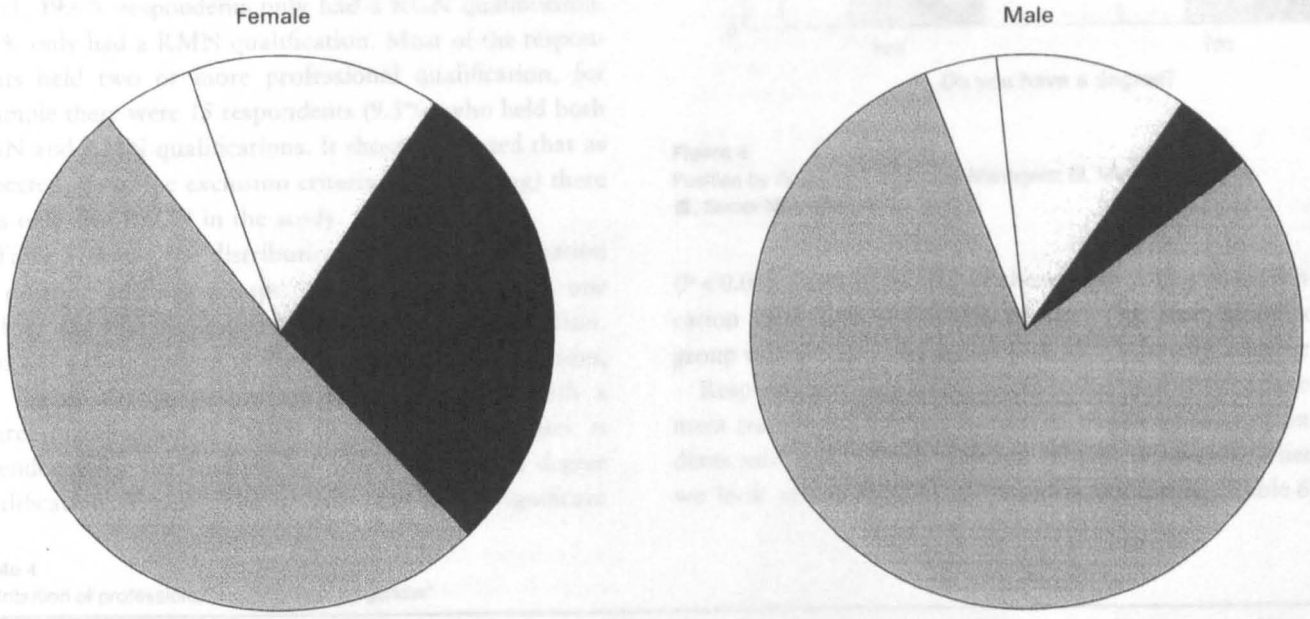

Figure 3
Female and male profiles by marital status. ■, single; ▨, married; □, widowed; ▦, separated or divorced.

they came from (Table 3) may suggest that although the current job title may have changed, the job holder may not.

When we look at Table 3 current position by previous job titles it was found that 31.1% of the first line managers' previous job title were sister/charge nurse. A

Table 3
Previous job title by current position*

Previous job title	*Current position*			*Total* n = *158*
	First Line Managers n = *45*	*Middle Managers* n = *84*	*Senior Managers* n = *29*	
Clinical Nurse Manager/Clinical Services Manager (*n* = 34)	20.0%	28.6%	3.4%	21.5%
Nursing Officer (*n* = 25)	22.2%	14.3%	10.3%	15.8%
Sister/Charge Nurse (*n* = 21)	31.1%	8.3%	–	13.3%
Senior Nurse Manager/Nurse Manager (*n* = 32)	11.1%	26.2%	17.2%	20.3%
Director of Nursing Services (DNS)/CHief Area Nursing Officer (CANO) (*n* = 25)	2.2%	8.3%	58.6%	15.8%
HV/District Nurse/District Midwife (*n* = 8)	8.9%	4.8%	–	5.1%
Others (*n* = 13)	4.4%	9.5%	10.3%	8.2%
Total (*n* = 158)	100.0%	100.0%	100.0%	100.0%

* Column percentage.

total of 58.6% of the senior managers were DNS/CANO and mostly they kept their position at senior level. Respondents who had a title as Clinical Nurse Manager, Clinical Services Manager, Sister, Health Visitor/ District Nurse previously, are now working largely either at first line management level or middle management level.

Table 4 shows the different nursing qualifications held by the female and male respondents. As can be seen, majority of the respondents (89.9%) had RGN qualification. As one might expect a higher proportion of men were RMN (68.6%) compared with 14.0% of the women. This might reflect the general trends in the NHS. A total of 31, 19.6% respondents only had a RGN qualification, 4.4% only had a RMN qualification. Most of the respondents held two or more professional qualification, for example there were 15 respondents (9.5%) who held both RGN and RMN qualifications. It should be noted that as expected, given the exclusion criteria (see sampling) there was only five RSCN in the study.

Table 5 shows the distribution of degree qualification by position and age groups. Overall approximately one in four (23.4%) respondents has a degree qualification. There is a clear pattern of the higher the level of position, the higher the proportion of senior managers with a degree qualification ($P<0.05$) (Fig. 4). Similarly there is a tendency for the younger age groups to have a degree qualification (Fig. 5). The χ^2 test was again significant

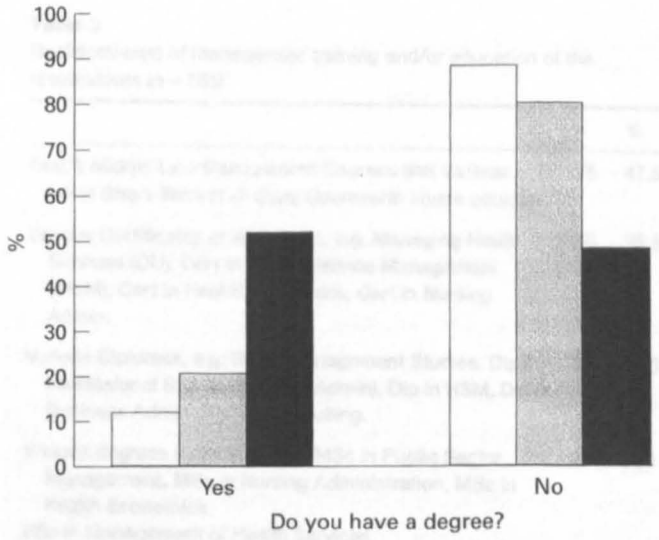

Figure 4
Position by degree. □, First Line Managers; ▨, Middle Managers; ■, Senior Managers.

($P<0.05$). Overall 45.9% of those with a degree qualification were under 40 years of age. The least qualified group was the 50+ age group with 18.9% having a degree.

Respondents were asked whether they had any management training/education. A total of 81.0% of the respondents said 'yes' to this question (Fig. 6). However, when we look at the type of the training/education (Table 6)

Table 4
Distribution of professional qualifications by gender*

Gender	*RGN*	*RM*	*RSCN*	*RNMH*	*RMN*	*HV*	*DN*	*Certificate/Diploma*	*Teaching*	*Other*
Female ($n=107$)	103	40	5	2	15	21	18	19	6	12
%	96.3	37.4	4.7	1.9	14.0	19.6	16.8	17.8	5.6	11.2
Male ($n=51$)	39	2	0	6	35	0	3	7	1	2
%	76.5	3.9		11.8	68.6		5.9	13.7	2.0	3.9
Total ($n=158$)	142	42	5	8	50	21	21	26	7	14
%	89.9	26.2	3.2	5.1	31.6	13.3	13.3	16.5	4.4	8.9

* Totals do not add to 100.0% as respondents may have more than one qualification.
RGN (Registered General Nurse).
RM (Registered Midwife).
RSCH (Registered Sick Children's Nurse).
RNMH (Registered Nurse in Mental Handicap).
HV (Health Visitor).
DN (District Nurse).

Table 5
Distribution of a degree qualification by position and age groups

Do you have a degree?	*Position*								
	First Line Managers			*Middle Managers*			*Senior Managers*		
	Age groups								
	30–39	*49–49*	*50+*	*30–39*	*49–49*	*50+*	*30–39*	*49–49*	*50+*
Yes ($n=37$)	15.4%	10.5%	7.7%	39.3%	14.8%	6.9%	80.0%	50.0%	40.0%
No ($n=21$)	84.6%	89.5%	92.3%	60.7%	85.2%	93.1%	20.0%	50.0%	60.0%

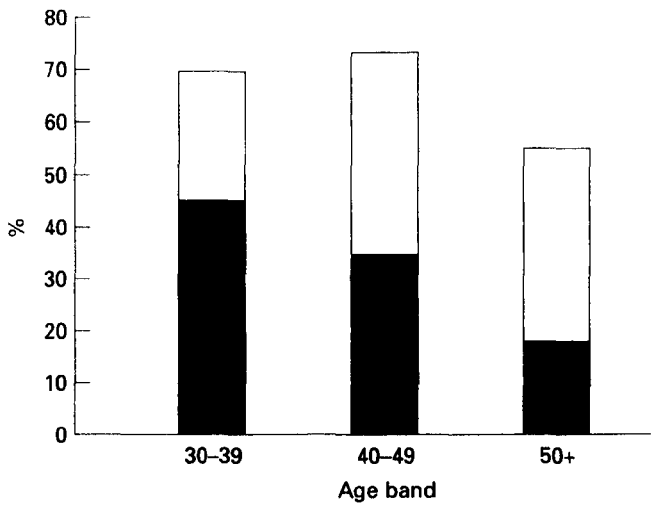

Figure 5
Age groups by degree. Do you have a degree? □, no; ■, yes.

almost half of the respondents (47.5%) indicated that they had attended first and middle line management courses and a variety of short-term courses. These courses were not counted as formal management training. When we exclude this kind of training as formal management training, it is found that 48.1% of nurses in management had a formal management training/education qualification(s) (Fig. 7); e.g. a certificate in Health Service Management, a degree in Public Sector Management (Table 6). A detailed analysis of formal management training of the respondents (i.e. the number of nurses who had MBA degree) is provided in Appendix 2. In a study Forrest (1983) found that in total 10.3% of the subjects had not received any formalized management

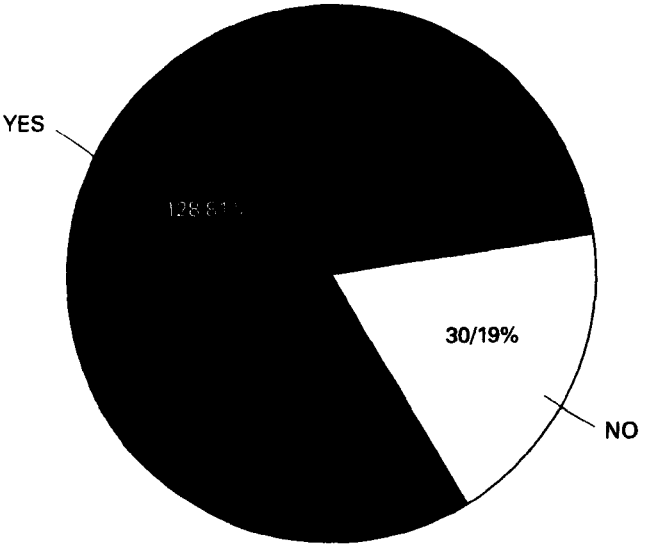

Figure 6
Distribution of management training qualification (includes all types of management training identified in Table 6).

Table 6
Qualification(s) of management training and/or education of the respondents ($n = 158$)*

	n	%
First & Middle Line Management Courses and Various Level Short-Term (1–7 days) Courses/In house courses	75	47.5
Various Certificates or equivalent, e.g. Managing Health Services (OU), Cert in Health Service Management (IHSM), Cert in Health Economics, Cert in Nursing Admin.	40	25.3
Various Diplomas, e.g. Dip in Management Studies, Dip in Professional Studies (Nursing Admin), Dip in HSM, Dip in Business Admin, Dip in Counselling.	22	13.9
Various degrees including MBA, MSc in Public Sector Management, MSc in Nursing Administration, MSc in Health Economics BSc in Management of Health Services	16	10.1
Others, for example Foundation Business studies, Rainbow, MESOL	8	5.1
No management training at all	30	19.0

* Totals do not add to 100% as respondents may have more than one training/education qualification.

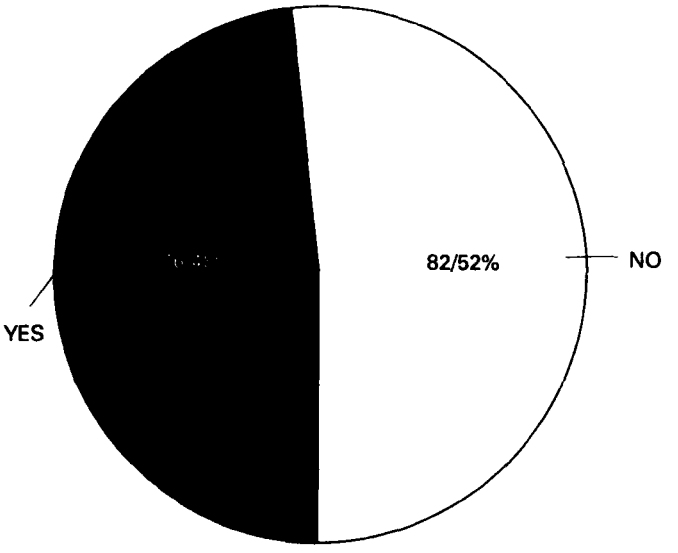

Figure 7
Distribution of management training qualification (excludes first and middle line management courses and other short-term courses).

training including first and middle line management courses. In our study this figure was 19.0%.

Table 7 shows the distribution of management training qualification by current position. Of the senior managers, 37.9% had a certificate qualification compared with 15.6% of the first line managers. Again a degree qualification in management was more likely to be held by senior managers than first line managers.

As can be seen there is a significant relationship between current position level and having a management training

Table 7
Management training qualification by current position*

Current position	First & Middle Line Mgmt Courses & Other Short Courses	Various Certificates	Various Diplomas	Various Degrees (BSc/MSc/MBA)	Others
First line manager ($n=45$)	60.0%	15.6%	6.7%	4.4%	
Middle line manager ($n=84$)	38.1%	26.2%	15.5%	8.3%	10.7%
Senior line manager ($n=29$)	58.6%	37.9%	17.2%	24.1%	3.4%

* Totals do not add to 100.0% as respondents may have more than one training/education qualification.

($P<0.05$) (Fig. 8). In total of the senior managers, 72.4% had a formal management qualification, e.g. certificate, diploma, or degree, compared with 24.4% of the first line managers (Fig. 8). If we include all first and middle line management courses and short courses as formal management training, 96.6% of senior managers and 73.3% of first line managers had a management training. In other words the more senior the position, the more likely the individuals was to have had a management training.

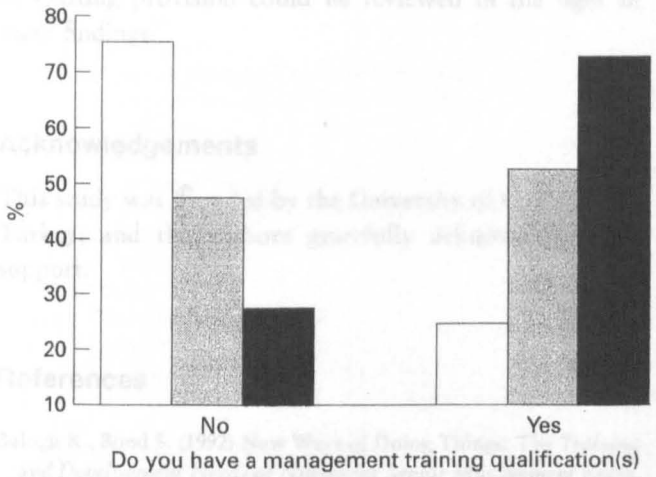

Figure 8
Management training/education by current position (excludes first & middle line management courses and other short courses). □, First Line Managers; ▨, Middle Managers; ■, Senior Managers.

The respondents were asked to give their opinion on the level of management training/education required to be able to perform their work satisfactorily. On the job training was reported by the majority of the respondents (78.5%). A total of 104 nurses in management (65.8%) emphasized that degree level education in management was necessary in order to carry out their job satisfactorily. This view was confirmed in another question, that 62.0% of the respondents agreed that higher degree education is necessary preparation for nurse managers/nurses in management (Table 9).

As can be seen in Table 8, in particular 79.3% of senior managers suggested that degree level education in management is needed in comparison with first line managers 46.7%. When we look at the cross tabulation of this question by degree (Table 9) we found that 83.7% of people those who have degree level education agreed with this statement ($P<0.05$). These findings may suggest that senior and middle managers are more aware of management training needs of nurses in management than first line managers.

Table 8
Kind of management education/training required for the job by current position ($n=158$)*

Current position	Degree in management	Degree in nursing	On the job training	Others
First Line Managers ($n=45$)	46.7%	15.6%	86.7%	13.3%
Middle managers ($n=84$)	71.4%	16.7%	77.4%	10.7%
Senior Managers ($n=29$)	79.3%	20.7%	69.0%	3.4%

* Totals do not add to 100% as respondents may have given more than one response.

Table 9
Degree level education is a necessary preparation of nurses in management

Have a degree?	Statement: Degree level education is a necessary preparation of Nurses in Management					
	Strongly agree	Agree	Uncertain	Disagree	Strongly degree	No answer
Yes ($n=37$)	43.2%	40.5%	2.7%	2.7%	2.7%	8.1%
No ($n=121$)	6.6%	48.8%	19.8%	19.8%	3.3%	1.7%
Total ($n=158$)	15.2%	46.8%	15.8%	15.8%	3.2%	3.2%

Conclusion

This study's initial findings indicate that nurses in management feel that degree level education and on the job training are necessary in order to do the job satisfactorily. This implication may suggest that it is necessary to encourage nurses in management to take formal management education/training. It is also widely recognized that nurses have the potential to be effective managers (Hewison 1994) and there are many opportunities for them but they should be properly prepared and should have appropriate management training in business and financial issues.

Later papers will address the results of the last four research questions. Initial results make it clear that support for nurses undertaking management courses is important. It is suggested that the objectives and content of existing provision could be reviewed in the light of these findings.

Acknowledgements

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Appendix 1

Current job titles of the respondents

Present title	*n*
First Line Managers ($n=45$)	
Clinical Nurse Manager	15
Clinical Co-ordinator	3
Senior Nurse	6
Acting SNM/Acting Nursing Services Manager	3
Clinical Manager	2
Night Duty Co-ordinator	5
Senior Practitioner Nursing	8
Nursing Practice Development Officer	1
Clinical Section Manager	2
Middle Managers ($n=84$)	
Nursing Services Manager	15
Clinical Services Manager	11
Nurse Manager	11
Senior Nurse Manager	10
Service Manager	7
Locality Manager/Locality Nurse Manager	5
Business Manager	4
Operational Manager	4
Directorate Nurse Manager/Directorate Manager	4
Deputy Director of Nursing and Patient Services	1
Care Group Manager	3
Quality Assurance Manager	1
Assistant Director of Nursing	1
Contracts Manager/Contracts & Marketing Manager	3
Service/Business Manager/Site Manager	1
Divisional Nurse Manager	1
Principal Nurse	1
Quality Co-ordinator/Senior Nurse	1
Senior Managers ($n=29$)	
Director of Quality/Chief Area Nursing Officer	2
Director of Contracts and Standards/Chief Area Nursing Officer	2
Director of Nursing & Human Resources	1
Chief Nursing Adviser & Director of Quality	2
Unit Nurse/Director of Quality Assurance	1
Director of Professional Services & Quality	1
Director of Planning & Quality	2
Nurse Director	1
Director of Strategic Planning/Nursing & Quality	1
Director of Nursing & Quality Assurance	8
Director of Nursing	2
Director of Nursing Quality & Community Services	1
Divisional General Manager	1
Executive Director of Nursing & Quality Assurance	1
Director of Nursing Services	1
Hospital Manager	1
Matron	1
Total	158

Appendix 2

Detailed distribution of formal management training qualification ($n=76$)*

	n
Various Certificates or equivalent	40
Managing Health Services (OU)	12
Cert in Health Service Management (IHSM)	9
Cert in Health Economics	9
Cert in Nursing Administration	3
Cert MGMT	1
Cert Professional Management	1
Cert in Decision Making in the NHS	1
HNC [1 business; 3 Management Services]	4
*Various Diplomas***	22
Dip in Management Studies	11
Dip in Professional Studies (Nursing Admin)	4
Dip in Personnel Management	3
Dip in Health Services Management	1
Dip in Business Administration	1
Dip in Health Economics	1
Dip in Counselling	1
Diploma (no specification is given)	1
*Various degrees****	16
MBA (Master of Business Administration)	10
MSc	6
Public Sector Management (2)	
Nursing Administration (1)	
Health Economics (1)	
No specification given (2)	
BSc in Management of Health Services	1
Others	8
e.g. Foundation Business Studies, MESOL, Rainbow	

*Totals do not add to 100% as some respondents may have more than one qualification (Not all the categories were mutually exclusive, e.g. one can have a certificate and a degree qualification).
**Two respondents had a diploma in management studies and a diploma in personnel management.
***One respondent had both BSc and MBA degrees.