

New Public Management and Nursing Relationships in the NHS

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Declaration

I declare that none of the work contained within this thesis has been submitted for any other degree at any other university. The contents found herein have been composed by the candidate, Louise Hoyle.

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Abstract

Western governments face increasing demands to achieve both cost efficiency and responsiveness in their public services leading to radical and challenging transformations. Following the imposition of New Public Management (NPM) approaches within England, it is argued that similar elements of NPM can be also seen within Scottish healthcare, despite policy divergences following devolution. This thesis considers the influence of NPM on Scottish hospital frontline nursing staff in their work. It explores the ways in which managerial practices (specifically professional management; discipline & parsimony; standard setting & performance measurement; and consumerism) have shaped the working relationships, interactions, and knowledge-exchange between managers, staff and patients and the ability of staff to carry out nursing duties within an acute hospital setting.

The study is a qualitative interpretivist study grounded in the methodology of adaptive theory and draws upon the works of Lipsky (1980) in order to explore how the front-line nurses cope with and resist the demands of the workplace. Based on thirty-one qualitative interviews with front-line nursing staff in an inner city hospital in Scotland, this thesis presents the findings resulting from nurses' views of management, finances, policies, targets, audits and consumerism. The findings show that these nurses believe there has been a proliferation of targets, audits and policies, an increasing emphasis on cost efficiency and effectiveness, a drive for professional management and a greater focus on consumerism in NHS Scotland. These are all closely linked to the ethos of

NPM. From the findings it can be seen that many elements influence the working relationships of the frontline hospital nursing staff.

The study suggests that the main reason for conflict between managers and nursing staff is due to their differing foci. Managers are seen to concentrate on issues of targets, audits and budgets with little thought given to the impact these decisions will have on patient care or nurses' working conditions. Furthermore the findings highlight high levels of micro-management, self-surveillance, control and the regulation of the frontline nursing staff which has led to tensions both between nursing staff and managers, but also with patients and the public. Finally, although there has supposedly been policy divergence between Scotland and England, this thesis has identified many similarities between Scottish and English polices and NPM approaches continues to influence the working relationships of front-line nursing staff within this study despite the rhetoric that Scotland has moved away from such practices.

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Abbreviations

A&E	Accident and Emergency Department
ACS	Acute Coronary Syndrome
AFC	Agenda for Change
AHA	Area Health Authority
C-Diff	Clostridium Difficile
CPD	Continuing Professional Development
CQI	Clinical Quality Indicators
CRAGs	Clinical Outcome Indicators Reports
DHA	District Health Authority
DHSS	Department of Health and Social Security
DOH	Department of Health
EBM	Evidence Based Medicine
EBP	Evidence Based Practice
EBHC	Evidence Based Health Care
ESRC	Economic and Social Research Council
GMS	General Medical Services
GP	General Practitioner
HAO	Health Authority Practitioner
HCA	Health Care Assistant
HEAT	Health Improvement, Efficiency, Access and Treatment
HEI	Healthcare Environment Inspectorate
HEI	Higher Educational Institute
HMC	Hospital Management Committees
HRC	Honorary Research Contract
IPR	Individual Performance Review
IRAS	Integrated Research Application System
ISD	Information Services Division (Scotland)
JCC	Joint Consultative Committee
LAA	Local Area Agreement
LHA	Local Health Authority

MAU	Medical Assessment Unit
MEWS	Modified Early Warning Score
MRSA	Methicillin-resistant Staphylococcus Aureus
MTM's	Market Type Mechanisms
MUST	Malnutrition Universal Screening Tool
NAO	National Audit Office
NHS	National Health Service
NI	National Insurance
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NP	Nurse Practitioner
NPM	New Public Management
NS	Nurse Specialist
OPSI	Office for Public Service Information
PAC	Public Accounts Committee
PAF	Performance Assessment Framework
PCTs	Primary Care Trusts
PFI	Private Finance Initiative
PI	Performance Indicator
PPP	Public Private Partnership
PROMs	Patient Reported Outcome Measures
PRP	Performance-Related Pay
PSA	Public Service Agreement
R&D	Research and Development department
RCN	Royal College of Nursing
RCT	Randomised Control Trial
REC	Research Ethics Committee
RGF	Research Governance Framework
RHA	Regional Health Authority
RHB	Regional Hospital Boards
RM&G	Research Management and Governance
SG	Scottish Government
SN	Staff Nurse

SNP	Scottish Nationalist Party
SOA	Single Outcome Agreement
STAG	Scottish Trauma Audit Group
VAT	Value Added Tax
VFM	Value for Money
WM	Ward Manager
WM/S	Ward Manager/Sister
WM/CN	Ward Manager/Charge Nurse
SHAPE	Scottish Health Authorities Priorities for the Eighties
QIS	Quality Improvement Scotland

Chapter 1: Introduction to Thesis

Introduction

According to the literature, Western governments face increasing demands to achieve both cost efficiency and responsiveness in their public services leading to radical and challenging transformations (c.f. Klein 2008; Taylor-Gooby 2008; Ham 2009; Kuhlmann *et al.* 2009; Sims 2010; Christensen & Laegreid 2011). The emergence of New Public Management (NPM) approaches has been heralded as a way to improve the efficiency and effectiveness of public services by politicians and policy makers. Following the imposition of NPM approaches within England, it is argued that similar elements of NPM can be also seen within Scottish healthcare despite policy divergences following devolution. This thesis considers the influence of NPM on Scottish frontline nursing staff in their work. It explores the ways in which managerial practices have shaped the working relationships, interactions, and knowledge-exchange between managers, staff and patients and the ability of staff to carry out nursing duties within an acute hospital setting.

In this introductory chapter, I present a brief context to the research study. Some information about my personal reasons for undertaking this study is provided and then the chapter provides a brief context for the rise of New Public Management within the NHS before considering the potential impact this can have specifically within Scotland. It focuses on how the emergence of NPM approaches have influenced working conditions within the NHS. Then I describe how I have developed my research

questions in order to understand the perspectives of front-line nursing staff on their relationships with managers, colleagues and the general public and the tensions between the role qualified nurses think they should have within the organisation compared to the reality which they report experiencing. In the last section of this introduction I set out the structure for the remaining chapters of the thesis.

Personal Background

When I qualified as a nurse in 2003, I commenced my nursing career initially in orthopaedics, then in medical assessment, before moving to the accident and emergency department (A&E) of Liverpool's city centre hospital. During this time I gained much experience and developed a particular interest in workplace violence. When the opportunity arose I decided to undertake a MSc. at the University of Stirling in criminology, which allowed me to further develop this interest in workplace violence. This sowed the seeds for the current thesis; seeds which developed over two masters' dissertations and which have been refined and expanded upon through the three years of this PhD. As I continued in my studies I started to come to the realisation that violence is not simply about aggressive individuals entering the hospital environment, or about inadequate staff, but rather can be linked to organisational characteristics such as staffing levels, lack of equipment and a demoralised workforce. Having been a qualified nurse, these issues were very important for me, and I started to think about how management can influence the work at the front-line for nursing staff. As this interest further progressed, the opportunity to undertake a PhD arose, which I embraced without hesitation. I believed this would give me an opportunity to further explore the

role of the organisation in shaping the working lives of front-line nurses and to allow the voices of such nurses to be heard.

Having read widely in sociological, social policy, and nursing journals I realised, that while writers widely discussed potential reasons for a discontented workforce, there was little written about the effect of management decisions and its implications for front-line nursing staff. Although there was much literature about how NPM has been introduced, its aims and how it has affected the NHS as a whole, there is little focus on one of the largest workforces in the NHS – nurses. In particular, there was even less in relation to Scottish nurses: most of the literature available spoke about the UK (meaning England) or the English NHS, ignoring their Scottish counterpart. Despite nurses in Scotland being employed by the NHS and registered via the same nursing body as English nurses, there was little information about how the supposedly different approach of management in the NHS Scotland, which is based on professionalism, compared to the English marketization (Greer 2004), and how the supposedly unique Scottish policies impact on their work.

Background and Context for Research

The NHS is the largest employer in the UK and within Scotland specifically, there are 68,133 nurses and midwives (ISD Scotland 2011a). The NHS provides free healthcare for all UK citizens at the point of delivery regardless of circumstances. This an important industry in which there is much investment from tax payers money and it is a key interest politically. Nurses make up a significant proportion of the NHS workforce and are responsible for providing much of the care to patients. Despite this, the

experiences of patients accessing services tend to be the focus of research. However I would argue that this is overlooking an important area; the experiences of the workforce need to be addressed. It has been well established that if staff are feeling demoralised, undervalued and overworked then poor patient care is an inevitable outcome (cf. Newman *et al.* 2001; Smith & Dixon 2008). Within the Royal College of Nursing (RCN) employment surveys (Ball & Pike 2005; 2007; 2009)¹ it was reported that some healthcare changes have potentially negative effects for nurses (such as changes to junior doctors' working hours and increased loads for out-of-hour services provided by nurses). Workloads and staffing are reported as a major source of nursing stress, with more than four in five nurses seeing their workload as too heavy and their pay as poor (both in comparison to other professionals and relative to the work they undertake). One in four nurses in Scotland says that "patient care is compromised at least one or twice per week" due to staff shortages (Ball 2009: 46).

Significant changes in the NHS occur frequently as each successive government puts forward plans as how to restructure the NHS (as will be seen in chapter 2). However, one of the biggest changes in more recent times is the introduction of New Public Management (NPM); this style of management has developed from the ideologies of managerialism. In 1983 Sir Roy Griffiths stated that the NHS needed general managers who were not clinically based. The belief was that management skills were the most important element and not knowledge of the area. If an individual was not clinically based, they would be able to make harder decisions due to their detachment and it would mean the authority and power of the medical profession in management decision making were limited (Harrison & Pollitt 1994; Pollock 2005). This approach was

¹ The 2009 RCN survey is currently the most recent survey available.

implemented by the then Conservative Government (under Margaret Thatcher and then John Major) and has since been expanded on and developed by the New Labour Government under Tony Blair and later Gordon Brown. Since the election of a Coalition Government under David Cameron, there has been much discussion about how changes in the English NHS will be implemented and managed, with the publication of plans for NHS reforms in England in 'Equity and excellence: liberating the NHS' (DOH 2010). Post Devolution in 1997, Scotland has been seen to have a different approach to the management of the NHS. Although as I shall argue, the impact of managerialism within Scotland can be seen to mirror England to a certain extent, according to the literature this changed post devolution, a view which will be contested within the thesis.

Dissatisfaction in the NHS

The pressures on the NHS have arisen from new demands which are related to changing demographics, changing beliefs in relation to citizenship and consumerism, along with the "transformations of welfare states operating within a framework of neoliberal policies" (Kuhlmann *et al.* 2009: 512). Outputs are now actively being managed within the NHS to ensure that quality and efficiency are achieved alongside democratic legitimisation; the need for choice and individuals having a voice has purportedly driven this (Clarke *et al.* 2007). As a result, new forms of governance have emerged within the NHS, via performance management (the setting of targets and monitoring via audits), managerialist strategies (using organisational forms, practices, and values of private sector 'for profit' organisations) and State-sponsored policies (for example: the 'Patient's Charter' (DOH 1991) and 'Choosing Health: Making healthy choices easier')

(DOH 2004a) which are meant to have strengthened the role of the public (health consumer), along with the changing roles of health professions and within medicine (McKee *et al.* 2006; Witz & Annandale 2006; Kuhlmann *et al.* 2009). However, such changes have not successfully strengthened the role of the public within health services, as will be seen throughout this thesis. Furthermore, it will also be highlighted that the changing roles of health professionals has not solely been about enhancing practices for the benefit of the public and staff, but rather has also been used as a way to achieve cost savings and limit the power of medical professionals.

The RCN surveys mentioned previously, highlight that nursing staff are dissatisfied with their working environment (Ball & Pike 2005; 2007; 2009). Nursing staff are reporting finding themselves in an environment that is more about service delivery in relation to performance management than patient care. There is a clash of cultures between the nursing staff and management. This can lead to staff believing that their work is now just an endless series of technical tasks and demands; there is little time for patient contact and care. Care is delivered in a specific format, where it can be measured, monitored and audited to assess for its efficiency. Arguably, this is a far cry from what the majority of nurses state as their reason for joining the nursing profession: which is to provide the best possible quality of care and assistance to patients and their families (Jackson 1998; Traynor 1999). Greene (1996) and Schmitz *et al.* (2000) argue that managerial staff do not recognise the suffering and difficulties that are experienced by staff. Tensions arise as managers lack clinical expertise to make judgements on patient care and so staff and managers potentially have different sets of priorities. The aim of this research is to explore how the impact of issues such as changes in management style and the rise of NPM approaches influence the relationships that occur

between nursing staff, their managers, other members of staff they work with, and patients.

Development of Research Questions

The literature has highlighted a gap in our understanding of how NPM influences the work and relationships of front-line qualified nursing staff. Therefore, the central aim of this thesis is to explore:

In what ways have the introduction of New Public Management (NPM) approaches within the Scottish NHS influenced and informed the working relationships of qualified nursing staff with their managers, other staff members and patients?

In exploring the influence of NPM approaches on front-line nurses in Scotland, I hope to consider the ways in which these have shaped the experiences of the staff and their views. With this aim as the basis of the thesis I developed the following research questions:

- How do nursing staff perceive their working relationships with managers/ other staff/patients?
- What factors influence how nursing staff interact and communicate with managers/other staff/patients?
- To what extent if any, is there a tension between how qualified nurses view what their role within the organisation should be and the reality which they experience?

- In what ways do the organisational structure and management policies shape interactions that occur between front-line nursing staff and managers/other staff/patients?

In order to study the influence of NPM approaches on front-line qualified nurses, it is important to recognise the epistemological assumptions that influence this research project. This is an interpretivist study grounded in the methodology of adaptive theory (Layder 1997; Layder 1998a), which means that the study focuses on the perceptions of the participants and how their sense of normality and security depend on their relationships. This is discussed in chapter 4, where I develop my conceptual and methodological approach.

Outline of Chapters

In chapter one, I have discussed my personal background which has led to the development of this thesis project and I have provided a brief context to the research study and the current state of research in this area. I have highlighted a gap in the literature concerning the influence of NPM policies, procedures and approaches on the relationships of qualified nursing staff with their managers, colleagues and the public. I then described how I developed my research questions in relation to the question of how NPM approaches influence and inform the working relationships of qualified nursing staff.

In chapter two I discuss the key structural changes that have occurred within the Scottish and English NHS since its inception in 1948, highlighting how there have been

similarities and differences between the two countries' developments. This chapter provides background information essential to understanding NHS organisation and how policy can inform the running and focus of an organisation. This chapter then discusses the emergence of managerialism and in particular NPM approaches to managing the NHS in the UK generally and the significance of such approaches in Scotland specifically. The role of organisational culture is explored in order to help explain how NPM approaches have developed within the NHS and also how they can cause conflict within established cultures. Finally, the chapter focuses on Lipsky's (1980/2010) notion of street-level bureaucracy and how this can relate to the field of nursing.

The focus of chapter three is on how NPM approaches influence front-line nursing practices and relationships within an acute hospital setting the Scottish NHS. Initially an outline of how nursing practices have developed and progressed from a vocation to a profession is offered. The chapter then provides a discussion on four key areas of NPM which have been identified as being important within NHS Scotland. These are: the influence of professional management (looking at the backgrounds of NHS managers); the rise of discipline and parsimony in the NHS (doing more for less); standard setting and performance measurement (with a specific emphasis on policy, targets and audits); and consumerism (looking at the implications of consumer rights and service quality). These four features are seen to be the most pertinent within Scotland, although this is not to say other elements of NPM do not have a part to play in shaping relationships and practices in NHS Scotland.

The methodological approach to this study is explained in chapter four. An interpretivist stance informed by Layders' domain theory is highlighted as underpinning the

epistemological assumptions within this thesis. I describe the rationale for the use of a case study, and for using one-to-one semi-structured qualitative interviews as my research tool. I outline practical details of my research design and process. The way that the analysis of the interviews is undertaken is explored, and the merit of using QRS Nvivo software is discussed. This section provides a detailed account of the study population, recruitment process and ethical procedures (covering both NHS ethical approval and Research & Development (R&D) approval).

In chapters' five to eight, I present my findings in relation to the four key areas of NPM identified above as having most influence and how these shape the work and relationships of front-line nursing staff. These areas were identified from within the literature review and the respondent's interviews. In chapter five, I focus on the influence of hands-on professional management in the NHS. This chapter looks at how nurses believe the background of their senior managers influences the nurses' day-to-day work and also their relationship with management. It also highlights nurses' views regarding the growth in the number of managers and the different types and levels of management in NHS Scotland. Finally it offers a discussion of the changing role of the ward manager.

In chapter six, I examine the influence of discipline and parsimony in resource use (also referred to as 'doing more for less'). This chapter explores how nursing staff view financial management in the NHS and how budgetary decisions influence the nurses' ability to work in the way that they would wish and their relationships with both managers and the public. Key areas that are focused on with regards to finances are equipment and medication resources; staffing resources; and the impact of privatisation

and centralisation of services. The chapter then goes on to explore issues of power, resistance, coping strategies and the changing roles of nursing in response to financial constraints.

Chapter seven looks at how performance measuring and standard setting influence the work and relationships of front-line nursing staff. This chapter discusses the ways in which political viewpoints influence policy decisions within the NHS and how nurses perceive such decisions. Next, key policies derived from these political decisions are discussed in terms of how they influence the work and interactions of the nurses. Finally there is an exploration of how the proliferation of targets and audits, key elements of NPM, affect the day-to-day work of frontline staff and highlight the problems and tensions that arise as a result. The final findings chapter (chapter 8) analyses how the advent of consumerism and notions of patient rights influence the relationships of nursing staff and the general public. This chapter explores how respondents view the term 'consumerism' and whether their understanding reflects governmental aims. It also focuses on the influence of the 'Patient's Charter' (DOH 1991) on relationships within the NHS and the impact this has had. Finally, the relationship between consumerism, the media and the nurses is discussed.

In chapter nine, I consider the key findings in chapters 5-8 and relate the conclusions to the literature review in chapters 2 and 3 and answer the research questions. It focuses on the four NPM approaches that are pertinent to Scotland and how these have shaped the interactions of the nursing staff. Specific themes of power and authority, resistance and coping, accountability and the 'good nurse' are explored within the context of NPM. The work of Lipsky (1980/2010) is used to offer explanations of the findings and

a critique of Lipsky is offered. Chapter ten highlights the contribution that this study has made understanding the ways in which NPM approaches within the Scottish context have shaped the working lives of front-line nursing staff. I then consider the value of the case study and interpretivist approach taken in this study and areas for future research.

Chapter 2: New Public Management

Introduction

The primary concern of this thesis is to explore the influence of NPM on front-line nursing staff practices and relationships in the Scottish NHS. The purpose of this chapter is to understand how NPM has developed from the 1980s and the forms which it has taken. This will allow the research questions to be located within an existing body of literature and to identify themes that develop in the analysis that follows.

In order to do this, the chapter begins with an outline of the structural changes that have occurred within the Scottish and English NHS since their inception in 1948. It is important to understand how policies have been developed and changed as the NHS has developed within the United Kingdom (and specifically Scotland), as this demonstrates that decisions made regarding the NHS are clearly influenced by politicians and their political ideologies. This chapter provides the background information necessary to understand the organisation itself. Each policy change that is made can affect the organisational culture and working ethos. These policies impact on the day-to-day working lives of the members of staff employed and they also affect the way the NHS is perceived by the general public. The focus then shifts to the emergence of NPM within the NHS and its significance both north and south of the border. Following this discussion, central elements of NPM will be identified. The role of organisational culture will be explored to help understand the way NPM has been allowed to develop a

specific organisational culture within the NHS but similarly has caused conflict with the established cultures.

Finally, this chapter explores Lipsky's (1980/2010) notion of street-level bureaucracy. To date there has been very little written which draws upon Lipsky's (1980) classic study of street level bureaucracy in relation to nursing. Lipsky's work has continuing relevance today and within the field of nursing, specifically in relation to his ideas of discretion of front-line staff. This study will draw upon his work to help offer explanations for the findings in this thesis.

A Brief History of Organisational Changes in the NHS

The NHS was established on 5th July 1948 in the UK, although the NHS in Scotland was established under a separate NHS (Scotland) Act in the same year. Since its inception the Scottish NHS has always maintained a separate identity from the Ministry/Department of Health in England and Wales. Despite this, due to political power being based in Westminster until devolution in 1999, the health policies governing both the English and Scottish NHS have been similar. When the NHS came into existence in 1948, it was the first system in Western society to offer free medical care and offered universal entitlement (Klein 2008) to the entire population and is a publicly funded and owned system (Talbot-Smith & Pollock 2006).

Since its foundation, the NHS has been of interest to politicians (Rivett 1998; Greener 2003; Glennerster 2007). The developments and changes introduced by Governments can have an influence on election results and so it is an important institution for political

parties (Ham 2009). Furthermore, the Government has been (and remains) responsible for the allocation of finances for the system. This can help to explain the continual focus on and importance of the NHS for politicians. As will be seen within this section, the political ideology of the Party in Government is reflected in the changes that have occurred within the NHS.

The NHS has constantly undergone reviews and management style changes since its establishment in 1948. These have often reflected political ideologies as Governments have changed. In the 1960s the structure of the NHS was re-examined and restructuring occurred following ‘The Porritt Report’ (Porritt 1962) in England and Wales. Within Scotland the ‘Salmon Report’ (HMSO 1966) outlined structural plans for the Scottish NHS. Further reports such as the ‘Cogwheel Reports’ (HMSO 1967; HMSO 1974) in England and Wales and the ‘Brotherston Report’ (HMSO 1971) in Scotland looked at the role of medical professionals and nurses within management structures of the hospital. However, the first major restructuring of the English and Welsh NHS was undertaken in 1974 and reorganisation in Scotland following the ‘NHS (Scotland) Act’ (Crown 1972). In the 1970s the issue of cost became a crucial focus which was connected in part to the 1974 oil crisis and there were wider economic problems in the UK and difficulties in managing and financing public sector services (McCafferty 2006), therefore changes to the NHS were introduced in an attempt to make the NHS more cost effective. According to Klein (2008: 73) the 1974 re-organisation was also about promoting managerial efficiency but also satisfying the professionals (reconciling conflicting policy aims for these groups) and so allowing an effective hierarchy to be created; the slogan “maximum delegation downwards, maximum accountability upwards” demonstrates the aim. However the 1974 re-organisation did not reconcile the

conflicts between professionals and management aims, rather there was disillusionment for all.

In 1979 the Conservative Party was elected into power. The new government argued that the NHS was not being managed effectively or efficiently and so radical changes were required to address this. Klein (2008: 3) suggests that that the main focus prior to 1983 “had been with the organisational *structure* of the NHS, attention now switched to the organisation *dynamics* of the NHS”. The focus of the Conservative Government was on market disciplines as a “solution to the ills of the public sector” (Osbourne & McLaughlin 2002). In 1984, following the ‘Griffiths Report’ (1983), general management was introduced, (this has had significant influence both within England and Scotland) despite there being problems with the report. The report argued that the NHS had no coherent system of management at a local level and lacked any continuous evaluation of its performance (The Kings Fund 2011).

The Griffiths Report – From Consensus Management to General Management

There was an ideological thread running through the reforms proposed in the Griffiths report. It was about changing the governance arrangements in the NHS (McTavish 2000). The underpinning reasoning for the changes to the management organisation and employment of non-health managers was supposedly that business style approaches were thought to be better than the public sector ethos. Therefore, the NHS should be run similarly to a private business. This would then allow the NHS to be more efficient and cost effective. For the Thatcher administration, professionals were seen to undermine governmental power and so imposing managers with little or no clinical background would help to limit the authority and power of the medical profession. These medical

professionals were seen to be a barrier in the development and control of the NHS (Harrison 1992; Klein 1998; Peckham 2003; Yu & Levy 2010). It is the radical changes that were brought about by the Griffiths report which are labelled 'general management' (Pollitt *et al.* 2007).

Up until 1980 the NHS had evolved on the "basis of rational planning" which aimed at distributing healthcare resources and services throughout the country on the basis of need (Talbot-Smith & Pollock 2006: 3). However, although instructions were issued by the DOH there was much discretion in how local services were delivered and organised. This was because decision making power was devolved to regional health authorities (RHAs) and district health authorities (DHAs) (Talbot-Smith & Pollock 2006). Griffiths saw management by consensus as being reactive and concerned with crisis management. Therefore, this needed to be replaced by general management. General management represented a radical change to both organisation and management across the NHS. It was intended to offer active, strategic direction and to devolve responsibility through a clear structure of line management and devolved budgets. There was the replacement of the pre-existing system of consensus decision-making (which was made by multidisciplinary teams of chief officers with a single chief executive or general manager at RHA, DHA and hospital (unit level) of the NHS) with general management (Pollitt *et al.* 1991). The General Managers of hospitals were to be operationally and professionally accountable to their counterparts in the district health authority (DHA).

There were also changes within DHSS, which aimed to reduce the perceived fragmentation that was identified within policymaking and management processes. This

led to the development of a health services supervisory board which was tasked with establishing objectives and priorities for the health service. There was also the instigation of NHS management boards to oversee the implementations. Previously, the board had been made up of the secretary of state, the chief medical and nursing officers, the permanent secretary of the DHSS and Sir Roy Griffiths. The new board had a chief executive that was “in effect the general manager for the whole of the NHS in England” (Pollitt *et al.* 1991).

Managers were to be appointed who had management experience but not necessarily health experience (a lack of health experience being preferable as this was thought to mean individuals would be more objective in their decision making), although these posts were still open to persons from all NHS occupations. A general manager (regardless of discipline), at Authority level would be charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the Authority. These general managers were now subject to incentives and sanctions which were introduced; they were employed on short-term contracts and were required to undergo individual performance reviews (IPR) which was linked to performance-related pay (PRP) (Pollitt *et al.* 1991). The Griffiths report however, was vague and offered no concrete recommendations on a number of matters (Pollitt *et al.* 1991; Harrison & Wood 1999). This meant that the roles of new managers and the shape of the local organisational structures were left to develop themselves. There were concerns from clinicians about the development of general managers as threatening the medical professionals, as Horner (1983:1473) wrote:

“If the general manager has no power to control medical activities, he is almost certainly irrelevant and unnecessary. If he does, then he represents an extremely serious threat to the independence of British medicine”

Despite such concerns, this management style was meant to encourage a responsible individual at every level of an organisation who has authority, accountability and the ability to plan and implement decisions; the aim being to provide better lines of authority and accountability. It also argued that there is greater flexibility in team structures and a greater emphasis on clear leadership. However, there were difficulties for clinicians to move into management, both in England, Wales and Scotland (Fatchett 1999; McTavish 2000).

This development of general management was not without problems. For example, there was also no real recognition of the importance of the role of nursing within the NHS, unlike for medical staff (where Griffiths has argued they were natural managers at unit level). This led to friction within the NHS as many nurses and medical professionals were outraged at the idea of being managed by a non-health professional. There was a belief that non-health managers would not be able to make decisions based on effective patient care. According to Fatchett (1999:18) a common view was that “nurses can only be led by nurses”. Not only were nurses unhappy about the exclusion of nurses from management, but also the hierarchal structure of nursing was seriously affected and general managers felt to be pre-occupied with the nursing budget as a way to make major savings (Bolton 2004a).

Management budgets were introduced by Griffiths (later to be known as resource management), and tighter systems of control (this was building upon performance

indicators) were to be introduced. Furthermore, it was proposed that NHS managers needed to be more aware of consumer opinion of the organisation and the way services were delivered (Pollitt *et al* 1991). With regards to Griffiths wish for a ‘mixed economy’ of health care, this period also saw an increase in the privatisation and marketization of support services and care. Scotland, like the rest of the UK was subject to the Thatcherite zeal to develop the use of market mechanisms (Stewart 2004), although within Scotland there appears to have been little concerted interest amongst doctors in the backing of private care (McTavish 2000).

In 1983, the abolition of health districts² in Scotland and their replacement with “units of management” exemplified the move to “disaggregate in order to promote increased accountability and efficiency” (Mackie 2005: 51). By the mid-eighties all local authority health bodies had to appoint a general manager who had clear executive authority (Woods & Carter 2003). This indicates that the implementation of managerialism within Scottish health boards was in reality a very similar experience to that in England and Wales. Similarly, the drive for efficiency was evident in the Scottish Health Authorities Priorities for the Eighties (SHAPE) framework and reflected the ideologies of the Thatcher Government and the Griffiths Report. This framework was meant to shape policy and spending within key areas, but documentation following the monitoring of this showed that the concern was almost exclusively on cost and expenditure (McTavish 2000). During this era, audits and performance indicators were also introduced. Targets and audits were meant to show performance in relation to expenditure and to enable the effective management of resources. However, these indicators did little to improve performance and by 1987, the health authorities were in

² District health authorities (later called health authorities) were regional management bodies.

debt, there were long waiting lists and hospitals wards were being closed (Rivett 2008). This was despite statistics showing that there was higher spending, an influx of cash into the NHS and an increase in staff numbers and the number of patients treated.

In 1987 the Department of Health identified consumerism as a means of increasing efficiency in the NHS (Bolton 2004). A major objective of the 'Promoting Better Health' white paper was to ensure the service became more responsive to the needs of 'consumers' (DOH 1987). Consumer choice was seen as a way to counter professional power and authority which were thought to hinder organisational change (McGinnis 2011). If professional authority was challenged and diminished then this would all for a more market-driven NHS which means increased efficiency and cost effectiveness. This resulted in a significant cultural shift, with the introduction of the 'internal market' as outlined in the white paper – 'Working for Patients' (DOH 1989), this was passed into law as 'The NHS and Community Care Act' (OPSI 1990). This Act applied both within Scotland, England and Wales; there were no separate Scottish policy documents for what was "arguably the most significant restructuring of the NHS since its inception" (Mooney & Poole 2004: 463) as market-mechanisms (via the internal markets) were established.

However, Scotland did not willingly embrace the internal market as Greer (2004: 200) states: in Scotland "advocates of the internal market had always been weaker and professional elites stronger". Further to this there was more unwillingness for the Scottish NHS to "go down the managerialist road so evident in England in the 1980s" (Hunter & Williamson 1991; McTavish 2000; Stewart 2004: 107). The reason for this is that there has been a stronger public ethos amongst professionals and the public in

Scotland and is also due to Scotland's consensual and corporatist traditions (Stewart 2004). The purpose of the internal market was to establish private style business mechanisms in the NHS. General management, internal markets and consumer choice would save the NHS. The belief was that such an approach would address issues such as long waiting lists which had been caused by a lack of finances in the NHS while there had been increasing demand for services. This was in line with the Conservative Government's enthusiasm for market principles in the NHS and the ideological view that private is better than public.

Within England and Wales in 1991, the introduction of market mechanisms via quasi markets was very different from that of the 1974 reorganisation (Harrison *et al.* 1999). A quasi market refers to the "separation of purchaser (insurer) and provider (treatment) functions, which were both previously managed by central government and its regional subsidiaries. The purchaser/provider split was intended to stimulate competition between providers. Providers would no longer be guaranteed a flow of patients; instead, NHS hospitals and other providers of acute and specialist services would need to attract contracts with regional bodies responsible for purchasing care on behalf of their populations" (Brereton & Vasoodaven 2010: 11). The stated aim was to increase the speed of response from the service to the consumer and fostering innovation with competition was one of the key elements of the plan. The internal market and purchaser/provider split meant that 'purchasers' (these being health authorities and some GP's) were given control of a budget to buy health care from providers (these being acute hospitals, and organisations who provide care e.g. residential care and ambulance services). In order to be a provider, organisations became 'NHS trusts' which were independent organisations with their own management which were then

competing with other NHS trusts. The first NHS trusts came into fruition in 1991 and by 1995 all healthcare was provided by trusts. ‘The NHS and Community Care Act’ (OPSI 1990) led to healthcare trusts competing with one another for business (this applied throughout the UK), the aim being to create a more responsive, efficient and less bureaucratized service.

The publication of ‘Framework for Action’ (Scottish Office 1991) by the Chief Executive for the NHS in Scotland, identified changes that were designed to promote the concept of managed competition and public choice. The proposals included the setting up of NHS Trusts and the creation of General Practitioner (GP’s) fundholders in Scotland. The first NHS Trusts in Scotland came to realization in 1992 and by 1996 there were 46 NHS trusts within Scotland (Woods & Carter 2003). The underlying philosophy was based on internal markets. NHS trusts became the providers which competed to win contracts from the health boards (the purchasers) in the belief that this competition would mean value for money (Mackie 2005). Within these trusts, clinical governance became a mechanism to manage and constrain primarily clinical activities via budget constraints, whilst performance targets and the publication of performance from hospitals, departments and even individual doctors aimed to allow for increased visibility and accountability to be seen by commissioners and the public generally.

Le Grand *et al.* (1998) argue that the purchaser/provider split was largely successful; however Brereton & Vasoodavan (2010) contend that comparisons have been difficult to make. Furthermore, Light (2001) and Enthoven (1999) conclude that the reforms were too controversial and politically charged which meant they suffered from too much governmental intervention to make them effective. As Light (2001:1173) states:

“Managed competition made health care more politicised than before, with a greater chance that some market player would make a mistake and create a front-page embarrassment. The government therefore found itself in the position of having to watch every player and every move in order to spot slips so that it could catch them before they became embarrassing falls.”

Other authors such as Boyett & Finlay (1995) indicate that there was a lack of government support to aid the reforms and so they were not entirely successful.

In 1997, Labour returned to power and pledged the abolition of the internal market, although still suggesting that it would build on what had worked and remove those that had failed. This brought about a period of further instability within the NHS. The white paper ‘The New NHS – Modern, Dependable’ (DOH 1997) outlined a service that would be based on partnership and performance, involving another change of structure. At the same time in Scotland in 1997 the white paper ‘Designed to Care – Renewing the National Health Service in Scotland’ (Scottish Office 1997) was published; advocating fundamental changes in the organisation of the NHS in Scotland. The emphasis was on the replacement of the internal market within healthcare. There was increased support within Scotland for the return of welfare state values rather than business style values (Birrell 2009).

The Labour Government’s election in 1997 and subsequent devolution for Scotland marked a significant change for the Scottish NHS; the then Secretary of State for Scotland (Donald Dewar) recommended changes in the way the NHS in Scotland was run via ‘Designed to Care – Renewing the National Health Service in Scotland’ (Scottish Office 1997). The focus was to be on restoration of the Scottish NHS in the

wake of previous reforms which were viewed as having attempted to dismantle the NHS as a public service (Stewart 2004). This put an end to the internal market, GP fundholding and contracting for services in Scotland, unlike in England. This was seen to be showing a commitment by Scotland to a public sector ethos and to fit with Scotland's traditions of governance. The purchaser/provider split was replaced by a strategic/service divide (Mackie 2005) and in 2000, Scotland abolished the purchaser/provider split completely. The Scottish government published 'Our National Health: A Plan for Action, a Plan for Change' (The Scottish Government 2000), outlining the plan for Scotland to return to an integrated system meaning that there is a single body (in this case The Scottish Department of Health) which is responsible for planning and providing all healthcare services.. Following devolution in Wales in 1998, the report: 'Improving Health in Wales – A Plan for the NHS with its partners' (2001) proposed new structures and organisational change for the NHS in Wales, (Talbot-Smith & Pollock 2006), which also signified a move away from the English structure of the NHS.

Following this in 2002 unified health boards were introduced within Scotland. These health boards became responsible for long-term direction of the organisation while the trusts (acute and primary care) were charged with the operationalisation of the strategy. The health boards became accountable to the then Scottish Executive and needed to produce a 'health plan' for the area it covered. These health plans then became the key tool in Performance Assessment Frameworks (PAF's)³. Later in 2003, 'Partnership in Care' (The Scottish Government 2003b) incorporated proposals for unified health boards and the abolition of NHS trusts; and these changes were enacted in 'The NHS

³ PAF's are used by the Scottish Executive (2003) to monitor achieved performance levels.

Reform (Scotland) Act’ (The Scottish Government 2004). ‘The Local Government in Scotland Act’ (The Scottish Government 2003c) abolished the legislative basis of compulsory competitive tendering in Scotland, it does however allow for local authority trading in three different forms (Mackie 2005: 187). These being: 1) with another authority (where income generated is not restricted); 2) with other public bodies (where the local authority may trade its own surplus capacity in staff services, property and facilities, income is not restricted); and 3) with other parties (must trade own surplus, and income made will be subject to financial limits set by ministers). The aim has been to reflect Scottish ideals of governance and co-operation, thus the fragmentation caused by market mechanisms in the 1990s needed to be addressed and to allow for unified health and social care services which focused specifically on the needs of patients (Stewart 2004).

Following devolution the separate identity of the Scottish NHS has been strengthened. Although there remain a number of health policies that still fall under the jurisdiction of Westminster (which include the regulation of healthcare professionals, abortion and human fertilisation issues, xenotransplantation and the control and safety of medicines), the Scottish Parliament now has the ability to pass primary legislation and amend or repeal existing Acts of the UK Parliament. However, despite these changes, according to HMFA (2008), in terms of operation, much of NHS Scotland is similar to that of England and Wales (although there are substantial organisational differences which need to be taken into account). The main differences are as follows:

- ‘NHS Scotland reports to the Scottish parliament rather than the UK Parliament

- There is no regional tier in Scotland between NHS boards and the Health Department
- There are no NHS trusts in Scotland
- There are very few non-NHS healthcare providers in Scotland”

(HMFA 2008: 199)

NHS Scotland is now accountable to the Scottish Parliament. This has allowed political bodies new freedoms to pursue and develop their own health policies (Smith & Babbington 2006). Despite this, with regards to funding, Scotland still remains relatively dependant on Westminster. Historically, the ‘devolved’ countries have actually received more per head of population than in England, as the amount received has been negotiated, within Scotland, based on a formula known as the Barnett formula⁴. The responsibility for then distributing this allocation to the different services and different areas is the responsibility of the devolved country.

The use of independent (both private and voluntary) organisations within NHS Scotland is limited, and usually only resorted to, to enable the reduction of waiting lists rather than being seen as a source of mainstream providers of care, as is the case in England (Talbot-Smith & Pollock 2006). Since devolution, each healthcare system has had a different emphasis. Broadly in Scotland this has involved an emphasis on professionalism, and in England, marketization. Professionalism within Scotland is meant to be about aligning organisation with existing structures of medicine. This is to be achieved through a reduction in the layers of management and replacing them with clinical networks; thereby increasing the role of professionals in rationing and resource allocation (Greer 2004). By contrast, the markets in the English NHS involve

⁴ For a fuller explanation of the Barnett Formula see: HMFA (2008).

independent trusts/firms contracting out work to each other; with an emphasis on competition, management and regulation in order to get the best value for money.

There is much variation between the organisational and management structures that work within England and Scotland (Lane & Jenkins 2007). Regardless of this variation, across the UK, the NHS remains a service that is intended to be ‘free at the point of delivery’ and paid for by taxes. Despite there being differences they both face similar challenges: “they must ration resources in life and death situations and they must rely on articulate, popular, unmanageable professionals to do it” (Greer 2004: 4). They must also cope with close contact between the political systems and health services, demonstrate ‘value for money’ from taxes, manage professionals, ration legitimately and also “somehow disengage their politicians from the management of and accountability for the frontline services” (Greer 2004: 4). A key argument of this thesis, however will be that despite the structural differences between Scotland and England, the impact of the business style approach and the “business culture to hospital management” (Pollock 2005: 87) for front-line nursing staff in Scotland is similar to that felt by their English counterparts. The influence of NPM approaches in the 1980s continues to be felt throughout the UK NHS.

Managerialism and New Public Management

Through the 1980s, in the UK, Lapsley (1994) advised that the NHS can be seen as inefficient and unresponsive to consumer demands; a drain on the public resources and part of a dependency culture which prevents the success and growth of an organisation. In response, the government then introduced organisational changes into the NHS (as

has been discussed previously) and adopted ideas such as efficiency and value for money within their policy guidelines. As discussed in the previous section, one of the major changes in the NHS was to attempt to enforce a business model with the introduction of general management. This came about in 1984 primarily due to the Griffiths Report and the growth of managerialist approaches within the NHS. This research will focus on the influence of New Public Management (NPM), which can be seen to have developed from a managerial ideology, on the relationships between managers and nursing staff; nursing staff and colleagues, and nursing staff and patients.

It is important to understand what is meant by managerialism in order to understand the significant impact it has had on working practices within the NHS and its links to NPM. The growth of managerialism has been closely linked to the rise of neo-liberalism on government policies since the 1980s: “the neoliberal state should favour strong individual property rights, the rule of law, and the institutions of freely functioning markets and free trade” (Harvey 2005: 64; Evans 2009). This ideology developed within a political context, under Mrs Thatcher and the Conservative Party. Mrs Thatcher held the belief that those who could should have to pay for their own healthcare (Timmins 1996). The policy aim was towards a business approach to management to increase efficiency and reduce costs within the NHS. Clarke and Newman (1997: 23) discussed that: “management...was the agency which inherited the task of dismantling the old regimes and providing a new regime...around which organisations could be structured”.

As was highlighted in Timmins (1996:384), there was to be the “rolling back of the frontiers of state”. Previously Clarke *et al.* (1994a: 4) argued that ‘managerialism constitutes the means through which the structure and culture of public services is being

recast'. The changes during the 1980s and 1990s, involved the creation of the managerial state, leading to fundamental changes to structures, cultures and practices or organisations. These include:

“new arrangements for financial accountability and the measurement of ‘effectiveness’; the ‘marketization’ of structural arrangements between those who provide welfare services and those who pay for them; the ‘marketization’ of relations within service organisations; and attempts to change established relations between providers and consumers” (*Exworthy & Halford 1999: 3*).

Managerialism, “offers both a method and a philosophy for achieving efficient and effective administration” (Minogue 1997: 17). Within this world view, Hudson (1997: 393) highlights that it has been concerned with reducing the scale and role of public service bureaucracies, much talk of “value for money, efficiency, effectiveness, and performance review” and a focus on implementation where “getting things done” decisions must quickly be translated into action. Pollitt (1990) argues that the brand of managerialism found within the NHS has been mainly neo-Taylorist in nature, meaning that NHS managers see their role as an attempt to control the organisations so that it works in the most efficient manner possible (Learnmonth 1997). However, this approach also lends itself to the belief that when a public service or policy ‘fails’ then it must be due to poor management, which means in order to solve this issue, ‘better’ management must be needed. What is often the outcome is the use of practices and attitudes of the private business sector management (Minogue 1997; Elmore 1997), as these are considered superior to public sector management styles (meaning that public sector management is bad whereas private sector management is good and should be adopted in the NHS). NPM is presented as a means of change from old-fashioned

bureaucratic managers and to instil an entrepreneurial drive into the public sector which will then meet the needs of the public in the future (Exworthy & Halford 1999).

NPM was designed to represent a shift away from bureaucracy towards more flexible forms of organisation; characterised by the business-style model of managerialism being introduced into the public sector (Hood 1991; Kolthoff *et al.* 2007; Harrison & McDonald 2008). This principle is defined by Pollitt (1990) as involving increases in efficiency; the use of ever-more sophisticated technologies; a disciplined labour force; an implementation of professional management roles and managers being given the right to manage.

Defining NPM can be difficult and contentious, however, Dunleavy and Margetts (2000: 13 cited in Pollitt 2003: 27) offer a short and simple explanation: “disaggregation + competition + incentivisation”. Key elements are: a shift of focus of management systems which were about inputs and processes towards outcomes and outputs; an increase in the level of measurement and quantification occurring (especially in the forms of performance indicators and/or explicit standards); a preference for more specialised and autonomous organisations (rather than multi-purpose hierarchical ministries/departments); and a substitution of contracts or contractual-like relationships for previous hierarchical relationships; the blurring of private and public boundaries with the development of Public Private Partnerships (PPPs)⁵ and the contracting out of services (Pollitt 2003: 27).

⁵ Partnerships are developed between the public sector organisations, for-profit commercial companies and non-profit voluntary organisations to undertake an initiative, for example the building of new NHS hospitals.

There has been the development of markets and market-type mechanisms for the delivering of public services and an emphasis on consumerism and service quality. Finally it can be seen that there has been a shift in priorities of public sector services from universalism, equity, security and resilience to those of efficiency and individualisation (Hood 1991; Pollitt 2003). However, when discussing the developments of NPM, it is important to realise that they are not as cut-and-dried as they appear: the impact is not universal or uniform across public sector services or within areas of such services.

NPM is presented as being beneficial for the taxpayers and consumers and anti-bureaucracy (Power 1997b; Pollitt 2003; Harrison & McDonald 2008) and that gaining more effective control of work practices allows for reduced costs and increased efficiency. However, Harrison and McDonald (2008) that NPM has not entailed a turn against bureaucracy, but has instead replaced management hierarchy with regimes of regulation. Midwinter and McGarvey (2001) argue that it would better be called performance management rather than regulation. Despite regulation supposedly being against the spirit of NPM, in reality NPM requires it (Power 1997b).

“NPM has come to provide a philosophical underpinning for government reforms in the UK, US and several other countries, so that its appearance in the NHS can be seen as simply a part of the wider project; as conventional wisdom about how to address the contemporary combination of economic constraints and rising public demands”. (Harrison & McDonald 2008: 101)

The doctrine of NPM especially under New Labour included “a culture of hierarchy, command and control, measurements and meeting targets” (Hunter 2007: 59). There is an emphasis on quantifiable performance measures; market-testing and competitive

tendering instead of in-house provision; a strong drive for cost cutting and a focus on output rather than input targets. According to Walsh (1995) key characteristics include: improvements in quality; an emphasis on delegation and devolution; good information systems; an importance on contracts and markets; measurements of performance, audits and inspection. With regard to authority and control NPM is meant to be about indirect control as opposed to direct authority:

“The strategic centre attains its objectives though creating processes of management that involve appropriate incentive and value commitments, the emphasis is not so much upon managers’ right to manage, as upon the need for managers to be appropriately motivated and believe in the right things” (Kolthoff et al. 2007: 3).

Furthermore, a central feature of NPM is the separation of politics and management (Walsh 1995). Politics and politicians should have a part to play in deciding the broad policies and target setting for managers, but should not be involved in the day-to-day operational issues (Audit Commission 1990). The combination of internal markets, performance measures and monitoring/auditing aim to overcome the “incentives of self-interests” (Kolthoff *et al.* 2007: 4). Figure 1 offers a summary of the key features of NPM which have been discussed in this section. It is these features that have influenced and informed the research project and the research questions that are being asked.

Key elements of New Public Management:

- ‘Hands-on’ Professional management in the public sector
- Standard setting (targets) and performance measurement (audit)
- Preference for more specialised and autonomous organisations
- Blurring of private and public boundaries and the contracting out of services have occurred
- Stress on private sector management styles moving away from public sector ethos
- Development of markets and market-type mechanisms for the delivering of public services
- Discipline and parsimony in resource use (‘doing more for less’)
- Emphasis on consumerism and service quality.

(Adapted from: Hood 1991; Pollitt 2003; Hunter 2007)

Figure 1: Key features of NPM

New Public Management in Scotland

Since devolution, Scotland has moved the furthest away from the English NHS structure, since it abolished the purchaser/provider split, which was originally introduced in the early 1990s (Talbot-Smith & Pollock 2006; White 2010). The Scottish NHS now has an integrated system, with a single body which is responsible for planning and providing all healthcare services. It is this body that faces nation-specific pressures and must show appropriate performance outcomes (Storey *et al.* 2011). There is limited use of the private or ‘independent’ sector; they are generally used as a means to reduce waiting lists rather than a mainstream provider of care (Talbot-Smith & Pollock 2006). Authors such as Mackie (2005) argue that NPM peaked in the late 1990s and that since 1997 and in particular devolution there has been a decline in the use of

marketplace mechanisms. This has led to a debate as to whether NPM is as influential in Scotland as in England. Cairney *et al.* (2009) assert that England has continued with the NPM ethos, engaging in competition, contracting-out, private/public provisions and consumerism whereas in Scotland the emphasis is on more traditional social democratic/welfarist models of delivery (Viebrock 2009 Mackie (2005) comments that there has been a decline in the market-place dimensions in Scotland but as will be seen NPM has not gone away and elements have been retained and can be seen to have an influence within Scotland.

There are still considerable similarities between healthcare in England and Scotland with the majority of policies being almost identical either side of the border. For example:

“powers of well-being; Best Value; retention of business rates at the centre; ring-fencing of grants in accordance with central priorities; support for citizen participation and encouragement of various means to boost electoral turnout” (McConnell 2004: 236).

The healthcare financing system within Scotland and within England to-date has retained similar characteristics of those introduced in 1948. Revenue is overwhelming via general taxation which is amalgamated into a single pool. Services are then provided to the population free at the point of entry (Smith & Hellowell 2012). Resource allocation within Scotland and England continues to be on a needs-based allocation formula. Until now healthcare financing with Scotland and England have been similar however, this is likely to change once the reform plans put forward by Langsley in England are implemented.

In Scotland the involvement of the private sector in the NHS has officially been discouraged. For example, there has been a ban on private contracts for hospital cleaning and catering services. However, similar to England, within Scotland there has been the use of independent (both private and voluntary) organisations to provide increased capacity to overcome waiting time targets (Talbot-Smith & Pollock 2006). There have also been PPP projects within Scotland, for example in 2009, there was a new PPP project which commenced in NHS Forth Valley (the New Larbert Hospital). There have also been plans to commission £500 million of new infrastructure through PFI (Smith & Hellowell 2012).

With regards to quality, many of the mechanisms used to ensure quality of services in the English NHS are also employed within NHS Scotland. Both English and Scottish NHS organisations are required to ensure that there are internal mechanisms to monitor and improve the quality of care being provided (clinical governance arrangements) (Talbot-Smith & Pollock 2006; Storey *et al.* 2011). There are also performance standard setting, targets, audits, monitoring, and inspections. It is noted by Hazell & Jervis (1998) that professional bodies in Scotland are likely to prefer conformity in areas such as clinical practice, education and training. The Commission of Scottish Devolution at the time recommended that health professionals in Scotland were regulated via Westminster (Calman 2009). This is because the influence of professional self-regulation by professional regulatory councils (e.g. the GMC) applies UK wide. As in England 'Agenda for Change' has resulted in annual development reviews for staff and pay restructuring for both Scottish and English employees alike (DOH 2004b). Furthermore, within the UK, citizens expect a comparable standard of service and provisions regardless of where they live in the country (Haydecker 2010). This may

help explain why there has been less divergence in policy and the running of the NHS in Scotland compared to England than was perhaps anticipated. Appendix 1 (which was put together by the author) further shows the areas where NPM with nursing can still be seen within Scotland and how these compare to England. Although Scotland claims to have moved away from marketization to have an emphasis on professionalism, as I shall argue, the influence of NPM is still alive within NHS Scotland and that the differences between England and Scotland to date have been overstated.

Organisational Culture

The notion of organisational culture is important within NPM in understanding the operation of the NHS. NPM drives the way in which an organisational culture can develop or can cause conflict within the established culture. According to Davies *et al.* (2000) the notion of organisational culture is an elusive concept, for which there are many competing interpretations and differing definitions. Despite this, Morgan (1986: 112) argues that when we talk of culture we refer to “the pattern of development reflected in a society’s system of knowledge, ideology, values, laws and day-to-day ritual”, it could also refer to the degree of change and/or refinement that can be seen in such systems of belief and practice. However, Morgan (1986) goes on further to claim that the concept of culture could be used more generally to show differences between different groups of people who lead their lives in different ways. The culture of an organisation can be difficult to understand by those who are not part of that organisation; the beliefs, routines and rituals are seen as strange.

Once an organisational culture starts and begins to develop, there are practices which occur to help solidify the acceptance of core values. There can come a time when the

organisational culture needs to change; this could be due to external factors, such as societal changes, that means the organisation must adapt and change (Luthans 1995). In the case of the NHS governmental changes in policy, these can strongly influence the management and ethos of the organisation. The changing policies and the development of managerialism, in particular the introduction of NPM, have caused a significant change in the culture of the NHS. There is now an emphasis on efficiency and cost containment. As highlighted by Maitlis and Lawrence (2003) the most powerful groups can dominate decisions made within an organisation, decisions that may not be the most appropriate for the organisation. The possession of power is critical in determining how decisions are made (Lynch 2004). Power is discussed in chapter 3.

Despite changes occurring, it can in reality be difficult to change old cultures and the newer changes can be met with resistance. Pheng (1998) highlights that whenever change is introduced into an organisation, then employees will often either resist or resent the changes (this will be discussed further in chapter 3). Obstacles such as entrenched skills, staff relationships, roles, and structures all work together to reinforce the traditional cultural patterns. For example in the 1980s, the Griffiths reforms tried to overlay an overtly managerial culture onto the NHS organisation with an “otherwise extant public service orientation” (Davies *et al.* 2000: 113). This caused a change in the culture, in this case - the development of budgets and contracts. However, these were not as successful in penetrating the entrenched values and beliefs that underpinned clinical practice and so clinical autonomy remained and caused conflict between managers and staff.

Effective management of today's organisations and human resources face enormous challenges:

“downsizing, diversity, the knowledge and information explosion, global competition and total quality are not only some of the latest buzzwords, they are representative of the harsh reality facing managers now and in the future” (Luthans 1995: 3).

Managers and staff are expected to perform to a high standard despite such challenges in their workplace. Garside (1998: S13) comments that “most people working in healthcare organisations do not wish to alter their location, style, or mode of working”. This means that these individuals will not embrace or engage with the plans for change, and will actively resist to some extent. The level, intensity and effectiveness to which individuals resist is crucial, and impacts on the ability of the establishment to make changes effectively. The culture of the organisation will influence change via its norms, values, behaviours and policies. This can be enhanced by rewarding behaviour that supports the adoption of new ways of working and in some way penalise behaviours that do not. As previously mentioned change can cause conflict and those in authority must manage these tensions effectively.

Street-Level Bureaucracy, Discretion, Coping and Resistance

Although there have been many studies which apply the work of Lipsky for analysis purposes, these have mainly been in public sector areas such as employment and social work. To date very little has been written which draws upon Lipsky's (1980) classic study of street level bureaucracy in relation to nursing. The studies that have been undertaken tend to pertain to community nursing (cf. Walker & Gilson 2004; Bergen &

While 2005). My belief is that Lipsky's work has continuing relevance today and within the field of nursing, specifically in relation to his ideas regarding discretion of front-line staff. Traditionally nursing has been viewed within a hierarchical structure, where it would be anticipated that the use of discretion by staff would be limited. However, I would argue that discretion is as important within the day-to-day work of front line nursing staff as for other public-sector workers. Nursing has been transforming itself as a profession (as will be explored in chapter 3) and is moving away from the traditional hierarchical structure and the medical patriarchal model of 'Doctor knows best'. This means nurses have become increasingly responsible and accountable for their own actions. This study will draw upon the work of Lipsky to help offer explanations for the findings in this thesis.

There is an argument that Lipsky having been written in the 1970's and focusing on American public services is no longer relevant for British street-level bureaucracies of today. Authors such as Howe (1991a) are unconvinced by the use of Lipsky's framework following the changed context in which bureaucracies now operate compared to the 1980s where there was greater practitioner discretion and management influence. Authors such as Cheetham (1993) and Howe (1991a&b) question the applicability of Lipsky in the changed context of social work (due to the rise of NPM ideals and marketization). Howe argues that managers have removed or severely limited the influence of professionals and so managers now control practice. The aim in the 1980's was to limit the authority of professionals and Howe argues that discretion has been removed from the street-level bureaucrats and now solely lies with the managers, this has been achieved via procedures, policies, targets, surveillance and budgets: "managerial strategies are designed to minimise reliance on skills and actions of other

groups...workers know what to do...practices become regularised and standardised” (Howe 1994b: 158).

This view is not shared by many present-day commentators authors such as Baldwin (2000; 2004), Ellis *et al.* (2007), and Evans (2010) disagree with Howe’s (1991a) and Cheetham’s (1993) viewpoints. For example Baldwin believes that Lipsky continues to have contemporary relevance for understanding discretion in street-level bureaucracies. Both Evans (2010) and Baldwin (2000) highlight that there have been significant changes in terms of an increasingly managerial environment and a lack of resources but the essential characteristics of street-level bureaucracies persist. In relation to social work for example, Evans and Harris (2004) assert that Lipsky continues to be relevant within British social service studies and his account of the American public organisation can be seen within contemporary managerialised social service departments in the UK.

Nurses as Street-level Bureaucrats

One aim of this study is to explore the extent to which nurses can be described as street-level bureaucrats. Lipsky defines street-level bureaucrats as “public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work” and he defines street-level bureaucracies as “public service agencies that employ a significant number of street-level bureaucrats in proportion to their workforce” (Lipsky 1980/2010⁶: 3). Much of Lipsky’s text concentrates on those working in social services, the police and the education services; however, he himself identifies health workers as street-level bureaucrats:

⁶ The original book ‘Street-Level Bureaucracy: Dilemmas of the Individual in Public Services’ was published in 1980; however, an updated expanded edition was published in 2010. In this latest edition, there is an additional chapter where Lipsky revisits and reflects on significant policy developments that have occurred since the original edition. It is this 2010 edition that has been quoted throughout this thesis.

“typical street-level bureaucrats are teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officials, **health workers**, and many other public employees who grant access to government programs and provide services within them” (Lipsky 1980/2010: 3).

Nurses can be seen to be street-level bureaucrats in terms of Lipsky’s definition, as they interact directly with the public as part of their job and use discretion in their daily work. In Lipsky’s analysis, the characteristics shared by street-level bureaucrats include: ‘non-voluntary’ clients, a need to “process workloads expeditiously”; substantial autonomy in their individual interactions with clients, and an interest in ensuring and furthering that autonomy; conditions of work that include inadequate resources (including financial, personnel and time), a demand that exceeds supply, ambiguous and multiple objectives, difficulties in defining or measuring good performance, and a requirement for rapid decision making (Lipsky 1980/2010: 18). From this definition, it can be seen how nurses fit the title of street-level bureaucrat.

Nurses position in implementing policy is a unique one which can be very influential (Loyens & Maesschalck 2010) and they can be thought of as “agents of social control” (Lipsky 2010: 4). There is a wealth of literature on the topics of policy making and policy implementation (cf. Hill 1997) and Lipsky argues that policy-making can take place as much at street-level as it does via the more traditional top-down approach. Nurses working within the NHS interact with citizens on a daily basis, and can influence the treatment and experience of these citizens. It is those individuals (street-level bureaucrats) who produce public policy as “street level leaders” (Vinzant &

Crothers 1996: 147) despite being in the lower layers of a hierarchy (Meyers & Vorsanger 2007; Loyens & Maesschalck 2010).

Hospitals also have many of the defining features of Lipsky's (1980/2010) street-level bureaucracy. Hospital bureaucrats like other public sector bureaucrats' work in difficult conditions, with a lack of resources, a demand which exceeds supply which leads to staff having to meet conflicting goals of quality care at low cost (Lipsky 1980/2010: 29). Clayton Thomas & Johnson (1991) for example identified the American urban hospital as a street-level bureaucracy due to the urban hospital having many of the characteristics outlined by Lipsky (1980/2010: 3). Street-level bureaucracies are hierarchical organisations where there is substantial discretion at the base of the hierarchy - it lies with the front-line staff (Piore 2011).

Discretion

Lipsky's theory is based on the notion that in order to implement policy discretion is involved. The core argument is that discretion is not only unavoidable but it also necessary within welfare bureaucracies. Those individuals directly involved in delivering policy at street-level, exercise their discretion in how policies are carried out. It is this ability for street-level workers to "make rules or interpret policy at street-level that constitutes the "bureaucratic" element of their activities" (Taylor & Kelly 2006: 630). In the use of discretion, Ellis *et al.* (1999) identifies discretion being used as a way to fill the gaps within public policy, whereas Balwin (1998) purports that discretion is used as a way to undermine official policy. So, discretion can be used by practitioners in a variety of ways, and not necessarily to benefit the patient (Evans & Harris 2004).

A criticism of Lipsky is that he focuses on the similarities of the street-level workers and as such overlooks the influence of occupational status and how professional workers can be required to utilise discretion due to their professional attributes (Evans 2010). For example, Skolnick (1966) proposes that there is a difference between delegated and unauthorised discretion in his study of the police. Delegated discretion means that an individual has the ability to carry out discretionary decisions, but they must be in line with the standards of the institution and that there must be criteria for justifying decisions that are using discretion (this is based on the premise that all cases should be treated alike). This means that street-level workers are being asked to utilise discretion due to their professional status. Unauthorised discretion on the other hand is when discretion is used in order to satisfy personal or institutional motives.

Policy that is delivered by nurses is generally immediate and will be personal; decisions are made at the point of contact within the hospital or community environment. As street-level bureaucrats, nurses have considerable discretion in determining the nature, amount, and quality of benefits and sanctions provided by their organisation, despite policy which dictates that discrimination will not occur within the NHS. Due to the nature of the type of work, nurses will undoubtedly be influenced by their own thoughts, for example whether the patient is seen as 'deserving' or not. Although all patients will be entitled to treatment, nurses will perhaps go further for patients whom they see as more deserving, or whose behaviour they choose to overlook or not (unauthorised discretion). However, this does not mean that nurses are not restrained by rules and regulations. Nurses are accountable for their actions and omissions as part of their code of conduct (NMC 2008), and are also bound by NHS directives.

With regards to conforming to the formal structures of authority, Lipsky (1980/2010: 16) indicates that workers for the most part accept the legitimacy of these structures, and are not in a position to disagree with them. However, if the street-level bureaucrats (in this case nurses) do not agree with the organisational views and preferences of the managers then their goals will not be the same, which can lead to noncompliance by nurses and also to conflict between managers and nursing staff. Front-line nursing staff can have distinctly different interests to those in a position of authority, thus leading to this noncompliance or a lack of cooperation. For example nurses can employ coping strategies such as absenteeism, aggression towards the organisation and negative attitudes (alienation, apathy) which can impact on the work being undertaken. These sorts of actions can mean that it limits the organisation's ability to achieve its goals, as staff are not working as efficiently and effectively as they could be. Staff must use discretion in processing a large workload when they are under-resourced, which means short-cuts and simplifications to cope are developed. Such coping mechanisms are generally unsanctioned by the management. Lipsky (1980/2010: 45) further indicates that the development of coping strategies may be against an agency's policy, but the fact they are being utilised is actually critical for survival and for staff to perform their jobs.

The priorities of staff nurses, compared to those of management, can lead to conflict: "street level bureaucrats may consider the right of managers to provide directives, but they may consider their managers' policy objectives illegitimate" (Lipsky 2010: 18). Managers tend to be focused only on performance and the cost of such performance. Due to this, managers can try and restrict workers' discretion to ensure results are achieved. But due to nurses expecting the right and ability to make critical discretionary

decisions, the restrictions imposed by managers on staff can often be seen as illegitimate. There is a tension between having a professional status as a nurse but also the need to comply with superiors' directions. In order to cope with such tensions Lipsky (1980/2010: 21) argues that street-level bureaucrats will use the rules, regulations and administrative provisions to evade, or change policies that will limit their discretion. However, Taylor and Kelly (2006: 639) argue that "liberation from rule-setting and devising coping mechanisms in the workplace has not occurred because of the high levels of accountability and scrutiny generated under public management".

Institutions are trying to gain authenticity, although this can be rhetorical, by offering commitment to fairness and equity for all (Lipsky 1980/2010: 22). However, those working at the frontline are often dealing with the apparent unfairness of treating all individuals similarly. There are always different circumstances, (e.g. personal characteristics, incomes, living conditions, family commitments for patients) and not recognising these differences and treating people accordingly (which means some people will be treated differently to others) means treatment can be unfair. Also, these standards for fairness and equity will still not dictate actual practice because there are also personal biases from the street-level bureaucrats involved. Street-level bureaucrats can therefore be more sympathetic and helpful in some circumstances compared to others which are not supported by the formal structures; such biases are very difficult to remove.

There is another reason that street-level bureaucrats require a level of discretion, which is that the public and professionals do not want a computerised public service which is rigid in its application, despite managers trying to develop a 'one size fits all approach'

via numerous policies, protocols, checklists, directives and targets (Lipsky 1980/2010: 23). Discretion allows frontline staff to intervene on behalf of clients and also to discriminate amongst them, allowing some individuals to be prioritised (which is needed within the medical area- some individuals will require quicker or more treatment than others). Regardless of this, bureaucracies are hesitant about personalised service deliveries, despite promoting policy rhetoric of individual/patient-centred care (e.g. The Scottish Government 2010b).

Coping and Resistance Strategies

As proposed by Lipsky (1980/2010: 23), workers often have minimal resources to resist management decisions. However, a key aspect of resistance within a work place is that of informal collective attitudes and practices (Mulholland 2004). Nursing staff in many respects are collective workers, and as such the groups evolve to form defensive alliances due to their experiences of workplace relations at the street-level (Bain & Taylor 2002). These types of alliances will develop as workers identify with each other and staff will then act together, collude, collaborate and co-operate due to changes to management practices. However, some have argued that managerial approaches which incorporate individualising strategies have eliminated such forms of resistance within the workplace (Frenkel *et al.* 1998; Kinnie *et al.* 2000). The increasing surveillance of the workers, the standardisation of working processes and a customised bureaucracy have meant that the degree of autonomy held by workers is limited (Frenkel *et al.* 1998; Mulholland 2004). Despite this, Van den Broek (2004) asserts that these managerial imperatives have not been so successful in causing increased individualisation and therefore ambivalence within workforces, rather “these control mechanisms embodied

significant levels of managerial coercion and therefore attached varying levels of resistance” (Van den Broek 2004: 2).

The notion of the ‘collective worker’ (Lucio & Stewart 1997) remains important within the workforce. Collectively workers can employ mechanisms such as sabotage, working to rule, work avoidance, absenteeism and high turnover (Mulholland 2004). Taking part in actions of opposition to managerial control can result in the emergence of collective practices and tacit alliances. Modes of employee social control include gossip, confrontation, resignation, toleration, theft, sabotage, non-cooperation, collective action, formal complaints, violence and legal action (Tucker 1993). Although in his study these forms of social control were identified for temporary workers and the majority thought to be individual tactics, similar modes can be seen within the more permanent workforce generally and with groups of employees, not just individuals. Gossip is often a first step for aggrieved employees, where they seek others to share their problem. This is generally not about gathering support for a collective confrontation with management. Rather gossip acts as a type of “settlement behaviour” where participants pass judgement assigning fault and blame (Tucker 1993: 31). This means that overt action is generally absent and the employer in most cases will be unaware of the grievance (cf. Merry 1984). Gossip can also be used by individuals to reinforce their position prior to taking action, to gain supporters and obtain assistance in the handling of conflict (cf. Black & Baumgartner 1983).

Confrontation is about trying to work out a resolution with a representative of the organisation (usually a supervisor). It is often seen to be a risky strategy as staff can be concerned about being reprimanded or fired as a result of attempting to share the

problem with their managers (Tucker 1993). Resignation is simply ending employment with the organisations and although workers can leave employment without voicing complaints, resignation is more likely to occur following active measures of managing the problem. There are significant costs associated with training qualified nursing staff and replacing those who leave and so it is not as simple for management to just replace workers who do not comply due to the significant cost implications. Another mode of employee social control is one of toleration, where the grievance is not expressed in an outward manner; no action is taken by the employee to ensure that the issue is addressed by the organisation. This could also be seen as acceptance from the employee.

Theft can be used by subordinates to sanction superiors in order to seek restitution or compensation from the organisation by taking “matters into one’s own hands” (Tucker 1989: 332). Sabotage can be employed in several ways such as the deliberate destruction of company property or voicing dissatisfaction (‘bad mouthing’) which can damage the reputation of a company (Baumgartner 1984; Tucker 1993). Non-cooperation involves employees responding to perceived injustices by not performing a required task(s). For this to be effective the subordinate must ensure it is a task that cannot easily be undertaken by another individual (requires a specialised skill). Collective action can be understood as a grievance/issue that is not limited to an individual but rather involves several affected employees acting in unison with others. Formal complaints mean that employees seek redress via established formal procedures or legal action. An individual (or group of individuals) uses the legal system to address the dispute or grievance. With regards to violence, this is more likely to be aimed at specific people.

Further to this, nurses share with other workers the need to think of themselves in a favourable light. Generally workers do not comment that they are doing a perfect job due to such constraints as time and resources – they “see themselves as fighting on the front-line of local conflict with little support and less appreciation by a general public whose dirty work they have to do” (Lipsky 2010: 82). If they are working inadequately then workers do not see it as their fault. In order to deal with the inadequacies in their practice, workers develop coping strategies. This is perhaps by limiting the demand if possible so as to maximise the available resources and lower the objectives which are being tried to achieve. Workers seek to simplify their tasks and narrow the range in perceptions – “they try to create routines to make tasks manageable” (Elmore 1997; Lipsky 2010: 83). This is also linked to workers discretion; (Loyens & Maesschalck 2010). This is not a new development (Satyamurti 1981; Loyens & Maesschalck 2010), for example Hirschman (1970) discusses notions that are applicable in nurses coping in the work environment – ‘voice’ and ‘exit’. The ‘exit’ option would be the workers leaving the relationship; if staff are dissatisfied then they can show their dissatisfaction by leaving the employment of the organisation. ‘Voice’ on the other hand would be staff trying to improve the relationship by vocalising dissatisfaction and grievances. However, Nielsen (2006) points out that these types of coping mechanisms are not just about managing difficulties and frustrations, but they can also be used by workers to gain a sense of satisfaction in their work. Further to this Elmore (1997: 249) argues that workers resist the attempts of management to alter their discretion or change the way they work, they: “resist hierarchical management – because these things are a concrete expression of their special competence, knowledge, and status in the organisation”. The forms of coping that have been identified from the literature are summarised in Table 1.

Table 1: Forms of coping and resistance strategies for front-line staff

Acceptance/Toleration	Employee(s) does nothing (non-action). Continues to follow the rules believing there is nothing they can do about it
Alter/Discretion	Employee(s) will bend policies or rules in order to make their working conditions and tasks more appealing or manageable
Work Avoidance	Employee(s) will deliberately not undertake work where possible
Confrontation/Voice	Employee(s) will raise the issue or problem with management in a hope of resolution
Exit/Resign/leave	Employee(s) terminates their employment with the organisation
Formal procedures/Legal Action	Employee(s) follows the formal organisational channels or takes formal legal action against the organisation
Gossip	Employee(s) will talk with each other but rarely voice feelings to management
Non-Cooperation	Employee(s) do not follow the policy or rules, they simply break the rules.
Sabotage	Deliberate actions will be taken by an employee(s) to cause difficulties or problems within the workplace
Theft	Employee(s) will steal from the organisation
Work to Rule	Employee(s) only undertakes tasks that are part of their job description and do no further work outside of this

The benefit of collective resources means that public sector workers have strengthened their position for resisting. However, that is not to say managers cannot sanction employees. In the case of Ward Managers, they are in a position of authority which can recommend advancements, dictate when the individual will work and when their days off will be, and can generally make the job more or less desirable. Street-level bureaucrats, due to their discretion and position as “de facto policy makers” (Lipsky 2010: 24), increase the dependency managers have on these individuals.

These frontline staff can reject a way of working, only undertake the minimum level of work required, and work rigidly to the guidelines with no flexibility if they disagree with their management, thus reflecting poorly on managers. However, it needs to be noted that this can be difficult for front-line nursing staff as these particular individuals are faced with life-threatening situations which cannot be ignored. Also senior managers can lack the ability to intervene effectively or extensively in the way work is performed or undertaken, thus further showing their dependency. Therefore it can be seen that the relationship between managers and street-level bureaucrats can be one of potential conflict.

According to Lipsky (1980/2010: 18-19) street-level bureaucrats will have different aims and goals to those of managers in the NHS. However, Evans (2010: 5) highlights this as a criticism of Lipsky stating that this perspective is limited due to its lack of analysis regarding “the nature of management and of the influence of professional status on discretion”. For Lipsky managers and street-level bureaucrat’s work in different ways, have different priorities, values and commitments. Managers are focused on policy implementations whereas the workers are attempting to make working conditions bearable and to try and control the direction of their own work. However, there must be

compromise between such managers and workers. Within nursing, this raises questions with regards to local managers (in the case of nursing this would be individuals such as ward managers and lead nurses), as according to Lipsky these managers would be presented as obedient to the organisation.

Lipsky (1980/2010: 19) characterises managers as a unique group which, cast in a particular role, is seeking to control practice and limit discretion, but according to Evans (2010: 165) findings which focuses on managers (opposed to Lipsky's 1980s study which focused on practitioners), managers are "using their discretion to adapt, change and subvert policies" in similar ways to practitioners. Lipsky portrays local managers and street-level bureaucrats as having fundamentally different orientations, but this may not always be the case. For example within nursing, it is important to mention that Ward Managers who remain clinical will find themselves torn between management priorities and the goals of ward level patient care.

The central remit of a bureaucracy according to Wilson (1973 cited in Elmore 1997: 249) is ensuring that the front-line worker is doing the right thing; therefore meaning that the job of administration is to control the discretion of workers. The techniques employed by hierarchical management are those of budgets and planning systems, clearance procedures, reporting requirements, evaluations, monitoring and audits (linked closely with the central ideals of NPM). These aim to structure the behaviour of workers; however, there is a disjuncture between these managers and front-line workers who can see such techniques as incidental to the real work of the organisation. The front-line worker is more focused on coping with the immediate pressures of a job and learning "a relatively complex set of work routines that go with one's specialised

responsibility” (Elmore 1997: 250). This can account for the sceptical response that can be given by frontline workers when asked about policy implementation.

Summary

As has been discussed in this chapter, both the Griffiths Report (1983) and ‘The NHS and Community Care Act’ (OPSI 1990) have been significant in shaping structural changes within the Scottish and English NHS. The rise of NPM and business style practices can be linked to the Griffiths report where general management was introduced. Since the advent of NPM in the 1980s research demonstrates that working practices of most public sector workers have been affected by managerialist policies, however this impact has not been uniform (Ferlie *et al.* 1996; Brunnetto 2002). Key elements of NPM have been identified as being important within the NHS (See Figure 1 page 42). Within the Health service in the UK, there has been the development of quality initiatives, which in reality have been “a front for the political objective of cost cutting in the provisions of some public goods and services” (Brunnetto 2002: 5). This has led to a culture which is about ‘doing more for less’ (Pollitt & Bouckaert 1995). Although there have been differing policies within Scotland and England, this chapter has shown that NPM continues to have an influence on NHS Scotland (although perhaps not as strongly as in England).

Lipsky’s (1980/2010) notion of street-level bureaucracy has been discussed, and will be applied for analysis purposes within this thesis. Currently there is minimal research linking both British nursing and Lipsky. However, it has been noted that discretion is important within nursing (as with other public workers), despite nursing have traditionally been seen as having a hierarchical structure. The ways in which front-line

staff can cope with the demands made upon them or resist management have been explored in this chapter. Such strategies can be employed by the individual workers, but there can also be collective responses. These have been summarised in Table 1 (page 59).

The next chapter will consider those elements of NPM which are deemed particularly pertinent to Scotland. It will examine four of the key influences of NPM in more detail, these being hands-on professional management, discipline and parsimony in resource use, standard setting and performance measurement, and consumerism and service quality. The chapter will show the influence they have within the Scottish NHS and on nursing practices specifically.

Chapter 3: Nursing and New Public Management

Introduction

The purpose of this chapter is to provide an account of four key areas of NPM and how they influence front-line nursing staff practices and relationships within the Scottish NHS. The chapter will explore each of the areas in turn; these being ‘hands-on’ professional management; discipline and parsimony in resource use; standard setting and performance measurement; and consumerism and service quality.

The chapter will briefly explore the nature of professionalism, before looking at how nursing practices have changed over time, and how the progression from vocation to profession has gradually occurred and the significance of it for nurses. It is important to understand the development of nursing and locate it within the structural changes and policies that have influenced the NHS within Scotland. The next part of this chapter explores the four key areas of NPM which have been identified as being important within NHS Scotland and the influence of these upon the nursing profession. ‘Hands-on’ professional management within the NHS developed from the introduction of general management within the NHS, and can still be felt within Scotland’s health service which has led to (and continues to cause) tensions between professionals and managers. According to Hood (1991:4) this ‘hand-on’ professional management means having a manager who is active and visible; who has discretionary control of organizations from named persons at the top, and is ‘free to manage’. With regards to lines of accountability this ‘requires clear assignment of responsibility for action not

diffusion of power'. The relationship between professionals and managers is discussed along with ideas relating to power and authority and how these might cause conflict.

With regards to discipline and parsimony (doing less for more), the drive for financial accountability and efficiency is explored to determine how NPM mechanisms (including the impact of privatisation and centralisation of services within the Scottish NHS) have been employed to achieve these. These mechanisms are discussed in terms of how they impact on the front-line nursing staff and the role they have in shaping relationships and working conditions. With regards to standard setting and performance measurements, the influence of target setting and auditing is explored. These have played a significant role in shaping current practices and focus within the NHS. Finally the influence of consumerism within the NHS is discussed. I look at how the notion of the patient as a 'customer' has changed the relationship between patients and staff and the consequences this has had within the workplace. These four features are seen to be the most pertinent within Scotland and have had a significant influence on front-line nursing staff (and their relationships) within Scotland (though this is not to say that those other elements listed in Figure 1 (chapter 2, page: 42) do not have a part to play in shaping NHS Scotland).

Professionalism

This section will briefly outline the nature of professionalism. A profession according to Friedson (1977: 16) can be defined as: "special kinds of status groups – as organisations or workers who have gained a monopoly over the right to control their own labour". A profession is a controlling occupation which possesses a status of superiority and an

advantage within a division of work. A unique body of knowledge, a code of standard/ethical conduct for individuals, an altruistic service, the level of power and authority the group has with regards to training and education, lengthy socialisation to the work, autonomy in practice and state registration are all seen to be key characteristics of a professional status (Freidson 1983; Richman 1987; Maloney 1986; Ruddy 1998). Professionalism on the other hand is often viewed as a process through which occupations advance, and in which the final state is being a profession (Ruddy 1998).

Professionalism has two main areas, these being occupational domains which attempt to establish professional control (cf. Freidson 2001) and occupational closure (cf. Abbott 1988), which means that professional workers are able to govern themselves and any outside interference is limited/mitigated (Noordegraaf 2007). Noordegraaf (2007: 765) describes it as: “about applying general, scientific knowledge to specific cases in rigorous and therefore routinized or institutionalised ways”. It is about a high level of education; making inferences; treating clients; making specific decisions; analysing cases; giving specific advice based on learning, knowledge, expertise and technical abilities; an accrument of standardised skills, learning how to behave competently; along with making sense of situations and knowing how to react appropriately. It is also about disciplinary control of practices (Abbott 1988; Fournier 1999; Freidson 2001). Professional work is institutionalised, individuals are autonomous and professionals associations regulate the professionals.

In the public sector professionals are seen as having ‘occupational’ or ‘organisational’ as opposed to ‘status’ professionalism (c.f. Elliot 1972; Freidson 1983; Noordegraaf

2007). Professionals in public domains are part of the large organisations systems and are “subject to cost control: targets: indicators: quality models; and market mechanisms, prices, and competition” (Noordegraaf 2007: 763). In the case of nursing emerging as a profession, it is seen as “a consequence of the mechanism of medicine” which remains subject to this medical profession (Freidson 1990; Dingwall & Allan 2001; Datwyler 2007: 133). Furthermore, nurses can be seen as bureau-professionals. This is because their role involves both professional and administrative functions. Newman & Clarke (1994: 22) define bureau-professionalism as a “combination of professional expertise couple with the regulatory principles of rational administration as the means of accomplishing social welfare”. It is a mix of bureaucracy and professionalism and as such nurses have to be both bureaucrats and professionals within their work.

What is interesting is that more recent developments in nursing’s quest to be accorded professional status, has occurred at a time when other professions including medicine have been under attack claims to status undermined (Exworthy & Halford 1999; Finlay 2000). Within nursing there seems to be a contradictory process of both professionalisation and de-professionalisation (this will be further explored in the subsequent section). Evetts (2011) highlights that there are challenges to professionalism, and that managerialism has perhaps influenced the changes to professional’s values (although currently this is speculative). It has been documented that powerful professional groups have often been resistant to managerial intervention and control. Such groups have historically had much autonomy, with a high status which had provided them with power (e.g. doctors), but changes in organisations have mean that these employees are now subject to increased control which has affected their work (such as the imposition of targets and standardisation of work procedures). This

has led to changing occupational values of the profession (Evetts 2011). As such the relationship between manager and professional has changed, whereby managers become supervisors.

However, professionalism can be challenged in many ways. For example in the case of the medical profession, neoliberalism and managerial control, the rise of consumerism, the introduction of new professional methods (e.g. targets/audits) and new professional workers (such as nurse practitioners) have weakened the autonomy of doctors at the front-line (c.f. Exworthy & Halford 1999). Professionals must therefore adapt to social changes, capitalist pressures, consumerist tendencies as well as organisational and bureaucratic realities (Noordegaaf 2007).

Nursing as a Profession

Some commentators suggest that the 'heyday' of nursing was in the 1970s when medicine and nursing were seen as complementary and consensus management was prevalent (Walby & Greenwell 1994). Up until this point nursing was seen as a traditional vocation where wards were clean, safe and nurses were always nearby (Warren & Harris 1998). However, the structure of nursing was changed following the Salmon Report (HMSO 1966), a different ward structure appeared, the status of nursing was to be upgraded and nurses were then able to step away from the bedside and enter into management roles away from the ward (Warren & Harris 1998). This meant a change in the training of nurses, and the drive for nursing to be seen as a profession similar to medicine or law began.

However, as recently as 1992 nursing was not seen as a profession. Commentators such as McEvoy (1992) and Bridges (1991) noted that there was a variety of ways in which progress had been made towards nursing developing into a profession. For example these include: the creation of professional organisations, development of codes of practice and ethics, development of conceptual frameworks of practice, opportunity for degree courses and the emergence of nursing research. Despite these advances, Watkins (1992) argued the attitudes from nurses themselves prevented nurses taking strides professionally. Rundell (1991) believed that the public in general and nurses in particular deferred to doctors instead of allowing nursing to be valued as a profession that is as skilled and valuable as medicine.

Inequalities in relation to gender within society are reflected within the nursing workforce (Robinson 1997). A traditional view that is “the good women” (Nightingale 1881: cited in Vicinus & Nergaard 1989: 385) become nurses, a view seemingly tied to the socially constructed notion of women’s work, which in turn legitimises the lower status given to nursing work as opposed to medicine⁷. According to Salvage (1990) this view was challenged by many nurses, as it was seen to downgrade the work of nurses as being ‘natural’ and intuitive ‘women’s work’ and so not even an occupation. Despite the steps taken by nurses to obtain recognition as a profession, Kozier (2008) argued that that modern definitions of nursing are still diverse and numerous, with nursing appearing to be a jack-of-all-trades. A further reason given as to why nursing is not viewed as a profession, is that the traditional and masculine defined models of professionalism have meant that the argument for nurses to be recognised as professionals has fallen predominately on deaf ears (Davies 1996). The concept of

⁷ See for example Oakley (1984) and Game & Pringle (1983) for further information on this notion.

professionalism within the NHS (in particular medicine) has stereotypical male traits such as: competitiveness, detachment from care, independence in decision making, control and rationality. These traits are in contrast to the stereotypical view of nursing as reflective, attached and caring (Fatchett 1999).

A further problem for the professionalization of nursing was the attitude that “nurses have to be all things to all people to prove they are good professionals” (Fatchett 1999: 113). To develop as a profession, there is a need for good managers, teachers, practitioners, researchers, politicians and writers as is expected in other professions. However, within nursing Watkins (1992) argued, a nurse who voiced that nursing should be a profession was often vilified and isolated by other nurses, perhaps due to occupational solidarity being poor within nursing unlike within medicine, where they tend to support their own and have powerful representative organisations. Within nursing unions it can be seen that there is competitive bidding for members on the one hand, whilst on the other fiercely defending a hierarchical status, which makes it possible for collaboration with other NHS employee groups (Cohen 1993).

The Griffiths Report (1983) did little to help nursing establish itself firmly as a profession. For a start the right for nurses to be automatically represented on health authority management teams was removed (Walby & Greenwell 1994), so nurse’s voices were effectively removed. Post 1980s, most arrangements became discretionary, with some nursing roles turned into senior management roles with job descriptions relating to quality assurance (Robinson 1992). These changes meant a move away from Taylorist styles of management towards New Wave Managerialism, as the more highly trained nurses remained the typical nurse and did not move into management roles

(Walby & Greenwell 1994). A Taylorist style of management is one of 'scientific management', as its core control is achieved via supervision, and efficiency improvements are created by splitting complex tasks into simple tasks which are easier to manage and so can be performed by less skilled (so cheaper) workers (Flynn 1994). New Wave Managerialism (also known as New Human Resource Management) is about using the "workers capacity to treat work as a creative arena", the idea being that if you have a positive commitment by employees to work, this will create individuals who will work harder, be more creative and be engaged (Walby & Greenwell 1994: 57).

Nurses have been subjected to Taylorist forms of management far more than doctors. This is because the organisation of nursing has involved a far more "bureaucratic form of governance, with closer supervision, greater accountability for mistakes and a clearer hierarchy of command" (Walby & Greenwell 1994: 62). Nurses have always had a hierarchical management system that is reflected in the job titles (e.g. Charge Nurse, Nurse Manager, District Nursing Officer) demonstrating a Taylorist element in its management style. It can also be seen that nurses historically have lacked influence and 'political clout' in relation to key health policy decision making processes which ultimately have an effect on patient care (Antrobus 1997). The Griffiths Report (1983) did little to address this, and according to Warren and Harris (1998) the changes occurring were detrimental to nursing itself leading to low morale, poor retention and recruitment of staff, hostility from the public and a decline in patient care. Since then, various changes have occurred within nursing, with the stated aim of ensuring that the NHS is more efficient and cost effective, if the rhetoric is to be believed; the extent to which this had led to an improvement in patient care is discussed in this thesis.

However, as nursing education developed, following the changing structures of the NHS since the 1980s, and in particular with ‘new nursing’ being the underpinning notion for Project 2000 nurse training, the process and philosophy of professionalism in nursing has shifted (Fatchett 1999). According to Beardshaw and Robinson (1990) this was a move away from task-orientated nursing towards care that is tailored to the individual needs of the patient. This was linked to the rise in evidence-based practice (EBP), which was seen as a way to advance nursing by offering validation for nursing practice (Malloch & Porter-O’Grady 2010). EBP and patient safety initiatives were also highlighted as a way to achieve quality improvements within the clinical governance frameworks; “a major feature of clinical governance is guaranteeing quality to the public and the NHS, and ensuring that clinical, managerial and educational practice is based on scientific evidence” (McSherry & Haddock 1999). EBP and patient safety initiatives will be discussed in more detail later in this chapter. In doing this the aim was to substitute nursing’s long established hierarchical, bureaucratic model with a professional model of organisation. With this there has been a challenge to the biomedical ties of nursing to medicine, and recognition of the importance of emotion and wider social aspects of care and health (Butterworth 1992; Williams 1993). This has paved the way for nursing to be seen as a profession in its own rights

According to Salvage (2003: 13), nurses have:

“always inhabited a rather uncomfortable social space somewhere between the ‘true’ (i.e. male-dominated, powerful, elitist) professions like medicine and law, proletarian occupations like domestic work and health care assistants, and unpaid ‘women’s work’ in the family home”.

Due to this perceived weakness in the struggle for recognition as a profession nurse reformers attempted to mimic the institutions and cultures of ‘true’ professions by

striving to become a profession (Schwirian 1998). Nurses have in more recent times, attempted to reorganise into a system that is representative of a more traditional profession (such as medicine). Greener (2009) claimed that in the 1990s and 2000s nurses became more professionally focused and the number of nurses moving into management roles meant that barriers and stereotypes surrounding the role of nursing will be challenged. Noyes (2011) further supports this arguing that in developed countries nursing as a profession is now generally held in high esteem. Nurses have been pursuing new pathways and nursing has become far less homogenous. For example nursing staff now undertake many different roles from management, to doctor replacements in areas such as triage, diagnosis or administering intravenous drugs. Developments such as the walk-in centres and NHS were nurse focused; nurses were the first point of contact as opposed to doctors for the first time. This was partly due to: cost, the need to improve access to services and due to the shortage of doctors (Rivett 2008). Nurses in reality often had the clinical expertise and with further training such as the 'nurse practitioner' training were capable of undertaking these new diverse roles.

The 'New Nursing' philosophy focused on holistic treatment of the patient as opposed to the "fragmented specialist functions" undertaken by many different people (Walby & Greenwell 1994: 63). This developed via the concept of 'primary nursing,' whereby each patient has a primary nurse who organised their care. This is moving away from the task orientated practice that has previously been seen within nursing to one which is patient/consumer orientated, thus tying into the ideology of NPM, in which consumerism and patient quality has been highlighted as important. It can be seen that nursing has been shaped to reflect such ideologies.

According to Walby and Greenwell (1994) it was this notion of consumer-orientated care that helped drive up the levels of training and education for nurses. Up until 1988, the training of staff was undertaken within the ward arena like an apprenticeship. However after this point training was moved into the higher education section. This could be seen in the 'Project 2000' programme for nurse education. This was where nurses moved into the general higher education area, rather than remaining attached to hospitals. At the same time as the increased level of training for new nurses, there was the introduction of a new grade of healthcare assistants, who only had six months' worth of training as opposed to the full three years nurse training. These healthcare assistants would not have the same pay and conditions as fully trained staff (NHS Careers 2011). So, nurses are now required to have qualifications (diplomas/degrees) and within Scotland all trainee nurses are registered on degree programs (Shields *et al.* 2011). The rationale given for this is that degree trained nurses give better patient outcomes than those with lower academic qualifications (Klein 2007; Rafferty *et al.* 2007; Kendall-Gallagher 2011).

In the 1970s there were usually no more than two registered nurses per ward shift, and frequently on night shifts there were in fact no ward-based registered nurses. There were enrolled nurses who made up roughly one third of the qualified workforce and students who delivered much of the basic nursing care along with a few auxiliaries (Fittall 2004). Agency and bank nurses were virtually unknown. Now there are qualified nursing staff, very few enrolled nurses, student nurses who have become supernumerary and a new role of healthcare assistant. The make-up of nurses and support workers has shifted. Despite the introduction of the new nursing programme, there was a continuing concern about those trained staff working on temporary contracts (bank or agency staff)

as it was thought that these staff were unlikely to develop on going knowledge of the ward or patients within an area and so this detracted from the New Nursing project, as the primary nursing style could not be implemented due to staff not being based permanently in one area. The use of bank and agency staff has become almost universal, this is to cover absences due to sickness and also where wards are short staffed due to vacancies. It has been argued by Davis (1990) that this type of worker could eventually lead to the collapse of conventional nursing; “the development of this temporary workforce potentially undermines the development of more professionalised nursing occupations” (Walby & Greenwell 1994: 63).

Health professional roles have constantly been changing although such changes have occurred more rapidly over the past thirty years. The patriarchal medical profession has become less acceptable and nurses are becoming more independent and confident – they are no longer prepared to be subordinate to medical staff and are more likely to work collaboratively (Allen & Hughes 2002). New posts have been created, such as nurse practitioner and consultants to supplement care on the wards; and in addition to all this more subtle changes have been made to shift role boundaries, impacting quite significantly on the work that nurses undertake (Fittall 2004).

Doctors continue to make the overall clinical decisions, and generally nurses remain in a subordinate position, but boundaries and roles are becoming more fluid between the professions, for example nurses can now prescribe within a limited remit, make assessments, monitor chronic conditions and undertake counselling roles. Despite these changes, Witz and Annadale (2006) argue that this advancement in the role of nursing is not necessarily for the benefit of the profession but rather it is due to financial

considerations. Labour costs are seen to be a major issue within healthcare and salaries of staff account for two-thirds of all healthcare costs (Saks & Allsop 2007). One strategy is that of changing the job remit of staff via role enhancement, substitution, delegation and innovation (Sibbald *et al.* 2004; McKee *et al.* 2006). Tasks are moved lower down the hierarchy and so keep more expensive staff levels low; not simply just by shifting doctors roles to nurses, but also nursing roles to health care assistants and support workers (whether regulated or not).

With regards to the changing roles of nurses, there have been contributing factors that have brought about change; some have been for altruistic reasons and others less so. According to some, these developments have occurred due to diligent practitioners and professionals stepping outside of their traditional boundaries. The role of colleagues being receptive to the proposed changes along with the willingness of managers, governments, professional and regulatory bodies to accommodate these developments has been essential (Salvage 2003). However, the “value and worth of nursing” can perhaps also be articulated in the language of managerialism (Hewison 1999:1382). The developments of nursing can be seen to challenge the traditional hegemony of doctors and so the progression of nurses can help to limit the authority and power of the medical profession. Furthermore, nursing professional bodies can use this development to help to improve the status and respect of a professional occupation (Kirkpatrick *et al.* 2011; Noordegraaf 2011; Evetts 2011), which means it can help to raise the profile of nursing as a profession (Bourgeault *et al.* 2004; Carvahlo 2008).

A further factor that has influenced the acceptance of different nursing roles has been the reduction in junior doctors working hours. Not employing more junior doctors to

cover the shortfall has led to opportunities for more specialised nursing practice. However, this can also be seen as the exploitation of nurses and a dilution of the ‘caring role’ of the nurse, as they are become more technical. This changing/overlap of roles has also led to concern regarding registered nurses potentially being replaced with cheaper options such as healthcare assistants (Salvage 2003; Gainsbury 2009).

Evidence Based Practice (EBP) and Patient Safety

The NHS has experienced many forms of quality improvement and there has been a shift away from regulation via the professional body to more managerial techniques of quality assurance. This has led to a proliferation of external regulatory bodies (Walshe 2002). The emergence of NPM has been linked to the:

“devolution of public service controls, administration and planning to local-level service managers and providers, often accompanied by the enhanced use of external performance measures, targets and regulatory bodies” (Waring 2005).

The introduction of clinical governance has established a framework for service managers and professionals to deliver improved standards in clinical quality (DOH 1998). Clinical governance is “intended to ensure the continuous improvement of services, as well as the involvement of patients” (Talbot-Smith & Pollock 2005: 113). Under the umbrella of clinical governance and the need to regulate and manage clinical performance, evidence based practice, risk and patient safety has further emerged (McSherry & Haddock 1999; Waring 2005).

Evidence Based Practice (EBP)

EBP can be defined as:

“the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, the practice of evidence-based medicine means integrating individual clinical expertise with the best available best external clinical evidence from systematic research” (Sackett *et al.* 1996: 71).

Put simply this means EBP is about ‘basing intervention on proven effectiveness derived from empirical research’ (Gray & McDonald 2006: 7). According to the literature the aim of EBP, or evidence-based health care (EBHC), is to question the basis of decision making in healthcare (Blomfield & Hardy 2000). This means that decisions should be based upon evidence as opposed to “habit, tradition, intuition or peer opinion” (Loftus-Hills *et al.* 2003: 150). EBP has been driven by political, social and economic factors, this includes the need for cost containment and attempting to equalise care throughout the country.

During the 1970’s the economic climate was in crisis (as has been discussed in Chapter 2), and there were attempts to restructure economies and reduce expenditure. This led to a greater focus on healthcare interventions and their cost. The aim was to reduce unnecessary expenditure and become more efficient (Flynn 1992). This was to be achieved via measuring and monitoring treatments and approaches. In 1972 the ‘Briggs Report’ (DHSS 1972) called for nursing to become a research based profession and prompted a change in nurse education. Nurse training was to be taken out of the hospital setting and moved into a higher educational setting (Project 2000). There was also an

expectation that all nurses would be aware of the research process and research methods training became a compulsory part of student training (Buckledee & Macmahon 1994; Blomfield & Hardy 2000).

The 1980's saw an increase in the amount of research that was being undertaken and used to guide the medical profession and clinical practice. In 1991 'Research for Health: A Research and Development Strategy for the NHS' (DOH 1991c) was published. This document stated that the strategy's aim was to ensure that care in the NHS is based on high-quality research which will improve the health of the nation. By 1993, the 'Report of the taskforce of the strategy for research in nursing, midwifery and health visiting' (DOH 1993) highlighted that nurses needed to develop research skills and expertise and utilise research findings to inform practice. This was to ensure nurses could demonstrate that their approach was scientific and based upon research findings as opposed to tradition and thus help to raise the profile of nursing into a profession.

The notion of practice based on available evidence by many would be thought to be unchallengeable. However, we need to be careful in complete acceptance that EBP cannot be questioned. EBP needs to be considered within the context of neo-liberalism and NPM strategies (c.f. Rhodes 1994; Peters 1996). There are a range of criticisms of EBP. EBP is based on a positivist/scientific approach. Therefore, evidence tends to be gained via experimental design (randomised control trials), review (collection of studies examined to determine what they can offer) and meta-analysis (results from a series of studies are pooled and tested). The seminal work of Cochrane (1972) has become highly influential (Reynolds 2000) and there has been widespread adoption of EBP within

clinical practice in nearly all areas of allied health, health policy and health management (Gray & McDonald 2006). This means that EBP can be overly restrictive:

“it limits the sorts of phenomena that can be studied, dealing best with those aspects which can be rendered ‘visible’ to and hence measureable by the research tools of positivism” (Gray & McDonald 2006:14).

There is a narrowness in what is seen to constitute evidence. For example the views of service users may be ignored because their views are not quantifiable. EBP is based on a managerialist ethos, and it is supposedly about ‘what works’; but, this means the evidence ignores the underlying structural factors and social determinants of health. EBP also tends to devalue some the practices which are important within nursing; such as, the emotional relationship that nurses can build with patients, the importance of empathy and listening.

Patient Safety

Incident reporting is not a new phenomenon in the health service (Walshe 1999). Although, a focus on patient safety has further developed due to an increasing awareness of adverse incidents within the NHS, for example the Harold Shipman case⁸, the organ scandal at Alderhey Childrens Hospital⁹ or the Bristol Royal Infirmary Hospital regarding the care of children receiving complex cardiac surgical services¹⁰. Such incidents have led to enquires and action taken in order to prevent further occurrences. Areas focused on have been: reporting and learning from incidents, poor professional practice and the importance of professional regulation in relation to protecting and safeguarding patients (NHS Scotland 2007).

⁸ See <http://www.shipman-inquiry.org.uk/> for full information.

⁹ See <http://www.rlcinquiry.org.uk/> for full information.

¹⁰ See http://www.bristol-inquiry.org.uk/final_report/Summary.pdf for full information.

Within England and Wales the National Patient Safety Agency (NPSA) was established in 2001, although in June 2012 the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) were transferred to the NHS Commissioning Board Special Health Authority (the Board Authority). Within Scotland the NHS Quality Improvement Scotland (QIS) was set-up. QIS, similar to NPSA, has been responsible for patient safety through clinical governance work and the patient safety support unit (NHS Scotland 2007). In 2008 the Scottish Patient Safety Programme came into fruition and aims to achieve: “a reduction in healthcare associated infections, improved medication systems, higher reliability in the application of quality care and most importantly safer care for patients” via a range of interventions in surgical, medical and critical care which further aims to contribute to “supporting frontline capacity and capability building in the NHS workforce to improve the services they provide” (HIS 2012: 1).

The aim of such initiatives and developments is to ensure that practice is based on evidence and that policy and procedures are followed as this is believed to ensure the safety of patients and that mistakes are learnt from. Such developments have also occurred to allowing nursing to obtain their status as a profession. In order to maintain professional credibility nurses needed to adopt EBP in a similar way to their medical counterparts (Wall 2008). This has in part also led to the proliferation of policies and audits within the NHS, alongside the rise in managerial practices. EBP has been influential in the development of restrictions to practice. This has supposedly, in turn allowed nurses to become more accountable for their practice, to supposedly be able to make decisions based on evidence rather than tradition.

The Case of Ward Managers

Wong (2004) observes that Ward Managers in hospitals not only have a case load of patients, but they also have more budgetary and managerial responsibilities than nursing duties. This means that the role of the nurse, and in particular the Ward Manager is not just about treating patients but also having knowledge and awareness of resources (Pope *et al.* 2002). This can lead to conflict since it will restrain their autonomy to make clinical decisions which are best for the patient, as they will be balancing that with costs and resources (Som 2009).

Further to this, performance measures and target setting mechanisms according to Maddock and Morgan (1998) attempt to reduce professional autonomy and also act as a disincentive for policy change, as they can interfere with the ability of staff to reach agreements and work collaboratively. This can mean that the managerial standpoint of fast turnover of patients' and the restriction of hospital admissions ignore the holistic model of care, which leads to tensions between the "professional ethos of patients welfare and the managerial perspective of efficiency" (Wong 2004; Som 2009: 305). Such significant changes in working practices for senior staff (with them now having to manage budgets, people and actively support junior staff to embrace organisational change) means that there is discontent with the managerialist approach (Brunnetto 2002; Townsend & Wilkinson 2010; Hutichison & Purcell 2010). This leads to demoralised staff (not just Ward Managers), who feel vulnerable and suspicious of change where managerialism means a move of focus from improving the quality of services to that of efficiency related performance targets (Maddock & Morgan 1998).

The cost cutting aim of managerialism means that professionals acting as middle level managers (Ward Managers) have to use bureaucratic strategies in order to ration and restrict resources, which can be seen to conflict within their professional ethics (Brunnetto 2002) This has led to ambiguity in the identity of those professionals undertaking managerial roles, as Gleeson and Shain (1999: 470) point out, many professionals who are performing management tasks are faced with a dilemma of balancing the “potentially conflictual relations between professional and managerial interest”. This means these managers are expected to manage both people and budgets whilst constantly addressing efficiency goals and also managing the concerns of the professionals and colleagues which have arisen due to the reduction of their autonomy (Brunnetto 2002; Hutichison *et al.* 2010).

Key Aspects of New Public Management

These next sections will discuss the key aspects of NPM in relation to nursing that are pertinent to this thesis. As was seen in Figure 1 (chapter 2, page: 42) there are eight key features, however, this thesis will explore four of these in detail (although these sections will incorporate discussions regarding all the elements listed in Figure 1). These are: ‘hands-on’ professional management; discipline and parsimony in resource use (doing more for less); standard setting and performance measurement and consumerism and service quality. These four features have been identified as being the most pertinent for the Scottish NHS and are expected to have a significant influence on front-line nursing staff within Scotland. This is not to say that elements listed in Figure 1 which are not discussed in detail will not have an influence within Scotland.

‘Hands-on’ Professional Management

Historically, the NHS according to Bevan was for the professionals (e.g. doctors) to run and manage (Bevan 1948). During the earlier part of the NHS (1948-82) clinical doctors made the decisions on which patients to accept, how to investigate and treat them, and whether to admit them and how long they would stay, showing that managers were not the most influential actors in the organisation, rather this was reserved for the doctors (Harrison & Pollitt 1994). However, this changed, from 1983 onwards after the Griffiths Report (1983) and the introduction of general management. Successive restructuring of the NHS has seen the rise of management and managers that are not healthcare/medical professionals.

Hunter (2007) argues that this has moved away from the patriarchal model whereby the doctor knows best and the consultant ran the ward. Part of the dilemma for public health is due to the rather crude management models that have been imposed on many healthcare systems which were implemented by politicians who had little or no managerial experience and were largely ignorant concerning how large organisations function (Hunter 2007). This has caused tensions between professionals and managers, as professionals are now viewed as a problem for management due to the close association between professionalism and autonomy (Harrison & Pollitt 1994). With the rise of managerialism it could be argued that managers wanted to limit the power and autonomy of professionals so as to gain increased control of the NHS (under the guise of allowing for increased services and efficiency). For Thatcher professionals were seen to undermine governmental power, and by imposing managers with little or no clinical

background this would help to limit the authority the medical profession (Harrison 1992; Harrison & Pollitt 1994; Klein 1998; Peckham 2003; Yu & Levy 2010).

Pollock (2005) states that senior managers within the NHS now include individuals who have minimal or no training or experience within the public sector or the principles of healthcare delivery: “arts graduates of all descriptions, ex-army officers, and increasingly, people seeking a change from private enterprise” (Pollock 2005: 1), all the managers in the NHS need to have now is a knowledge of business methods. The background of managers in the NHS is of interest because the Griffiths Inquiry intended a change in the types of people employed as managers, the aim having been to engage non-clinical managers in NHS posts. However, despite its rhetoric, the Griffiths reforms were not successful in attracting or retaining managers from outside the NHS for example, from business and other public services including the military (Exworthy *et al.* 2009). Many clinicians now occupy many managerial positions, which connect both clinical and managerial agendas; for example by 2007 over 50 per cent of managers and 32 per cent of chief executives had a clinical background (The NHS Confederation 2007). This does not mean however, that the appointment of managers with clinical background signifies a return to the old hospital administrator role. The fundamental structure, running and ethos of the NHS has changed since the 1980’s, and the role of a general manager is very different to that of consensus management (as has been discussed in chapter 2 (pages: 24-36).

Following the Griffiths report (1983) general managers replaced management by consensus and created a different management structure. Following this there was a proliferation of management roles within the NHS (Smith 1991; Slevin 2003; Wise

2007) which is reflected in the number of management roles available within the NHS. For example, NHS Careers website lists 78 types of managers for the NHS Management including: clinical management, estates and facilities management, financial management, general management, health informatics management, human resources (HR) management, information management and practice management (NHS Careers 1997: 165-174).

The Kings Fund (2010) highlighted that 1,177,056 full-time equivalent staff were employed and of these 42,509 were managers or senior managers. During 1999-2009 the number of staff increased by approximately 35% and the number of managers increased by approximately 82%. This means that the proportion of managers rose from 2.7% in 1999 to 3.6% in 2009. However, it is pointed out by the NHS Confederation (2007) the proportion of managers in the NHS is relatively low for the size of the organisation and that the proportion of managers in the whole UK workforce equated to 16% in 2009, which is significantly larger than the 3.6% within the NHS. Furthermore, there is concern about the financial implications of the rising number of managers in the NHS. However, the rise in pay for managers has risen slightly less since 1998 than other groups of NHS staff, and much lower than rises of consultants pay (Thorlby & Maybin 2011).

With regards to managers within the NHS, Appleby (2001) asserts that there is always a demand for doctors and nurses, whereas managers in the eyes of the public are not seen to be of value for the NHS or patient care. When Labour came to power in 1997, their policies reflected some of this view, and a target was set to reduce bureaucracy over five years and by reducing bureaucracy (meaning management) £1billion would be

saved. Appleby (2001) questions the number of managers actually needed in the NHS, as for example Soderlund (1999) found that between 1991-94, the input of management across and within hospitals did not have any correlation with improved productivity (as measured by average cost per adjusted inpatient episode), therefore suggesting that there is minimal relationship between an increase in management costs and expenditure and increases in efficiency (c.f. Pollock 2005).

Managers and Professional Relationships

Interpersonal relations within organisations are bound to cause conflict or disagreement between people. Schermerhorn (2000) suggests that managers can spend a lot of time dealing with conflict in the following forms:

- **Substantive conflicts versus emotional conflicts:** substantive conflicts involve disagreements over issues such as goals/targets, allocation of resources distribution of rewards, policies and procedures and job assignments. Emotional conflicts result from feelings of anger, distrust, fear, dislike, resentment and other personality clashes.
- **Functional conflicts versus dysfunctional conflicts:** the benefit of conflict for organisations and individuals can depend on the strength of the conflict and how the conflict is managed. Functional (constructive) conflicts can help stimulate people towards greater work effort, co-operation and creativity. However, in the case of dysfunctional (destructive) conflicts, these can be distracting and interfere with more task-relevant activities. Also too little conflict can lead to complacency and the loss of creative high performance.

Conflict within organisations can be caused by issues such as role ambiguities, resource scarcities, task interdependencies, competing objectives, structural differentiation, and unresolved conflicts (Pheng 1998). Within the NHS conflicts can occur at all levels,

between managers, staff and patients. Fatchett (1999) indicates that professionals have become ever more wary of managers due to the development of a professionally constraining environment which has been created by a bureaucratic and corporatist NHS agenda and style which is linked to NPM. This leads to a “low trust relationship and a souring of relations” between clinical staff and their managers (Lynch 2004: 130). Focusing on the relationship between professionalism and managerialism, there is the shift in the ‘legitimacy’ of management in the public sector. This means that there has been a call for general management (i.e. management from non-professionals). This was not a new concept, but in the 1980s, calls for managerialism in the public sector became more widespread. Prior to this period, arguments relating to professional control and autonomy had curbed such plans (Exworthy & Halford 1999).

Professionals presented a problem for management because of the close association between professionalism and autonomy which then gave rise to conflict (Harrison & Pollitt 1994). This argument can be seen when looking at the relationship between medical staff and managers, but the same view may not apply to nurses and management. According to Witz (1992) this is because nurses’ claim to professional status has been fragile due to the indeterminate nature of their knowledge, skills and nursing’s inability to effect social closure. It is further debated that elements of traditional professionalism are “considered antithetical to nursing ideals” (Adams *et al.* 2000: 543).

Although there is some debate as to the professional status of nursing (which has been discussed previously), professionals working in the public sector (including nurses) have often moved into managerial positions as they climb the career ladder (Exworthy

& Halford 1999). Despite this, the debate surrounding managers and professionals remains a persistent theme and has further prominence in the contemporary analyses of the public sector when new forms of managerialism have emerged. According to Traynor (1999: 141) nurses set up a dichotomy between management and themselves in “terms of values and priorities”. The majority of the dualisms oppose care and money, but there has been an element of alienation by many nurses; caring was seen as a moral and epistemological privilege. This means nurses tended to adopt a position of ‘moral superiority’. The practicality of good quality care delivery was contrasted and discussed as under threat from both management and the profession’s own leaders and educators, who attempt to theorise or complicate matters rather than look at the actual practicalities of delivering care on the ‘shop-floor’. This has further compounded the difficult relationships between those in a position of management and those who are front-line staff.

Power and Authority

Tied in closely with the roles of managers and professionals is a debate surrounding power and authority. With regard to management and authority, authority is power that may be legitimised¹¹ within a specific social context; only when power is part of an official organisational role does it in reality become authority (Pheng 1998). Once this authority is legitimised, there is the legitimate right to use resources to accomplish expected outcomes. The persons of authority who make decisions are often restricted to the top level of the organisation (Luthans 1995; Schermerhorn 2000). As is expressed by Pheng (1998: 35) “authority originates in the ownership of the organisation”.

¹¹ See the writings of Weber for more in-depth discussion of the legitimacy of power and authority. Sources to view include: Parsons (1964) and Gerth & Wright Mills (1991)

Authority can be seen to be closely linked to responsibility; this is because a manager is responsible for accomplishing certain results and requires the authority to achieve these outcomes. The provision of the resources must be at a sufficient level to ensure that the manager can meet the expectations; however, authority can be delegated to an individual who needs the resources but responsibility cannot (Pheng 1998). But, managers often hold individuals responsible for specific tasks, but do not delegate sufficient authority for them to do their jobs well; meaning that managers try to remove their responsibility for results, and at the same token are unwilling to give delegate authority for resources (Moorhead & Griffin 1995). Within the NHS the recommendations of the Griffiths Report (DHSS 1983) for general management that were adopted by the Thatcher Government meant that the power/knowledge status quo was substantially changed (Lynch 2004). Power had been removed, limited or reduced for professionals and given to managers

In relation to power, this refers to the capacity which the manager has over an employee. The power bases are what the manager controls which enable him/her to manipulate the behaviour of the employee (Pheng 1998). Pfeffer (1981: 7) argues that there are four types of power bases. These are:

- **Coercive power:** this is dependent on fear. An individual reacts to the power being wielded out of fear for the ramification that may occur if he/she does not comply. At an organisational level this coercive power could be the power a manager has for dismissing, suspending or demoting an employee.
- **Reward power:** this the opposite of coercive power, in that it is the power to reward. People will undertake what is asked because it will results in positive benefits. This can for example include salary/bonus rewards.

- **Persuasive power:** this power base results in the allocation and manipulation of symbolic rewards. If an individual can hire individuals, manipulate the media, control the allocation of status symbols or influence a group's norms, then he/she has persuasive power.
- **Knowledge power:** knowledge or access to information is the power base. When an individual in a group or organisation is able to control the information and when that information is needed to make a decision, then that person has knowledge based power.

There are further arguments regarding power and how it is maintained within organisations such as Foucault's notion of disciplinary power. The historical roots of this stem from prisons where the desire for obedient prisoners resulted in constant surveillance. The processes set up in prisons were about creating docile bodies (Burrell 1998). This is characterised according to Foucault (1995), by a meticulous control of the body and subtle coercion: this means a person will have a hold over others so that they conform to a desired manner (Lupton 1997). Foucault's analysis of power is a tool that can assist in the understanding how both patients and nurses exercise power and resist it. This also helps to challenge the notion of the 'power-less nurse' (Gastaldo 1997; Gastaldo & Holmes 1999). This notion of disciplinary power can be exercised in three ways. Firstly via hierarchical observation (gaze): this can be in two forms, discreet and indiscreet. The indiscreet form can be seen in nursing due to overt recording and documentation; it is indiscreet as people are usually aware that observation and recording is occurring (Ryles 1999). Discreet observation is when people are largely unaware of the 'gaze'. So, in healthcare this can be seen in the way there has been an increasing emphasis on responsibility and accountability within the profession. It can also be seen in how patients have been increasingly been given responsibility for their own health, and surveillance is now dependent on the individuals' self-management

(Gilbert 2001). This has been reflected in UK policies such as *The Expert Patient* (DOH 2001) and *Self-Care – A Real Choice* (DOH 2005b). However, despite patients self-managing and care becoming individualised and responsabilised, they are still expected to report to healthcare professionals.

Secondly this can be via normalised judgement; different roles and responsibilities become ascribed and gradually develop into the norm (Hui & Stickley 2007). This means that nurses can cast normalising judgements over patients, but similarly nurses will also be under the gaze of managers, colleagues, patients and also themselves. Nurses will learn to monitor, censor and regulate their own behaviour against normative standards (Hardin 2001). Surveillance encompasses cultural and process practices and over time becomes more than just a way to directly control employees and patients (Lynch 2004).

Nurses will compare themselves with colleagues as to how they think they should be (Allen & Hardin 2001). For examples nurses are held in a discourse that portrays them as caring and self-sacrificing and images of the ‘ideal’ nurses are used as points of reference for practice and as a way to measure their own performance against these idealised norms (Wellard & Bethune 1996; Ryles 1999). The third element is that of examination, which utilises a normalising gaze. Experts are called upon to make judgements of what is normal. If someone is seen as deviating from the norm then punishment and increased surveillance can occur (Bradbury-Jones *et al.* 2008).

Power can be difficult to define, but according to Salancik and Pfeffer (1977 cited in Pfeffer 1981: 3) it is not difficult to recognise or experience: “the ability of those who

possess power to bring about the outcomes they desire”. The production of knowledge can result in the constant changing of power relations (Wellard *et al.* 1996), so although managers, nurses and patients have different positions within the health hierarchy (by virtue of their status), because power is not fixed, it can be exercised in different forms by any of them, as it is dependent on the culture (Bradbury-Jones *et al.* 2008).

“Power is not exercised simply as an obligation or a prohibition on those who ‘do not have it’; it invests them, is transmitted by them and through them; it exerts pressure upon them, just as they themselves, in their struggle against it, resist the grip it has on them” (Foucault 1995: 27).

Foucault (1998: 95) asserts that where there is power there will always be resistance. Nurses will be relatively powerless in some situations; however they will be powerful in others (Bradbury-Jones *et al.* 2008). They can exercise power over patients and they can also demonstrate power over managers in the ways in which management decisions or tasks are resisted. Similarly patients can exercise power, for example they can choose not to attend appointments, refuse or not adhere to treatment, and not provide information.

Looking especially at managers, it is often taken for granted that managers and professionals are different, and the work they do is quite distinct (Exworthy & Halford 1999). The notion suggests that managers run bureaucracies, where they establish and apply rules. Managers rely on power and authority that is gained due to their status within the bureaucratic hierarchy as well as their knowledge of organisational politics and practices that have been achieved via practice and experience within an organisation (Pheng 1998). Traditionally, managers have been seen as conformist, self-interested and career motivated, whereas professionals are often seen as altruistic and driven by an

ethical commitment to their expertise/profession. Professionals on the other hand are seen as committed to providing excellent/expert services and advice due to specialist knowledge which “supersedes the confines of any single organisation” (Exworthy & Halford 1999: 1). However, researchers have long debated the complexities in distinguishing managerial work from professional work, indicating that the boundaries are in fact more blurred than the assigned stereotype characteristics would suggest (Savage *et al.* 1992).

Drive for Discipline and Parsimony in Resource Use

“The demand for services to become more accountable was a demand for public managers and professionals to look beyond their boundaries to the world beyond” (Ranson & Stewart 1994: 221)

One of the key aims of NPM was to modernise the public sector by increasing market orientation in the public sector with the premise that it would lead to greater cost efficiency. According to Ferlie *et al.* (1996) NPM in action, in reality amounts to little more than a straightforward concern with cutting costs and doing more for less (Wilkinson 1995). There has always been a concern regarding the expenditure within the NHS, as this public service is paid for by taxes and so there is a call for expenses to be accounted for¹². Informed by monetarist theories, a reduction in public expenditure was the main objective of public sector restructuring in the 1980s (Exworthy & Halford 1999). Despite this aim, the budget cuts failed to occur (Clarke *et al.* 1994a) and expenditure in fact rose between 1983-1992 (Farnham & Horton 1996). Nonetheless the

¹² Within the NHS third party payment is in place. Financial contributions are collected from groups irrespective of the immediate health needs of those individuals; in the U.K via national insurance contributions. These contributions are collected by a third party (i.e. the government), who then employ the resources to provide or reimburse healthcare providers for care (Ellis & Hartley 2004).

drive for financial accountability and efficiency has had a huge impact on the organisation and the underlying principles of public sector organisations (Exworthy & Halford 1999). One of the clearest examples of this is the marketization of the public services, as can be seen when looking at the considerable changes within the institutional structures and interrelationships within the NHS.

Due to increased bureaucratisation and managerial control of the NHS, the central theme of marketization became one of cost containment, which was often thought of as reducing the length of stay for patients and decreased expenditure on each case. This has meant that there has been a greater commitment to the costing and pricing of public services' activities in far greater detail than in previous years (Exworthy & Halford 1999). The emphasis on output controls being linked to resource allocation has seen the emergence of 'best value' policies which are linked to performance indicators, audits and assessment. Also, the ideal of discipline and parsimony in resource use has emphasised the need for cost cutting, doing more for less and controlling workforce demands.

An outcome of this is that rationing occurs within the NHS to limit costs, such as rules which may exclude certain drugs being available on the NHS. This can cause difficulties between staff and patients, as people may be expecting certain treatments, and the treatment may not be offered on the NHS due to cost implications. In relation to the politics within an organisation, such politics can influence the allocation of resources (Pheng 1998). This means that most decisions are made in a climate of ambiguity, facts are rarely completely objective and so are open to interpretation, thus individuals within organisations will use their influence to push the results to support

their goals and interests; known as politicking (Pfeffer 1981). This can be seen within the NHS and the allocation of resources. For example with regards to cost expenditures and the services offered within the NHS. When looking at specific areas of care, funding can be allocated depending on how 'profitable' the service is seen to be. If a service is profitable then those individuals responsible will have greater influence to exert in the decision making process, and markets are targeted at this service (e.g. day surgery, obstetrics), whereas if the service makes a loss (e.g. services for older people, the chronically ill) then these are not targeted for services, and have a limited budget. This can mean that those services which make a loss will receive less funding. A potential outcome of this is that patient care could be affected; also there can be longer waiting times for access to those services with a lower budget.

Lipsky (2010: 34) reports that "public expectations of, and demands for, certain public services increase over time". In the case of health, as technologies and treatments have developed, the public's expectation of what the NHS should do for them has increased. This puts further pressure on the NHS; there is a never-ending demand for health care but there have to be limits as there are costs involved. The more that is offered, the more will be required. There are further issues with providing a service through street-level bureaucracies as although there will always be a demand, the time of demands can be unpredictable. Think for example of individuals presenting to an A&E department; patients will not appear at regularly spaced intervals. It is this unpredictability that causes considerable costs for the service and increasing pressures and demands on the staff as there will not be enough resources at certain busy times. This is a situation that is unlikely to be resolved, and Lipsky (1980/2010: 33) questions whether this would

even be possible to resolve. Even when increased resources have been provided, this has not meant that there have also been improvements.

“The problem of allocation of resources, of priorities, of “rationing”, will always be with us. Supply will never meet demand: increasing supply will never meet increasing demand. There is no solution to the problem”.
(Samuels 2006: 1).

This could be due to the fact that salary raises are part of the cost outlays, but this does not increase the resources for the public. The demand for services means that the organisation must ration or limit the services it provides. However, these organisations cannot be seen to be rationing services or entitlements, they must show that they are undertaking strenuous efforts in order to maintain services. The Government will ask them to ‘trim the fat’ or it’s about streamlining and being more efficient – but this should not reduce the quality or quantity of vital services. Organisations are forever seeking to become more efficient, work with less, and this tends to be in the guise of removing ‘non-essential services’ which politicians assure us will not impact on vital and necessary services.

It is this business style model (NPM) that underlies the push for efficiency savings and performance measurements (e.g. targets) which has led to fewer qualified staff looking after patients with more complex needs. This means those nurses taking on the role of ‘bed manager’ are having to act more like bailiffs, trying to evict patients in order to make room for new patients. The pressure on beds means that the need to discharge patients is always at the forefront of nursing staff thoughts. It also sees patients moved between different wards and marooned as ‘medical outliers’ (meaning patients who are on a ward which is not an appropriate speciality for their condition), and patients who

are not discharged quickly enough for the system being labelled as ‘delayed discharges’ or ‘bed blockers’ – and seen as problematic patients who are in the way (Pollock 2005).

Pollock (2005) believes that the constant need for cost-cutting by managers has created a continual conflict between staff and hospital managers. Managers are trying to meet their targets whilst staff are focused on maintaining or improving the quality of care. In the present climate, public agencies are under great pressure to reduce costs and increase productivity. There are several ways according to Lipsky (1980/2010: 171) in which an organisation can erode the quality and cost of a service without actually appearing to do this; they include: “substituting paraprofessionals... and conversely forcing professionals to handle clerical and other routine chores, reducing the time they have to interact with their client” (Lipsky 1980/2010: 171). Managers are also likely to cut staff or to increase the amount of work done by existing staff in order to increase productivity. There is also the belief that street-level bureaucracies will fill vacancies with employees who lack the required skills or resources, for example the potential to replace a qualified nurse with a health care assistant.

Lipsky (1980/2010: 159) argues that politicians and governments who are looking to reduce expenditure by cuts or constraining budgets must turn to street-level bureaucracies if they want to reduce public spending. For example, if there is a perceived lack of accountability within public workers then they are more likely to have their numbers decreased. However, efforts to increase bureaucratic accountability can be detrimental to services; they can decrease service quality when some conditions of public bureaucracy are at the forefront. Street-level bureaucrats must have discretion due to the nature of the work requiring human judgement to some degree; this cannot be

programmed, as individuals will need to treat clients depending on their unique situations/circumstances. Therefore street-level bureaucrats need to be accountable to the client; if they are instead accountable to the bureaucracy then service quality can diminish. Despite the need for discretion and a level of autonomy, public managers still try to make workers more accountable to the institution by limiting their discretion and range of alternatives; manuals and policies are written to cover any contingencies and performance audits and sanctions are applied retrospectively if needed to help modify behaviour to that which is wanted by the bureaucracy.

Although there are concerns over less money, in reality the gross expenditure on health in Scotland has risen year on year since 2010 (Audit Scotland 2010) and within Scotland it was announced that there would be an increase of £11.4 billion spending on health, though this is a slower rate of funding increase compared to previous years (The Scottish Government 2010a). This means the NHS will be under pressure as costs relating to pay, energy, prescriptions and demographic changes are rising at a faster rate than the funding increases (Audit Scotland 2010). The RCN (2010) commented following the budget that health boards will still feel the rising costs of the NHS and staff will continue to lose jobs or not be replaced in a bid to save money, so it is difficult to see how patient care will not be affected. Health Boards in Scotland aimed to lose almost 4,000 posts in the year 2010-11, which included 1,500 qualified nursing posts.

Audit Scotland (2010) report that the financial and political pressures for the Scottish NHS are: rising costs in drugs, paying salaries, utility costs and VAT bills plus the rising demands due to demographic changes, universal commitments and access targets (or waiting times). With regards to these, the cost of NHS salaries has risen more than

60 percent in cash terms since 2003/4 and so this has absorbed much of the increase in funding in the NHS. The Consultant contract, the General Medical Services (GMS) contract and Agenda for Change (AFC) have contributed to this expenditure. The actual cost of implementing the Consultant contract and the GMS contract were significantly more than expected and allocations made for these were insufficient to meet these additional costs (Audit Scotland 2010). The use of locum doctors (particularly agency locums) has also had a significant cost; in 2010 this equated to 4.3 percent of overall medical expenditure. This demand has mainly been caused by the implementation of the 48 hour week European Working Time Directive (WTD) and covering hard-to-fill vacancies. Further expenditure costs are seen in relation to the PFI/PPP contracts since the commitment for health bodies to fulfil these contracts is a fixed cost which must be paid irrespective of changes to funding levels¹³ (Pollock 2005). Pollock (2005) further highlights that it is impossible to know how much money is being diverted away from clinical care to the private sector as the public expenditure data does not show this nor do NHS accounts.

Privatisation and Centralisation

Over the last three decades, many countries have been experiencing changes in the way public services have been provided (Pollitt & Bouckaert 2000). These reforms have reduced, and are still continuing to diminish, the borders between the public and private sectors. Some services have been ‘contracted out’, meaning that public authorities retain responsibility for ensuring provision of the service, payments, setting of standards and requirements, but the work is actually undertaken via contract by another organisation.

¹³ These contracts, already in place, were costing £136 million for the year in 2010 (Audit Scotland 2010)

What has been happening within the public sector (for example the NHS) is a replacement of public values such as citizenship, representation, impartiality, equality and justice, with market values such as consumerism, competition, productivity and profitability (Hacque 2001; Pollitt 2003). Public services have always had to operate within a global budget and resource allocations, but this is more dramatic. This has allowed for cost-led competition to evolve within the NHS and other public services. Early examples are those of catering, cleaning and laundry services within the NHS. These services, previously performed 'in house' by staff directly employed by the local authority, were then farmed out following competitive tendering from any provider in the public or private sector. It was thought that 'in house' provision was inefficient because it did not have to be competitive (Exworthy & Halford 1999); from this quasi-markets appeared.

There has been a phenomenon of privatisation in the public sector domains (e.g. private Finance Initiatives (PFI). This means that the government approaches a consortium of bankers, builders and service operations which then raise funds for the hospital build on behalf of the government, for this they will then be awarded the contract for the design and build of the hospital along with the operations for the supporting facilities for 30+ years. However, it is the hospital that is responsible for paying back the debt, the interest and shareholder's profits out of its annual budget.

There has also been the introduction of contracts with companies to providing catering services or cleaning services such as Sodexo), activities that have originally been seen as the domain of governmental organisations are now being performed by non-governmental organisations or even the business sector (Boston 1995; Rainey 2004;

Loyens & Maesschalck 2010). There has been a blurring of boundaries between the public and private sector, resulting in an increase in cooperation between the two, but there has been a compromise to avoid complete privatisation to ensure that the government continues to retain control (Rainey & Bozeman 2000; Loyens & Maesschalck 2010).

The development of public-private partnerships (PPP's), between the public sector organisations, for-profit commercial companies and non-profit voluntary organisations to undertake an initiative have occurred, such as the building of new NHS hospitals. Finally, another development that has been seen is that of “market-type mechanisms (MTM's)” (Pollitt 2003: 20) being used in the public sector. These mechanisms mean that public sector organisations have to compete with each other in one way or another (Pollitt *et al.* 1998; Pollitt 2003). The overall costs of such initiatives for NHS Scotland are unknown.

Staff Shortages

Resource inadequacy is a practical consideration within the NHS. Street-level bureaucracies characteristically provide fewer resources than are actually needed in order for workers to do their job adequately; this is seen in terms of patient to staff ratios (especially registered nursing staff) and also in the amount of time allowed for the work to be done (Clayton Thomas & Johnson 1991). In the present climate public agencies are under great pressure to reduce costs and increase their productivity. As has been mentioned before, there are several ways in which an organisation can erode the quality and cost of a service without actually appearing to do so. Managers are likely to cut staff or to increase the amount of work done by existing staff, in order to increase

productivity. Nationwide there are constant reports of inadequate nursing levels to provide safe and effective care. Inadequate nursing staff ratios can impact on the provision of high quality care, which raises concern (Seago *et al.* 2001) and it can also be linked to unrealistic nurse workloads (Joint Commission on Accreditation for Healthcare Organisations 2002).

The UK has to look at substituting staff with less skilled and cheaper staff grades due to financial pressures placed on the NHS. Spilsbury and Meyer (2001) argue that not only are doctors being substituted with nurses, but registered nurses are also being replaced by healthcare assistants in order to help reduce costs. Nurses can feel threatened by talk of “changing the skill mix, shifting roles and breaking down boundaries” between the professions (Salvage 2003: 17), with employers using changing skill mixes as a way to dilute the number of highly qualified staff with less qualified workers or making staff take on more advanced tasks without the requisite training or reward.

Jobs are becoming more flexible, leading to nurses taking on roles that were previously the domain of junior doctors. Unqualified staff such as healthcare assistants are frequently undertaking the roles of qualified staff. There is an increase in the use of agency staff. According to Cronin & Cronin. (2006) the use of bank and agency nurses to supplement the workforce is almost universal. There can be seen to be significant costs associated with the use of such temporary staff, and there is an impact on delivery of care, and the working environment as well as the financial performance of the employing trust (Cronin & Cronin 2006). New posts have also been created such as nurse specialists and consultants. Such changes have shifted the boundaries of job roles and have made significant changes to the work that nurses undertake (Fittall 2004).

Working Hours and Nursing Roles

The Working Time directive (U.K Parliament 1998) imposed an upper limit of 48 hours per week for junior doctors. However, there are exemptions and opt-out clauses to this. This has meant that its impact has been mitigated, and within the UK, 11% of all employees work over the stipulated 48 hours per week (Kodz *et al.* 2003). Within the healthcare profession, a national survey of NHS staff in England found that 66% of staff were routinely working longer than their contracted hours (Healthcare Commission 2007), this compares with 53% in the UK workforce generally.

Dowling *et al.* (1996: 1211) claim that there has been a “quiet revolution occurring in the divisions of labour” between the medicine and nursing professionals. Nurses are now undertaking clinical work that would have previously been undertaken by doctors (DOH 1991b). Adams *et al.* (2000) in their research argue that nurses are doing increased overtime to fulfil their new job remits, which require them to look after and be responsible for a larger group of patients, a wider range of clinical specialisms and more less qualified or unqualified staff. Staff are also under pressure to learn new tasks and skills and become proficient quickly. Rather than employing more junior doctors to cover the extra work left due to the reduced working hours, nurses have been employed or encouraged to take over these roles as part of their normal duties. This can be seen to be as a cost cutting exercise (Spilsbury & Meyer 2001; Rivett 2008), since these staff members’ salaries are less than medical staff salaries. However, according to Adams *et al.* (2000: 550) staff increasingly believe that patient care is being compromised and that specialist skills and knowledge are devalued due to this transfer of roles.

Advanced practitioners (those nurses with expert skills) can now undertake specific medical tasks, if they are trained to do so, as well as the ‘traditional ‘nursing functions, and although this was developed under the guise of a professional project, the reality could be that it fits better with the substitution of medical roles (more expensive) with nursing (cheaper) labour (Adams *et al.* 2000). This helps fill the remit for cost containment and increased cost efficiency that has resulted from the introduction of managerialism within the NHS; it replaces a more expensive option of care with a cheaper one. Nursing staff are trained to undertake potentially the same role as a doctor, but they will be paid at a lower rate for the same task.

Standards setting (Targets) and Performance Measurement (Audit)

Griffiths in his report (1983) made the central claim that the NHS lacked clear chains of control and accountability¹⁴, hence the recommendation of the introduction of general management. Practices of accounting and auditing are central in the operation of the administrative ideals of NPM (Power 1997a). Within this, the evaluation of performance is an essential element within a responsible relationship:

“Being accountable may mean...no more than having to answer questions about what has happened or is happening within one’s jurisdiction...But most usages require an additional implication: the answer when given, or the account when rendered, is to be evaluated by the superior or superior body measured against some standard or expectation, and the differences noted: and then praise or blame are to meted out and sanctions applied. It is a coupling of information with its evaluation and application of sanctions that gives accountability or ‘answerability’ or ‘responsibility’ their full sense in ordinary usage” (Dunsire 1978: 41).

¹⁴ Accountability and responsibility refer to the obligation to answer for one’s actions and to ensure that one has accomplished what has been agreed (Degeling *et al.* 2003).

Within the Griffiths Report (1983: 19) it was commented that “the NHS...still lacks any real continuous evaluation of its performance...Rarely are precise management objectives set...” However, following the introduction of the internal market in 1991, there was an increase in the development of performance indicators (Smee 2005), the most significant of which being the ‘Patient’s Charter’ which contained tables on how providers were performing on standards set (DOH 1991a). However, Smith (2005) asserts that despite the development of performance tables within the NHS, little attention was focused on them. It was not until the election of New Labour in 1997, that performance indicators developed into the NHS Performance Assessment Framework (PAF)¹⁵ (DOH 1998). After this, performance indicators for health authorities and NHS trusts were published and the development of a system of performance ratings (including star ratings) occurred (Ham 2009), based around the key areas highlighted in the PAF.

To enable the assessment of performance, a number of organisations arose which were to be involved with audit activity. The National Audit Office (NAO) and Public Accounts Committee (PAC) within England assess on behalf of parliament and include looking at value for money. They are complemented by the Audit Commission which plays a role in both financial and performance audits and national studies of major policy issues (Ham 2009). Within Scotland there is the National Audit Office (Scotland). This growth in audits is not only linked to the establishment of new organisations to regulate and inspect health services, but there has also been an increased involvement by independent organisations and the Government itself (e.g. The King’s Fund).

¹⁵ The key areas for the PAF were: 1. Health improvement, 2. Fair access, 3. Effective delivery of appropriate health care, 4. Efficiency, 5. Patient/carer experience and 6. Health outcomes of NHS care.

Degeling *et al.* (2003) discuss how the reforming of clinical work organisation, performance and monitoring has been at the top of the policy agenda for over 25 years, the main reasons being: increased costs of healthcare, doubts over appropriateness of existing patterns of organisation and worries over accountability. Various approaches have been put into place in order to address such concerns, however these can be seen to be 'top-down' approaches via market mechanisms and moral persuasion (DOH 1997; DOH 1998). They include capped budgets, tightening spending controls, and increasing range of performance indicators in the case of market mechanisms; and in the case of moral persuasion can include clinical audit, quality improvement and evidence based clinical practice (The NHS Confederation 2007). Both these market mechanisms and moral persuasion can be linked to the ethos of NPM, along with the governmental target and audit culture which has developed and which is linked to the removal of power from professionals (Clarke *et al.* 1994b; Exworthy & Halford 1999; Pollock 2005).

Since the 1980s there has been an increasing regulation of professionals; managers have sought to limit the autonomy, discretion and legitimacy of the medical professionals and to a lesser degree nurses (Clarke *et al.* 1994b; Exworthy & Halford 1999; Pollock 2005; Taylor & Kelly 2006). Professionalism involves acting on autonomous judgement whereas management involves getting other people to do what one wants, thus there is potential conflict. The proliferation of audits, targets and policies can perhaps be seen as a direct consequence of NPM and the drive to regulate the medical (and to a lesser degree the nursing) profession to conform to the ideals of NPM. NPM is concerned with State withdrawal from the public sector as a direct service provider, instead taking on a more regulatory role which is achieved via accounting, auditing and other instruments (Power 1997a). In reality this has only been partially achieved, although it has provided

a shift from the welfare state to a more regulatory or evaluative state (Day & Klein 1990; Power 1997a).

The policies since the 1980s within the UK are now aimed towards making professionals and other street-level workers more accountable for their actions via audits, monitoring and controls. They aim to challenge control by the professionals over service delivery (Hood 1991; Lane 2000) as it was felt that professional discretion was an obstacle for public service reform “especially if professionals were able to resist change or re-interpret policy at street-level” (Taylor & Kelly 2006: 632). Linked to this are the development of devolved management, application of commercial (private) management methods, emphasis on performance measurements and targets, shorter hierarchies with strong line control (e.g. the development of service managers), increased service involvement and most importantly the proliferation and strengthening of quality auditing (Taylor & Kelly 2006). This reflects the notion that professional’s discretion according to Lipsky (1980/2010) is being curtailed by bureaucracies. It is important to note however, that many of the managers who became in effect direct agents of central government, such as service managers had previously spent time as the street-level workers and therefore the idea that managers have little understanding of the nature of the workers problems is perhaps not accurate (Taylor & Kelly 2006). Flynn (1994) reports that it is not a simple division between either professional autonomy or that of bureaucratic control. The enhancement of the power of such managers has meant that street-level professionals have lost some of their autonomy to governing bodies and inspectorates which hold both them and the managers accountable (Taylor & Kelly 2006).

Measuring job performance in street-level bureaucracies is very difficult (Lipsky 1980/2010: 48). This is because the outputs are generally linked to services provided or validity of discretionary decisions made; these are very difficult to scrutinise if it's issues of quality. There is ambiguity in the goals and so how can you operationalise and assess such goals? Also, within street-level bureaucracy there tends to be less scrutiny of workers, partly due to the nature of the job making it difficult, and also due to supervisors needing to respect the workers' claims of professionalism and that workers are expected to exercise some discretion, which therefore requires them to have some freedom from supervisors. All of these issues mean that performance measurement can be problematic.

Despite these difficulties, bureaucracies do establish performance measures, but these measures tend to have little to do with the appropriateness of workers' actions or fairness of treatment, but rather focus on some aspects of performance to measure. They are looking for reports on what can be measured as a way to exert control. This means the workers' behaviour will come to reflect the sanctions and incentives that are inherent to the measures employed. There is an emphasis on training and experience as a way of assessing quality – but there is little evidence to support whether training and experience actually lead to doing a better job. This inability to accurately measure the performance of the workers means there are issues for controlling agencies. Supervisors and managers can discipline workers', but “not to the point of closely guiding workers' activities towards agency preferences, unless they can monitor performance and determine who is or is not measuring up” (Lipsky 2010: 53).

Manuals are provided to try and standardise responses by street-level bureaucrats to their clients and to provide instruction. Performance audits are also meant to increase awareness for workers that management is watching them and so they should take greater care in their work, and performance measures are designed “to control employees’ behavior” (Lipsky 2010: 165). Supposedly, valid performance measures can enhance public sector services; however there remains a need to assess quality control of workers to ensure that the standard is always maintained regardless of the level of production. There is also an issue that workers will firstly focus their efforts on the activities that are measured; this can be to the detriment of other activities and the quality of care.

Audit

According to Power (1997b) auditing has become the key tool of NPM. There has been an ‘audit explosion’, due to a convergence of financial and non-financial audit and inspection practices which are often informed by quality assurance (Power 2003; Lapsley 2008). This emergence of the audit explosion is located within the broader context of NPM. Accountants have developed the notion of audit to promote financial accountability, particularly in situations of mistrust and imperfect knowledge. The rise of auditing as a means to encourage/promote accountability represents the “financialisation of relationships which were once bureaucratic or professional” (McDonald 2006: 109) and is about calculation of costs, rations, surpluses, deficits, appreciation, depreciation, profits and losses in pursuit of financial accountability and efficiency. Governments have used the audit bodies as a way to gain control in order to improve performance of public bodies (Flynn 2002).

“The impact of audit on management is a significant phenomenon in the public sector” (Lapsley 2008: 88). Audit creates a mechanism through which managers can be evaluated. This can therefore mean that auditing can shape the behaviour of managers and make them act in a way in which their actions can be verified specifically by auditors (Power 1996). Auditing the implementation of policy and evaluating its impact and outcome are continuous activities with the NHS (Ham 2009). There is a wide range of audit arrangements within the UK (e.g. health departments, NHS bodies, parliamentary committees, Audit Commission, Care Quality Commission, independent foundations). Within Scotland, Audit Scotland (along with the Auditor General and Accounts Commission) aim to ensure that organisations (including the NHS) spend public money properly, efficiently and effectively (Audit Scotland 2011). This is done via financial and performance audits and councils are legally obliged to be involved in a rolling programme of audits of Best Value.

Audits can have a positive impact according to Davis *et al.* (2001), as they have the potential to improve services by the setting of targets. Audits provide increased accountability to the public and politicians; they can show successes and failures; provide lessons to others, and can also help reduce potential wrong or ineffective actions due to the fear of external scrutiny (Davis *et al.* 2001; Blackman *et al.* 2006). However, there are potential costs associated with audits, in particular complying with the audit; they can be detrimental to staff morale; distract from the actual service delivery; stifle innovation and creativity as these may be perceived as too risky (linked to accountability) and also issues with the robustness of the data which can mean that reported performance ‘improves’ although there is actually no real underlying improvement (Smith 2005; Bird *et al.* 2005; Blackman *et al.* 2006).

Targets

Currently within the NHS, the target-driven approach, where nationally decided targets dictate the organisation strategy, resource allocation and evaluation of performance, is clearly seen (Som 2009). Managers and clinicians thus face dilemmas of how to:

“address the paradoxical political agenda of meeting targets on the one hand whilst continuously improving the quality of clinical care on the other hand within the resource constraints of the NHS” (Som 2009: 210).

Government initiatives with the NHS are increasingly target-driven and include targets aimed at improving access to care, patient experience and staff training (Freeman *et al.* 2010).

Following devolution, policies differed. Within Scotland a system was developed based on the idea of Performance Assessment Frameworks (PAFs) (Scottish Executive & Department of Health 2003) and moved away from the developments of star ratings and league tables introduced in England (Bevan 2010). Despite this divergence in policies, this does not mean that Scotland does not have similar targets set. For example Scotland does not have the ‘naming and shaming’ performance management of waiting times. However, Blackman *et al.* (2006) and Bevan and Hood (2006) contend that both Scotland and Wales are developing stricter performance management arrangements perhaps due to indirect pressures from the high profile of waiting time list comparisons between the countries (England having been outperforming both Scotland and Wales).

The effect of targets on patient care is controversial. On the one side some have argued that they have improved the quality of care, whereas others have disputed this and

raised concerns about unintended outcomes for patients, which have occurred due to the targets (Bevan & Hood 2006; Propper *et al.* 2008; Gubb 2009; Kelman & Friedman 2009; Freeman *et al.* 2010). A target achieved is generally seen as evidence of good performance; however its true impact may not be seen. For example after the targets for in-patient and outpatient waiting times were introduced, waiting times were moved to diagnostics (Gubb 2007) and bed occupancy rose to levels which are associated with high risks of infection (Orendi 2008). Despite these potentially negative consequences for patient care, the Government then introduced further targets for the 18 week referral to treatment and for the reduction of MRSA and C. Difficile as opposed to understanding the impact of the original targets within the hospital and the reasons for rising infection rate levels (Seddon 2008).

Gubb (2009) further argues that targets devalue the customer (patient) as it means organisations are focusing on arbitrary figures rather than patient care – they mean that individual/isolated parts of the system rather than the whole are focused on. A further problem with targets noted by Bevan & Hood (2006: 149) is that they assume that priorities can be “targeted, the part that is measured can stand for the whole, and what is omitted does not matter”. Therefore it is possible that most healthcare performance indicators do not provide an accurate or complete picture (Bevan & Hood 2006). This can mean that clinicians find themselves in a difficult situation where they are attempting to deliver the best quality care on the one hand and on the other trying to meet the pressure of central government to increase the through-put of patients by the NHS organisation (Som 2009).

Hunter (2003) believes that targets can have a negative effect for practitioners as they can distort priorities. Managers will tend to focus on what can be measured (targets). Targets have also been criticised for a lack of robustness and systematic auditing – they focus on what can be measured easily rather than looking at the wider picture (Bevan *et al.* 2006). For example, official statistics report that 97.2% of patients are seen within the four hour target set for accident and emergency departments within Scotland (The Scottish Government 2010c). This could be seen to be positive as it means the majority of people are passing through an A&E department within four hours. However, research shows that the targets are being achieved but with the employment of dubious management tactics. There are examples which suggest that patients are moved to clinical decision units, making incoming patients wait in ambulances, admitting patients unnecessarily, inappropriately discharging patients' early and miscoding data (BMA 2005; Bevan *et al.* 2006; Gubb 2007; Mayhew *et al.* 2008). All of these actions can be detrimental to patient care, but it is only the statistics which are focused on.

Consumerism and Service Quality

A further aim of NPM has been for the voice of the 'consumer' to be heard. Consumerism is defined in the Chambers Dictionary (1994: 220) as: "the protection of the interests of buyers or goods and services against defective or dangerous goods". In the case of the NHS, this would mean the protection of patients who are receiving or using NHS treatment of services. The image of the consumer according to Newman and Vidler (2006: 193):

“stands at the heart of attempts to reform health systems to meet the demands of a ‘modern’ world in which citizens are assumed to have greater access to information and improved confidence in challenging clinical authority.”

A consumer is an active agent who exerts a choice in the market place of public services. This has been a dominant theme in the market model of public service and social welfare provision under Thatcher reforms and also this image of the consumer underpins the Labour Government’s focus on modernising services (Farrell 2010). However, it must be acknowledged that ‘consumers’ are rarely able to exert choice as they might in the commercial world. According to Newman (2005) the idea of this consumer choice also underpinned some quasi-market relationships and purchaser/provider splits via ‘proxy consumers’ (those public bodies who act as purchaser) and also underpinned the later developments within the ‘Citizen’s Charter’ (The Cabinet Office 1991).

A development that is a characteristic of public service provision in the last 20 years is the increased role that clients, customers or users have had in evaluating service delivery. There have been various charters introduced such as the ‘Citizens Charter’ (The Cabinet Office 1991) which cover all aspects of public services. This is meant to have established the principle of a bottom up pressure, although in reality it is questionable whether the expectation concerning the interest in these services which the charters tried to develop has been achieved (Ackroyd & Bolton 1999). The ‘Citizens Charter’ (The Cabinet Office 1991) emphasised the principles of choice, ownership, and responsibility; aiming to improve the quality of public services by giving the public information regarding the choices they can make, and about their rights of redress and

recompense. The result such charters have had is that professionals are more aware of their actions and the potential for complaints (and their impact), which managers must address. However, it should be noted that the response of clients can be related to how well the service is funded (Taylor & Kelly 2006). Bolton (2004) looking at nurses believes that nurses have become the determinant for how patients see quality, however, they are caught between patient expectations of high quality on the one and lack of resources on the other.

The introduction of market principles into the NHS placed those who can/will receive care into the role of consumers. This notion of consumer choice underpinned initiatives such as the 'Patient's Charter' (DOH 1991), which had been about putting the Citizens' Charter into practice within the NHS, and the publication of hospital league performance tables (Rhodes & Nocon 1998). The introduction of the 'Patient's Charter' by Major in 1991, listed a range of standards for the NHS which was supposed to help to raise expectations but "in reality it only gave patients the option of complaining but few other rights, which has encouraged a sharp increase in litigation against the NHS" (Pollock, 2005: 50). This remained a core part of the Conservative Government's programme until 1997 (Drewry 2005). Subsequent to this, policy guidance such as the 'New NHS – Modern, Dependable' (DOH 1997a) and 'The NHS Plan' (DOH 2000) were introduced by the Labour Government when they came to power which updated and replaced the 'Patient's Charter' (DOH 1991a); this was simply a repackaged version of the 'Citizens Charter' (Drewry 2005).

Since then there has been a whole host of documents relating to patient choice and rights, for example: 'Choosing Health: making healthier choices easier' (DOH 2004a)

and ‘Creating a Patient Led NHS’ (DOH 2005a). Within Scotland again there has been policy guidance which has been updated and altered since the introduction of the ‘Patient’s Charter’ (DOH 1991a) by the then Scottish Executive. In 2003 ‘Patient Rights and Responsibilities’ (Scottish Executive 2003) consultation commenced and has culminated in the ‘Patient Rights (Scotland) Act’ (The Scottish Government 2011). Patient choice has been seen as a necessary counter to the professional power and authority which were thought to impede organisational change; it could be argued that this shift towards consumerism was to facilitate the removal of authority and power from the medical profession who were coming into conflict with management. This consumer authority could come into conflict with professional authority, meaning that the whole structure of professionalism on which their authority was legitimised (training, qualifications, membership of peer association, peer regulation and supervision) is undermined (Rhodes *et al.* 1998).

Further to this, the ability of self-regulated professions such as medicine to act in the best interest of patients and the public has now been questioned (Kuhlmann *et al.* 2009). Therefore, clinical autonomy has become constrained in a variety of ways over the last decade or more through the rise of managerialism, the use of market mechanisms, the introduction of targets and performance measures (such as quality measures), but the consumerist model adds a further challenge. The fact that patients are more likely to be informed, articulate, empowered and more demanding means that there will be a loosening of what is termed the knowledge-power knot on which professional power rests:

“across both of these challenges to professional power the government is construed as ‘on the side of’ the patient in the face of the intractability of professional power and producer dominance” (Newman & Vidler 2006: 200).

The interaction between consumerism and professional practice is messy and can be used to legitimatise claims in a variety of ways for example by professionals with a commitment to user-centred services or by managers to challenge professional power. It can also be used by service-users themselves to make new claims and demands.

Historically patients were more passive in the healthcare process, unquestioning of the decisions made on their behalf regarding their health and healthcare. However consumer rhetoric has acted in a way so as to redefine patients as customers, meaning they are no longer seen as passive recipients of care (Bolton 2004). As part of this, management sees the notion of ‘quality’ as a common objective, which has led to changes in working practices and the introduction of quality assurance and audits, for example. Nurses have become one of the main targets for managements’ quality enhancing initiatives (Bolton 2004). It is the nurses who are expected to shape the interactions between patient and hospital, and they are expected to meet the patients ‘raised expectations’ and more importantly to deal with the disappointments when those expectations are not met.

Despite the promise of consumer choice, over the last decade or so, progress in this area has in reality been slow, user involvement initiatives often taking a low priority. There is a strong discourse on consumerism and choice, as can be seen by the level of policy guidance, however this hasn’t meant that patients and users have more “consumer

mechanisms” (Powell & Greener 2009: 112). Patients still have little choice and decisions are often made by health professionals on their behalf. Looking further at the notion of consumerism in practice, it can be seen that patients have little opportunity to exercise real choice (Powell & Greener 2009), and the choice would be of little value if the options are not appropriate or available (Gilbert 1995). Newman and Vidler (2006) state that there cannot be a ‘real’ customer when it comes to the NHS, as he/she does not pay directly for the service, and may in reality be an unwilling or involuntary service user. It is further argued that the individual may actually have little choice due to the absence of real competition (Clarke & Newman 1997). The notion of choice should mean increased empowerment of patients, but this may not be the case. The need to choose can create “confusion and stress, irreconcilable dilemmas, risks and a sense of inadequacy” (Rhodes *et al.* 1998: 75). Also, in focusing on individual’s needs, the consumerist approach fails to address the role of public services in tackling the collective needs of society. Rather, the focus has stressed the individual as opposed to the collective (Powell & Greener 2009) and the rights have not until recently, with the introduction of the ‘Patient’s Rights (Scotland) Act’ (The Scottish Government 2011), being legally enforceable.

Lipsky (1980/2010: 48) argued that clients are not seen as being important; it is rather the work-related peer groups, professionally related standards, expected work standards and public expectations that will influence the role behaviour. This could help to explain why staff are resistant to client’s demands. Although the street-level bureaucrats interact with clients (and treat them), this does not mean that they think the clients should have a say in the way services are being provided. However patient voices can be heard within the NHS, so street-level bureaucrats on some levels must acknowledge

clients' views and opinions and in some cases respect them. There are pressures on staff to accept such views and wanting their respect.

For there to be a true consumerist market, then the consumer would need to have: adequate information and a practical range of alternatives, competency to make the decision rationally, option for free choice, a readiness to make quality comparisons, protection by legal rights and the possibility of redress. Within the NHS these conditions are rarely met in full. Saltman (1994) claims that many of the management initiatives, including customer care training for staff and patient satisfaction surveys, are not about empowering patients, but more designed to increase the market share of organisations. Similarly, Croft and Beresford (1992) see a fundamental conflict between the emphasis on consumer choice, which is aimed to improve efficiency, effectiveness and economy along lines of consumer satisfaction and the politics of empowerment whose aim is to give patients greater control.

Summary

“Service organisations, and the professionals who work in them, have to reconcile – and mediate between – business rationales, inspection, audit bodies, professionals norms of good practice, and public desires and expectations” (Newman & Clarke 2009: 97)

As has been discussed within this chapter there has been considerable change within the institutional structures and interrelationships in the NHS, due to the increased bureaucratisation and managerial control of the NHS. The central theme is one of cost containment, which is often thought of as reducing length of stay and decreased

expenditure on each case. The goals are now ones of efficiency and quality; although these two goals are frequently at odds with each other. Nurses are increasingly driven by such managerial imperatives (Young & Brown 1998; Smith 2002), so as to find themselves more under surveillance and increasingly monitored, reported on and scrutinised; nurses are now caring within a corporate context (Hutchinson *et al.* 2006). This increased managerial and bureaucratic focus has amplified the monitoring of individual and group performances; as nurses are not well represented in financial or decision-making forums and processes they continuously come under the scrutiny of those who are in power over nursing. Performance is judged by those in power (or who have power) and in the terms they describe and sanction. This form of intense scrutiny exacerbates the stress experienced in the day-to-day work of nurses (Young *et al.* 1998; Edwards & Burnard 2003).

According to Adams *et al.* (2000), increasingly nurses are feeling that they are doing more for less. They have to cope with increased workloads, less money, less staff and less available work time. These tight resources do not only impact on the staff but also creates concerns about the quality of patient care and welfare; managers can feel that the value of nursing has become marginalised. Further factors have also significantly increased nurses work pressures, these being the fact that nurses have had to step into fill the vacuum left by junior doctors working fewer hours. It emphasised the desirability of professionals developing a wider set of skills so the patients' experiences can appear seamless and so enhance their experiences (Adams *et al.* 2000). The influence of consumer choice and consumerism has also helped to shape the changing face of nursing and the NHS.

The following chapter will offer a discussion of the methodology and methods used within this thesis. It will offer an explanation and justification for the choice of a case study, the recruitment of participants to the study and offers a reflection on the practical and ethical issues encountered throughout the research process.

Chapter 4: Methodology

Introduction

The findings presented in the subsequent chapters are based on a case study within an inner-city hospital, where semi-structured interviews were undertaken with front line nursing staff based in A&E, MAU, surgical receiving, medial or surgical wards. During a three month period in the summer of 2010, 31 interviews were conducted at the study site. The interviews were undertaken with registered nursing staff who were between Band 5 and Band 7, and varied in length between 20 minutes and 1 hour, generally lasting approximately 45 minutes. Information was also collected about the interview in the form of field notes. In this chapter, the methods used will be described in detail and the justification for the chosen approach will be made. The section will also focus on the advantages and disadvantages of the methods, and there is a comprehensive discussion and reflection regarding the practical and ethical issues encountered throughout the research process.

It is important to note that this fieldwork was undertaken during the summer of 2010, when a general election for the Westminster Parliament was being held following which a coalition government was formed. During the lead up to the election, there was much focus on the 2008 financial crisis and the need for spending cuts to be made within public services (Audit Scotland 2008; The Economist Intelligence Unit 2010). Although Scotland is devolved (as was discussed in chapter 2, pages 32-34 and 42-45), Scottish MPs continue to maintain their seats at Westminster and there remain close links,

shared policies and finances between the UK countries. This means that the effects of the economic crisis are being felt similarly across Scotland and England. At the time of the interviews a new budget was still being debated and was yet to be announced, causing concern within Scotland about the money they were to receive and how this would impact on Scottish public services such as the NHS.

Aims of the Research

This study focuses on the ways in which managerial practices shape the working relationships, interactions, the knowledge-exchange, and the ability of front-line nursing staff to undertake their work in an acute hospital setting. It looks at how nurses based in emergency arenas (A&E, MAU, surgical receiving), medical and surgical wards view their working relationships, how they interact with other members of staff (in particular their managers), how nurses feel management decisions have influenced their day-to-day practices within the hospital and their views of the management changes and developments as perceived by them. Literature relating to NPM has been explored in the previous chapters, and it can be seen that there is little information available in relation to the working relationships between nursing staff and their managers, other staff members and the public. In order to address this and to further enhance our understanding, the aim of this project is to see:

In what ways (if any) has the introduction of new public management approaches within the NHS influenced and informed the working relationships of qualified nursing staff with managers, other staff members and patients?

Further questions that will be investigated to address this lacuna in the literature will include:

- How do nursing staff perceive their working relationship with managers/other staff/patients?
- What factors influence how nursing staff interact and communicate with managers/other staff /patients?
- To what extent, if any, is there a tension between what qualified nurses think their role within the organisation should be and the reality which they experience?
- In what ways do the organisational structure and management policies shape interactions that occur between staff members?

Study Design

Firstly, it is important to recognise that all research will have epistemological assumptions from the start (even if they are not explicit), which influence the way the research is understood and interpreted (Travers 2004; Crotty 2005; Blakie 2009). This research is no exception and it is an interpretivist study grounded in the methodology of adaptive theory (cf. Layder 1996; Layder 1998a; Layder 2006). This means that it focuses on subjects' perceptions of others and themselves, and how "their sense of normality and security" depend on the quality of their relationships. There is also an emphasis on the "dual influence of general theory and theory grounded in research data" (Layder 2006: 302). Since the research is concerned with gaining an understanding of individuals' perspectives and experiences of the impact of NPM on their working relationships, an interpretivist approach has been taken (cf. Atkinson *et al.* 1988; Crotty 2005). The intention of this research was to understand how NPM and general

managerial practices and policies were interpreted, understood and experienced by front-line nursing staff and the impact they had on the working relationships, interactions, knowledge-exchange and the role of the nurse generally.

Layder believes there is a gap between those who specialise in social theory and those who collect and analysis empirical research; adaptive theory is an attempt to bridge this gulf as it incorporates both the generation of social theory alongside on-going empirical research (Dermott 2000). Theorising should be a continuous process alongside all the stages of research (Carlsson 2003). In this respect, adaptive theory provided a useful conceptual framework as it attempts to use prior theoretical ideas and models, which then feed into and guide on-going analysis of data, as well as allowing for the generation of new theory from the data itself. It “emphasises the dual influence of general theory and theory grounded in research data” (Layder 2006: 302). This means that both behavioural phenomena (such as activities, meanings and lived experiences) and systemic phenomena are included. So, there is an equal emphasis on the discovery of theory and the employment of prior existing theory.

In the case of my own theoretical views, the work of Derek Layder and adaptive theory has the most resonance. Layder can be seen to argue that the social world includes both subjective and objective aspects (Carlsson 2003). Adaptive theory attempts to discover the underlying structures which have caused or generated particular events and patterns. Within adaptive theory, both positivist and interpretivist theories can be drawn upon in order to look for the most powerful explanations; adaptive theory looks at both objectivism and subjectivism in terms of its ontological presuppositions (Layder 1998a). There are multiple levels of stratification; this means that social reality cannot be

studied as a single unit or a “unitary whole, which is susceptible only to one kind of explanatory principle, theoretical assumption, or methodological approach” (Layder 1998a: 86). Rather it is a much more complicated process and thus simplistic approaches which only focus on the objective or subjective fail to allow an individual to fully understand all aspects of the social world and how they relate.

Layder emphasises that there is an interconnectedness between different aspects of social life, and that rather than trying to reach a balance between structure and agency, it would be better to study the social world through four analytically separable domains, through which everything is connected. Figure 2 (page 128) shows that the domains are: the self; situated activity; social settings; contextual resources. There is also a general dimension of history and structure¹⁶ and agency¹⁷ needs to be considered. It can be seen that the social domains incorporate different levels and dimensions that are applicable to all research and so allows for a greater appreciation of the multifaceted nature of research than other types of middle-range theory or grounded theory. Too large an emphasis on structures means that the power of actors is denied and so it does not account for human beings making a difference or changes and too great an emphasis on agency can mean that the constraints acting on individuals are overlooked (Carter & Sealey 2001). However, also running the domains together, known as conflation (cf. Archer 1988; Archer 1995), will lead to a theory which cannot capture the complex relations between each of the domains.

¹⁶ Structure according to Sewell (1992:27) is “constituted by mutually sustaining cultural schemas and sets of resources that empower and constrain social action and tend to be produced by that action”. Geertz equates it with “political instruments,” “institutions,” and the “power element” (1973, pp. 331, 337).

¹⁷ Agency tends to be juxtaposed to structure and is the “actor’s capacity to reinterpret and mobilize an array of resources in terms of cultural schemas” (Sewell 1992: 19). It is human action and free will.

The elements that interconnect these domains are those of power, social relations and positions, discourses and practices. However there is not a necessary or fixed sequence to these elements, rather these elements are loose and have flexible positions in relation to one another (Carlsson 2003). Therefore, the importance of the domains and their interconnections will have different influences depending on the research. Overall, the aim is to bring together both macro and micro analyses of structure and agency, which are mapped onto four interlocking and equally dependent domains of life (as seen in Figure 2) The benefit of this approach is that it recognises that research cannot be all-encompassing; the use of domains means that a researcher is able to view the separate research elements and undertake empirical research focusing on these (Layder 1998b).

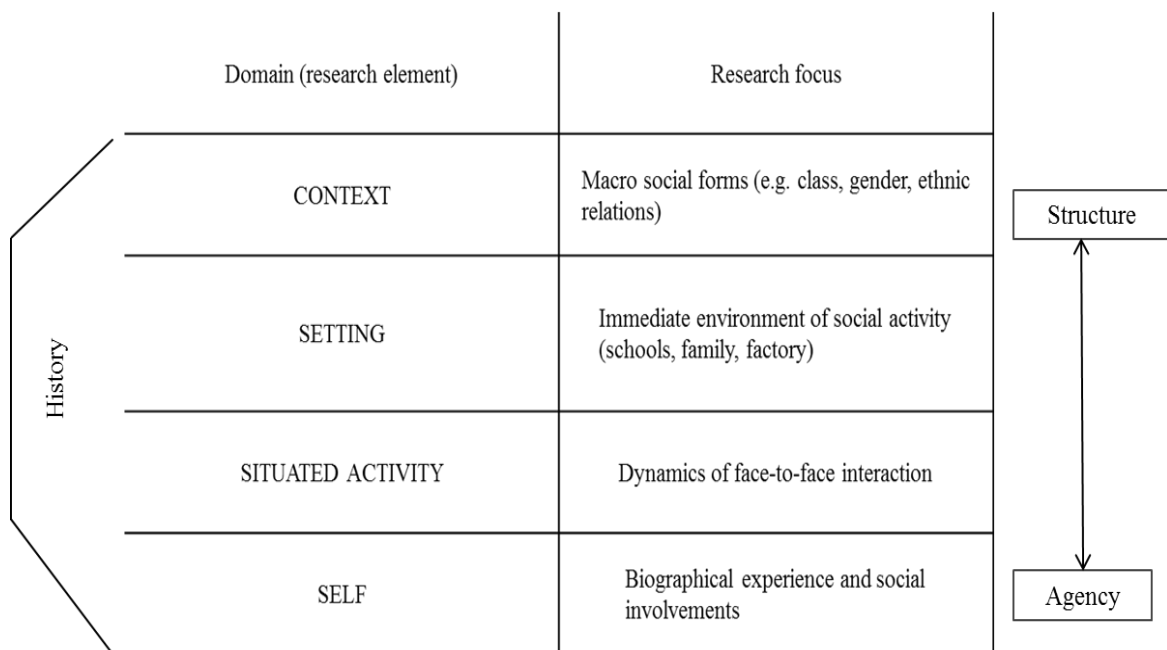


Figure 2: The research map (adapted from Layder (1996) and Carter & Sealey (2001))

The research map in Figure 2 describes levels of organisation which can also be seen as potential areas of research, if the research aims to be exploratory. It therefore has helped in the development of questions throughout the research process and prompted

theoretical reflection throughout. Adaptive theory has also informed the methods for this study in determining the most appropriate method. Thought was given to the domains as discussed by Layder, to decide which domains were pertinent to the research questions in this project. Consideration was given to the domains, which would influence how social actors encountered and negotiated these influences and finally how these encounters and negotiations generate the have influenced the social environment that is encountered by subsequent actors and agents (Carter *et al.* 2001). In the findings chapters to follow, domain theory will not be used formally, but in a broad sense rather than as a rigid structure for analysis purposes.

A case study involving semi-structured interviews within emergency areas, medical and surgical wards in the hospital was the most appropriate method for accessing the in-depth and rich data about the effects of managerial policies for front-line nursing staff. This research focuses on the face-to-face interactions that occurred between the researcher and the interviewee, but the interviews in themselves consider the interactions that occur between the interviewees and other individuals they work/communicate with; domain theory is concerned with these interactions. This research has already been informed by theory and developed within the influence of theory; it also aims to develop theories in relation to the subject matter. Adaptive theory allows me to utilise theory both as an informative tool and for generating theory.

Qualitative Research

This qualitative approach offers a number of strengths that will assist with gaining an insight into qualified nurse perceptions. Denzin and Lincoln (2000:3) argue that qualitative research involves the:

“studied use and collection of a variety of empirical materials – case study; personal experience; introspection; life story; interview; artefacts; cultural texts and productions; observations. Historical, interactional, and visual texts – that describe routine and problematic moments and meanings in individual’s lives.”

The aims of this research determine that a more quantitative approach would not be appropriate as the aim was to understand how NPM priorities and assumptions have shaped and informed the practices and relationships of hospital front line nursing staff. The PhD thesis aim was to look at individuals’ views and experiences of changes within the management structure where they work and how this influences their working relationships. NPM has been a gradual changing of processes, which has been developing since the 1980s following the Griffiths report, but the gradual changes are still on-going within the NHS today. A qualitative approach allows in-depth and revealing information to be obtained, and this method provides an opportunity for the discovery of personal perspectives. Furthermore qualitative methods look more deeply into the behaviour of individuals and groups within particular social settings rather than in broad populations (Holliday 2002).

Case Study

A case study was chosen for this project because it allowed the study to be detailed and intensive (Platt 1988; Bryman 2001), due to the phenomena being studied in context (Yin 1993; Yin 1994; Holloway & Wheeler 1996; Creswell 1998; Robson 2002). It is important that the research reflects the interconnectedness of different aspects of social life as put forward by Layder (1996). One of the advantages of using a case study, is that a relationship forms between the researcher and participant (a close collaboration of kinds) whilst also allowing the participant to tell their stories. This then provides insight for the researcher to better understand the actions and reactions of the participant. This PHD thesis explores the professional practice of staff within the NHS and the influence of policy and management on this practice; hence the use of a case study. A case study approach permits a deconstruction then a reconstruction of various phenomena making it a valuable method. This is especially true within health science as theory can be explored and developed, the evaluation of programmes can occur and interventions developed because of its flexibility and rigour (Yin 2003).

For this particular research project, a single case study has been selected for several reasons. Firstly there were practical issues, because negotiating access to a health board is a lengthy process (Blunt *et al.* 1998; Hallowell *et al.* 2008; Mallick & O'Callaghan 2009) and there were time limitations for the project. Secondly, it was decided that a comparative approach was unsuitable, hospitals are not uniform and the policies and practices implemented within them will vary. NPM itself is not uniformly applied and the influences it has on nurses practices are seen to be gradual and differ between hospitals and health boards (Pollitt 2003). The research was designed to capture both circumstances and conditions that are commonplace for nursing staff within the hospital

arena. Hence the decision to interview staff within emergency arenas (A&E, MAU, surgical receiving), medical wards and surgical wards.

Validity, Reliability and Generalisability

Being able to provide validity and reliability for your research belongs to a more positivist tradition of research and it does not fit easily with an interpretative perspective (Kelle & Laurie 1995). The application of these criteria to qualitative research (seen as softer data than numbers) has been the subject of much debate (Kelle & Laurie 1995), raising concerns over the subjectivity of the data that emerges from a qualitative tradition (Silverman 1989). However, the purpose of interviewing in qualitative research is to focus on the phenomena they investigate and so repeatability and reliability is less important (Parahoo 1997). This research study has been an exploration for understanding and has not been about achieving quantifiable results.

Flyvbjerg (2006: 219) argues that you cannot generalise from a case study or that the case study is subjective and so allows too much scope for the researcher's own influences and interpretations; thus, the "validity of case studies would be wanting". This can depend on what is meant by generalisability and whether it is really the desired outcome. The question of generalisability could be approached in a different way. The concept of 'possibility' (Silverman 2001: 297) is important and social practices that are possible are central when studying cases within institutional settings (in this case a hospital). This means it is likely that various practices can be considered generalisable even if the practices are actualised in similar ways across different settings. Results are not generalisable for the clients but rather they can be generalisable as descriptions of what the individual professional can do. Researchers such as Lincoln and Guba (2000)

and Stake (2000) argue that there is no need for case studies to be able to make claims of generalisability, it is not the aim of the research to be generalised, and this does not detract from the value of the work; but, rather the research of a particular case occurs for its own sake (Gomm *et al.* 2000); some cases are of sufficient interest to a target audience for the findings to have an intrinsic value (Stake 1994). In the case of this research, the aim was not for the findings to be generalisable as it was primarily an exploratory piece of research.

Data Collection

The selected case study site

The hospital selected for this research project is a large, long-established hospital located within a Scottish inner city. Due to the large size of the hospital and the specialities, it was an ideal case study site as there was a large staff population to target and it allowed for views from the different specialities to be heard.

Interviews

Interviews are probably the most widely used method in qualitative research (Snape & Spencer 2008). They can take different forms, but the key feature is that they provide an undiluted focus on the individual. This provides a unique opportunity for detailed investigation of personal perspectives and for understandings of personal context. This research specifically employed semi-structured interviews since they are advantageous in allowing the acquisition of knowledge without restricting answers, but still enabling a focus on the more important questions (Barbour & Schostak 2005). Qualitative interview methods not only assist with generating understanding, they are also

beneficial for equalising power relationships between the researcher and participants (Bergen 1993). These power relations will be discussed later.

Other research methods were considered for this study, but were discounted, surveys were deemed inappropriate because this study is about individuals' perceptions and experiences which could not be captured or explored within a structured quantitative survey (cf. Sapsford 1999; Punch 2003; Czaja & Blair 2005). Focus groups (cf. Barbour & Schostak 2005) were discounted as there was a possible issue with individuals not wishing to discuss potentially sensitive information in front of others, therefore semi-structured interviews were felt to be more likely to obtain open, honest and in-depth responses. Ethnography (cf. Hammersley & Atkinson 1995) was also not felt to be appropriate, as this study has been about nurse's perceptions and observations.

The interviews themselves were flexible with the interview questions acting as a guide to the conversation (Lewis 2008) allowing for discussions to develop and be explored. An interview schedule was drawn up which was designed to draw out respondents' views and experiences of NPM, and their working relationships within the NHS. This schedule focused on the following topics¹⁸ the role of nursing; positive and negative features of relationships between nurses and managers, colleagues and patients; financial accountability, efficiency, targets, audits and monitoring; consumerism and also working conditions.

The interviews were one-to-one, which guided the content of the interview and prompted interviewees to express thoughts and opinions. This approach meant that

¹⁸ This guide was developed following a review of relevant literature. The full discussion guide and form for demographic information can be found in appendix 2 and 3

research participants were able to provide answers with as much detail as they wished to disclose and, as the researcher, I was also able to ask for further information and guide the interview, ensuring that the key research questions were addressed. The interviews were tape recorded with the participant's permission, and lasted between 22 minutes and 1hr 03 minutes. It was anticipated that the interviews would last no longer than an hour; generally they lasted approximately 45 minutes. A private space for the interviews was negotiated within the hospital areas, and varied from the use of a visitor and relative room, to the staff common room, the Ward Manager's office, an equipment training room and a seminar room. All of these were away from the immediate ward and so offered privacy. However, several of the interviews were interrupted, which is unsurprising when interviewing qualified nursing staff whilst they are on shift due to the nature of healthcare.

Power Relations

When looking at control and power relationships within research (interviews in particular), often the researcher has the greater control and power, therefore researchers must be aware of this, and should minimise the extent to which they "intrude on the generation of authentic accounts" (Lewis 2008: 85). With regard to establishing rapport with the research interviewees, the researcher's previous experiences and personal attributes can influence the interaction and the establishment of rapport. Sharing some aspects of cultural background or experience can be helpful in building rapport and enriching the researcher's understanding of participants accounts, including language, nuances and subtexts (Lewis 2008). Having previously worked as a registered nurse within the NHS, I anticipated this could help facilitate easier discussions and help build

rapport. During the interviews, I found this to be so, and once interviewees were aware that I was a qualified nurse, I found them more willing to talk to me.

With regard to positions of power within the interviews, my previous role as a staff nurse meant that I felt that I did not have greater power than the nursing staff as I could interact on a similar level to the Band 5 nurses. However, when interviewing more senior and experienced nurses (in particular Band 7 nurses and nurses with more than 10 years' experience) I felt that they were actually in a greater position of power, as in some cases they could influence whether I had access to further members of staff in their area of work and they also had more knowledge and experience of working within the NHS than I did. I felt that in some cases it could have potentially been disadvantageous to disclose my nursing background when I was junior to the participants. Initially, this led to some anxiety and nervousness at the commencement of interviews with such a staff member. However, once the interviews commenced I quickly realised that due to the nature of the topics their seniority allowed for greater insight and it was not drawing on clinical nursing skills so they treated me as an equal.

Population and Access

The negotiation for ethical approval and access commenced at an early stage of the project, as it was anticipated this would take a considerable amount of time based on the findings reported in literature concerning the NHS ethical and R&D processes (cf. Stalker *et al.* 2004; Elwyn *et al.* 2005; Reed 2007; Tysome 2007; Hallowell *et al.* 2008). Ethical and R&D approval will be discussed in more detail later on. As has previously been noted a case study approach was employed and the fieldwork was based at a large inner city Scottish hospital. Negotiating access within organisational contexts is a key

part of the early stage of research (cf. Feldman *et al.* 2003) requiring patience and sensitivity (Lewis 2008). The gaining of access took nearly 6 months. Fieldwork was carried out over a 3 month period in the summer of 2010; involved several trips to the hospital and dealings with many different gate keepers. It was found that different gate keepers within the areas of the hospital included within the study assisted in a variety of ways. There was no one approach for gaining access to frontline staff; rather it was individual to each speciality and ward. This meant it was quite time consuming and frustrating at times.

One issue that did impact on the research was the interviews being disturbed or interrupted. Despite interviews happening away from the ward, other nursing staff would occasionally interrupt with a question or asking for some guidance from the nurse being interviewed. When this occurred, the interview then re-commenced after the interruption. Also, on one particular occasion an interview had to be terminated early due to the nurse being required back on the ward immediately which meant issues were not explored fully. These interruptions meant that the conversation was halted and participants lost their train of thought, meaning that I would have to remind them of what was being discussed or had to re-introduce topics being discussed.

Study Population

The initial aim was to recruit 30 qualified nurses, split between medical, surgical and emergency services; in the end 31 interviews were undertaken. The nurses selected had to meet certain criteria in order to be included in the study. The participants had to be qualified nursing staff (Band 5 and above), who were contracted to work in the specified areas (no bank or agency staff). They had to have a minimum of two years

qualified nursing experience within the chosen hospital, because newly qualified nurses are still trying to consolidate clinical skills and learning the running of the ward rather than contemplating management changes and their relationships with other staff and managers (Gerrish 2000; Hole 2009).

The areas included in the study were acute medical and surgical wards along with accident & emergency and acute medical receiving (The medical assessment unit has been classified within the emergency arena as it has a very rapid turnover due to the nature of its being an assessment unit compared to the other medical wards). Nine of the interviewees were from the emergency arenas, thirteen from the surgical wards and nine from the medical wards (making a total of thirty one participants).

Within the sample, twenty two participants were female compared to only nine being male. Using ISD (2010) figures when looking at the hospital nursing and midwifery population generally, 11% are male and 89% of the population is female. The population of this study has a similar gender split, although not the same ratio, about 28% to 72%. Gender divisions are not being explored in this PhD thesis, although gender is an important issue and nursing is known to be a female dominated profession (White 2010). The influence of gender is potentially a very large research area and it would have meant that this research would have had to seek a different sample to accommodate an analysis on gender, which is a different research project and so would have detracted from the main focus of this study. In future research however, it would be interesting to explore gender differences in relation to the influences of NPM on front-line nursing staff.

Twenty of the participants were Band 5 nurses, four were Band 6 nurses and seven were Band 7 nurses. Using figures provided by ISD (2010), when looking at the banding of staff within the hospital environment (nursing and midwifery included), 12% of the hospital nursing and midwifery staff are a Band 7 level, 24% Band 6 level and 64% Band 5 level. Staff ages ranged between 21 and 65, with more of the participants being below 40 than above (nineteen below 40 compared to twelve above). This is much higher percentage under 40 than the general nursing and midwifery population working in hospitals in Scotland, where staff under 40 years old only equate to 35% of the total, and 65% over 40 years old (ISD 2010).

Staff were asked about their length of service in the particular hospital being researched. They were also asked how long they had been a qualified nurse; there were very few cases where there was any difference between the two figures. Therefore for this research I used length of service reported at the research site, which ranged from two years to over fifteen years. Twelve members of the population had five years or less experience, eight participants had between 6 and 15 years' experience and eleven had over fifteen years length of service. Appendix 9 provides a summary table showing the participants' demographics.

Methods of Data Collection

The interviews were audio recorded as it allows for an accurate record of the discussion and allows the researcher to use positive body language and eye contact during the interview (Kvale 1996). These recordings were then transcribed. However, some participants refused to be recorded and so hand written notes were made at the time of

the interview detailing the discussion had. Interviewees' notes and transcripts were made available to the individual nurses if they requested to view them.

A field notebook was also kept which enabled the researcher to document further conversations and comments, and also to summarise the key points and themes that arose through the interview. The fieldwork diary also noted other types of interaction, such as the negotiation for access to staff and also reflections on any ideas and questions raised, as well as the overall feeling about the interviews.

Ethical Issues

The research complied with the British Society of Criminology's Code of Ethics (BSC 2006), Economic & Social Research Councils' Research Ethics Framework (ESRC 2005) and the British Sociological Association's Statement of Ethical Practice (BSA 2002). In order to ensure the research was ethically sound, several issues needed to be addressed.

Informed Consent

Consent can only be given if the research participant has been given the fullest information concerning the nature and purpose of the work. In the case of this research project, written consent was obtained (Appendix 4). This meant there was an accurate record of an individual's consent if an issue were to arise, and it also ensured that the interviewee understood what the research was about and what their involvement in the project entailed. (An information sheet was provided - Appendix 5).

Confidentiality and Anonymity

Throughout this research project, data was kept in accordance with the Data Protection Act (OPSI 1998). In keeping with legal requirements audio recordings were kept on a secure encrypted database. Transcripts were anonymised, and a code system used to identify the participants. Only I as the researcher was aware of the codes.

In relation to data storage, tapes and transcripts were not be labelled in ways that could compromise anonymity and identifying information was stored separately from the data. All personal details were kept confidential, and documents that held personal information such as staff band, length of service, location were kept in a secure place where only the researcher had access. All the names and identifying characteristics were changed in order to protect the anonymity of the participants. The location of the hospital has not been given and any details or features that could make it identifiable have been altered or removed.

Ethics Procedures

This research project was required to obtain approval from the School (previously Department) of Applied Social Science ethics committee prior to any field work being undertaken. The departmental committee then determined that the research met the required ethical criteria. This research also required NHS ethical approval, as it was being undertaken on NHS property with NHS staff.

NHS Ethics

The public and research/policy communities expect that ethical practices are adhered to within all research (Thompson & France 2010) and ethical review should ensure that the benefits of any research will not be at the expense of exploiting potentially vulnerable participants (Smajdor *et al.* 2009). Also, ethics are there to protect the researcher, their institution and the organisation where the research is being undertaken (ESRC 2005; Lewis 2008; Social Research Association 2009). Following increasing concerns about misconduct and fraud within medical research (DOH 2005; Howarth *et al.* 2008), systems have developed outside the professional bodies to regulate all research conducted within health and social care settings (Kielmann *et al.* 2007). This has led to ethical practices being removed from agency-based to institutional based governance (regulation); this has led to a set of ethical guidelines and frameworks which researchers must adhere to. Therefore, NHS ethics approval was needed for this PhD fieldwork.

The potential ethical impact on the participants was thought to be minimal by the researcher as it included no clinical interventions. The topic being covered was also considered not to be particularly sensitive in nature and was not attempting to access individuals that would generally be viewed as vulnerable. However, it was acknowledged that when asking questions about working environments and management, there is the potential for participants to view this as a sensitive topic and it could raise issues (such as: conflict with colleagues, tensions, bullying, neglect, abuse) which have ethical implications. Within this project, it was made clear via the project information sheet and consent forms what the participant could expect, what information could be disclosed if necessary, their rights and where help/support or assistance could be accessed.

Research and Development (R&D) Approval

Following approval from the NHS research ethics service, it was then necessary to obtain permission from the specific hospital site where the field work was to be undertaken. There were numerous delays with R&D (unlike with REC); no significant ethical issues were raised by the ethics committee, neither were any concerns raised by R&D in relation to ethics, design or conduct of the study. However, it took considerably longer to obtain R&D approval than ethical approval. R&D approval and a letter of access were finally obtained 5 1/2 months after the process began.

Data Analysis

Despite criticisms of the use of computers in previous years (cf. Richards & Richards 1992; Di Gregorio 2003), specialist computer software is now more acceptable and is thought to legitimately aid the analysis process, although it is not a replacement for analysis, merely a useful tool to assist. The transcriptions and field notes were analysed using QSR NVivo 8 software (NVivo training already had been undertaken). The software aims to increase efficiency and effectiveness; it allows you to manage data; manage ideas; query data; graphically model and report from the data (Lewins 2006; Bazeley 2008). This software package is meant to allow for greater transparency in the research process, and provides an audit trail for the project (Coffey *et al.* 1996; Bringer *et al.* 2004; Johnston 2006). Nvivo allowed transcripts to be coded, memos to be added and the cataloguing of data. This process of highlighting and cataloguing allowed easy retrieval of the relevant passages, while keeping the data within their context so that the potential for misinterpretation could be reduced (Bryman 2001).

A preliminary analysis of the data was integrated with the data collection process as part of a process of continual reflection. Field notes were made at the time of interviews and highlighted any themes that appeared to be of interest to the researcher at the time of interview. Once fieldwork had been completed, a set of thematic categories (cf. Ritchie *et al.* 2008) were developed for this project as the researcher became familiar with the data. This thematic framework allows data to be reviewed and referenced according to key themes, which had previously been established during the development of the research project and issues that emerged at the familiarisation stage. It was important to recognise that the development of a thematic framework required decisions to be made in terms of the salience of ideas and potential connections or links between topics (Matthews and Ross 2010). Initially the themes were quite broad and required further refinement; also further themes were identified through the analysis process as the researcher became more familiar with the interviews. This meant that development of thematic categories were an emergent and iterative process, which allowed first insight into connections between themes.

This approach incorporated both inductive and deductive methods of data analysis. The data analysis was also produced with theoretical concepts in mind, although it was anticipated that new themes would emerge along the way, which was indeed the case. However, the first step of analysis was in identifying a broad set of thematic categories which were established during the literature review and incorporated into the semi-structured interview (an inductive approach). These broad categories were then translated into nodes within QSR Nvivo. There was then a second pass through the data and further themes emerged (a deductive approach). These themes were coded on the transcripts in Nvivo along with any links between the existing nodes and the new themes.

Rigour

Reflexivity is important within qualitative research (Parahoo 1997). The researcher continuously reflects upon their own values, preconceptions and how they can affect the responses of the interviewees. A further development from this reflexivity is that researchers will then return to the participants and find out whether they agree with the interpretations offered by the researcher, so seeking validation from them; this also provides an opportunity for clarification about any of the research (Parahoo 1997). In reality, bias (for example) can impact on other research methods (e.g. within questionnaire design or within historical research); this is no different. The fact is that it may occur more frequently within case study research and perhaps not always be addressed and overcome (Yin 2009).

In using QSR Nvivo, the analysis had increased rigour; the software allowed for coding to be carried out more systematically as the coding could be checked and compared to how other data was coded, not so easy when coding is undertaken by hand (Richards & Richards 1992). Nodes could be seen and the coded information was traceable back to the original transcripts and so this meant that the original context in which the comments were made could be seen, producing an internal audit trail. Comments and memos were also attached to the coding, so the decision-making process for codes could be seen; also descriptions were offered for the different codes to show what they would and would not include. Coding was used in a standardised way for each transcript and the study has attempted to avoid a commonly perceived mistake, which is to sensationalise less common themes that have emerged without providing adequate context and explanations of the “mundane features of an interaction” (Hasenfeld 1985:

623). In order to avoid this, the need for transparency was vital, therefore field notes aimed to be a faithful summary of the interview encounter (Strauss & Corbin 1990) and the transcripts were verbatim.

Summary

This chapter has described the case study approach taken in order to understand how managerial practices (in particular the influence of NPM) shape working relationships, interactions, knowledge-exchange, and the ability to undertake the job role, between managers, staff and patients in acute hospital settings. An interpretivist stance informed by Layders' domain theory has guided the choice of a qualitative research project utilising semi-structured interviews as a research method with the ability to answer the projects research questions. This chapter has also looked at the methodological issues surrounding the research. It has given a detailed account of the population studies, recruitment processes and ethical procedures. It highlighted both the practicalities within the project and the areas that could have caused concern, giving a reflective account of the processes as they were negotiated.

The next four chapters (chapters 5-8) will present the results and findings that the case study has yielded. These four chapters specifically discuss the views of the respondents on the influence of management in the NHS (the rise in professional management); doing more for less (discipline and parsimony in resource use); standard setting and performance measurement (policies, targets and audits), service quality and patient rights (consumerism). These elements of NPM approaches have been identified as being

crucial for the front-line nursing staff during the analysis and so are the focal areas for this thesis.

Chapter 5: The Role of Management in the NHS

Introduction

A key element of NPM has been the drive for professional management within the NHS, meaning the employment of managers who have managerial experience (in a variety of industries), but little or no experience of healthcare (see chapter 3, pages 84-86). The underlying principle is that healthcare professionals do not know best, and that managers who have the skills to run a business should not need prior knowledge of the organisation (Pollitt 1990a; Exworthy & Halford 1999; Pollock 2005; Hunter 2007). In fact for NPM, this lack of familiarity with healthcare can be seen as preferable to someone who has been acquainted with the business (Strong & Robinson 1992; Hunter 2008). This is because these individuals are seen as impartial and removed, so can therefore make difficult decisions more easily.

With neo-liberal ideologies, the 1979 Conservative government envisaged a NHS that would move away from its public ethos and instead be run like a private business (as discussed in chapter 2, pages 38-39). This chapter will explore respondents' views on how this approach to management affects their day-to-day work. Three of the aims of the thesis are to better understand how nursing staff perceive their working relationship with their managers, to discover factors which influence their interactions and communication, as well as to identify any tensions (or potential tensions) between nurses and management. Therefore, this chapter discusses the respondents' views of

how the changes in the background¹⁹ and role of managers influenced their work at the frontline and their ability to communicate with the different levels of management within the hospital. Generally, within the discussions, the levels of management being spoken about by respondents were those managers who were above the ward level. However, the role of the Ward Manager is specifically discussed in terms of how the role has changed, and the implications that has had for the Ward Managers themselves and the rest of the nursing team whom they manage.

The Background of Senior Management

The respondents commented upon the professional backgrounds of senior managers (senior managers being non-nursing managers for example the hospital manager and finance manager). Many of the respondents argued that: *'management is now less likely to be nursing'* (Female, NS, 6-10 years). Several of the respondents highlighted that in previous years, management was more likely to have experienced nursing: *'management more than 15 years ago were still mainly nurses, now management aren't always nurses, they don't always have a hospital background...'* (Female, WM/S, 15+ years). For several of the older nurses, there appeared to be a view that the NHS was better in previous times when they believed that the managers were more likely to have had a nursing or medical background.

However, although the literature supports that historically management may have had medical backgrounds, nurses were much less likely to move into senior management positions compared to their medical counterparts (Harrison & Pollitt 1994). Between

¹⁹ A key theme that emerged during analysis was that of the clinical or non-clinical background of managers.

1945 and 1982 clinical doctors were the most influential actors in the organisation, who were responsible for deciding the length of stay, the investigations required, and treatment options. Furthermore, post the introduction of the 'Griffiths Report' (1983), nurses were even more unlikely to move into management roles (Walby & Greenwell 1994).

Although many of the respondents stated that managers did not have a nursing background, several of these same nurses within their interviews also talked about managers who did have clinical experience: *'I think managers away at the top don't work in the wards anymore, they're not under the same pressures'* (Female, SN, 6-10 years). This is a bit of a contradiction, as although initially nurses claimed that managers did not have a nursing background, the data actually indicates that the respondents may not in fact know the backgrounds of some senior managers.

The introduction of general managers with little or no medical background into the NHS has been a deliberate strategy within the framework of NPM. However, this supposed proliferation of non-health managers in the NHS has not actually been that successful, as non-medical professionals did not enter the managerial systems in large numbers (Exworthy *et al.* 2009). The numbers of managers who have a clinical background occupy more managerial positions compared with those who do not have a clinical background (The NHS Confederation 2007). This makes it even more interesting that the respondents frequently discussed the impact of managers with no health background, when they are not as common as those with a health background. The resentment shown by respondents towards their managers due to the belief that management decisions were not being based on health knowledge is not fully justified.

Despite this, the belief that there has been an explosion of non-clinical managers has influenced the relationship the nurses have with management. This is because when staff do not agree with the decisions being made, the organisational views or the preferences of managers, then the front-line nursing staff believe the goals of the managers will be different from theirs. This will lead to non-compliance and conflict between managers and staff (Lipsky 1980/2010: 18-19) which is attributed by the nurses to a lack of understanding of healthcare from the managers:

Because a lot of the time these people are only managers, they don't actually have background knowledge within a ward area, or how behind the scenes works in regards to the running of a ward, or, you know, they're not medically minded, they're management minded (Female, SN, 6-10 years).

But sometimes I think some of the more senior managers who I'm sure do very good work, the people on the shop floor don't really know who they are or what they do, or they only hear names or only see faces and they think 'what do they do?' And then they make decisions that we don't agree with, and then you think they're up there in the glass house; they just make decisions about our life and they know nothing about what we do (Female, WM/S 15 + years).

This conflict can be seen within the responses of the interviewees. If the background of a manager were not in health, then decisions that the front-line staff disagree with were seen as illegitimate, (under the premise that how can a manager possibly know what it's actually like at street level) and resisted. The differing forms of resistance that are employed by the respondents are explored throughout the findings (chapters 5-8).

There was a resentment on the part of some respondents towards their managers as they indicated that the manager's focus was not appropriate to what nurses' saw as the main focus of the NHS:

...at-the bedside care is the most important thing...and I think sometimes that's forgotten, and it's very important to remember that patients are number one, and that's why we are all here, and that gets forgotten in amongst it all (Female WM/S, 15+ years).

As highlighted in chapter 2 (pages 24 -36) and chapter 3 (pages 85-86) the introduction of non-clinical managers was an aim of the Conservative government to instil private sector management approaches into the NHS. This is because under the ideology of NPM, management centrally stresses efficiency and effectiveness of services and thus undervalues the experiences of patients. The notion of managers not being '*medically minded*' but instead being '*management minded*' (Female, SN, 6-10 years) is an interesting one and links to the idea that clinical managers are not the most appropriate managers according to NPM rhetoric. It suggests that people cannot be both medically and management minded because these are seen as two distinct roles which are not compatible. If this is accepted, it therefore means that you cannot have a medically minded manager and so there will permanently be frustrations. Respondents claimed that managers never understand the roles and needs of nursing staff and vice versa. However, in practice the roles are not completely distinct or incompatible; both doctors and nurses have to manage a variety of issues on a day to day basis. Also there are practitioners who are both clinical and in a position of management such as ward managers.

Many of the respondents highlighted that a lack of understanding of healthcare by managers has led to a workload increase. This was due to having to explain decisions, report on targets and offer explanations if the targets had not been met: *'there's phone calls constantly from managers that don't nurse at all, just constantly on your back asking...'* (Female, SN, 6-10 years). This raises questions about who is seen to have legitimate authority (cf. Weber translations in Parsons 1964 and Gerth & Wright 1967) and responsibility in relation to resources. Pheng (1998) argues that managers can (and do) hold individuals responsible for specific tasks; however Moorhead and Griffin (1995) believe that managers are reluctant to delegate sufficient authority for individuals to do their jobs well, which means that managers are removing responsibility from themselves, but at the same time are unwilling to provide and delegate their authority over resources. Several of the front-line nursing staff felt that they were being held responsible for outcomes, but they did not have the appropriate resources to meet the targets. This will be further explored in chapter 7.

Several of the nurses reported that that management was more focused on issues such as budgets and targets rather than on patient care and clinical needs. This led to some asserting that patient care was being compromised by management decisions:

Obviously budgets are the big issue and they're complaining about overspending, but they've not been in the wards to see that it's not suitable for them to run understaffed or without products that we need (Female, SN, 6-10 years).

This raised concern for the nurses as they viewed their primary role as providing the best care for patients and they viewed management decisions as leading to compromises

in patient care (due to issues such as budgets and time). The expectations of the nursing staff were not being met because of management decisions.

One of the difficulties that the respondents voiced was frustration between what they thought nursing should be and what they experienced as 'reality'. Part of the reason for this divide was attributed to the NHS management and its influence. Several of the respondents highlighted feelings of powerlessness: *'we're [nurses] at the very bottom, probably the very bottom of the ladder, so your voice doesn't really get heard'* (Female, SN, 3-5 years): *'not so much a pleb, I'm just one of the workers'* (Female, SN, 6-10 years). Many reported that nurses were not treated as they should have been, that they were victims of management decisions and that their voice was not heard: *'but I don't have much influence in what happens here. Basically we're told what to do and carry it out'* (Male, SN, 3-5 years). The respondents implied they were victims because they felt management was not listening to them and there was nothing they could do to change the outcome.

Nurses share the need, like other street-level workers, to be seen in a positive light. Therefore they feel that the blame for poor care must lie with forces outside the control of the individual as opposed to it being their fault. This was reflected within respondent's comments, for example: *'you try to be as responsible as you can and try to do as much for the patient as you can, but sometimes the time restrictions ...'* (Female, SN, 2-3 years) and *'it's just that as your workload increases you're struggling to keep up ...'* (Female, SN, 15+ years). This led to the resentment of management (as has been demonstrated in the interviews). Staff try to retain power and so resist managers, because of the belief that if the managers are not medically trained then their decisions

cannot be legitimate and so the respondents de-value their role as a way of coping with what they perceived as the injustices of management decisions being the cause of below standard care.

As mentioned previously, many of the respondents disclosed that they believed their voice was not considered or heard and so felt alienated by decisions which left them feeling powerless to influence managers to ensure that what they view as best care practices are achieved or established. Decisions were thought to have been made at ‘the top’ with front-line staff left to implement them even if they did not agree with them. This suggests that decisions are made via a ‘top-down’ structure (cf. Sabatier 1986; Sabatier & Mazmanian 1979). However, there is much literature to support the suggestion that ‘top-down’ approaches to policy implementation are limited, and there was the inevitability that implementation will be adapted at the street-level (cf. Lipsky 1971; Elmore 1978 in Hill 1997). Despite this, one reason why respondents were estranged from management was due to a lack of transparency in how decisions were made, which led to frustration and resentment as the front-line staff did not understand the reasoning behind such decisions. This, along with the belief that managers lacked a clinical background, caused nursing staff to employ different mechanisms to circumvent the policies and decisions. These will be explored in the following sections and subsequent chapters.

The Number of Managers

Many of the respondents commented on the sheer number of managers, and that there were larger numbers than previously seen within the NHS. This was both in terms of

nurse managers and other managers in the NHS. . This is interesting as the respondents could not support their opinions with actual figures. This view has developed due to the media reporting higher numbers of managers, rather than being supported by academic research (see for example: Ramesh 2010; BBC News 2010). As highlighted in chapter 3 (page 72), literature demonstrates levels of managers in the NHS is actually lower compared to other organisations of similar size (The Kings Fund 2010) although the number of managers in the NHS has risen between 1999-2009.

Managers were spoken about by respondents as a category. They were not seen as individuals but rather as a homogenised group, which had specific character traits. Within the media, managers have been demonised in recent years and there has been much coverage regarding the unnecessary levels of managers in the NHS and excessive bureaucratisation. Management are being blamed for the perceived failings of the NHS, and in the eyes of the public are not seen as being of value for patient care (Appleby 2001). The majority of interviewees commented that this increase in the number of managers was a negative development (which reflects general views in the media): *'there is money wasted with 'people working with clipboards' but staff are needed on the wards'* (Female, SN, 15+ years). However, a few respondents were less critical about the apparent large number of managers:

You do need the levels of management that are there, because you have to have a boss for a certain amount of people. You can't just have one boss who deals with, I don't know, however many thousand employees or whatever. So I think you do need your levels, you need a boss for a boss for a boss, if you like. And somebody's got to be at the top (Female, SN, 2-3 years).

There is an imagery associated with managers within the NHS. As stated above they are 'people working with clipboards' (Female, SN, 15+ years), seen as normally being based in an office and are not often on the wards, as opposed to front-line staff who actually undertake the work. This has helped to increase feelings of animosity and resentment towards senior management:

Too many Managers... it's just steadily got more and more and more as the years have gone on. There's not enough shop floor workers, because they've employed more Managers... There are certainly more Managers, there's more working up that team. Every Manager's got a Manager, who's got a Manager, who's got a Senior Manager (Female, NS, 15+ years).

The majority of interviewees reported that they did not understand the need for all of these managers and commented upon a lack of understanding of their roles. This meant that there was a cultural divide. Culture refers to knowledge, ideology, values, laws and day to day rituals (see chapter 2: pages 45-47). The culture for managers is different from the culture for nurses. The emphasis for managers is seen as one of efficiency and cost, whereas these were not the most important concerns of the respondents (rather bedside patient care was); thus a cultural divide emerged. The roles of managers were seen to be incompatible with the roles of nursing staff thus leading to conflict, tension and resentment. The respondents themselves offered conflicting information since they claimed not to understand the roles of the managers yet at the same time suggested that they did not want to. What seems more likely is that they did not understand the need for, or the legitimacy of a particular 'manager' rather than the role itself.

The respondents remarked that their role was: '*just delivering patient care generally on a daily basis*' (Female SN, 3-5 years) regardless of budget and targets whereas they clearly viewed managers roles as being focused on budgets and targets (therefore there were competing value systems). The nursing staff interviewed appeared to rely primarily on their own beliefs, values, knowledge and rituals to guide their practice; they were not empty containers waiting to be told the latest beliefs and understandings by management. Within an organisation, there can be different and competing values, which come from different professional groups having different views on the nature of their work and the business of the organisation (Morgan 1986; Davies *et al.* 2000). They have opposing perceptions of what are appropriate outcomes and what are acceptable standards which govern behaviours and actions. This is important to understand when looking at how managers and nursing staff interact, and can offer an explanation for the differing foci of the front-line workers and the managers. NPM ideology (cf. Hood 1991; Power 1997a; Stewart 1998; Hunter 2007) is reflected in management structures within NHS organisations. However this ideology ran counter to what respondents viewed as important.

Levels and Types of Management

Throughout the interviews, participants mentioned different types of managers with whom they had contact or were aware of within the hospital. Table 2 comprises the types of management cited. All of the respondents identified at least one of the management types listed, with many mentioning multiple managerial roles. Ward based managers were discussed as well as those who were thought of as more elevated in the nursing hierarchy. The respondents also referred to managers who were not viewed as

part of the nursing hierarchy, but rather separate from it. These individuals were reported not to have any authority over the front-line nurses, but were responsible for other groups of individuals in the hospital who provide resources or services such as catering, porters and pharmaceutical products.

Table 2: Types of managers identified by interviewees

Director of Nursing
Associate Director
Director of Quality
Hospital Manager/ General Manager
Service Manager
Bed Manager
Catering Manager
Lead Nurse/ Clinical Nurse Manager/ Nurse Manager
Nursing Co-ordinator
Ward Manager/ Line Manager
Nurse Specialist/Nurse Practitioners
Deputy Ward Manager
Ward Co-ordinator
Porter Manager

As highlighted earlier the respondents suggested they were unsure of the roles of the managers, yet they were able to identify where within the organisational system the managerial roles lay, and how the roles did or did not interact with their own roles (Figure 3). Once the types of managers were identified, the respondents were then asked how they interacted with those individuals. Figure 3 shows the **perceived** interactions between managers and the respondents. It has been developed from how the respondents explained and described the management structure, but it is not necessarily reflective of how management view the structure. It is worth noting that the

respondent's perceptions were similar to the view the organisation had of the management structure from a ward level as shown in Figure 4.

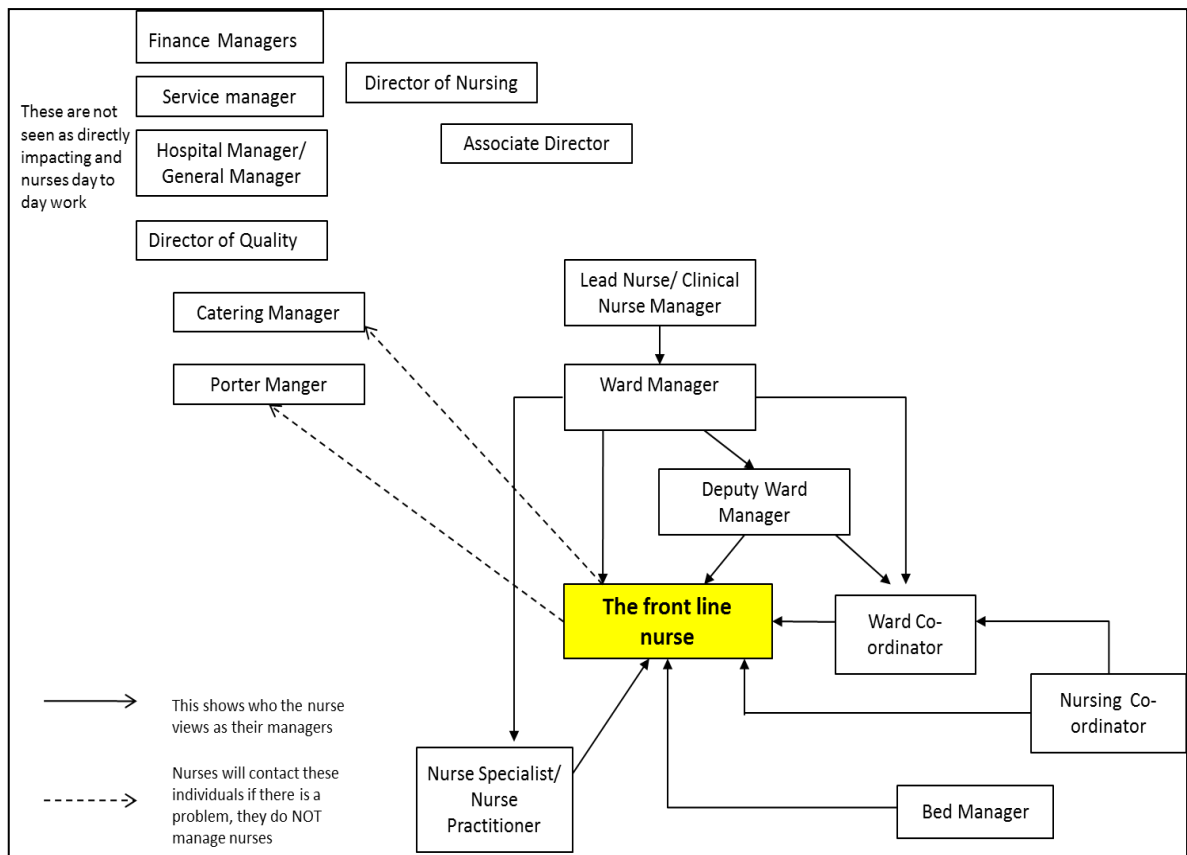


Figure 3: Diagram of how nurses **perceive** the management structure

As can be seen, the relationships do not necessarily follow a linear structure and are quite complex. Figure 3 is incomplete; it only incorporates management levels that the respondents mentioned, there are other levels and types of managers that were not discussed during the interviews. The respondents were not specifically asked at the time of interview to name managers. Those mentioned were raised during the natural course of discussion and were subsequently identified during the analysis process. The respondents were able to name the managerial roles, but most voiced the fact that they did not know what the roles involved or how they influenced the nurse's day-to-day

work. This was seen to lead to tensions for the staff, as this lack of understanding or lack of willingness to acknowledge the roles of the managers created a discord, resulting in respondents therefore resisting organisational changes and demands. However, as will be discussed later, several of the respondents asserted that they did not wish to have communication with such managers and did not want to understand their roles within the organisation.

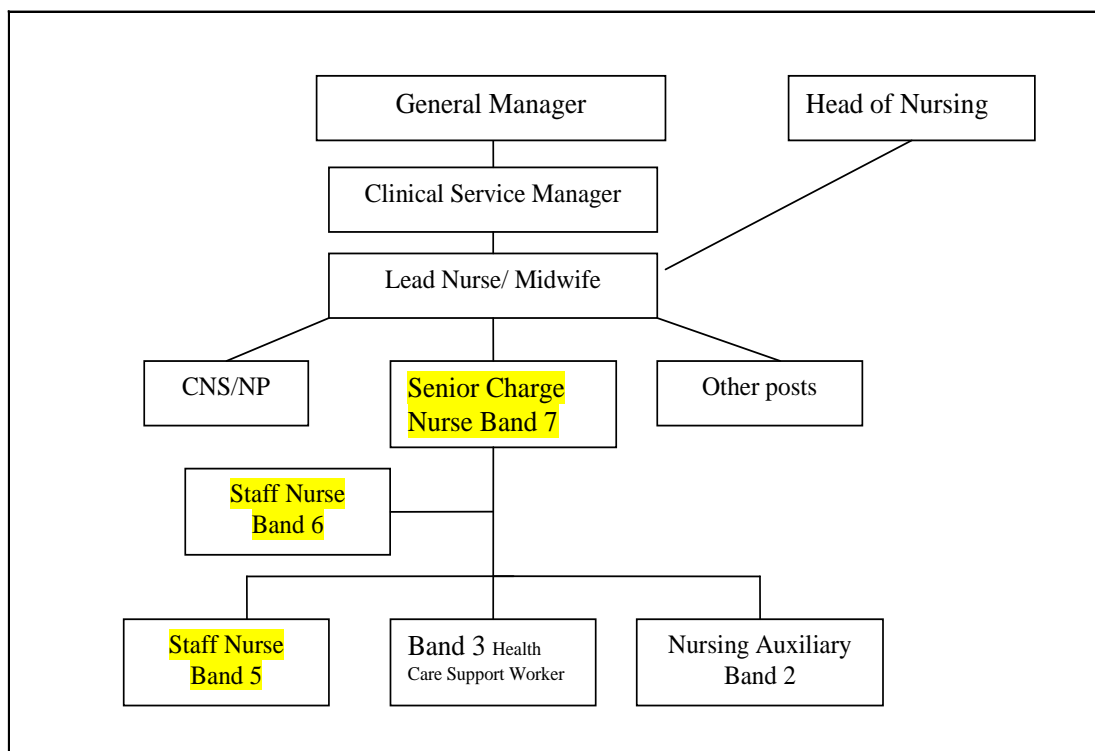


Figure 4: Organisational diagram provided by the fieldwork site showing their concept of the nursing structure. The positions of staff interviewed in this study are highlighted in grey.

It is not surprising that all the respondents made a clear distinction between those managers who were seen to be within the nursing hierarchy, and had a clinical background, to those who did not. This is because they had a better understanding of nursing roles compared with those managers who were not within the nursing hierarchy. This led to a ‘them and us’ mentality, where the respondents showed empathy towards the tensions they believed managers such as Ward Managers and Lead Nurses were

under, and offered understanding; *'and I know it's not the sisters on the wards making decisions. I know that it is coming from above'* (Female, SN, 3-5 years). This was compared with those managers not based at ward level, where the respondents not only stated that they had little understanding of their nursing roles, but the majority were also quick to argue it was those decisions that were having an adverse effect on the nurse's work:

Pressures for the minute have been maybe for the last couple of months, has been mainly our budget spending, and it has made a difference on our ward because we have, as I said, not obviously the dressings available that we need. Basic dressings, tablets, our staffing as well, it's been quite hard lately' (Female, SN, 3-5 years).

Figure 3 identifies a clear chain of command for nursing; however outside of this immediate nursing hierarchy the respondents were uncertain of where managers fitted within the overall organisation (although they clearly identified them as more senior as they had the ability to influence nursing care via policies, targets, audits and budgets). As previously explained, following the Griffiths Report (1983) a different management structure emerged. There was a proliferation of management roles within the NHS (Smith 1991; Slevin 2003; Wise 2007) which is reflected in the number of management roles available within the NHS and identified by the respondents.

Lines of accountability mean that certain areas such as catering and laundry are no longer the concern of nursing staff, as these are provided by separate organisations²⁰. This is despite these services still being essential for patient care. It means that the managers of such services have no authority over the nursing staff. However, nursing staff will have to interact with these managers if there is a problem with the service.

²⁰ These services have been privatised or centralised which is highlighted in Chapter 3 (pages 86-88) and further discussed in Chapter 6.

These findings showed that although respondents stated they did not know what the managers do, it is more likely that they did not wish to interact or engage with such managers. It also highlighted that managers in the organisation and the management system/structure itself had not been conveyed clearly to the nursing staff.

Limiting Contact

Many of the respondents articulated that they would not actually want contact with other levels of management. This strategy of limited contact was seemingly developed by the staff in order to limit the influence of such managers on their day-to-day work, and as a way of the respondents trying to cope with their current workloads. Several of the respondents remarked that interacting with more managers further increased their workload and removed them from the patient's bedside:

and we are particularly busy, and they call to say 'what can we do?', 'what's the problem?', and you're so busy juggling all these different plates to try and get things done and to make sure the patients are safe and transfers are done safely, that it feels as if they're, you know, they're on your case, as it were (Female, WM/S, 15+ years).

As was discussed in chapter 2 (pages 46-59), there are several ways in which front-line workers develop mechanisms to resist, change or to cope in their day-to-day work; it can be seen that the respondents were deliberately trying to limit their contact and avoid situations with management above ward level, this was not identified as a coping/resistance strategy within Table 1 (page 59).

One way to ensure limited contact yet still be informed is to keep to a hierarchy or a chain of command for contact with managers (as seen in Figure 3 and Figure 4). Several

of the participants reported that relying on the dissemination of information via this hierarchical structure was the best way to achieve this. It would be very time consuming for senior managers to meet with front-line nursing staff who were already complaining about the limited time they had to spend at the patient bedside. This is a further example of the respondents demonstrating how they saw limited value in the manager's role and the extent to which they saw their authority as legitimate. By limiting contact with such senior individuals, it meant that the respondents could also resist their authority to some degree as there is little communication between them. One can therefore conclude that the respondents were more aware of the roles of the managers than they initially indicated, or else they would not have been able to articulate why they did not want involvement

Valuing Nursing Roles

Many of the respondents remarked that they did not feel valued by the organisation or the managers. The majority reported that their role was not understood or respected, for example: '*sometimes you just feel like cannon fodder*' (Male SN, 3-5 years) and '*you're just a number basically*' (Female, SN, 3-5 years). Several of the respondents commented on the need for the nursing role to be seen as vital, but often believed management viewed them as more expendable compared with other professions in the NHS:

I would say obviously the nurses are like the backbone of the hospital. I would say, I don't think they're recognised as that. I think it all seems to be that nurses seem to be the kind of fall guy (Female, NS, 15+ years).

As discussed in chapter 3 (pages 68-77), nursing has struggled to be viewed as a profession and has had a lower status compared to that of medicine. To train a nurse costs less than to train a doctor, and several respondents indicated that the organisation

would be more prepared to scapegoat an individual, who can be replaced more easily and at less cost (such as a nurse compared with a doctor). This was made possible due to increasing accountability and the individualisation that has developed within the NHS: *'now there is much more onus on the individual to be competent. Nursing management are not responsible, it's the individual'* (Female, NS, 15+ years).

The Role of the Ward Manager

One managerial role discussed in some detail, was that of the Ward Manager. This position has seen considerable change over the past decade and has been influenced by the ideology of NPM. Most of the respondents spoke about the changing remit of the Ward Manager both from the point of view of the Ward Managers themselves and the other nursing staff regardless of length of service or where they were working in the hospital. Traditionally, these individuals would have been known as a 'Sister' or 'Charge Nurse' (depending on gender), which has little connotation with manager or management within the names, whereas more recently these individuals have been re-named 'Ward Manager': *'I'm soon not going to be a Sister, I'm going to be a Ward Manager'* (Female, S/WM, 15+ years) and as such according to Bolton (2000) have also had a change in their role. As was highlighted in chapter 3 (pages 82-83) this means that Ward Managers/Sisters/Charge Nurses continue to have a case load of patients and are responsible for the running of the ward area, but that their Ward role also includes budgetary and other managerial responsibilities (Pope *et al.* 2002; Wong 2004).

During the interviews, those respondents who were in a position of management (so should technically be called 'Ward Managers') claimed that some of the changes to

their role were not what they had anticipated and were not what they expected when joining the nursing profession. This is despite nurses having long been involved in management functions in the NHS (Carpenter 1997). This has meant several respondents were reluctant to adopt the title Ward Manager and also accept the associated changes to their job role. This is similar to findings from Bolton (2005: 6) who stated from her research that: “nurses are keen to dissociate themselves from the title of managers and see their role as that of mediating the excesses of NPM”.

The Ward Manager role has different responsibilities and connotations compared with the previous roles of Sister/Charge Nurse titles and several of the respondents remarked that the increased managerial role was not what they became a nurse for. Historically ward sisters have undertaken line management responsibilities in the form of training, organising and monitoring junior nurses work (Bolton 2003). But, as highlighted by Brunnetto (2002), the cost cutting aim of NPM means that those professionals acting as middle level managers (Ward Managers) are being forced to adopt bureaucratic strategies in order to ration and limit resources, which conflicts with their professional ethics. There is now a larger emphasis on the role of ‘manager as opposed to ‘nurse manager’ (Bolton 2003: 124). The role has developed from one of leadership and support for nurses, to also cover budgetary issues, policy implementation, HR management, and management of quality issues (Bolton 2003). This leads to resistance to change.

There were staff who referred to themselves as ‘Sisters’ along with those who referred to themselves as ‘Ward Managers’. This is a simple example of how some of the respondents were actively resisting an organisational change (still referring to

themselves (and expecting others to do so too) as ‘Sister’ rather than ‘Ward Manager’) though other individuals seemed to have accepted the change. This resistance can indicate a lack of communication, the way changes were imposed on staff, and a clash of values; a cultural clash between the ideology and values of NPM compared to those of professionals and also the development of organisational cultures (see chapter 2 pages 45-47) with differing perspectives on what was important or necessary. As commented on by Som (2009), these conflicting roles can lead to confusion and frustration as their attempts to make the best and most appropriate clinical decisions are linked to balancing costs and resources. In their comments, participants found it difficult to balance the two: *‘and you’re so busy juggling all these different plates to try and get things done’* (Female, S/WM, 15+years).

The respondents (both the Ward Managers and staff nurses), commented that the role of Ward Manager (unlike that of ‘Sister’) was not simply about managing and guiding junior staff but also more general managerial responsibilities such as the meeting of targets and budgetary responsibility:

The Ward Sister is a very different job now from when I qualified a very long time ago [laugh]. So there wasn’t anything like as much management involved in the day to day running of the ward, it was more... you were more clinical based, you were more looking after your staff rather than all the other... the budgetary responsibilities and all that that we have now, Ward Sisters didn’t have that initially (Female, WM, 6-10 years).

The majority highlighted that the change in focus meant that Ward Managers were less clinical than they used to be: *‘the Sisters are like rota’ed in to do less in the ward, whereas when I first started they were a wee bit more hands on’* (Male, SN, 3-5 years).

Furthermore, the need for such performance measures were seen to create discord and discontentment within the workforce and prevent collaborative working (Maddock *et al.* 1998) as they limit professional autonomy. This was discussed in chapter 3 (page 65). Again, this is a reason why some staff were reluctant to embrace the role of 'Ward Manager'.

Those respondents who were Sisters/Charge Nurses/Ward Managers reported that much more of their time was spent on management type activities, and less on patient care: *'but that role has changed over the years and now I'm at the point where I do one clinical day and I've got three management days'* (Male, CN/WM, 15+ years). This impacted on the other nursing staff as they reported it led to an increase in their workloads. The majority however, did not blame the Ward Manager for this increase in work, and acknowledged the positive work along with difficulties of the role which were outside the control of the Ward Managers:

Well the Ward Managers are less involved with patients. They are pretty much office based now, ... our Ward Manager comes down to the ward and she's involved... she's aware of what's going on certainly... She pretty much pops back in and out during the day, but they got so much stuff to do that, again, the paperwork chain, so it's quite difficult for them to manage to maintain looking after a side of patients. I've got, to some aspects, a lot of things to do but I still have to make sure that I've got my whole... I've still got a full workload to do as well. So I'm more looking after the clinical aspects and she's more the managerial thing (Female, SN, 15+ years).

There was a tension between the more managerial role of Ward Manager alongside the more traditional clinical role of a Sister/Charge Nurse (this view was reflected both by

those in a position of management and the general nursing staff): *'I feel the Ward Manager role is now becoming more managerial rather than nursing'* (Female, NS, 6-10 years).

This demonstrates that policy is not made and then simply imposed on staff, but rather nursing staff need to accept policies into their daily usage. It is also important to note that a policy is never completely new, but rather it is placed on top of old practices which themselves are re-created from old policies. As such, policies only become accepted into the core values of staff over time, so that they become part of the organisational culture. The 'Nursing Sister' has long been an accepted role and had a prominent position within the NHS. The changing of the name from Sister or Charge Nurses to Ward Manager means a change to a job title and role that is seen as iconic within healthcare and nursing. Therefore, it is perhaps not surprising that this change was being resisted by respondents. If there is no incentive for staff to adopt a change, then it will be very difficult for a change to be accepted.

In addition to this, there are obstacles such as entrenched staff, relationships, roles and structures which continually help to reinforce traditional organisational patterns. Garside (1998) highlighted that the majority of individuals working within healthcare organisation do not want to change their location, style or way of working. This is not to say that not changing is negative; it depends on the type of change and the rationale for the change. If staff are not supportive of a change then it will be resisted in a variety of ways. Here it can be seen that collectively the nursing staff including those in a managerial role of Ward Manager, but who still thought of themselves as Sister/Charge Nurse, were employing mechanisms to resist a change they perceived as not being

beneficial for them; they were altering and not cooperating with the policy by not adopting the name change.

The Ward Managers/Sisters/Charge Nurses interviewed voiced that in their opinion they had to be concerned with budgetary matters and cost saving (a key tenet of NPM) and it was difficult for this not to take precedence over patient care - due to the targets and pressures placed on them from their managers. The development of the manager's role can be linked to the drive for efficiency and effectiveness. The remit of Ward Managers is changing in line with the political ideologies under the guise of NPM in order to regulate the behaviour of nurses. This is to try and ensure organisational goals are achieved and to have in place an individual who is accountable for any budgetary issues and perceived failings of the ward over which they preside. This has led to difficulties for Ward Managers and other nursing staff alike.

Summary

NPM has had a significant influence on the relationships the respondents had with their managers and their day-to-day work. The introduction of senior managers with little or no clinical experience since 1983 has been seen as preferable by politicians. This was seen to cause tensions for the research participants, although as was discussed, this wish for non-health managers has not been implemented to the extent anticipated by the Government. Despite this, many respondents believed that most senior managers did not have health experience, which led to the questioning of the legitimacy of managers' decisions. It should be noted that most of the respondents in practice, related only to managers within the nursing structure rather than the senior management of the hospital whose roles they did not understand, but were willing to criticise.

Respondents identified differing cultures between managers, who were seen as *'management minded'*, and professionals who were seen as *'medically minded'* (Female, SN, 6-10 years) which means that there are differing priorities. This, it was reported, led to conflict between managers and staff as the respondents did not necessarily believe managers were making decisions in the best interest of patients, but instead were focused on budgets and targets. Further tensions arose when respondents felt that their workload was increased due to having to explain clinical reasons for their actions and decisions to managers as they were not familiar with healthcare. However, this belief by respondents regarding the background of managers as being non-clinical was perhaps misguided as has been discussed.

There was some animosity towards senior managers, as respondents highlighted that there were too many managers in the NHS, and the employment of these individuals meant there were fewer nursing staff. The nursing staff viewed their role as being more important and of more value than those of managers, despite initially reporting a lack of understanding of management roles. It appeared that respondents felt there was limited respect for their role within the organisation, leading to a complex relationship which impacted on the interactions which occurred, and the development of different strategies by the nurses in order to cope with such complexities. Respondents were seen to question the legitimacy and authority of managers. The respondents argued that due to the conflicting foci of nurses and managers tensions arose. This was due to the belief that nurses aimed to provide excellent quality care, whereas managers were seen to concentrate on issues of budgets, targets and audits with little regard to patient care or the respondents working conditions. The respondents appeared not to raise their

concerns, anxieties or disagreements formally via confronting or voicing their views to management, but in more subtle ways such as non-cooperation, the use of discretion, altering policies, and via more informal mechanisms.

The case of the change in the role of Sisters/Charge Nurses to that of a Ward Manager has been used as an example to demonstrate how staff resisted changes that they did not feel were in the best interest of nursing staff or patients. Using Lipsky (1980/2010) as a way to analyse the use of resistance and discretion within the nursing workforce, it can be seen that staff employed several methods in order to resist management policies. In particular, strategies relating to avoidance, alteration or non-cooperation were seen (e.g. Sisters and Charge Nurses refusing to be called Ward Managers). Within Lipsky's analysis of street-level bureaucrats, there are many reasons why workers will resist management policies. Nursing is no exception, alliances were developed at the front line and workers (in this case nurses) identified with each other and colluded, collaborated and co-operated to resist changes they disagreed with.

The next chapter will consider how budgetary decisions affect the working relationships and practices of front-line nursing staff. Another key feature of NPM is discipline and parsimony in resource used, which translates into doing more for less within the NHS.

Chapter 6: 'Doing More for Less' in the NHS

Introduction

A key element of NPM as explored in chapter 2 (page: 36-42) is to achieve more effective control of work practices and to increase efficiency. This involves cost cutting, 'doing more for less' and controlling workforce demands (McDonald 2006; Hunter 2007). Since the introduction of NPM in the 1980s there has been a continuing focus on 'value for money'. The issue of resources within the NHS has been an issue since its inception; however, the drive for efficiency connected to targets and audits has increased since the 1980s. Also discipline and parsimony in resource use has emphasised the need for cost cutting. Doing more for less is a central component of managerialism and NPM (Hood 1991; Pollock 2005; Hunter 2007), therefore working more efficiently and stretching resources further. The introduction of competition into the NHS has also been seen as a means of enabling cost cutting. The emphasis on output controls which are linked to resource allocation has also seen the emergence of 'Best Value' policies which have performance indicators, audits and assessment attached.

Respondent's comments showed that they were constantly aware of the pressure to manage their resources. They believed that, ultimately, cost saving exercises were not always focused on best practice or treatment for patients. This chapter therefore explores how the nursing staff viewed finances in the NHS and how budgetary decisions influenced their day-to-day working. It helps answer the research questions relating to how nursing staff perceive their relationship with managers and how

organisational structures and management shape their interactions. Highlighted are some of the tensions that nursing staff face within the workplace, which they feel are attributable to financial decisions and control of resources.

Drive for Cost Efficiency

Within this section, key areas that are focused on are those of: equipment and medical resources; staffing resources; along with the privatisation and centralisation of services. These areas were the ones most frequently discussed by the respondents, many of whom reported that care within the NHS cannot, and has not become more efficient by simply following policy implementations. Rather, care was being compromised due to a lack of resources; there was not enough to go round to make the system work: *'there's always cuts, cuts, cuts, cuts... how they're supposed to run a health service in this day and age and cut constantly is beyond me, but hey ho'* (Female, SN, 2-3 years).

Respondents highlighted many areas in which they felt there was a lack of resources, including patient to staff ratios, equipment, treatment options and utilities. With regards to time, the interviewees argued that it was the influence of issues such as staffing levels, management demands and a lack of equipment that led to significant time pressures within their work. The majority discussed a variety of ways in which managers and management generally reduced expenditure and cut costs. Most claimed that this had a negative impact on patient care:

Another example from the ward ... it's a 20 bedded ward, and we're only getting 16 rolls a day. So people aren't getting the option of having a roll in the morning, and sometimes if that's the only thing someone

wants to eat, you can't go 'oh here's two', 'sorry, you can only have one' or 'none' if they're the last person to get served (Female, SN, 3-5 years).

It is difficult to determine if this reduction in finances is a new phenomenon. As highlighted in chapter 3 (pages 85-87), there has been a continuing drive for efficiency since the 1980s, but this tends not to be reflected in respondents' comments. Rather they tend to report that financial constraints are being felt more acutely at present compared with previous years. Whether this is actually true, is perhaps debatable and could depend on the length of their experience. Expenditure on the NHS has increased overall (Audit Scotland 2010). However, recently this has not been in line with inflation due to the economic climate (although the impact of this newer development was only starting to be felt at the time of fieldwork). It could be that the experiences reported did not differ from the struggles in previous years but this cannot be assessed in this research.

There is research showing that money being spent within the NHS is being spent in areas other than at the frontline (Pollock 2005). This is important because nursing staff were concerned about the lack of resources available to them, when the finances were potentially there but being diverted elsewhere. As discussed in chapter 5, according to the respondents there are now more managers within the NHS. If respondents believed that more money was being diverted to management roles rather than to the frontline, this can help to explain some of the hostility demonstrated when discussing management in the NHS. Generally, the comments with regards to finance were mainly focused on the belief/perception that there was simply a reduction in money available in the NHS. The fact that all the respondents believed this is important as it influenced their viewpoints. It was also more likely to result in increased tensions between

management and staff over financial decisions and where money was being allocated. This point is explored in further detail later in this chapter.

Equipment and Medication

With regard to equipment and medication, staff reported difficulties when it came to having a choice since what was available on the NHS was determined by cost. The majority claimed they were expected to only use the cheaper options which they were thought were not as good as more expensive alternatives, thus impacting on a patient's treatment and care:

Well certainly in the last few years, the cost cutting measures have come into place and just within the last few weeks, our dressing choices have changed again and it's not for the better, I don't know who is the panel that decide on what dressings can go on a list, but it's really ineffective (Female, SN, 6-10 years).

I mean, everything you get now - paper towels, stuff for cleaning, is all cheaper, your antibiotics are all cheaper, everything's all cheaper. It takes longer to work, the patients are here longer, costing the health service more money, whereas if you used the dearer antibiotics, they'd be out quicker... (Female, NS, 15+ years).

This lack of resources seemed to not just be a perception by the nurses, but is currently a fact at the front-line. One of the issues that arises with the advances in medicine and technology is that more treatment options become available. However these are increasingly expensive and so there is a debate as to what can be provided due to cost and the pressures already placed upon the NHS (c.f. Dixon *et al.* 1997; Doyal, 1997; Newdick 2005; Gubb 2008; Klein 2010). As highlighted by Lipsky (1980/2010: 33),

within street-level organisations the “demand for services tends to increase to meet the supply”. The more additional services are provided, then the demand will increase to use them – there is a never ending pressure on resources so where do you draw the line and limit what can be provided? “There is no imaginable limit to the amount of health care the population would seek and absorb if it were truly a ‘free good’, available with significant or implicit costs” (Lipsky 1980/2010: 34) However, this limiting of resources does not fit with notions of ‘Best Practice’ for the nursing staff. The term ‘Best Practice’ is quite a vague term and so can be open to interpretation. It means the best way of doing the job, but this will mean different things to different groups within the NHS. Currently there are targets and audits associated with achieving this; however it is debatable as to whether targets and audits really demonstrate effective care practices, which is explored in detail in Chapter 7. For managers, ‘Best Practice’ does focus on limiting of resources and the associated cost savings. According to the respondents, managers’ focus was on budgets and targets as opposed to patient experience and care. The differing foci of managers compared to nursing staff are discussed throughout all the findings chapters (5, 6, 7 and 8).

Many respondents had a clear view of what they thought their role as a professional nurse should be. However, their day-to-day experience was different from these views and therefore led to frustration, anger at the system and resentment of those who make the financial decisions. This was because as the nurses perceived that financial decisions were not made to ensure excellent care, but rather were about cutting and controlling budgets. Thus a cultural clash between managers and nurses, and even politicians (as was commented on in chapter 5 (page 167)). Nurses reported that they were constrained by limited resources and felt that this should not mean they were blamed for poor

standards of care. They themselves were frustrated about the lack of resources, which made it impossible in their opinion, for acceptable standards of care to be provided:

It angers you a bit, but then I know there's nothing I can do. We can only do what we can, we can try; we see a lot of things change which we feel is for the worse, but it's out of our hands to change it. It's frustrating a lot of the time but you have to get on with it (Male, SN, 3-5 years).

As highlighted within chapters 2 and 5, nurses want to be seen in a favourable light, and so poor care cannot be seen to be due to their practices but rather influenced by others, such as management decisions. This is not simply about the relationship of the nursing staff and management; the majority of respondents also believed that the limiting of resources impacted on their relationship with patients: *'I think a challenge is explaining to patients why things can't be done – whether it be time constraints or...'* (Female, NS, 15+ years). Furthermore, the respondents argued that patients were often dissatisfied with the service and so became more difficult and aggressive, as is further discussed in chapter 7.

Staffing Resources

The respondents commented not only on the limiting or availability of choice, but also on a reduction in the number of nursing staff employed and working within the ward areas:

Well there's a couple of people leaving and we're not replacing them... Well we're going to be getting more patients ... I think now with the new Government ... I don't know much about politics or anything like that – they keep on saying 'things are going to change, jobs are going to get cut, they're not going to take people on' (Female, SN, 2-3 years).

This view held by the respondents - that there would be reductions in nursing staff was accurate (Johnston 2009; Scottish Parliament 2010). At the time of the research, the NHS was cutting the numbers of employees. According to ISD (2011b) figures, between March and September 2010 there was a decrease of 1,855 nurses in NHS Scotland. The SNP government stated that this reduction, is not a cost reduction, but rather is linked to a planned reduction in the workforce and number of acute beds being provided by the NHS as part of a wider plan (Nicola Sturgeon, Cabinet secretary for health and wellbeing in Scotland, cited in BBC News 2011). However, most of the respondents indicated that they felt the reduction was linked to financial difficulties in the NHS. Typical comments were made, such as: *'they're going to cut the money that is coming into the NHS drastically; we're going to be losing staff'* (Female, SN, 2-3 years). There was also concern over the number of jobs available within the NHS:

now, there's going to be big cuts anyway, ..., so when I qualified ten years ago, I could've walked into a job and I had my choice of jobs, and there's hundreds of nurses looking to qualify soon, and jobs are pretty much non-existent at the moment (Male, SN, 6-10 years).

There was a minority of staff who believed that those nurses currently in post would not lose their jobs, that is, staff would not be made redundant, but if staff decided to leave they would not be replaced. This suggestion that there is a reduction in the number of nurses is not unfounded as previously mentioned, but the concern regarding staff-patient ratios has not just appeared since the current economic crisis, but rather has been an on-going worry for nursing staff (Scott 2003) for a variety of reasons as was seen in chapter 3 (page 88-89).

There has been a rise in the number of healthcare assistants (HCA's), who have been trained to carry out roles that were previously seen as the remit of registered nurses; and nursing staff undertaking tasks which were previously the domain of junior doctors. Spilsbury and Meyer (2001) assert that the NHS is substituting some doctors with nurses and some nurses are replaced by HCAs; the majority of respondents believed this was occurring. This is not new phenomena; these changes have gradually happened since the 1980s. This changing of role and closer control of the workforce is usually referred to as deprofessionalisation. Deprofessionalisation is often discussed in social work literature, but there is little within nursing literature. However according to Rogowski (2010: 21), the result of deprofessionalisation is that "instead of a profession based on knowledge, understanding, skills and collegial relations, we now have a so called profession whereby managers dominate, their focus being on budget controls, targets and computer exemplar completion". Lipsky (1980/2010: 171) argues that there are several ways to erode the cost (and quality) within an organisation without it being seen. They include using paraprofessionals, and forcing professionals to undertake clerical and routine chores, which will then reduce the amount of time that can be spent with a client. Respondents concurred with this and commented that they felt they were being removed from the patient's bedside due to an increase in paperwork and other clerical chores, and also that HCA's were increasingly undertaking the roles of registered nurse on the wards.

Several of the respondents reported that one of the ways in which the organisation reduced costs was through limiting bank and agency staff usage: *'say if somebody's off sick, they're saying we can't replace like for like...or you don't get a replacement'* (Female, WM/S, 15+ years). Rather than providing cover for a missing member of staff for

the duration of their shift, bank or agency staff were being provided only to cover part of the shift or no replacement was being offered:

...all the bank staff ... who used to cover a six hour shift are now asked to cover a four and a half hour shift, so that's like two and a half hours without either an auxiliary or a staff nurse that you used to have. So, that's ultimately impacting on the staff on the ward because you're needing to try and fill two and a half hours of a task basically (Male, SN, 3-5 years).

According to the majority of participants, this meant that workloads increased for the remaining staff nurses and there was less time to spend with patients. This reduction in staffing levels was reported by respondents from all areas of the hospital included in the study; the majority commented that due to a poorer staff patient ratio, there was a reduction in quality of care. As was highlighted in chapter 3 (page 88), street-level bureaucracies characteristically provide fewer resources than are actually needed in order for work to be undertaken adequately in terms of staff ratios and time (Clayton Thomas & Johnson 1991). The majority of respondents argued that this was continuing to take place within the NHS, has led to increased tensions within the workplace, a deterioration of working conditions has placed more pressure on them as qualified nurses:

Cutting staff numbers as well, that's the biggie isn't it. They cut the numbers of staff then the remaining staff are left to deal with the shortfall which adds more pressure as well (Female, SN, 2-3years).

However, providing fewer resources than necessary is not a necessarily a product of NPM. Lipsky undertook his research in the 1970s before the rise of NPM and recognised this issue at that time. There were comments that the lack of staff on the

wards meant that individuals were not able to attend training sessions as they were needed on the ward. Due to financial constraints, many study and non-mandatory training sessions had currently been cancelled:

We're even struggling with mandatory study days to try and get us on them, never mind voluntary ones. Don't know when the last time I seen a study day even advertised to be honest; it's been a long time (Female, SN, 3-5 years).

This lack of training again impacted on the respondents work and they suggested it was tied into budgetary considerations. This can impact on patient care, as staff are not gaining or refreshing their skills. Several respondents reported feeling frustrated by this, but remarked there was little that they could do to rectify the situation.

The participants demonstrated little understanding of finances and the financial decision making processes above the ward level, therefore the 'budget' was something of a mystery to front-line staff and it was out with their control; management was making these decisions, which increased resentment and frustration for the front-line staff. Many stated that decisions were being made by managers who did not understand the pressures of patient care at ward level. In this case, not providing the same cover caused concern over working within understaffed or poor skill mix areas. This was seen to be detrimental to staff morale and ultimately patient care: *'With budget cuts, we're bringing in bank nurses late, which means there's less of us on the floor so actually spending time with people in the patient environment becomes a challenge'* (Female, WM/NS, 11-15 years). This was felt by participants to be disadvantageous for the service provided by nurses and ultimately to have a negative effect on patient care. Many argued that the budgetary decisions were made due to politics and patient care was not considered. This created

animosity between the nursing staff and management, resulting in a poorer working environments and dissatisfaction.

The majority of staff interviewed reported feeling powerless to improve their working conditions and patient care due to the lack of resources available. They reported that their voices and concerns were not heard - decisions were political in nature and not about patient welfare or the NHS. This political agenda was not seen to be in line with the needs of the respondents and therefore they employed coping mechanisms to deal with the feeling of powerlessness and to overcome their concerns. The staff were more likely to use their own discretion at street-level in order to better their working conditions (known as unauthorised discretion (c.f. Skolnick 1966)).

If staff do not hold the organisational views and preferences of managers, then their goals and aims will be different (Lipsky 1980/2010: 13-15) and so nursing staff will resist changes being implemented and the legitimacy of the managers' decisions will be questioned. The notion of managers not being able to understand the 'shop floor' and having differing priorities has been discussed in detail in chapter 5 (pages 136-138). All of the respondents reported difficulty at some point in accepting management decisions, when costs were cut or limited, which led to frustration, tension and ultimately alienation of the nursing staff. There were many ways in which the respondents actually asserted their own power and resisted management decisions or developed mechanisms to cope, which will be discussed later in this chapter.

Centralisation and Privatisation of Services

Competition has been introduced into the NHS via mechanisms of privatisation and centralisation (Pollock 2005; Hunter 2008), as a way to improve efficiency. Within this area two elements of privatisation were discussed by the respondents; the privatisation of cleaning and of catering. There were few comments about other areas of privatisation in the NHS Scotland). This is perhaps not as surprising as there has not been the same emphasis on privatisation as there has been in England, and there is a general belief that Scotland has not followed the same route (Pollock 2005). However, as seen in chapter 2 (page 43) and chapter 3 (pages 86-88), there have been various privatisations occurring within Scotland including public-private partnerships; several of the newer hospitals and centres of excellence have been funded via PFIs and PPPs. The main areas where centralisation was raised was with regard to the supply of stock and the rise in centres of excellence.

Several of the respondents remarked on how the cleaning of hospital wards has been privatised:

I mean, when I initially qualified there was one domestic per ward and that was her ward... nowadays, they've got one girl on a minimum wage covering four wards and wonder why they've got infections (Male, NS, 15+ years).

There are no longer individual domestic staff to cover particular areas/wards and so they were no longer seen as part of the ward staff by the respondents; rather domestic staff are expected to cover a variety of areas and wards. This led to concern regarding infection control and general cleanliness within the hospital. It also created problems

regarding responsibility according to the respondents. There were more debates about who was responsible for cleanliness – nursing staff or the contracted cleaners. This caused difficult working relationships and also a lack of trust and support between domestic staff and ward staff.

Respondents highlighted issues relating to ward stock and how the ordering process has been more formalised and more bureaucratic. This is interesting as it perhaps goes against the notion of centralisation as there are no longer local stores within the hospital; rather each ward is responsible for their own stock and budget. There are generally no longer pooled (areas sharing stock) resources available. There is however a centralised depot outside the hospital, from which wards have to order and there are only scheduled deliveries for stock. This has led to frustration for nursing staff, due to delays in obtaining resources and thus a drop in quality:

That's a big, big change. Everything seems to be cost cutting...If you needed something you phoned for it, when I trained, if you were short of urinals you phoned and the porter brought you up a box. Now you need to go through a clerk who has to go through an ordering system and you have to wait days (Male, NS, 15+ years).

Oh it's changed dramatically because every hospital had its own local stores ... But they've centralised it in a huge place somewhere out... Buts that's only because they've centralised the resource, making it more effective, they said, and efficient but the quality bit goes off it (Female, WM/S, 6-10 years).

The use of centralised services as a way to save costs and be more efficient, is in line with NPM ideology, but according to respondents, it has led to an increase in bureaucracy. Respondents argued that such practices were due to budgetary constraints

and the drive for efficiency, referring again to the need to save and account for money within the NHS, as a core component of NPM. It is the need for cost efficiencies that is driving this centralisation. As a consequence, coping strategies were developed. These included: refusing other wards a loan of their stock, and hoarding stock and equipment, which could be less cost effective. These are good examples of front-line nurses having power. The nurses were resisting the management policies and adopting their own ways of working. Staff were not co-operating, they were bending and breaking the policies, using their discretion in order to make their working conditions more manageable.

The drive for parsimony and efficiency in resource has led to individuals becoming more accountable for their resources use; the need to meet targets and be audited meant that respondents believe that ward managers must demonstrate where money is being spent and on what:

...but to oversee that care is provided well, and that the budget is made use of to the best it can be so that, you know, waste is minimal, efficiency is high (Male, SN, 3-5 years).

This reflects the increasing emphasis on the individual responsibility of staff. In particular Ward Managers were expected to account for all the ward usage and again this created tensions between management and the nursing staff. Many staff believed that the previous method of stock supply was better for patient care compared to having centralised stores, arguing that prior to the introduction of centralised stores, stock was more readily available and they did not have to be so aware of budgetary constraints, which they appeared to think should not have been a primary consideration when caring for patients. The belief was that nursing should focus on patient care and not be

concerned with budgetary issues and that budgets should not be the responsibility of the nurse.

Centres of excellence

During the discussion about the overall structure of the NHS, comments were made regarding the development of centres of excellence and specialist hospitals. As highlighted in chapter 3 (pages 86-88) the premise for the development of centres of excellence was that they would allow best practice and specialised care for particular problems (Donaldson 1992). Could the agenda however, have been more influenced by the potential cost savings of such ventures?

There were mixed views surrounding these developments. Several respondents reported concern over the closure of smaller and more rural hospitals in favour of the centres of excellence as they stated that it can make it more difficult for patients and their families to attend the hospital and raised general points such as: *'medicine has changed very much in that you now have specific centres for specific things. It doesn't necessarily benefit the patient'* (Female, WM/S, 15+ years). However, several of the respondents commented that they could be beneficial and lead to improved care. Supposedly, the development of centres of excellence has been about streamlining services for them to be more effective both in terms of time and cost (White 2010). However, there was resentment for these developments: *'well obviously the whole centralisation of the service is going to impact hugely on the National Health Service. I think it's a shame that they're putting some services so far away'* (Female, SN, 3-5 years). There appeared to have been little negotiation with staff over the impact these developments would have for workers and the general public. For some of the staff there was concern as to how these developments would affect their

current positions and work location, with some thinking that they would be moved, and if they refused to do so, then they would lose their job. Those respondents affected by this felt they had not been taken into consideration during the process and that they were powerless to alter the decisions. This has led to a variety of responses; staff looking for alternative positions within the NHS (exit/resign/leave), resisting the change (via discretion/altering) or simply accepting the decisions being made and feeling helpless to oppose them (acceptance/toleration).

Power, Resistance and Coping Strategies

Respondents did not appear to be supportive of many decisions made by managers outside the ward level and reported a decrease in job satisfaction and difficulties in their day to day work:

I'll stay on and give the extra mile and make sure my forms are done before I leave. But you get no thanks and there's no financial reward for it, you're just expected to do it (Male, WM/CN, 15 + years).

Despite there being the potential for staff not to undertake the extra work or to stay over their shift time and to cope by simply working to rule (Mulholland 2004), none of the respondents stated that they would only work the minimum required. The majority voiced similarly to the respondent above that they often did extra and stayed over their designated time for no extra reward. Finishing off tasks and paperwork outside of the shift was seen as a way to ensure their work was completed and allowed respondents to feel they had done their job to the best of their ability, considering the constraints placed upon them. But this led to the front-line workers feeling demoralised in their work, as there was a lack of acknowledgement of their efforts and so staff felt alienated.

Limited resources according to many respondents impacted on their ability to undertake their work effectively: '*... and trying to find ways of cutting costs and cutting corners basically*' (Female, WM/SN, 15+ years). This also raised concerns over accountability and their status as a nurse:

It [accountability] is making sure that you're doing your job in a professional manner and you're aware of what you're doing is in the best interest of the patient and you're not doing anything that would harm your patient (Female, SN, 15+ years).

This pressure led to an increase in tension between management and staff. Several of the staff argued that management were to blame but were concerned that it was the nursing staff who were actually blamed, and used as a scapegoat for poor patient care. Within nursing due to the shared working conditions of workers, it would appear that the work is not alienated - there is camaraderie between the nurses and a sense of collective solidarity. However, according to Lipsky (1980/2010: 75-80) there are several reasons why the work could be considered as alienated. For example the ability to act as an advocate can be inhibited. Although the respondents were giving the appearance of being responsive, they were actually exerting energy in order to hide the lack of services and resources from patients.

Further to this, the respondents were alienated because as nurses they only work on a part of the problem – they deal with symptoms, but longer term issues and social issues are not addressed. There were resource constraints meaning there was little time to explore issues with patients, and respondents felt pressure to get patients through the system as quickly as possible, leading to job dissatisfaction: '*beds are a premium, and*

sometimes I feel that I spend my time managing beds instead of doing the job that I'm here to do' (Female, S.WM, 15+ years).

Pollock (2005) believes that the constant need for cost-cutting by managers, has created a continual conflict between staff and hospital managers which is reflected within this research. Managers were trying to meet their targets whilst staff were focused on maintaining or improving the quality of care. In the present economic climate, public agencies are under great pressure to reduce costs and increase productivity. Tensions arose because many of the respondents blamed the financial decisions made by management as the cause for a reduction in the time spent with patients or on tasks which then led to (what they saw as) reduced standards of care:

If everybody else is a lot busier, then you've got less time to spend with patients or you're maybe doing your job a bit more quicker than you should, or trying to rush things through. You're not going to be able to catch everything (Male, SN, 3-5 years).

As seen in chapter 3 (pages 75-79), NPM mechanisms have limited the power and autonomy for professionals in the NHS. One way in which many interviewees coped with this feeling of powerless was to assign blame and fault to the managers (and politicians) informally. In doing this the staff then removed any blame from themselves over poor care or services – they were not at fault. Staff reported that they: *'just have to cope'* (Male, SN, 3-5 years) and make the most of what is there. Respondents did not voice their dissatisfaction to managers, but rather voiced their feelings to each other collectively via 'gossip' (meaning informal discussions - see chapter 2, pages 51-52). The nursing staff were seen to draw strength from all feeling that they were in the same situation and offered support to each other.

Additionally, several respondents stressed that hospitals could actually have their funding cut if they did not meet specific targets, which were tied into financial goals (there is a fuller discussion of targets in chapter 7): *'the meeting targets like four hours because there's fines if you don't meet these targets, so they're under pressure to achieve these, d'you know what I mean'* (Female, SN, 15+ years). There are financial implications for the length of time a patient stays within the hospital; the aim is to discharge patients quickly as beds are expensive and generally required for the next admission (either emergency or elective to ensure those targets are met):

She felt, you know, she'd been looking after him for three days, and said 'I don't feel this man's ready for discharge' and the bed manager contacted the discharge Sister and the guy got interviewed and there was a whole big chaos because my colleague felt 'no I don't feel this man's ready to go', and the bed managers saying he's just blocking a bed and tried to get him out. Aye. I think it's a bad day when it comes to the point where they're that desperate for beds that you're putting people out who are evidently not ready to be discharged (Female, SN, 3- 5years).

According to many of the participants this was leading to early and (what were often perceived as) unsafe discharges and then rapid readmissions, thus costing the NHS more in the long run. Many were unhappy with such policies and pressures, again feeling that they were detrimental to patient care and also that it was contrary to their responsibilities as nurses. The majority maintained that patient care must be the main priority, rather than meeting the management requirements for discharging patients:

Why should I be concerned about freeing their bed [the patients] for somebody, when there's certain things I might still want to do prior to

*transfer...and it does cause me issues with bed management as well
(Female, SN, 15+ years).*

For nurses, patient care was about acting as an advocate for the patient and ensuring they were fit to be discharged; being pressured to move a patient who they did not feel was ready went against their ethical beliefs and also the nursing code of conduct (NMC 2008). Therefore managers were placing nursing staff in a dilemma and there were disputes over what managers wanted. This was seemingly difficult because the policies and targets with regard to finances were seen to be taking priority over the decisions of staff. Managers appeared to be questioning the nurses' ability to make correct decisions, whilst staff felt they were not trusted to make the right decisions. Control of the workforce, which ties into the ethos of NPM, was being done by controlling the resources and people via management. Staff felt they were unable to make decisions based on best practice and treatment. Rather they had to utilise the cheapest options available due to cost, which were perhaps not the best or most effective for patients. This in turn brought their professionalism and ethical values into question. They were aware that what they were providing was perhaps not ideal, yet felt powerless and unable to rectify the situation and were therefore alienated. However, staff found ways to use their discretion and had the ability to "make rules or interpret policy at street-level" (Taylor & Kelly 2006: 630).

This limitation on staff decisions via policies was seen as a lack of trust of the nursing staff. There was a reduction of choice and autonomy for nurses on the one hand but, at the same time, there was a drive for individualisation and accountability. This seems a bit of a contradiction and meant that respondents were in a difficult position where they

were meant to be working as accountable and autonomous individuals, although much of their authority was removed by policy decisions.

The Changing Roles of Nursing

Elements of the changing role of nursing can clearly be linked to the drive for cost efficiency and parsimony of resources within the NHS (see chapter 3, page 84). Although initially the development of specialist roles in nursing would not be thought as relevant to a discussion of efficiency and parsimony of resources in the NHS, the reason for such developments can be seen to be linked to financial stringency and has been shown as a way to make the NHS service more cost effective. Also, since the staff themselves are a resource within the NHS, there is an aim to make staffing levels and skill mixes as efficient as possible at the lowest practicable cost. This section will discuss the advent of nurse specialists within the NHS and the extension of other roles, as a substitution of medical (more expensive) with nursing (cheaper) labour (Adams *et al.* 2000).

Despite the recognition that there were fewer ward nurses (which was commented upon earlier in this chapter), it is interesting that when the respondents discuss Specialist Nurses, they reported that there were increasing numbers of such nurses employed within the NHS. Table 3 lists the types of Specialist Nurses mentioned by the

respondents. There are two levels of nurses listed, that of Nurse Specialist²¹ and that of Nurse Practitioner²².

Table 3: Types of Nurse Specialists and Nurse Practitioners

Nurse Specialist (NS) areas	Nurse Practitioner (NP) areas
Alcohol and drugs	Emergency
Back pain	Cardiology
Cardiac	
Diabetic	
Tissue viability	
Stroke	
Respiratory	

Overall, there appeared to be some animosity towards the Specialist Nurses, perhaps attributable to a limited understanding of their roles within the ward and also resentment of the job they undertake:

I think there nowadays, you know, I think it went too far... there's nurse specialists for everything and people get confused ... Now nurses do that because, you know... well obviously it's economically a lot cheaper (Male, NS, 15+ years).

There's probably more specialist types of nurses out there, there's more people going off the wards doing... like, you've got your Falls Co-ordinator and then... I don't know, there's supposed to be more ... care

²¹ "A clinical nurse specialist is a registered nursing professional who has acquired additional knowledge, skills and experience, together with a professionally and/or academically accredited post-registration qualification (if available) in a clinical specialty. They practice at an advanced level and may have sole responsibility for a care episode or defined client/group" (ISD Scotland 2004: 2).

²² "A Nurse Practitioner is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, characteristics of which are shaped by the context and/or country which s/he is credentialed to practice. A master's degree is recommended for entry level" (The Scottish Government 2003a).

nurses than what there used to be, everywhere seems to be specialising and going off that way (Female, SN, 6-10 years).

There are many other types of nurse specialists and nurse practitioners within the NHS, however looking at those specialism's identified within this research shows the diversity of the types of areas nurses are specialising in. Many respondents suggested that there should be more staff on the wards rather than higher numbers of nurse specialists and nurse practitioners (although this view was not supported by all the respondents):

I think we've got two specialist Sisters which we never used to have ... but they pop in now and again with a piece of paper asking to find a Band 3's job role or asking if we've got any discharge date on our discharge board or auditing how many staff lockers we have on the ward, which to me seems irrelevant when they could be in a ward helping us out (Male, SN, 3-5 years).

This negative view is surprising when at the same time staff reported that the advancements in nursing as a profession were a positive development. There was a view that these nurses were not 'proper' nurses as they were not there for personal needs (for example attending to hygiene needs and nutritional needs of patients) unlike ward nurses. Staff were frustrated with their workloads, and these nurse specialists were seen as one factor contributing to increasing workloads.

There is a cultural expectation of what a nurse should be and the tasks that they undertake. Nurses are normally seen as being at the bedside 'caring for the sick' and engaging in personal care. However as is seen within this research, this idealised view of nursing was not being described by the respondents, but rather that nursing has

changed and is constantly evolving. Nurse specialists in particular were not seen to conform to the traditional view of nursing and so were seen to be alien.

Alongside these newly developed roles, there has also been a growth in extended roles for nurses. This involves nursing staff taking on more/different clinical skills to what was previously within the job remit. Such extensions include: *'the likes of IV cannulation, the likes of venipuncture, likes of doing IV drugs, administering IV drugs'* (Male, WM/CN, 15+ years). The development of these more advanced roles within nursing, according to many of the participants, has been due to finances: *'this has come about due to a change in junior doctor's hours and financial issues and restrictions,* (Female, NS, 6-10 years). Respondents related this to the additional costs of employing staff and filling vacancies left due to the EU working time directive legislation:

working time directives from Europe has essentially stated that medical staff, junior medical staff, cannot work the hours they used to, a lot of the roles that they traditionally did were taken off them...were passed into nursing staff (Male, WM/CN, 15+ years).

The changes in nursing can also be seen to be a way of limiting the authority of the medical professional. Greater specialism in nursing helps to reduce the overall power of the medical professional, because nurses are more able to question their decisions. For managers, nurses can fulfil some the doctor's remits and so make doctors less important/valuable.

The majority of respondents initially commented that this role development, despite being linked to a money-saving exercise was also about advancing nursing as a profession and so has been seen as a positive step. So the reason behind such changes

in nursing was perhaps not initially questioned. Previously nurses were seen to be “handmaids” of doctors (Tosh 2007: 68) whereas the respondents asserted that they were now more autonomous in their practice and accountable for their actions due to progression of the nursing profession. Generally the respondents did not appear to have resisted this change to their work, unlike other changes which have been implemented within the NHS. These advancements were seen to have allowed nursing to become a recognised and accepted profession²³.

Although these developments were generally seen as positive, several respondents did raise concerns over whether such changes were: *‘detrimental to what nursing originally stood for’* (Male, WM/CN, 15+ years). There is a debate within nursing as to what the role of the nurses is and should be, which was reflected within many of the respondent’s comments: *‘just delivering patient care on a daily basis...you come in, you do drugs, you do ward rounds, that’s what your day consists of’* (Female, SN, 3-5 years). On the one hand there is this idealised notion of the vocational work, where nurses are attending to personal hygiene needs of patients (which the majority of respondents still hold as their view of nursing) and on the other, the nurse as a professional who performs technical procedures:

Some people can be cynical and say the roles that we’ve taken on are roles that doctors no longer want to do, the way that qualified nurses nowadays don’t want to wash. When I trained and qualified it was fantastic that you were doing a blood pressure...now these roles are getting handed down to less experienced and less knowledgeable members of staff and the whole thing’s changing (Male, WM/CN, 15+ years).

²³ There has been much debate over nurses as a profession (Witz 1992; Walby *et al.* 1994; Davies 1995; Fatchett 1999; Adams *et al.* 2000).

This therefore caused difficulties for some of the nursing staff, who appeared to be unsure of what their role should actually consist of. At present the identity of a nurse is being brought into question as it evolves. The fact that nurses are being paid less than their medical counterparts for fulfilling a similar role although perhaps more limited (which was acknowledged by several of the participants) did not seem to be viewed negatively, although these changes were seen to lead to an increase in workload and accountability.

However, whilst they embraced these role expansions/changes the nurses also reported feeling that what they had come into nursing for had changed and was being eroded: *'it's more technical now than what it has been in the past and sometimes that gets missed. The basic nursing skills and the fundamentals of nursing gets forgotten about'* (Male, WM/CN, 15+ years). The majority reported that they spent less time at the patient bedside which was seen as a negative development. So, in further discussion they voiced some concerns as to how nursing has been changing, and there was an element of nostalgia regarding patient focused nursing with the implication that this was 'better':

When I qualified as a nurse it was very much a hands-on profession whereby you delivered care that was seen to be at the bedside, where things like washing/dressing, the activities of daily living were the important things as a nurse then, but things have changed (Male, NS, 15+ years).

Thus the taking on of technical roles was attributed (alongside other issues discussed throughout this thesis) to causing a drop in standards of patient care due to removing the nurse from the bedside. It was seen to cause internal conflict for the respondents as they appeared to be unsure of what their actual role as a nurse should have been: *'this is not*

what I came into nursing for, it used to be more about patient contact and not the extended roles' (Female, SN, 15+ years). This is interesting, as although with regard to extended roles and developments within nursing the respondents indicated feelings of increased autonomy, in other areas of their work many of the respondents asserted that their practice was being restricted. The significant numbers of policies and guidance demonstrate a lack of trust for nursing staff and limit autonomous practice. Nurses are told that within their practice they must be accountable for all their actions and act autonomously (NMC 2008), yet via NPM practices, there has been a deliberate attempt to limit the discretion and authority of professionals (Pollock 2005; Lipsky 1980/2010). However, this pressure cannot eradicate the discretion or authority of professionals. This creates difficulty for the respondents, which has led to resentment and tension between themselves and those individuals who are attempting to manage and limit their practices.

Summary

This chapter has considered the influence of NPM on front-line nursing staff with regard to a drive for efficiency and parsimony in resources. The limiting of resources as a way of 'improving the efficiency' of the NHS has had significant implications for front-line nursing staff. The respondents felt they had little control over budgetary decisions and felt powerless to resist the financial constraints placed upon them, thus leading to resentment, animosity and frustration with management and their decisions.

The parsimony of resources is one way in which management can control and constrain the discretion of the nurses and the respondents. This is in line with NPM ideology

which aims to limit the discretion of professionals and provide management with a control mechanism. Policies are in place, which reduce the decision making and autonomy of the nursing staff. This meant that nurses were increasingly alienated and frustrated in their work. Despite this, nurses were not completely powerless and they developed strategies with which to resist or cope with such policies. Lipsky (1980/2010: 16-17) asserts that street-level bureaucrats will use their discretion and resist management decisions that they do not agree with, and this can be seen to be the case within the nurses. Respondents employed various mechanisms for coping or resisting the developments. Firstly, a few of the respondents commented that they were looking for alternative employment and so are looking to exit their place of work (Hirschman 1970). Other respondents simply accepted or tolerated the developments and changes. There were those who used their discretion to bend the rules and alter the policies to help improve their working conditions or for the benefit of patients. Furthermore, all respondents appeared to engage in gossip to help develop a feeling of workers solidarity, although a few suggested that they would voice or confront managers or use the formal organisation channels to raise a problem.

However, the financial decisions have had some positive effects according to the many of the respondents; they have helped elevate the profile of nursing so that it is seen as a profession. But, this raised questions about the role of nursing in general, as these changes are moving away from the traditional (and idealised) view of nursing to a different role for nurses. The respondents found it difficult to reconcile the newer roles with the traditional ones held by nurses, which created frustration and an increased workload as the staff tried to undertake both basic nursing care and the more technical treatments and assessments required.

The next chapter will consider how standard setting (targets) and performance measures (audits) are affecting the working relationships and practices of front-line nursing staff. Standard setting and performance measurement are key features of NPM; they are thought to be ways to control the workforce and limit discretion. The chapter will explore how the front-line nursing staff view them and the influence that targets and audits have within the NHS, and specifically on their own working practices and relationships.

Chapter 7: Standard Setting and Performance Measurement in the NHS

Introduction

NPM ideals are focused on results, outcomes and accountability, which means targets and audits have become key tools of NPM (Hood 1991; Power 1997a). Targets involve the setting of goals (at government, health board or hospital level), and they should be about shaping practices to ensure appropriate, efficient and effective care is being achieved. Since the development of NPM in the 1980s audit levels have grown due to: the perceived crisis of public spending and increasing pressure to ensure that there is 'value for money'; the attrition of public trust in professionals; the development of managerialist practices; and the related need for performance measurement and business style management ideals (Davis *et al.* 2001). Policy initiatives now incorporate targets and audits so that their performance can be measured and assessed in some capacity. The implementation of policy and the evaluation of its impact and outcome are seen to be continuous activities within the NHS (Ham 2009). Furthermore, inspection and audit of public services are now thought to be central to effective management and regulation. Governments are using audit bodies as a way of gaining control and attempting to improve public bodies (Flynn 2002).

Initially this chapter looks at how policies generally, through their development and implementation, have influenced the work of nurses and their interactions with colleagues and managers. It will then explore how the proliferation of targets and audits

in the NHS has affected the day-to-day work of frontline staff, highlighting areas where tensions might arise.

Politics and Policies

As has been seen throughout chapter 2 (pages 22-41) policies and politics are linked, which means that the Government plays an important role in shaping the NHS, as policies will emerge out of political ideologies (Pollock 2005; Talbot-Smith & Pollock 2006; Leys & Player 2011; Storey *et al.* 2011). In order to discuss the role of policies, audits and targets, it is therefore important to think about the politicisation of the NHS:

“system reform has been the norm, stability the exception. Measures denounced yesterday have become today’s policy solutions as the political parties have competed to steal each other’s clothes” (Klein 2010: v)

Changes within the NHS are directed by government and the influence of NPM has occurred due to Governmental decisions. Despite the changing social-economic climate following the financial crisis in 2008-9, a prevailing power of neo-liberal ideology continues to shape the policy decisions being made by government (Crouch 2011). Policy-making is seen as the product of political processes (Klein 2010) which is influenced by government ideologies, along with economic and social circumstances. The majority of respondents commented that they believed policies had influenced nursing as a profession and the running of the NHS generally: *‘it’s all politically driven depending on what party is in power at the time’* (Female, WM/S, 3-5 years).

The NHS since its foundation has always been of importance to politicians (Rivett 1998; Greener 2003; Glennerster 2007). When the NHS came into existence in 1948, it

was the first system in Western society to offer free medical care and universal entitlement to the entire population (Klein 2008). The developments and changes introduced by subsequent Governments have influenced election results as the general population takes an interest in the healthcare system and provision in the UK. The NHS is seen as an important institution by political parties (Ham 2009). The fate of (and changes to) the NHS is frequently debated, particularly within the media (for example currently there has been much discussion regarding the reform of the NHS in England²⁴).

Many of the respondents spoke about what they had seen reported in the media. This showed they were politically aware and was perhaps partially responsible for several of the participants believing the NHS was being used for political gain rather than focusing on the health needs of the public. They claimed that politicians were using the NHS as a *'kind of brownie point system'* (Male, WM/CN, 15+ years), and that by making promises and targets they hoped to gain votes. There was also concern over politicians being involved in policy making within the NHS:

The Government are people like Nicola Sturgeon or whatever - I mean, have they ever worked in an (...) department before? I doubt it, so they don't know what they're talking about in a way that people are giving us advice that have not got a clue, like, they don't know what they're talking about. As much as they're trying to concentrate on the patients, it's lost because there's just so many people that are sticking their oar in and trying to get stuff done that don't understand how the department works and don't understand how the ward works (Female, SN, 2-3years).

²⁴ There have been proposals for new reform arrangements in England outlined in the 'Equity and excellence: Liberating the NHS' report (DOH 2010).

It is generally thought that governmental policies are developed and implemented in the NHS via top-down mechanisms (cf. Sabatier 1986), although policy can be altered and adapted at street-level by front-line workers (cf. Lipsky 1980/2010). However, this development of policy above the street-level can be problematic. According to many of the respondents, the policies were not always appropriate; they were perceived as having being made by individuals who had little understanding of the pressures on front-line staff and they were not necessarily about best practice or patient care: *‘and it’s always patient care that gets worse because we’re trying to stick to all these random policies that don’t make sense’* (Female, SN, 2-3 years). Nursing staff are not alone in this view; this reflects the experiences of many street-level bureaucrats as discussed by Lipsky (1980/2010). As was explored in chapter 5 (pages 139-140), the perceived background of managers had a significant influence on how front-line nursing staff viewed the decisions made and the policies implemented.

Interviewees further highlighted new that policies to some extent reflected the current political agendas, and for several of the respondents were seen as being more about ensuring efficiency, saving money or alternatively being driven by the media:

“We will definitely do this for you by the year two thousand and this.”
“We can guarantee you will wait no longer than five seconds to see an oncologist.” *“We will guarantee that ten seconds to see a cardiologist.”*
“You’ll have your bypass operation in 10 weeks.” *They all use it as a political ladder to gain voters, to gain political strength. They usually use crime, the NHS and education as the three main key policy driven ideas that they will put out there so the general public will - they use it as a kind of biggest promise, hoping to get more voters (Male, WM/CN 15+ years).*

As was argued in the literature review, since the 1980s there has been increased regulation of professionals. Managers have sought to limit the autonomy, discretion and legitimacy of the medial professionals and to a lesser degree nurses (Maddock *et al.* 1998). Professionalism involves acting on autonomous judgement, whereas managerialism involves getting other people to do what one wants, thus there is potential conflict. One aspect of this has been the proliferation of guidelines, policies, targets and audits. This can be seen as a direct consequence of NPM approaches, and the drive to regulate the nursing profession to conform to the ideals of NPM.

Table 4 shows the different policies that were mentioned by the respondents. There was a variety of types identified, and they ranged from clinical skills for nurses (e.g. how to dress a wound or how to administer an injection), working conditions (e.g. maternity pay or sick leave) through to those linked to structural changes in the hospital (e.g. centres of excellence). Respondents commented that there were large numbers of policies for: *'every single thing that you do at your work'* (Male, SN, 6-10 years). The majority of the respondents believed that there were increased numbers of policies regulating their actions, along with raised numbers of targets *'there are lots and lots of targets. You could drown in targets'* (Female, WM/S, 15+ years) and audits *'we're getting bombarded with audits'* (Female, WM/S, 15+ years). However, it is difficult to ascertain if there has actually been an increase, although within social work, it is reported that the amount of guidance is 55 times longer than it was 40 years ago (Munro 2010). So it is not unreasonable to suppose that there has been a significant increase in the number of policies directing nurses' work.

Table 4: Hospital policies mentioned by research participants²⁵

	High Level	Low level
A&E/MAU	Agenda for change Budget Cleanliness Gender based violence Health and safety Hospital acquired infection Name change for Sisters NMC Overtime Staff training Waste disposal Repatriation	Administering drugs Alcohol Area specific (e.g. policy for medical receiving unit) Care plan Cleaning carpets Jewellery Medical conditions New gloves Setting up equipment (e.g. trolley for catherisation) Smoking Treating a condition (e.g. dressing for a finger laceration) Uniform Visiting hours Zero tolerance
Surgical	Clinical governance Family/work life Hand hygiene Infection control Maternity Moving and handling Named nurse (from 1987) No redundancy Sickness absence Centres of excellence	Blood transfusion Drug prescribing and administration Falls MRSA screening Standard procedures Visiting times Wound care
Medical	Hand hygiene Infection control Moving and handling MRSA Staff sickness Zero tolerance	Admission paperwork Alcohol withdrawal Medications for discharge

²⁵ For the purpose of this research I have split the policies identified by the participants into two levels. 1) High level (British specific policies, and Scotland specific policies), which affect major issues of employment, healthcare and behaviour and 2) low level (hospital and ward level specific, including clinical issues), which cover more minor issues are likely to be applicable to their hospital or ward level specifically.

However, a fear of litigation and a professed lack of support from the organisation were, according to the staff, leading to increasingly '*defensive practice*' (Female, NS, 15+ years) and so could also be partially responsible for the respondents having had an increased awareness of the policies in place:

If you do something wrong and it's comes back to you, the management will say 'well it's your own fault because there was policies there for you to read' so they've always got the policies there to cover themselves (Female, SN, 6-10 years).

I am taking defensive practice to mean that staff are being overly cautious due to fear of blame or litigation and so will not take any risks or deviate from policy regardless to whether it is in the best interests of the patient. This is therefore limiting advancements and hindering change and progress (cf. Titterton 2005). The majority reported that if you did not follow the policy, then you would be held personally responsible for any negative outcomes: '*there is much more onus on the individual to be competent. Nursing management are not responsible, it's the individual*' (Female, NS, 15+ years).. This is perhaps not unsurprising, however, if there are circumstances which mean that a policy had to be deviated from, then the staff remained concerned that there would not be support for them, even if it was the correct thing to do at the time.

Despite reservations about support from their employers, there was some debate amongst the respondents as to how important following a policy was. Some respondents argued that policies acted more as guidelines though others asserted that policies must be followed to the letter. It would be expected that nurses would follow policies, and be unlikely to deviate from them, unless there was concern that it would be detrimental to

the patient. However, this belief by some that policies could be adapted goes some way to explain why several of the respondents were less fearful about deviating from policies and the outcome of such actions than others. Many of the respondents saw policies as meaning '*essentially a set of guidelines as to achieving an end result*' (Male, WM/CN, 15+ years) whereas some declared that policies were seen in terms of legislation which must be adhered to:

Policy to me is a written rule or regulation or procedure regarding any aspect of nursing or medicine or whatever it is. Something that's been printed and is to be adhered to and followed (Female, SN, 2-3 years).

We can see that respondents coped with the policies dictating their work in different ways. Those who viewed them more as guidelines were more likely to adapt the policy or seek alternative ways to provide care if they disagreed with it (altering or using discretion) and were less concerned over consequences that might occur due to this deviation. Nurses working within the NHS interact with the public on a daily basis, and so can influence the treatment and experience of these patients (via the use of discretion).

Lipsky's theory of discretion is based on the notion that in order to implement policy, discretion is involved; in this case the nursing staff exercised their discretion as to how policies were enacted. The strategies that were delivered by nurses were generally immediate and personal; decisions were made at the point of contact within the hospital. The priorities of the nursing staff, compared to those of management were often different and therefore led to conflict. In their day-to-day work, all of the respondents were using discretion in processing a large workload when they were under resourced. The coping strategies were generally not sanctioned by the management. However, at

ward level, Ward Managers were aware of such practices, and from the interviews were also seen to engage in them.

For those who viewed policies more in terms of rules and regulations, they demonstrated an increased concern regarding the potential for blame along with the lack of support from management. Mulgan (2000) and Khatri *et al.* (2009) both suggest that there has been a growth in accountability and responsibilisation within the professions, which has led towards a culture of assigning blame. This has caused raised levels of anxiety, as the majority of staff declared that it was unrealistic to assume that staff would always adhere to regulations. This was due mainly to the sheer volume of policies in place in the NHS. It was felt not to be feasible for a member of staff to have read and remembered each one:

There's a policy for everything, isn't there, and you can't - with the best will in the world, you'll not know every single one word for word, apart from there being so many and nobody's going to know every single one - as long as you know the ones that you're working with, and that are applicable to your area, I suppose is the most important thing (Female, WM/S, 15+ years).

Again probably just the pressure on everybody trying to get it right, and that can't always happen in the real world. You can't always get 100% all the time. I suppose, like, not everybody knows every single policy off by heart either, so... it's obviously quite hard to follow them religiously kind of thing (Female, SN, 2-3years).

The above shows a feeling of animosity and frustration towards the perceived growth in the number of policies. Many of the respondents questioned whether there was a need

for a particular policy in the first place or whether a current policy needed to be updated or changed:

Not all are good –everything doesn't need to be written in files which may not be looked at. Decisions need to be left to integrity in some cases. The dangers are that people need to look beyond the standardised advice and need to use clinical decision-making skills; they are good as guidelines, but need to be interpreted (Female, NS, 15+ years).

Just some of the ones that they come out with ... a lot of them are with algorithms/flow charts, policies in how we deal with certain things, and you just think 'why do it that way?(Male, SN, 3-5 years).

The front-line nurses developed ways to cope with all the information. This often meant that many of the policies were ignored, if they were not felt to be relevant or necessary. This strategy is currently not identified within Table 1 (chapter 2 page 59) which summarises coping and resistance strategies. This mechanism differs from those listed because it is not about acceptance or alteration; rather it demonstrates that respondents were simply not engaging with the policy. It was not a case that they were simply not co-operating with the regulatory mechanisms of the organisation; but rather were more selective when they accessed and engaged with policies that controlled their working practice – they used discretion to determine when to engage with a policy (cf. Lipsky 1980/2010: 17). Other strategies were adopted. According to the majority of respondents, policies were only accessed when an issue arose: *'you will go off and look a policy up after it's become an issue'* (Male, SN, 4-5 years) or some specific information was required: *'it's always something to refer back on if you're unsure* (Female, SN, 6-10 years). The respondents used their discretion to decide when to refer to a policy. Until

there was a need to access the policy for information, the staff appeared to avoid referring to them, though they were aware that a policy existed.

The values of the front-line nursing staff were prioritised over management's values in the application of policy. In using their discretion, the respondents altered policies for their own, and/or patients' benefit. Several of the participants reported that there could be an issue with policies intended to be regulators of care and practice. Individuals can concentrate too much on the legal aspects and written word, to the detriment of patient care. However, the opposite of this was that several respondents believed that focusing on patient care whilst ignoring the policies, could also be harmful for patients. This raised the question of what made a 'good nurse' compared to a 'poor nurse':

I think that sometimes that people are so concentrated on the policies that sometimes patient care gets affected, like, you know ... I think some of the policies that come in, don't really apply to, or can't apply to us, because in the department and sometimes you look at them and think 'how can you possibly work by that, because it just doesn't make sense for a department like this'. (Female, SN, 3-5 years).

so the policies that probably do fall by the wayside are policies which some of the nurses regard as a bit daft, A good example, I suppose, is health and safety policy - health and safety would probably shoot us if they came down and saw us dragging a patient up the bed when they were resting, but at the end of the day we don't really care about health and safety when it comes to that. So we probably focus on patient care a bit too much and disregard, like, health and safety ..., everything about this department is 'rush, rush, rush, get people in, get people out'... sometimes we're a bit gung-ho and just do stuff, but that's just the way it has to be (Female, SN, 2-3 years).

What makes a 'good' nurse needs to be examined: is it one who always follows the rules or one who uses their discretion and ability to act as an independent professional? There is the potential issue that staff will focus more on 'doing things right' rather than 'doing the right thing' (Munro 2010: 6). Within social work, there has been concern that there is too much of an emphasis on following the rules instead of actually offering assistance and help. From the respondent's comments in this study, it was seen that many of them did not follow policies exactly, but were more flexible in their application. In order to achieve the best possible care for their patients, nursing staff and management need to be aware that 'a one size fits all' approach (which policies are based upon) may not be the most suitable. The fact that many of the respondents used discretion in their work was beneficial for patient care, as opposed to other nurses who did not use professional judgement. However, this use of discretion by nursing staff can mean that a nurse's professionalism and discretion are coming into conflict with the ideologies of NPM and the desire to limit the autonomy of professionals.

Targets in the NHS

Targets play an important role within the NHS; they are tied into the need to measure performance by the government. A key element of NPM is the increasing levels of measurement and quantification (Pollitt 2003). Along with the proliferation of policies, the majority of respondents also asserted that, in a similar way there was an increase in the number of targets set in the NHS which had to be met at the front-line. Table 5 shows the targets that were mentioned. (All of the respondents discussed at least one target within their work arena). There is a multitude of targets within the organisation;

this list is not exhaustive but only comprises the targets used to make a point by the respondents.

Table 5: Targets identified by respondents during interview

A&E/MAU	Management of Violence Unscheduled care HEAT Medication prescribing Hand washing Fall risk assessment Nutrition Pressure area development	Financial/budget Four hour target to be seen Reduction of latex Infection control Health and safety Length of wait to be seen in outpatients/operation Cardiac patients – rapid access if chest pain is experienced
Surgical	Referral to treatment within 18 weeks HEAT Four hour wait in A&E 12 weeks to be seen by a consultant Budget Number of Bank staff used	Pharmacy budgeting Infection control Referral time for cancer treatment estimated discharge Drugs
Medical	Infection control Estimated discharge Four hour wait Health and safety Nutrition Falls	Waterlow pressure area care Completion of MEWS Reduction in rates of MRSA Reduction in rates of C-Diff Hand hygiene Stock control

Many of those mentioned applied to all areas of the hospital; and many were mentioned as being audits (which will be discussed in a later section). One target that was mentioned within all the areas where fieldwork was undertaken, was that of the “four hour wait” to be seen in A&E. It was perhaps not surprising as there had been much media attention of this target. This target had an impact both within A&E and MAU along with the hospital wards. Most of the respondents remarked that attempting to meet this target had a knock-on effect of putting pressure on the other wards to free up beds; there was a pressure to discharge patients more rapidly. So, there was concern that

targets such as the four hour target impacted on patient care and patient safety. An example of this occurred within A&E causing concern, as there was pressure on nursing staff to move patients within the four hours, but the patient was not necessarily fit to be moved at that point in time. This caused conflict between nursing staff and management. Being moved before they were ready could have compromised patient safety and care, and nursing staff were put under pressure to persuade management that the individual could not be moved:

They do, they get upset, you can see them up here getting upset, where there's care that they want to deliver but they're told 'no, get him out of here, because this person in A&E is going to breach'. And then maybe the nurse is like 'I want to feed him and I want to give him his mouth care, and I want to...' 'No, we need that single room, get him out. There's a bed over in Care of the Elderly, move him. Phone over and get him moved now so we can get Mr X up so he doesn't breach' and they don't like that, and I wouldn't like it either. Because it's their patient and you know, they've not delivered the standard of care they would like to (Male, WM/CN, 15+ years).

A further consequence of the four hour target according to several respondents was patients being moved to inappropriate wards, rather than waiting for beds within suitable specialities:

Like you're so stressed about getting people out of Casualty for the four hour wait that you're just dumping them, in the best possible sense, in any ward, rather than making sure they go to the ward where... their own discipline rather (Female, WM/S, 15+ years).

This meant that the nursing staff on the inappropriate ward were concerned that they were inadequately trained to look after the specific condition of the patient; which could lead to a drop in the standard of the care and treatment received by the patient.

In discussing the impact of targets not all comments were negative and there were several areas where targets were highlighted as being beneficial. With regard to the positive impact targets had, respondents said: 'it can give us a structure for things' (Female, SN, 2-3 years) and 'targets are a good...they're a sort of drive' (Female, WM/S, 15+ years); they gave staff and departments something to aim towards, a goal, and guidance to work by. They helped to show achievements, provided encouragement and motivation for the staff, as well as identifying areas for improvement:

I think they can be positive in that you can up your game a little bit, you know, sometimes you'll be presented with something that might... I mean, there might be some things which is completely impossible, but I would say 99% of the time you pull out all the stops, you get there and you think 'well, you know, we've broken... a few sweat and tears but we've managed it'. So I suppose in that sense it maybe keeps you motivated, it maybe keeps you... I think if there's no targets, there's maybe a risk of maybe kind of slowing the pace a wee bit and just sitting back and... (Female, SN, 2-3 years).

Participants remarked that these types of targets helped improve relationships between staff both within the immediate work area and with medical staff within the wider hospital setting; team working was improved:

I think, we work really well with the A&E medical staff and getting people seen quickly and things ... calling doctors from other parts of the hospital to get in and start helping that way. So I think it does well, I

think we work pretty well with this kind of breaching target thing, I think it all comes together pretty good, our kind of medical staffing... I suppose it's... I think it marries it up... (Male, SN, 6-10 years).

However, the benefit of targets on improving care needs to be carefully considered. Although targets may be reached, can this truly gauge the quality of care? Several of the staff asserted that targets will not make you a good nurse, and they are not able to assess the relationship you have with a patient or their experiences:

You can meet all these targets but that doesn't mean to say you're a good nurse or not. That doesn't tell you whether you've got a good relationship with your patient, how your patients felt when they've been there. Just things like that, it kind of depersonalises things (Female, SN, 6-10 years).

The effect of targets on patient care is controversial, with many authors arguing that they have improved patient care, whereas others dispute this and have concerns about the unintended consequences (Bevan & Hood 2006; Propper *et al.* 2008; Gubb 2009; Kelman & Friedman 2009; Freeman *et al.* 2010).

The most common issue spoken about in relation to targets was regarding the pressure they placed on staff. Staff reported an increase in their workload and that there was a lack of time and resources to achieve all of the work required:

Yeah, because it's a huge pressure, it's a huge pressure. The nurses are... you know, you're working in minimum staff levels, remember that, so if you've got somebody that's unwell, you know, that takes two nurses to look after them, you're all running about like maddies... There's a huge amount, and no extra staff has ever been put in to account for all of

this extra work that's put on them, so yeah, it's very hard for the girls (Female, WM/S, 15+ years).

Yeah I think it can put too much pressure on everybody, including us, management... and then the patients suffer, but you know, they're obviously there for a reason and people much higher than where we are just now have brought them in for a reason, but I think yeah, they can put far too much pressure on a lot of things in the health service when your time should be on the frontline with the patients (Female, SN, 2-3 years).

This increase in workload led to resentment and frustration; the targets were thought to often be unrealistic and unachievable: *'it's all tied up with targets and unrealistic targets of moving patients through the system'* (Female, NS, 15+ years). NPM and targets are about increasing productivity; however, many of the respondents felt that they were overstretched and it was impossible to fulfil all that was required of them which then had a detrimental impact on patient care.

Several respondents asserted that targets could remove the focus of nurses away from patient care; some staff were seen to be more concerned with meeting targets rather than the providing excellent patient care: *'these targets can be positive but also can be negative, as they can become the focus and can take away from the time spent with a patient'* (Female, SN, 15+ years). Hunter (2003) argued that targets could have a negative effect for practitioners as they could distort priorities. This has implications for professionalism. It raises questions about what being a professional means and also regarding what makes a good nurse. Is it conforming to targets set by managers and the organisation, or is it prioritising what the front-line nursing staff believed to be more important - patient care? Furthermore it was felt that management were not

acknowledging the pressures that nursing staff were facing, and that managers prioritised achieving targets over patient care and safety:

There's phone calls constantly from managers that don't nurse at all, just constantly on your back asking you 'why is this patient rate so long?' So you're chasing things all the time which is annoying, because sometimes you can't do your job that you're supposed to be doing, for trying to answer their questions (Female, SN, 6-10 years).

The government more so or hospital managers who then put the pressure onto other departments, you know, the main one here being A&E would seem the main target. Seem to think, you know, because that's what the government see a hospital is running, they seem to forget there's maybe 60 wards attached to that hospital, they just seem to look at the point of view of 'well if we're moving patients through A&E, we can have a Patient's Charter to say you'll be seen at a clinic within four weeks, that's adequate' and it's not really adequate, when you've got so many other patients involved in their care, you know, in other wards that have got just as much responsibility...(Female, SN, 15+ years).

Targets can de-motivate nursing staff. It was believed by several of the respondents that the targets were developed when there had been a failing somewhere, but all areas were: *'tarred with the same brush'* (Male, WM/CN, 15+ years), thus when a new target was introduced, it sometimes had negative connotations for staff and led to increased frustration and despondency. Again this is linked to how the organisation is seen to be attempting to limit the discretion and autonomy of its workers. The proliferation of targets is shaping the day-to-day work of the nursing staff, as the staff are increasingly focused on meeting the targets due to the potential implications for their ward and their own registration if they are not met. Practitioners face difficulties in addressing the

political agenda of meeting targets, whilst also attempting to improve the quality of clinical care within the resource constraints of the NHS (Som 2009).

In a similar way to policies, targets can be used to set agendas; many of the participants believed that they showed staff what they should view as important; the values and ideals of the organisation, managers and even government (as opposed to those of the front-line staff) are prioritised and appear to be put to the fore. Staff will act in certain ways due to the pressures that targets place on them; targets can be seen to have a greater influence on staff behaviour than official guidance documents (Lipsky 1980/2010: 48-53). Nurses however, may not realise that it is actually about controlling their actions. In establishing targets staff are told what their priorities must be and they must conform to the organisational wishes and objectives (Blau 1963; Clegg 1998; Lynch 2004). Constant surveillance of staff actions along with specific mechanisms of training and educating the staff, ensure they have adopted the organisations ethos (Somerville 2001). There is little opportunity to deviate or ignore organisational demands, although discretion can be used to alter or circumvent policies to some degree. Targets, the organisation will argue, are aimed at encouraging high standards and help ensure these are met. However, as can be seen in the comments, the respondents do not completely reflect the organisational views and beliefs. They questioned manager's decisions and frequently resisted decisions.

Auditing in the NHS

Audits play an important role within the NHS; they are used to assess the impact of policies and outcomes of targets. An audit culture has emerged which is linked to the

introduction of NPM approaches within the NHS and the need to measure performance and control professionals (Power 1997a; Davis *et al.* 2001). The respondents commented that along with policies and targets there has also been a proliferation of audits, although this is unsurprising as audits are an integral tool used to measure targets.

Table 6: Audits identified by respondents during interview

A&E/MAU	Nurse practitioner (how many patients seen by a practitioner) Head injury Knife injuries HEI – infection control (healthcare acquired infection) Health and safety manuals Health and safety procedures STAG (Scottish Trauma Audit Group)	Tissue viability Mattress Antimicrobial prescribing Unscheduled care Four hour A&E targets Cardiology (ACS – Acute Coronary Syndrome) Venflon (cannula) Care for blood packs Hand washing
Surgical	Clinical quality indicators CQI's (these audit process indicators which determine if a patient is getting sicker) Early warning scoring system Falls MUST (Malnutrition Universal Screening Tool, this is about food and nutrition) Tissue viability Hand hygiene/washing Drug cardex HEI (infection control)	Cannulas Mattress Health and safety Antibiotic prescribing Care plans Blood transfusion checks Pain management Discharge dates Catherisation Domestic staff Safe patient environment DVT and prophylaxis
Medical	Bed Care plans Hand hygiene Infection control MEWS Hospital acquired infections	Sharps (this is the use and disposal of equipment such as needles) Nutrition Waterlow scores Cleaning

Table 6 shows the types of audits identified by the respondents, many of which were common throughout the hospital areas. These audits are required by management and so

must be completed by all wards and patient departments. Some figures are also required at a governmental level, and it is the responsibility of the individual hospitals to ensure the data is available from the 'shop floor' (Female, WM/S 15 + years).

The most common audit mentioned was in relation to infection control (although, the reason for this could be that the hospital was meant to have recently undergone a HEI inspection, and so this was still fresh in respondents' minds). The majority of respondents had informed me that the preparation for this inspection had added to their workloads, as it required extra cleaning and organisation for the staff to ensure the hospital was ready:

The positive thing is the cleaner the place is the less likely infections are going to affect your patients. The negative thing is you've got nurses doing far too much cleaning, which should be done by cleaning staff, d'you know what I mean, when this audit was coming up recently we were spending hours washing down walls, work surfaces and everything. Well, that was okay maybe on a nightshift when you didn't have a lot of patients in, but during the day it was unfeasible, but I thought we're doing the work that actually domestics should be doing here (Female, SN, 6-10 years).

The respondents had been frustrated by this, not only due to the amount of work it caused and how management had ensured the hospital was ready for the inspection, but also because the inspection did not take place when it was meant to. There appeared to have been little consultation with nursing staff prior to the event occurring and several respondents reported that there was a lack of understanding from management with regard to time pressures, the prioritising of work for the HEI inspection and the impact this had on front-line nurses' workloads.

The HEI inspection was to have been undertaken by a body external to the hospital, but the work is completed within the workplace by a variety of individuals and groups. There is no one person who is responsible for all the audits. They are being done for a variety of reasons, but how they are organised and undertaken varies; there seems to be no uniform approach to it. They could be completed at ward level by the Ward Manager or ward staff, by other hospital staff from different specialisms or as external audits by nurses from a different hospital and/or health board, professionals, groups or organisations. Respondents reported that often audits needed to be completed by certain dates, but it was up to individual wards to determine how they were completed.

For many, there was a further issue regarding how audits were undertaken; there was a view that audits were not always completely random or representative. This raises questions regarding whether audits are accurate and whether they do in fact improve practice. There were divided opinions from the respondents, as they identified both potentially positive and potentially negative impacts:

You know, instead of, as you say, 'I'm going to pick five patients today and I'm going to look at everything we do for them'. But then it's the randomness of it, you know, you say 'well who will I pick? The person who just came in yesterday or the person that's been in for three weeks/a month?' ... But an audit is not a solution necessarily to a problem. Because sometimes a problem can arise and people go 'lets audit it'. You go 'well no, let's look at it, a fishbone analysis' and an audit isn't the answer, you know, 'that patient's tea was cold let's audit it'. 'Let's see the 29 cups of tea, what the temperature is on average?' But you see, that's not the problem, you've got to look at circumstances. The patient's tea - was the patient at the bedside or in the shower, you know? (Female, WM/S, 15+ years).

In the case of audits which only involve a number of patients' files, there can be issues with the selection process as to whose records are included or excluded. There was also a view that an audit may not be appropriate for the issue that had arisen, and that other approaches may be more beneficial. There was frustration and concern expressed by many of the respondents to whether audits actually assessed care was questioned. As Lipsky (1980/2010: 48) argues, the evaluation of street-level bureaucracies is very difficult due to the level of discretionary decision making, so how can practice actually be assessed? Staff can make efforts to meet targets, but these efforts may not necessarily be the kind that was intended by those who designed the targets. It is very difficult to assess whether targets are being met via current audit mechanisms, as these tend to be numerical and do not actually assess patient care qualitatively. Smith (2005), Bird *et al.* (2005) and Blackman *et al.* (2006) highlight that, due to issues with the robustness of audit data it can mean that although reported performance improves, there is no real underlying improvement.

With regard to internal ward audits, different practices were occurring: audits were undertaken by ward staff generally on a rota system or allocated to individuals. There were wards where only selected staff were involved but there were wards where it was just the senior staff (e.g. Ward Manager) involved:

I mean, I should actually have the Staff Nurses taking part in it, but to be honest it's just really the Sisters that tend to do it – (...) or the Sisters take part. There's one or two Senior Staff Nurses that have done a handful, you know, that they've maybe been the cleanliness champions and they've done some audit with that - well there's actually six or seven staff that have done that - but I tend to do it, really just because the girls are busy with patient care (Female, WM/S, 15+ years).

We do have a rota system in this ward where we all do a different one every month. We're paired with another nurse and we share the workload obviously halved down the middle. So yeah, there's a good ten or so audits going on every month and I think the results are given to the Ward Manager and then she feeds them up the way to whoever they go to (Female, SN, 2-3 years).

Several of the respondents further highlighted potential issues in the quality of the audits (similar to the issues raised with regard to targets). As previously mentioned, many different audits are carried out either at ward level by ward staff or externally. Many stated that there were advantages and disadvantages with all of these approaches. For example if the audit were undertaken via external people, then the information was not fed back the ward staff:

then nine times out of ten, that information's not fed back to us until... so when it's ward based it's much easier to feed back the constant problems or the constant failings (Female, NS, 15+ years).

There appeared to be discretion in the way in which audits were tackled within the hospital directorates and even between wards in the same speciality. This again raises questions regarding who is the most appropriate individual or group to carry out the audits and whether audits are consistent and comparable between areas. Additionally, the respondents argued that audits could only be effective if the information gained by conducting them was disseminated back to the staff involved. If the information was not disseminated then it was felt that they served little purpose as nothing was learnt and no improvements were implemented.

There were other respondents who indicated that the results from audits were not necessarily accurate, because the results could be skewed or orchestrated in some way depending on who carried out the audit. This led to concerns relating to the validity and reliability of audits as a mechanism to assess performance:

The figures would be skewed for a number of incidences, but I'm talking about violence and aggression in particular, because that's something which we... that happens a lot here (Female, WM/S, 15+ years).

And the other thing the findings, depending on who's interpreting them, they can be manipulated any way you want as you know, you can get anything from them. So the findings have to be properly analysed (Male, WM/CN, 15+ years).

Although there was concern over how audits were undertaken, all of the respondents offer reasons for why audits were vital, for example in providing supporting evidence of performance and practice, allowing change to occur, and improving patient care:

A lot of what the old Nursing Officer's role was, a lot of their tasks have come down to Ward Manager or Senior Charge Nurse as it's now known, so a lot of their role and work has been passed down to us. That amongst other things. I think nursing has changed, you know, it's no longer that you can do X, Y and Z - you have to prove everything; you have to audit everything, you have to give reasons for why you're doing everything, you know, much more than you did 15 years ago (Female, WM/S, 15+ years).

The whole point in doing the audit is to try and show that if we change the system and we've compared it with a 'before' and 'after', we've done a comparison; if we do this and we're able to change the system for the benefit, then great we change it. Or if it shows that there's not going to

*be any benefit then fine, we've tried it and we know it's not going to work
(Male, WM/NS, 15+ years).*

Many respondents commented that audits encouraged team work, and helped people work as part of a team:

Whenever there's an audit done, we always get the results of it, so we know what we need to work on; we get a percentage so it shows everyone what we're working towards, and it has worked. I think it helps us work as part of a team, because then everyone gets involved then and it's not just the one person's responsibility (Female, SN, 6-10 years).

However, this apparently depended on who was conducting the audits, as the allocation of and participation in audits could cause stress and tension between individuals particularly when the staff felt they were overworked already and the audit was removing them from carrying out patient care. Audits, could also be used for educational purposes; *'they're educational, they teach us... they're too widespread to be specific, but they do teach us where we can improve things, and I think that is a good thing'* (Female, WM/S, 15+ years). These views reflected the management outlook on the benefits of audits; this again helps to show how organisational cultures and norms become accepted and internalised by the employees. There has been a shift in practice according to many of the respondents which indicates that audits are now seen as an essential tool to assess and change practice:

They are there for a reason and I think they let us know what we're doing well, let us know what we can improve on. So they are there to make practice better obviously (Female, SN, 2-3 years).

The influence of NPM can be seen in the proliferation of audits and the rise of the audit culture in a way that is similar to the proliferation of policies and targets. The workplace

is now more focused on controlling and restraining the staff. It appears to be increasingly linked to a lack of trust in the professionals with the implication that their practice needs to be surveyed as it cannot be relied upon to be accurate. This can be seen as a way to control staff and limit their autonomy in a similar way to the use of targets in the NHS to regulate and control.

Many respondents reported feeling demoralised by audit results and were concerned that they were constantly being watched, which was seen by some to be an insult to their skills as a nurse: *'sometimes you feel a bit aggrieved just because it's as if you're not trusted to do what you're meant to be doing; everything has to get double checked and checked'* (Male, SN, 4-5 years). Maddock and Morgan (1998) highlight that staff can become demoralised and grow suspicious of change when management audits and targets result in a move away from a focus of improving the quality of care and services to one that focuses on efficiency related performance targets and audits, which is similar to respondents views:

If they feel they're being watched by Big Brother, then it's not quite so interesting, hence the panic before the Healthcare Acquired Infection people came in. And to be quite honest, all those things were being done, it's the documentation that's being done. And this having to sign your name because you've wiped a shelf, is just a tad... it's kind of insulting to be quite honest, because it's stuff that we've done for years and nurses know how to wash their hands. I'm sorry but they do. Having pictures above the sink again is a tad insulting (Female, WM/NS, 15+ years).

Audits put added pressure on staff both in terms of workload but also in relation to concerns for their job and fear with regards to the results: *'this can cause frustration for nursing staff, it depends on how well the rationale is understood and also the increased*

workload means staff can be 'pushed to the limit' (Female, SN, 15+ years). Scrutinising workers can be difficult. Due to the professional status of nurses, those supervising and assessing need to be aware of this professional status and that discretion will be used, thus making it very difficult to measure the correctness of a nurses actions or the fairness of treatment.

There was also an issue in relation to responsibility and accountability. Who is to blame if the figures are not reached or if the audit is not undertaken or not carried out appropriately? This was reported to cause increased pressure on the respondents, which led to further resentment and tension due to a fear of being blamed or held accountable and the subsequent punishment or sanction:

And you know, what is the point in that? The point is that they were frightened that they would fail. But surely the whole point of audit is to see things how they really are and to give feedback and say 'here are the good points, the bad points are... and this is what you need to improve on, it's not a criticism, it's an observation we're here to help you.' But not, 'we're going to the Daily Record to say that there was a piece of faeces found in a commode that is used in a six bedded room and a bit was missed and we're going to the papers (Male, WM/CN, 15+ years).

Audits can also be used in terms of comparisons as pseudo league tables (Adab *et al.* 2002); this also was suggested as a cause of increased anxiety as respondents were concerned that audits were being used to instil competition between different areas or hospitals.

The proliferation of targets and audits mean that individuals become responsible for their own performance. This links to Foucauldian notions of disciplinary power and

surveillance (Foucault 1995). Methods of surveillance (via policies and audits) are employed by hospitals, which lead to workers and patients acting in certain ways (as discussed in chapter 3 (page 77)). Organisations seek to dominate through the discipline of its workforce:

It shows what weaknesses the wards have got. Whenever there's an audit done, we always get the results of it so we know what we need to work on, we get a percentage so it shows everyone what we're working towards, and it has worked (Female, SN, 6-10 years).

Because obviously it's keeping people on their toes and it's making people think twice about, you know, doing everything the way it should be done which can only positively impact on the patient's experience and the patient's care if the audits are there (Female, SN, 2-3 years).

The advent of ward level audits has led to respondents undertaking surveillance and discipline of their colleagues on behalf of the organisation; perhaps without realising that they have taken on this role. This can via persuasive forms of power (cf. Lukes 2005). Both discreet and indiscreet hierarchical gaze (critical observation) is occurring (Ryles 1999). Due to increasing accountability and responsibility within the workforce, surveillance can be seen to be reliant on the individual's self-management (Gilbert 2001). The respondents were governing their own actions and managed their own practice at ward level. This meant that the organisation had effectively abdicated their responsibility towards the staff. Despite this, due to the targets, audits and policies, organisations are still regulating behaviour, although they no longer offer a supporting role.

As organisational culture develops, it becomes part of the norm for audits to occur and practices to be assessed. As organisational norms become part of accepted practice, so they are less likely to be questioned; staff are therefore more likely to accept the organisational rules. When individuals question practices within the hospitals, they are questioning the organisational values and so are seen to be rule breakers. Conflict occurs at this point as there are now competing values. So does accepting the organisational values and norms and conforming to such make a good nurse? From a management perspective within the NHS, presumably the answer to this, would be yes. However, perhaps it is those nurses who question practices and decisions, who actually improve practice and patient care.

Summary

This chapter has explored how policies, targets and audits are understood, implemented and handled by the front-line nursing staff. As was highlighted in chapter 3 (page 73), managers can spend much of their time dealing with conflicts, for example substantive conflicts that involve disagreements over issues such as goals, targets and policies (Schermerhorn 2000). The differing views and priorities of managers compared with the front-line nursing staff has been explored and this chapter has identified some of the areas of conflict and also how the respondents cope or resist the standard settings and performance measures that have been employed within the NHS.

With regard to the proliferation of policies, coping mechanisms were employed by frontline nursing staff to cope, and they included resistance, alteration and deflection of those policies which nurses viewed as unbeneficial. This echoes the findings of Lipsky

in his book on street-level bureaucracy (1980/2010). The interviewees highlighted ways in which they attempted to overcome the unacceptable challenges of the job and how they did not always adhere to formal policy (a particular example of this is health and safety manual handling) often due to time constraints.

The majority of staff linked both targets and audits, targets are set and the achievements assessed via audit. Further to this, the respondents might treat both in a similar manner because targets and audits involve work for nursing staff and form part of the working culture, as they allow for evaluation of work being undertaken both by and around nursing staff. This is not only linked to measuring the performance of a particular area, but also to controlling the workforce.

There appears to be lack of trust of front-line workers by management as there are now vast numbers of policies, targets and audits governing the day-to-day practice of nursing staff. These are continual directing their work and attempt to limit the nurse's discretion. As a result, a culture of fear and blame has developed. This is perhaps because there is now little room for discretion, so if a mistake occurs or a target is not met, it must be due to not following the policies and guidelines and so the individual must be to blame regardless of the circumstances. This fear of making a mistake or not achieving a target is leading to defensive practices. This is where employees are working in a way that better protects their own interests and is less concerned with providing the best care for patients. Staff are more likely to avoid certain practices or procedures if they are perceived as risky or there is potential for an adverse result for fear of blame and their registration being affected.

As has been seen within this chapter, the types of audits and targets being identified and the perceived positive and negative impacts they have, are similar. The respondents reported that targets and audits have placed increased pressure on their day-to-day practice. This has led to coping mechanisms being developed by the respondents in order to cope with the pressures placed on them. Many of the strategies employed by the respondents were to be expected, for example using discretion and altering policies at the front line. However, the fact that nurses will ignore policies and not look at them if they are felt not to be relevant was not identified in the literature.

It has been seen that policies, targets and audits do impact on the relationship between the nursing staff and their managers. On the one hand these tools were seen as beneficial, for example by providing guidance and helping to improve teamwork, but on the other hand, they lead to frustration and animosity between staff and managers. For example they were often seen to prioritise the management agenda over patient care. They impacted on the role the nursing staff are undertaking and influence their practice on a day-to-day basis. Their use was seen to be a mechanism through which management controlled and limited the actions of nursing staff; this therefore led to resistance and defiance by the street-level workers.

The next chapter will consider how consumerism has affected the work and relationships of front-line nursing staff. A key feature of NPM is to allow the 'voice' of the consumer to be heard. However, there is much debate as to the effectiveness of this aim. Therefore, chapter 8 will explore how the respondents view consumerism and whether their understanding of the term reflects the aim of the governmental policies. The influence of the 'Patient's Charter' (DOH 1991a) on the relationships between

front-line nursing staff the public will be explored to determine the impact it has had. The relationship between consumerism, the media and the nurses within the NHS is also discussed as having an important influence for nursing staff and their relationships with management.

Chapter 8: Service Quality and Patient Rights

Introduction

A key part of NPM is an emphasis on consumerism and service quality (Hood 1991; Pollitt 2003); one of the key features has supposedly been for the ‘voice’ of the consumer to be heard (Newman *et al.* 2006). This drive towards a consumerist focus has its roots from the Conservative Government and was clearly seen in the development of the ‘Citizen’s Charter’ (The Cabinet Office 1991) and the ‘Patient’s Charter’ (DOH 1991a). These charters emphasised the principles of choice, ownership, and responsibility which aimed to improve the quality of public services by providing the public with information on their choices and their rights. This has been a dominant theme of the market-model of public service since the 1979 Conservative Government, and under the Labour Government (1997-2010), the image of the consumer was seen as underpinning the modernisation of services.

The influence of consumerism and choice can be seen by the level of policy guidance that incorporates the notions of choice (the notion of ‘choice’ is an ideologically loaded term that is normally linked to the ‘market’ (Crouch 2011)) and patient rights. However, this has not necessarily meant that patients and users have more “consumer mechanisms” (Powell & Greener 2009: 112). Arguably, patients still have little choice and lack the opportunity to exercise real choice (Powell & Greener 2009). Decisions are often made by health professionals on their behalf. Furthermore, as Newman *et al.* (2006) assert there cannot be a ‘real’ customer when it comes to the NHS, as the patient

does not pay directly for the service, and may in reality be an unwilling or involuntary service user.

Initially this chapter will explore how the respondents viewed consumerism and whether their understanding of the term reflects the aim of the Governmental policies. Next, the influence of the 'Patient's Charter' (DOH 1991a) and similar consumerist initiatives on the relationships between front-line nursing staff the public is explored to determine the impact they have had. Finally, this chapter explores the relationship between consumerism, the media and the nurses within the NHS.

What Consumerism Means

Consumerism is a word frequently mentioned within NPM rhetoric (Clarke & Newman 1997; McLaughlin *et al.* 2002; Dent 2006; Powell & Greener 2009); therefore it is important to understand how the respondents understood this idea in order to discuss how the nursing staff felt it influenced their work and relationships. Consumerism is defined in the Chambers Dictionary (1994: 220) as: "the protection of the interests of buyers or goods and services against defective or dangerous goods". In the case of the NHS, this would mean the protection of patients who are receiving or using NHS treatment of services. Generally, respondents were able to offer a definition for the term, although a few were unfamiliar with the word or concept. For those who were familiar with the term, there was a range of phrases offered as a way to define consumerism, as can be seen in Table 7. There did however appear to be reluctance by the respondents to accept the rise in the expectations and rights of patients, an escalation

of expectations caused by the introduction of policies and guidance such as the 'Patient's Charter' (DOH 1991a).

Table 7: Respondents views of consumerism

Appealing to the public
Buying and selling (retail)
Cost of services and paying for services
Individuals expectations of the service
Money
Patients as customers and clients
Patients/clients/customers opinions and being heard
People's Rights
Selling the hospital
Standards and quality
Value for money

In looking at the terminology used by the respondents, not only do they encompass several concepts, but they also reflect the ethos of NPM. Terms such as value for money, buying and selling, cost of services, standards and quality are all terms that can be identified within NPM. This demonstrates that the organisational culture has developed to reflect governmental doctrine, and this has been internalised by the respondents and become normalised. This should mean that the front-line workers come to incorporate these concepts in their work. However as has been seen in the previous findings chapters the nursing staff have not done so and do not completely agree with the organisational views.

There were mixed views as to whether consumerism had a place within the NHS:

It's not applicable to the NHS. Patients are not consumers as this gives a false idea of what the NHS is about. I suspect they are not best placed to decide what the right care is for them, and so they hand over responsibility to the NHS – relinquishing responsibility for their own health. There are however degrees, and everyone is entitled to information to make an educated and informed decision about what care they would like. Consumers would mean a demand and this would not be appropriate (Female, NS, 6-10 years).

This and others interviewees believed that patients were not suitably placed to make decisions concerning their care because they were not seen to have sufficient knowledge to be able to make appropriate and informed choices. Many of the respondents commented that responsibility should not lie with the patients who are not educated to make decisions unlike the professionals. The medical and nursing professions are perhaps reluctant to relinquish ownership of medical knowledge. There is a struggle over this ownership, since if healthcare professionals allow patients to make informed decisions, then this will limit their autonomy and importance.

Newman *et al.* (2006) indicate that if patients are more informed, articulate and empowered, then this will decrease the power of professionals. Professional knowledge is seen by interviewees as essential to make healthcare decisions. This has strong links to the paternalistic notion of 'doctor knows best'. Such changes can threaten the organisational culture and the way in which nurses' work will have to change as patients become more informed and articulate. There is a fear that nurses (and doctors) will no longer be a key source of information and this will have implications for their practice.

This could be a reason why some respondents were resisting the changes related to increasing the knowledge and rights of the general public in healthcare. The control of information, or the way information is rationed, can be used by staff to create barriers and confusion for patients and their relatives (Hall 1974; Laing *et al.* 2009). Despite this, and in apparent contradiction, several of the respondents reflected that patient rights and the notion of consumerism, have developed to have a prominent place within the NHS, and are increasingly important. This is seen by many to be a good thing. For example, a few highlighted that as taxpayer's money is contributed to the costs of the NHS via national insurance (NI). They believe that the public should have a say in the service and treatment they receive: *'because at the end of the day it's a service and people pay their National Insurance monies that they're paying for that, so probably yes'* (Female, SN, 6-10 years). However, this could be more about the individualisation of medicine which places the onus on the public to ensure they make the correct decisions regarding their health, despite them perhaps not being the best placed to make decisions (as they have not had medical training). Educational ability and understanding will influence the ability of an individual to be able to make informed decisions, causing potential problems.

A few of the respondents stated that consumerism was positive for the NHS, and this notion of giving patient rights is beneficial. However, the motives behind this development was not considered by the respondents- has the decision actually been made for the benefit of staff, patients and the NHS, or is there an ulterior motive driving the development? Patients questioning medical decisions and knowledge, helps to reduce the power and influence of the medical professional (a key aim of NPM approaches). There has been a deliberate attempt on the part of both Conservative and

New Labour governments to curtail the authority of healthcare professionals, and this could be seen as another element of achieving this aim. Furthermore, the government is aiming to make individuals more responsible (both staff and patients), to move responsibility from the state onto individuals. This helps to explain why there were increased concerns regarding litigation within the NHS and tension between staff and patients (often staff report that they do not feel respected by patients):

'I mean, I think people have got a right to expect a certain level of care and things, but the fact that we get people in here [saying] 'I pay your wages' and all that, you're thinking... you don't treat me like that (Male, SN, 6-10 years).

There is not only the struggle over knowledge and information, but many of the respondents perceived that patients were demanding services that they were not necessarily entitled to. Front-line nursing staff (due to their status as street-level bureaucrats) are in some way responsible for rationing the services they provide. As highlighted by Lipsky (1980/2010: 29), demand will always exceed supply, so if patients constantly demand more from a service, there will be an increased pressure on front-line staff to determine where the resources should go. Staff are therefore required to use discretion in the allocation of resources, despite the NPM approaches deliberately trying to limit the use of discretion.

The problem is it's not really like a business as it's never ending; a certain amount of money in a business will do this, this and that, and they you know what you have got. But in the NHS, a certain amount of money will do things but then more money will still be needed, it's a bottomless pit (Female, SN, 15+ years).

The fact that nurses ration services (and have to prioritise areas due to targets) will mean some patients' demands will not be met, leading to frustration for both parties, and it also has led to the respondents being put in a difficult position which they did not view as their fault. This in turn led to animosity between front-line staff and managers as was explored in chapter 5 (pages 134-140).

Patients as Customers and the Issue of Rights

As explored in chapter 3 (pages 104-106) there has been a debate surrounding how patients should be viewed. This is a continuing debate within the NHS, for a variety of reasons (see for example: Deber *et al.* (2005); Hall & Schneider (2007); Ratnapalan (2009)). The ethos of NPM places patients as consumers and customers of the NHS (Newman *et al.* 2006; Powell & Greener 2009; Farrell 2010), but there was resistance to this by many of the respondents:

Why do we need to change the name from patients to customers, if they're always getting the service they deserve, you know, then what difference is a name? I think I'll always think of them as patients (Female, SN, 15+ years).

This was similar to the resistance shown by senior staff to their name change, as was explored in chapter 5 (pages 150-155). If the staff embrace patients being called customers then would that change the way patients are seen and so alter the relationship between staff and patients? The word 'client' or 'customers' has different connotations compared to the word 'patient':

client to me has always been of a private nature or if I hear client I tend to think about a sales person or something ... this is a patient it's not a customer coming into the ward to get something and go away again, it

tends to make you think you're not dealing with sick people (Female, SN, 15+ years).

This also links in to notions of authority. The changing of a patient to a consumer reflects a business style of working; consumers have more rights and demand more than patients, which the respondents found difficult to acknowledge and disagreed with: *'consumers would mean a demand and this would not be appropriate'* (Male, CN/WM, 15+ years). Many firmly believed that patients should not have the same rights as customers within the retail area; this could be due to the nature of the service, and that it is free at point of delivery. Also, respondents distinguished between 'deserving' and 'undeserving', patients:

... some people are just genuinely daft and just don't know how to behave, don't know how to act. Whereas in that tiny, tiny minority that cause so much hassle and do kind of detract away from the genuinely nice people which are in the huge majority... we just get to see every corner of society in this job, you get to see the scumbags, you also get to see the nicest people in the world as well. I get kind of... you get to see the 20 year old drunk 'NED'²⁶ who can be so demanding, then you get to see the 80 year old wee wifey with a broken hip who will not ask for pain relief, purely because she doesn't want to hassle you... (Male, SN, 6-10 years)

Being able to make a distinction between 'deserving' and 'undeserving' patients, allowed respondents to prioritise the resources and also respondents would determine whether the demands of a patient were seen as legitimate or not. Nursing staff were likely to offer more support to those patients whose demands they viewed as legitimate. There is much literature available on how staff classify patients as good and bad,

²⁶ A 'NED' - this is a Scottish colloquialism meaning a youth who is uneducated and seen as a hooligan. In other parts of the country they might be called things such as hoodies, scallys, louts etc.

deserving and undeserving, and in the case of A&E, whether the attendance is appropriate or inappropriate (cf. Roth 1971; Dingwall & Murrary 1983; Jeffery 1979; Green & Dale 1990; Bellavia & Brown 1991; McGovern 1993; Sbaih 2002). Many patients will present with self-inflicted conditions resulting from self-abuse e.g. drugs, solvents, alcohol, obesity, not following medical direction, and nurses will have a personal subjective view and will make judgements (Samuels 2006). Although this should not influence treatment or care, as medical professionals should not make moral or social judgements, it is inevitable that this will happen, especially when there are limited resources. However, within retail, you should not be able distinguish between clients as they are paying at point of access, the saying being ‘the customer is always right’. So in treating a patient as a customer, does this mean that staff will not distinguish between them?

Lipsky (1980/2010: 48) argues that street-level bureaucrats do not necessarily think that clients should have a say in how the services are being provided. In allowing patients decisions, choices and the ability to assert their rights, then the professional knowledge and skills of nursing staff are being questioned. This is a way for institutions to limit the authority of professionals. By making the nursing staff increasingly accountable for their actions, blame is shifted from the organisation to the individual leading to: ‘*defensive practice*’²⁷ (Female, NS, 15+ years). Many of the participants remarked that the introduction of consumerist notions in the NHS meant that: ‘*you’re seeing the NHS getting taken to court for different things*’ (Female, SN, 2-3 years). This was therefore making staff more reluctant to use their discretion, as they would be held

²⁷ This was defined in chapter 7 (page: 193) as being when staff are being overly cautious due to fear of blame or litigation, and so will not take any risks or deviate from policy regardless of whether it is in the best interests of the patient. This is therefore limiting advancements and hindering change and progress.

accountable for all decisions and fear that they would not be supported by the organisation.

With regard to patients, it is not they who define the role of the nurse; rather it is the organisational culture. Several of the respondents commented on how patients made demands of the service although they did not understand the service or the way care was provided. This appeared to make nursing staff more resistant to patients' demands, which they did not see as legitimate. Labelling patients' demands as illegitimate is a way for staff to cope, as it provides them with a reason as to why they were not able to meet the demands, and to conclude that it was not the nurse's fault. As highlighted in chapter 2 (page 54), nurses share with other workers the need to be seen in a favourable light and that they are doing the best they can. When patients complain, they are questioning this view of nurses doing the best they can.

The 'Patient's Charter'

The aim of the 'Patient's Charter' (DOH 1991a) according to the then Conservative Government, was to provide patients with information on the standards of care they could expect and the choices they could make in relation to their care, with rights of redress and recompensation if this were not achieved. This document has subsequently been updated and replaced. However the majority of the respondents still referred to this charter by name and stated that it has had a significant influence on the relationships staff have with patients. The charter was introduced under the premise that it would establish a principle of a 'bottom-up' pressure to reform services; this would make the service more patient-centred and responsive to their wants and needs. The majority of the respondents do not believe that this has been achieved, but instead they felt it simply

caused unrealistic expectations from the general public regarding the services being provided by the NHS:

the public have got more of an awareness now of what they're supposed to have, and if they're talking about the Patient's Charter and things like that, where they're supposed to have certain things in place, you'll find people more outspoken about what they should have (Female, SN, 15+ years).

Alongside this, many respondents reported that raised expectations as a result of the patient's Charter, has led to misunderstandings concerning the rights and expectations of patients, which has caused frustration for both staff and patients:

I feel that many, many years ago it was so different. I'm not saying that relatives don't have respect anymore for nurses and doctors, but I definitely feel it's not the way it used to be (Female, SN, 15+ years).

Respondents' authority was being threatened by outspoken patients and relatives. Their decisions were being questioned, which led to feelings of resentment and to individuals becoming more defensive in their actions and practice.

In addition to this, several of the participants claimed that the 'Patient's Charter' and the subsequent documents have increased workloads, as they find they have to spend more time explaining the 'reality' of the situation, defending decisions and dealing with complaints. The comments being made within the interviews indicated that staff were concerned that patients were being given more power, although they did not have the relevant knowledge to be making informed choices:

I think it's difficult because then you would be thinking the customer's always right kind of thing and that's not always the case, and I think

sometimes... and I suppose that does make it difficult to kind of make your point, put your foot down a wee bit with certain patients ... it's probably really difficult because they think that they're always right and they should have X, Y and Z in this way, and that makes it difficult for us to say 'no it's not quite like that' you know (Female, SN, 3-5 years).

The respondents did not say whether such policy developments had improved patient care or choice of services. As was highlighted in chapter 3 (pages 100-106), there has been much emphasis on consumerism and consumer rights, but according to respondents, policies have not enabled greater choice or consumer-mechanisms to be employed within the NHS. The respondents claimed that the rhetoric of consumerism has not had the intended effect of providing more choice and rights for patients, but rather it has served to create a more disgruntled workforce and increased conflict between nursing staff and the general public.

Consumerism, the Media and Choice

The respondents spoke about how they felt nursing was represented by the media²⁸ and how this affected the public's views and expectations of the service. This, according to many participants, influenced their relationships with patients and relatives, and impacted on their workloads. The comments made in relation to the media were generally very negative. Staff made the link between the media, consumerism and the public's expectations of the service suggesting it was detrimental to the NHS:

The media very rarely promote or put good practice on the front page of a newspaper, because it's not sexy. MRSA, C.diff outbreaks all that's all

²⁸ The term media can incorporate newspapers, TV, film, magazines, radio and internet. However, within this chapter, the respondent's comments were mainly focused around discussions in newspapers and on TV.

sexy, it sells newspapers and everybody likes bad, you know, bad publicity 'look what the NHS are doing now'. And that relates back to consumerism by the public as well, what their expectations are. A lot of that is driven by the media in what's portrayed in the newspapers and on the news as well and if it's going to be negative they're going to come in with a level like 'if this happens to me I'm going to sue'. So it's a vicious circle (Male, CN/WM, 15+years).

Respondents reported that the information derived from internet and news stories had a prominent role to play in the higher expectations of the public regarding the types and levels of services available: *'their (the public) sense of expectation is higher because of access to internet'* (Female, S/WM, 15+ years). There has been a proliferation of information in relation to healthcare and illness within the public domain (such as via the internet), which also serves to increase tensions between staff and patients, as what has previously been seen as professional knowledge, has now moved into the public domain:

the internet's played a big part on their rights, their illnesses – they tend to look things up and that does make nursing and probably medicine a lot more difficult, because they expect a certain amount of care that maybe is not suitable for them (Female, SN, 6-10 years).

Down to consumerism, expectations and rights of patients have increased, they are far more aware – the use of the internet means they are better able to ask for what they think is the right operation/medication etc. they also see inconsistencies e.g. the postcode lottery. People are better educated and more outspoken about their views, some are good some are not. It is because of these types of issues that we practice defensive medicine (Female, NS, 15+ years).

This caused conflict and difficulties as nurses appeared to be struggling to retain their knowledge and power. This could be a reason why the majority viewed the media as generally negative for their profession. It was seen as threatening their authority and brought into question the quality of care being offered. Historically, patients were seen as passive recipients of care; however consumer rhetoric has acted to redefine patients as customers, who are no longer passive recipients (Bolton 2004). Patients are being encouraged to make demands and become more active consumers and to challenge professional power as a way to constrain nurse's autonomy and authority.

The issue is construed as being about 'informed patients' versus 'patient ignorance; which can lead to a power struggle over knowledge and access to appropriate knowledge. Online patient interactions are thought to lead to less authority for physicians as the patients' dependency on the 'expert' is reduced (Conrad & Stults 2010). This can lead to conflict between nursing staff and the patient/relatives, as the information and treatment being offered by staff is often not what is expected:

And for medicine and nursing the internet is the worst thing that ever happened, because they have a list of symptoms and they have a list of what should occur. Or what it says that should occur and that's not necessarily what will suit their relative. But getting that across is very often difficult (Female, S/WM, 15+ years).

Time must be spent explaining the differences between their expectations and the reality experienced thus increasing the workload of the nurse. However, many had the view that the information available to the public may not be accurate, or that the general public will not be able to interpret the information appropriately. Despite this, Conrad and Stults (2010) believe that on some levels the internet has been a good equaliser

allowing individuals to access the same information as the experts; however this information could be inaccurate, although the inaccuracy on internet information is reducing. For example, Bernstam *et al.* (2008) when analysing 343 websites for breast cancer information found only 5.2% were inaccurate.

Many of the respondents reported that the media portrayed them in a poor light; this again calls into question how the profession is seen. There was concern raised regarding negative media stories meaning that: ‘everyone [all nurses] is tarred with the same brush’ (Female, SN, 6-10 years):

And I think they sensationalise, very much so, and wrongly. I mean, if there’s problems, like the Vale of Leven outbreak²⁹ or Beverley Allitt killing children in Bristol³⁰ or wherever she was, then yeah things have got to be reported. But I think sometimes they just go overboard I think, and they don’t get all the facts and it’s not always correct ... I mean, it’s five minute news but can last a lifetime. Like all the superbug business, I mean I’m not denying superbugs are a very big problem, although the rates are getting much, much better now and have done for the last couple of years ... And I think the whole media circus is just, and it’s made people afraid, it’s made people lose faith in a lot, and it’s made them much more judgemental I think as well. And I think their expectations in that make it higher, which again puts pressure on
(Female, S/WM, 15+ years).

Respondents indicated that they felt the general public viewed all nurses and hospitals as the same, and that when coming into a hospital or accessing services, members of the public had a negative view of all staff due to the bad press published regarding the few

²⁹ At the Vale of Leven hospital there was an outbreak of C.difficile in 2007-8, which led to the death of 18 patients and the infection of 55 patients which was blamed on poor hygiene standards in the hospital.

³⁰ Beverly Allitt, a nurse, who was later dubbed the ‘angel of death’, was responsible for the murder of four children and attempted murder of nine others whilst in her care.

or the publication of inaccurate information: *'I think they [the nursing staff] get angry because it's not always accurate information that's on it [the news]'* (Female, NS, 6-10 years). This led to upset, annoyance and frustration by the nursing staff and caused difficulties between the relationships staff had with the public and media outlets. This was also thought to have contributed to the increase in nursing workloads, because the nursing staff believed it had meant an increase in the time spent with an individual on admission to hospital. For example, due to the poor image painted of the NHS by the media, when relatives (and patients) visited the hospital, they were looking for problems, and although something might just have occurred (e.g. spilling of blood on the floor) and the nursing staff were about to deal with it, relatives automatically assumed it was a lapse of good care and standards, when staff said that in reality there had not yet been time to address the situation:

And then the relatives, as I say, got their knickers in a twist, and, you know [laugh], their backs get up when they come in to see their mum and there's a wee bit of blood on the floor, d'you know, that's just happened - that kind of thing (Female, NS, 15+ years).

As was highlighted by Lipsky (1980/2010: 81), street-level bureaucrats wish to be seen in a favourable light. The participants stressed that media stories were placing the blame with the nursing profession, and did not acknowledge the difficulties or that it was outside their control, hence the feelings of animosity and resentment. There were however some contradictions in respondents arguments; on the one hand it was reported that the media caused difficulties for staff, but on the other that it provided patients with information which allowed for more informed decisions which was beneficial. Also the reporting of adverse events within the NHS, helped to improve the quality of the services provided and it meant the public was empowered: *'it's good because it means*

that patients and relatives now know what to expect and can comment' (Female, NS/WM, 15+ years).

The nursing staff often highlighted that their role was as an advocate for the patients, and so providing them with knowledge was important, and ensuring the quality of the services and care was acceptable, was seen as part of the nursing role. The NMC Code of Conduct (NMC 2008: 02) which nursing staff are required to adhere to (as part of their registration) states that nurses must be an “advocate for those in your care, helping them to access relevant health and social care, information and support”. Nursing staff are expected to follow this code of conduct, and it should inform their day-to-day practice. This however also links to ideas of individualisation and responsibilisation; not only are staff not working as individuals and being individually responsible, the government is also shifting these ideas onto the public. It is the public’s own responsibility to ensure they get the treatment required.

It was felt that the media increased the general public’s expectation with regard to what the NHS can offer, and that this could be negative when the NHS could not provide the treatment that was available elsewhere: *‘if it’s available in America, why can’t we have it?’* (Female, S/WM, 15+ years) such as via private firms thus leading to conflict when the expectations of the individual were not met. The philosophy of NPM has been a business style approach to the NHS, which within England has meant the introduction of competition, private sector management styles and an emphasis on choice for consumers (as was explored in chapter 2, pages 28-32). However, this choice is limited within the NHS, and even less apparent within NHS Scotland. Although there are some elements of competition within Scotland, this is on a reduced scale compared to

England. The respondents did not appear to distinguish difference between the English and Scottish systems despite Scotland supposedly having an ethos underpinning their NHS of professionalism, whereas England is meant to have an ethos of marketization. This could be because to the media reporting, generally refers to the UK NHS, which means the English NHS.

Summary

The understanding of consumerism and the role it plays within the NHS which is held by the nursing staff interviewed, did not take the same form as the policy documents intended. Those documents reflect the ethos of NPM for market mechanisms, and a business style approach within the NHS and so patients are seen to be consumers of the services offered. As was seen in chapter 3 the overall aim of consumerism has never been fully realised in practice. With the move away from competition within the NHS in Scotland, consumerism has perhaps taken on a slightly different meaning for front-line staff, one which cannot be about the marketization of the NHS, but rather highlights patient's rights and the responsibility in caring for their own health. Such a view is less in line with the ethos of NPM, but this revised view of consumerism as one of rights and responsibility has an important role within the NHS and clearly influences staff-patient relationships.

The revised view of consumerism can be seen to have an influence on the day-to-day work of the front-line nursing staff. Negative media portrayals, the perceived rise in more informed patients and the introduction of patient's rights via documents such as the 'Patient's Charter' (DOH 1991a) has apparently led to a perceived increase in the

workloads of the respondents. It has also led to increased tensions and the potential for conflict between nursing staff and the public. Nurses felt that their authority and their nursing role were being threatened by such changes, and so have employed techniques to resist such changes. These techniques include nurses not engaging with the rhetoric of consumerism, using their discretion in the allocation of rationed resources and on occasions viewing patient's demands as illegitimate.

Chapter 9: Discussion

Introduction

This chapter considers the key findings from this study presented in chapters 5 to 8 of this thesis, it relates the conclusions to the literature review in chapters 2 and 3, and answers my research questions set out on page 15 in chapter 1. The focus will be on the influence that the four NPM approaches have had on shaping the interactions of hospital front-line nursing staff and how the nurses manage the day-to-day work pressures they encounter. Themes have been revealed through the analysis. These are significant for understanding the relationships between nurses and their working practices. They are: power and authority; resistance and coping; accountability; and the ‘good nurse’. These themes will be discussed within the context of NPM approaches and draw upon Lipsky’s (1980/2010) work to offer explanations for the findings.

The Continued Relevance of Lipsky?

There has been a debate over the continued relevance of Lipsky for today’s street-level bureaucracies (cf. Howe 1991a; Cheetham 1993), given that Lipsky (1980/2010) wrote his book in the late 1970s prior to the rise of neo-liberalism and NPM within the NHS. Therefore, since its publication there has been an historical shift and numerous developments within the public sector. However, this view that Lipsky is no longer applicable is disputed by authors such as Baldwin (2004), Ellis (2007), and Evans (2010). Within social work literature, for example, there has been a sustained interest in Lipsky’s ideas on resources and discretion (Lewis & Glennerster 1996; O’Sullivan 2011). The use of discretion by practitioners has been found to exist still in social

services bureaucracies in the UK (cf. Ellis et al. 1999; Balwin 2000) despite authors arguing that due to the rise of NPM, discretion has been limited and that social work has become increasingly more regulated (Harris 1998; Jones 1999; Jones 2001). Regardless of this, research has shown social workers continue to be required to make decisions and interpret the rules: “the policies themselves are not necessarily as clear as proponents of the curtailment thesis would have us believe” (Evans & Harris 2004: 892). Evans and Harris (2004) further assert that Lipsky’s views of American public organisations can be seen within contemporary managerialised social service departments in the UK.

Lipsky’s work shows a variety of problems which street-level bureaucrats’ encounter. There are issues of over-regulation as there are numerous rules in the workplace (Clayton Thomas & Johnson 1991; Checkland 2004), and Lipsky suggests that such rules can decrease a sense of autonomy. Excessive rules and regulation which impose goals can conflict with professional norms (Lipsky 1980/2010: 29). This means there can be a conflict for nurses who priorities best patient care over organisational goals. Furthermore Lipsky highlights that a characteristics of street-level bureaucrats can also be as sense that they “work only on segments of the product of their work” and can feel unable to “control the outcome of their work” (Lipsky 1980/2010: 76). I argue that the rise of NPM within nursing has many similar traits to those found within social services and this research has shown that the nurses use discretion within their work, strategies are being employed to circumvent policies which are not agreed with, and coping mechanisms are developed to help overcome difficulties such as financial constraints. Therefore I consider Lipsky’s work to be relevant today for the aforementioned reasons, despite having been written in 1980.

Despite the continued relevance of Lipsky in the NHS and social service settings in the UK, his approach is not without weaknesses. Evans (2010: 22) argues that Lipsky should be seen as a “tentative framework rather than as a fully developed model of how all street-level bureaucracies work”. It is clear that Lipsky is very applicable and helpful in facilitating the analysis of the findings, but understandably it does not offer an explanation for all the findings that have emerged. Similar to Evans (2010), my analysis has had to be supplemented by drawing upon other theorists such as Foucault in order to offer fuller explanations for the findings. Further limitations have also been identified with Lipsky’s approach and both the limitations and strengths of Lipsky are discussed in the following sections, along with considerations regarding the key themes that have emerged from the findings.

Power and Authority

One of the main research questions of this thesis was concerned with the ways in which organisational structures and management policies shape the interactions that occur between staff members. This section will consider how the influence of policies which aim to reduce the power and authority of front-line professionals have led to conflict, and the development of mechanisms which nurses employ, to shape their working practices, in spite of those policies and other organisational structure and changes.

The introduction of managed markets into the NHS resulted in organisational change (Le Grand & Bartlett 1993), and reforms were seen to be “imposed as opposed to negotiated with the medical professionals” (Poole 2000: 103). The knowledge of

professionals was no longer seen as enough to justify the ways in which services were delivered (Newman 2011), and professional autonomy was thought to create “the dilemma that central policy is effectively nullified by the actions of individual professionals” (Exworthy *et al.* 2005: 108). Therefore the NHS markets were designed to reduce the influence of hospital doctors (Exworthy *et al.* 2005) by limiting their power and authority. As part of plans for reform to the NHS in line with managerialist ideology, the Conservative government in 1983 advocated the introduction of general managers. This allowed for a move away from a patriarchal model of ‘doctor knows best’ and gave managers greater control within the NHS (Hunter 2007). The belief was that managers with no clinical background would be more appropriate to manage in the NHS. This would mean that managers could be more detached and allow the NHS to become more efficient and economic; however this has led to the divergence of the goals and orientations of managers and front-line workers to diverge. Throughout the findings chapters, the respondents highlighted that they believed senior managers were more focused on efficiency as opposed to patient care. As Lipsky (1980/2010: 18) argued in 1980, the orientations of street-level bureaucrats and their managers will differ, a view reflected in respondents’ comments.

However Lipsky’s view that there is a clear divide between managers’ and workers’ roles is debatable; I argue that it is actually not that clear-cut. Despite the aim of managers being removed from the clinical sphere as advocated by Conservative governments in the 1980s and beyond, within hospitals there remained (and continue to remain) local managers, who have a clinical orientation. As such, street-level bureaucrats can be in a position of management. The overall aim of non-clinical managers has never been fully realised in the NHS, as over 50% of managers have a

clinical background (The NHS Confederation 2007). This means that professionals at the immediate and higher levels are frequently managed by fellow professionals (Freidson 1994; Evans 2010). For example, within nursing at the local level, ward nurses are managed by the Ward Manager, who is also a professional nurse, then above the Ward Manager is the Lead Nurse, who manages several ward areas, but remains a registered nurse.

However, simply because a manager has previously been a professional, does not mean that they retain the values of the professional. On the one hand, they may be more aware of the experiences at ward level and allow this to guide their decisions, but on the other, they may be pressurised to conform to managerial strategies. Evans (2010) in his study, found that local managers were far from uncritical about the policies they were to implement and did not simply accept organisational priorities – there was conflict between practitioners and the organisation regarding their role. Within this study, as has been seen in chapter 5 (pages 150-155), those individuals who are nurses and also in a position of management have difficulty in balancing the conflicting nature of their management role and nursing role – thus demonstrating that Lipsky's view of the clear divide between management and street-level bureaucrats is not easily separable, and the way in which Lipsky characterises managers must be questioned. This discussion highlights the conflicts the nurses have raised regarding management decisions and show that they frequently question the overall goals the organisation.

In order to limit the autonomy of the workforce, managers must be able to control their actions (Luthans 1995; Pheng 1998; Schermerhorn 2000). According to Foucault's

notions of disciplinary power³¹ (Foucault 1995) within the NHS there are various ways in which managers attempt to do this. ‘Indiscreet gaze’ is achieved by the overt recording and documentation, which is constantly required of nurses. ‘Discreet gaze’ can be observed in the emphasis on responsibility and accountability within the nursing profession, and in the way patients are increasingly expected to take responsibility for their own health. Via such subtle coercion, nurses conform to a desired way. Managers therefore are influencing and controlling their actions in the form of self-governance, using management policies such as targets, audits, explicit guidelines on how to carry out procedures, and a proliferation of documents that must be completed for each patient.

Although, there are many strategies in place to limit the autonomy of nurses, this does not mean nurses cannot influence their day-to-day work to some degree and retain some autonomy. Potentially they are in a powerful position when it comes to influencing and adapting the implementation of a policy. It was argued by Lipsky (1980/2010: 18) that if street-level bureaucrats do not agree with managers’ directives, then they can consider the “policy objectives illegitimate”, and so may use the rules, regulations and administrative provisions to evade or change policies to preserve their discretion .Although the respondents reported a lack of power generally, it could be seen from their comments that nurses had the potential to exert much power at the ward level. The staff were clearly resisting changes that they did not agree with and were shaping practices at the ward level.

³¹ An explanation of this is offered in Chapter 3, pages 77-79.

These power relations have an important role to play in the general interactions nursing staff have in the workplace and influence the way in which nurses undertake their work. The reported lack of power meant that nurses believed they were unable to influence any decisions that were made, which was a reason given for why nurses did not support, and thus resisted, management decisions. As was asserted by Foucault (1998: 95) – where there is power there will always be resistance. Power and authority are closely linked, and if authority is not seen as legitimate (Weber in Parsons 1964), then this can lead to the influence of those in a position of authority being questioned.

The clear aim of NPM approaches to limit the authority and autonomy of professionals was initially in relation to medical staff. Nursing has only more recently is viewed as a profession (cf. Watkins 1992; Fatchett 1999; Noyes 2011), and as nursing has developed as a profession nurses have been encouraged to be less subordinate to medical staff (Allen & Hughes 2002). New positions have been created which incorporate skills that were traditionally seen as the doctors' domain. Nursing staff can now question the decisions of their medical counterparts and are more likely to work collaboratively with their medical colleagues.

There is however a concurrent process of 'professionalisation' and 'deprofessionalisation' for nurses. This development of autonomy can cause problems, as on the one hand nurses are being told that they are 'autonomous practitioners' and so are accountable for their actions, which is professionalisation within nursing (Kopp 2001), but on the other hand, there are now deliberate attempts to restrict this independence via policies, procedures, targets and audits, which limits their professionalism – hence it causes deprofessionalisation. Furthermore, even if you

belong to a profession, there remain boundaries to your actions in the forms of legal, financial and time constraints. These developments within nursing have also caused an increase in the tensions within the workplace between managers and professionals and the proliferation of policies, targets and audits now aim to control the nursing workforce along with the medical profession (cf. Exworthy & Halford 1999; Maddock *et al.* 1998; Pollock 2005; Taylor & Kelly 2006). The result of the NPM approach is that regulation of, as opposed to trust in, professionals is seen as the best guarantor of quality.

The advent of consumerism and consumer rights is another means by which the authority and power of both medical and nursing professionals are limited, by giving a voice to the consumer (Newman *et al.* 2006; Pollitt 2003). As a result the general public have been made more aware of their rights to enable them to question and challenge the authority of those charged with their care. It can be argued that this has not actually been achieved. For example according to Powell and Greener (2009) patients continue to have little opportunity to exercise their choice. At the same time, this drive for consumerism has not had the desired effect for either patients or staff; comments from the respondents highlight that such developments have instead resulted in an increase in routine and daily conflict between the nursing staff and the public, because public expectations cannot be met due to limited hospital resources.

NPM approaches within the NHS are being used politically as a way to challenge and change the power relations within the NHS, specifically in relation to the medical profession. The development of nursing into a profession, raises questions with regard to the level of influence this professional group has within the NHS – are they as influential as the medical profession for example? Regardless, the aim of limiting

authority has not been successful: professionals (both medical and nursing) continue to exert authority and power in many ways (for example, by resisting management decisions) and they continue to question the legitimacy of management and the public in making health related decisions.

Limiting Discretion

According to authors such as Lynch 2004 and Hunter 2007, NPM approaches have attempted to limit the discretion of professionals in order to reduce the influence they have within the NHS. Professional judgement needed to be challenged in order for change to occur and market mechanisms to be adopted. In order to achieve efficient care and for costs to be contained, the system should not allow for discretion, as discretion means that services are not all the same. Despite this, numerous studies have shown that discretion continues to be used by street-level bureaucrats and plays an important role in their day to day work (see for example: Scott 1997; Wells 1997; Baldwin 2000; Wright 2003; Evans & Harris 2004; Evans & Harris 2007; Bertram 2010; Evans 2010; Ellis 2011; Johansson 2011). Autonomy has been limited and reduced, but it has not completely disappeared and so this means there is still space for individuals to resist. Within this thesis the findings demonstrate that the respondents used their discretion despite reports that policies were attempting to regulate and standardise care. There is a conflict between the organisation's attempts to regulate the workforce and remove discretion, and the fact that professionals are also required to use discretion in their work at the front-line.

One of the criticisms of Lipsky's study is that it overlooks occupational status; he ignores the potential for an organisation to request and expect professionals to use their

discretion because of their ‘professional’ status (Evans 2010: 19). Authors such as Skolnick (1966) acknowledge there is delegated discretion along with unauthorised discretion. The recognition of this is important, as it acknowledges a difficulty for nursing staff. Nurses, due to their professional status, are expected to make decisions and in some cases act autonomously based on their skills and knowledge as a registered nurse, despite also being told that they must follow the policies and guidelines. From the respondents’ comments, it was seen that nurses had difficulty in determining whether they were meant to use discretion in some situations but not in others; this has led to confusion and concern over accountability.

Despite NPM approaches aiming to limit and remove the discretion of professionals, it is argued that the discretion of the front-line staff has not been fully removed. The nurses in this study actively resisted the changes imposed upon them, and used discretion in making decisions in the workplace. This has also been found to be the case within other professions. For example Evans (2010: 3) contests the influence of managerialism as being “all powerful and pervasive” and questions whether the discretion of social workers has successfully been challenged and removed. Social Workers are still resisting, although this can be limited.

Resistance and Coping

A key research question focused on what influences how nursing staff interact and communicate with their managers, other staff and patients, and following on from this how staff perceive their working relationships with these individuals. This section

addresses the ways in which policy changes and their implementation affect the nurses' work and how they cope with or resist these changes.

There has been a drive from both Conservative and New Labour governments to transform the NHS in order to make it conform to a business model. Nurses are constantly being challenged and undermined in order to push the NHS in a particular direction. It results in a dynamic and conflicting process that takes place at the front-line, which is not static and constantly changes. At the front-line, street-level workers (nurses) are not always able to resist such changes and when this is the case, they fall back onto phrases such as 'patient care' and the 'good nurse' in order to show that they do not agree with the developments and approaches being taken within the organisation.

Table 8: Coping strategies identified in the literature and employed by the respondents

Strategy	Examples from the Research
Acceptance/Tolerance/Resignation	Respondents suggested that their voice was not heard and so they would accept that they could not influence or change the situation. (Chapter 5)
Alter/Discretion	Respondents used their discretion as to how resources were allocated and used. (Chapter 8)
Exit/Resign/Leave	Comments made by respondents that they are looking to leave their current positions. (Chapter 6)
Gossip	The nurses did not voice their dissatisfaction to managers, but rather voiced their feelings to their peers and drew strength from this – the idea of we are all in this together (Chapter 6)
Non-cooperation/Non-compliance/resistance	Respondents view management decisions as illegitimate and so did not comply with the decisions. For example Charge Nurses and Sisters refusing to be called Ward Managers. (Chapter 5)

Table 9: Strategies identified in the study but not in the literature

Strategy	Explanation³²	Example
Limiting contact	Employee deliberately attempts to limit their contact with an individual manager if they think it will have a negative influence on their work or time.	Respondents asserted that they did not want to communicate with managers for fear of an increase in their workload. (Chapter 5).
Ignore	Employee simply does not engage with managers or policies. They ignore what is said or written.	Respondents were selective and ignored a policy if it was not felt to be necessary or relevant. (Chapter 7)
Assigning blame	Employee assigns blame to another individual, in order to assert that the consequences are outside of their control.	Respondents blamed management decisions as a reason why things are worse now than in previous times. (Chapter 5)
Solidarity	Employees group together and offer support to one another as they share similar experiences.	Nurses showed support for their colleagues – developed a ‘them and us’ mentality which allowed for solidarity between the nursing staff. (Chapter 5 & 6)
Doing more	This is the opposite of working to rule, rather the employee is finishing off tasks and paperwork in their own time to ensure their work is completed.	Respondents undertook work and filling in paperwork after their shift has finished in order to feel that they had done the job to the best of their ability. (Chapter 6)
Defensive practice	Employee is working in a way that is not about ensuring the health of the patient, but as a safeguard against possible litigation.	Respondents were working in a way to try and limit any potential for their challenge to their ability and skills and so were less likely to take risks or deviate from the policies. (chapter 7)

³² This explanation has been assigned by the researcher and has been developed from the analysis of the data.

Throughout the findings chapters, the ways in which the nurses coped or resisted the daily demands placed upon them have been highlighted. The findings show that the nurses applied a wide variety of strategies to be able to carry out their day-to-day work. Many of these strategies were similar to those described in chapter 2 (page 51-57) although additional ones were also identified. These are presented in Tables 8 and 9.

Table 9 shows strategies identified during the analysis which were not previously identified in the literature. As can be seen, there are many different ways that nurses cope with the pressures of their work. It is worth noting that the strategies highlighted in Tables 8 and 9 do not claim to be exhaustive; it is very likely that there are other mechanisms being employed by front-line nurses, which were not identified by the cohort being interviewed.

Unlike other street-level bureaucrats, it is more difficult for nursing staff not to undertake work, as it would be detrimental to patient care and could potentially cause injury or even death. This can help to explain why several strategies identified in the literature were not seen in this study; these included work avoidance, undertaking formal procedures or legal action, theft of organisational property, working to rule or confronting management. It was interesting, however, that none of the respondents reported voicing their grievances formally, although in many cases comments were made regarding nurses having a lack of voice and not being listened to. It could be why the nurses believed that there would be little point in following formal procedures as they would still be ignored.

The NMC (2008:1) code of conduct clearly states that as registered nurse, you “must make the care of people your first concern”; this can also explain why there was no mention of working to rule. People, including nurses, will interpret the meaning of ‘working to rule’ differently. For some it may mean turning up on time, and undertaking what they see as the essential requirements of the job, (which can also be open to interpretation), and for others it could mean providing a high standard of care to a patient even if that means working outside the paid hours. Caring for patients is a continuous activity and as a nurse, you are ethically obliged to care regardless of whether or not the shift has finished. Several respondents commented that they would run over their shift times in order to wait for a member of staff to pass responsibility onto, or in order to complete the task/paperwork. If there is no one else available or if it is an emergency, then the nurse is expected to assist. The NMC (2008) code of professional conduct also highlights that in an emergency, in or outside the work setting, nurses have a professional duty to provide care. Further, nurses may feel morally obliged to assist. Unlike other street-level bureaucracies, which have been discussed by Lipsky, healthcare can be a matter of life or death and so cannot always wait.

Depending on the type of organisation, different strategies may be more applicable than others. One criticism of Lipsky is that he treats all organisations as being the same; there is an “absence of a nuance account” of the differences between different types of organisations (Evans 2010: 18). In political and financial contexts, organisations such as the police, social services, healthcare services (e.g. hospitals, nursing homes), employment agencies, education, and housing services are all public agencies, but all have different structures, policies, financial arrangements and are given different

political attention. Despite these differences Lipsky focuses on the “generic characteristics of street-level bureaucracies, the nature of their discretion, its control and its use” (Evans 2010:19). This generic focus does not allow for an in-depth view on the development of discretion that will manifest itself and be used differently depending on the organisation.

In this thesis the focus has been on front-line nursing staff. Their ability to use discretion and the types of opportunities where discretion is needed, will differ and will also have different outcomes compared with how discretion is used in, say, an employment agency. The types of coping strategies employed by the nursing staff can be similar to those suggested by Lipsky, but there are also strategies that were more specific to nursing staff and had not been identified in studies of other street-level bureaucracies. However, the fact that nurses use discretion and have developed coping strategies can be seen as being at odds with the traditional view of nursing, that it is hierarchical and that nurses tend not to question what they are being asked to do (Gamarnikow 1978; Salvage 2003). But this can be attributed to the changing role of nursing, where it has now become professionalised, with a supposed drive for autonomous practice, and thus a move away from a hierarchical structure (Allen & Hughes 2002; Greener 2009).

Accountability and the ‘Good Nurse’

A central question investigated within this thesis was ‘to what extent if any, is there a tension between what a qualified nurse’s role in the organisation should be and the reality which they experience’? It can be seen throughout the findings chapters, that the

nurses interviewed felt that the day-to-day experience of nursing differed from what they expected it to be. This led to tensions for the respondents, which were seen throughout the findings chapters.

The issue of nurses accountability was raised continuously throughout the fieldwork; not surprisingly, as it is an integral part of nursing and part of the NMC code of conduct (2008:1) which states that as: “a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions”. Thus nurses were very aware of their accountability for their practice and the potential ramifications if they did something wrong. What is interesting is that in the findings chapters, there was evidence of tension between having to follow policies and guidance exactly, and how these should be interpreted depending on the situation. There were different views on accountability, with several respondents arguing that if you could justify a deviation from a policy, then the hospital would support your actions, whereas other respondents argued that you must follow the policies to the letter, or else the hospital would not support your actions. Despite the views of some respondents that policies were not flexible, these individuals were still seen to employ discretion and utilise coping and resistance strategies even if they were not consciously aware of these actions.

Many of the respondents were concerned over making a mistake and there being a lack of support from management if something went wrong. Due to fears over accountability and worry connected to the potential for litigation, defensive practices were being adopted by nursing staff. This means there is a risk of staff giving self-protection from blame a higher priority than serving the best interests of the patient. There are potential

positives to defensive practices, such as being overly cautious and ordering all tests just in case, but generally it is thought to be detrimental to patient care (c.f. Titterton 2005; Mullen *et al.* 2008). Nurses may avoid undertaking certain practices or procedures if they are perceived to be risky, or there is the potential for an adverse result; however, taking this risk could be beneficial for a patient.

All of these issues can call into question the role of the nurse within the NHS, how the respondents viewed the job currently and what they expected from a nursing career. Differences between the anticipated nursing role and the actual role were raised. Many of the respondents stated that the reality which they experienced on a day-to-day basis did not reflect their expected views of the profession prior to commencing training. The role of nursing has been changing and respondents commented that it was less about care at the bedside and was more technical and political than they anticipated. It was these differences that led to tensions for the nursing staff and a questioning of the role of nursing generally. There is now debate as to what constitutes a 'good nurse', not just in relation to whether following policies to the letter is beneficial or not, but also with regard to what tasks nurses undertake. Does spending more time on more technical and managerial tasks make them a poor nurse compared to one who spends more time at the patient bedside giving personal care?

The proliferation of rules and regulations was seen as a way to improve the effectiveness and efficiency of patient care; care would become standardised, and this was thought to be a good thing (Hood 1991; Lane 2000; Taylor & Kelly 2006; Osbourne 2007). As was highlighted by the Munro report (2010: 6), in social work there is the potential for a focus to be more about 'doing things right' as opposed to 'doing

the right thing'. Within the respondents' comments, many of the nurses struggled over whether to follow policies to the letter or whether they could be viewed more as guidelines. There were increasing concerns linked to accountability and the potential for blame and litigation. This has meant that nurses are increasingly concerned over using their discretion in patient care and treatment, which could be to the detriment of the patient as taking informed risks can at times be beneficial (cf. Titterton 2005; Webb 2006).

Evidence Based Practice, Risk and Health & Safety in Nursing

There are factors such as clinical governance, evidence based practices and health & safety, which have been influential in shaping nursing as a profession and the day-to-day work of nursing staff. However, throughout the interviews, very little was mentioned about these areas. As was seen in chapter 3 EBP and patient safety initiatives (pages 78-82) are meant to have shaped 'new nursing'. The aim was to improve the status of nursing therefore allowing it to be seen as a profession. A key criterion for professionalism is that the profession must have a knowledge base. However, EBP was not an explicit focus of the research and was not discussed by the research participants in any detail. A number of respondents did however mention clinical governance briefly in relation to patient safety policy and there were references to EBP shaping practice. Few respondents mentioned training at all.

This is not to say that factors such as EBP, risk management or health and safety policies have not been influential in shaping nursing as a profession. It is simply the case that in this research they were not referred to in any detail. In many cases respondents

spoke about their accountability, the fact that some staff would avoid certain tasks or procedures if they were deemed to be 'risky', or that they would adhere to policy, which is based on the best available evidence or following health and safety procedures to ensure safety for themselves and their patients. This demonstrates the influence of such initiatives and that these influences could potentially further help to explain some of the phenomena that was observed during this research.

Summary

This chapter has offered a discussion of the key emergent themes from the analysis and the relevance of Lipsky's work to this study. As has previously been highlighted, the findings chapters focused on the four key elements of NPM which were pertinent within the Scottish NHS and for nurses. Whilst exploring the influence of these four elements for front-line nursing staff, commonalities emerged within all four findings chapters. The first is the issue of power and authority which shaped nursing roles and relationships. Overall, respondents reported feelings of powerlessness and an inability to influence management decisions. However, as has been shown, respondents employed various strategies to resist management decisions and alter the policies. This demonstrates that the nurses actually do have power to influence their day-to-day work, and are able to resist or alter policies and decisions they do not agree with, although the ability to resist is limited.

There were various resistance and coping strategies that were employed by the front-line nursing staff, in order to deal with the pressures placed upon them due to NPM approaches and their effect on relationships at ward level. The many strategies that were

employed were identified in Tables 8 and 9. Most of the strategies identified by the nurses were not aimed at bringing about change but rather they were more isolated and individual strategies. This could be seen as quiet resistance (cf. Scott 1990). None of the respondents mentioned any unions (although all the participants were members of unions) or any formal actions that they were engaged in to influence changes.

Finally there was much discussion by the respondents regarding what makes a 'good nurse'. Tied into this is the perceived importance of accountability for nursing staff and the effect this can have, for example the development of defensive practices. Despite this, there is an acceptance by the respondents that decisions being made by the nursing staff were generally made in the belief that it was in order to be a 'good' nurse.

The following chapter will offer a conclusion to this study. I will focus upon the influence of NPM within nursing in Scotland and how it has shaped the relationships and work of the front-line nursing staff. The chapter offers a summary of the key contributions this study has made to the literature in this field, implications for nursing and areas for future research.

Chapter 10: Conclusions

Introduction

This study has sought to understand how the introduction of NPM approaches within the Scottish NHS have influenced and informed the working relationships of qualified nursing staff in an acute hospital setting with managers, other staff members and the public. This has involved a case study approach using qualitative interviews with registered nursing staff at an inner city hospital in Scotland, in order to explore the views of front-line nursing staff.

I have considered how nursing staff perceive their relationships and factors that influence how the nurses interact and communicate with managers, colleagues and the public. The ways in which organisational structures and policies shape the interactions has been debated and further to this, the role of the nurse has been explored to determine whether there are tensions between what qualified nurses think their role should be within the organisations and the reality which they experience. This chapter will offer conclusions for the research questions outlined on page 15 in chapter 1. I will show the contribution that this research has made to the understanding of the influence of NPM on nurses within the Scottish context. I offer a consideration of the value of the case study and interpretivist approach taken in this thesis and finally identify some areas for future research.

The influence of NPM for Nurses in Scotland

There were four key areas identified by the respondents which are influenced by NPM; these being: 1) professional management; 2) discipline and parsimony in resource use; 3) standard setting and performance measurement and 4) consumerism and service quality (these were identified as key elements of NPM, as discussed throughout chapter 3). In chapter 5, the role of management in the NHS is shown to be significant. The NPM approach to introducing professional managers (as opposed to managers who have clinical experience) has led to difficulties between the respondents and managers; for example the perceived non-clinical backgrounds of managers has a negative influence on how respondents view their relationships with managers and the analysis has shown that there is much animosity and conflict as a consequence of this. Chapter 6 explores how financial decisions, of discipline and parsimony in resource use ('doing more for less') is seen by the nursing staff. It was shown that the drive for financial efficiency is leading to ever increasing concern by the respondents, who feel they have little control or power to resist financial constraints and that this causes resentment, hostility and frustration with management and also negatively influences the relationship the qualified nurses have with patients and relatives.

Standard setting and performance measurement were discussed in chapter 7, and can be seen to have a significant role to play in the day-to-day work of the respondents, with many comments being made in relation to policies, targets and audits. Often these are seen as affecting nursing staff in a negative manner, causing an increase in workloads and therefore lead to negative relationships between nurses, their managers and patients.

The fourth area focused upon was that of service quality and patient rights; again the influence of consumerism was seen to generally be a negative development for the respondents, as it led to increasing workloads and conflict with the general public, exacerbated by the effect of media comment and information available to patients via the internet (see chapter 8).

Policy Divergence

There has been a divergence in policy between Scotland and England with regard to the NHS (Greer 2004). A decline in market-place mechanisms within Scotland compared to England has been seen (Mackie 2005) and there is debate regarding the influence of NPM within Scotland (Cairney *et al.* 2009). However, as can be seen within this thesis, I have found significant similarities which remain between the NHS in England and Scotland. This thesis shows that NPM approaches continue to influence the working relationships of front-line nursing staff in a Scottish hospital although the rhetoric is that Scotland has moved away from such practices (cf. Mackie 2005; Cairney *et al.* 2009; Viebrook 2009). Despite the belief that the emphasis in Scotland is more on traditional and social democratic models of delivery (Viebrook 2009), Scotland can still be seen to be engaging in many NPM approaches such as consumerism, contracting-out of some services, discipline and parsimony in resource use and an emphasis on private management styles.

In the wake of the election of a Coalition Government in the UK in 2010, there have been proposals for new reform arrangements in England which have been outlined in the 'Equity and excellence: Liberating the NHS' report (DOH 2010). However,

following the election of a SNP (majority) government in Scotland, there is currently no proposal of similar reforms in the NHS north of the border. As has been seen in chapter 2 (pages 40-42), NHS Scotland is meant to have changed from marketization in favour of professionalism; but the influence of NPM can still be seen when looking at the comments made by the front-line qualified nursing staff in this study. It will be interesting to see if this influence will continue despite the increasing divergence that is set to occur in the organisation and running of the NHS in Scotland compared with what might be implemented in England (at the time of this research there has been much opposition for the proposed reforms in the English NHS and their implementation has been delayed for further consultation).

Key Contributions

This study has addressed a gap in the literature with regard to the influence of NPM approaches for front-line nursing staff in Scotland. There has currently been little research undertaken looking at the nurse's perspective of how NPM approaches influence working relationships, and there has been even less regarding the experiences of nurses in NHS Scotland. Whilst the sample size is small, the study raises some important issues in relation to NPM approaches and their influence on nursing relationships and practices which can then influence patient care.

With regard to research surrounding NPM and the NHS, there tends to be a focus on the UK NHS (often meaning the English NHS) and this can overlook Scotland and how nursing within Scotland may or may not be similar to that in England. Therefore an in-depth case study was chosen to explore of the influence of NPM approaches for the

working relationships of qualified nursing staff with managers, colleagues and the public specifically within Scotland. I have sought to make sense of how the nurses understand their role within the organisation and which factors they perceive to be the most influential in shaping their working practices and relationships in relation to NPM. As has been seen in this thesis, there are many elements that can influence this. It is worth noting that most comments were made regarding their managers; there was less focus on relationships with patients (or the general public) and colleagues.

The study argues that the main reason for conflict between managers and nursing staff is due to the differing foci of nurses compared with their managers, as it is felt that managers are seen to be concentrating on issues of targets, audits and budgets with little thought to the impact these decisions will have on patient care or nurses' working conditions. This has meant the legitimacy and authority of management decisions have been questioned. Policies, targets and audits were seen as tools, which, on the one hand provided guidance and structure, but at the same time led to frustration and animosity as they were seen to prioritise the management agenda over patient care. They were used as ways to limit and control the action of nursing staff. The rise of patient rights and service quality were also seen as an attempt to limit the authority of nursing staff.

Nursing staff have developed strategies at the front-line in order to cope with the influence of policy decisions and the interactions which occur between themselves, managers and the public. Many of these strategies were found to be similar to those identified by Lipsky (1980/2010) as being used by street-level bureaucrats. However, further strategies were also employed by the nursing staff in order to cope with work pressures. These demonstrate that discretion has not been completely removed from the

front-line and nurses retain power to influence their work. Throughout the findings, power and authority were seen to shape nursing roles and relationships, which was to be expected. The nursing staff reported feelings of powerlessness, but due to their status as street-level bureaucrats, they were actually in a position to influence the implementation of policies. If the nurses did not view them as legitimate and in the best interest of patients or their working conditions, then they were able to use limited strategies to adapt, change and resist the policy at the implementation stage.

The respondents suggested that if they were more aware of what managers were trying to achieve, and if they felt that their voices were heard and that they were consulted, then perhaps much of the tension and animosity would be reduced. However, on further exploration it can be seen to be more complex than this; rather it is due to conflicting roles and the differing emphasis of managers compared with the front-line nursing staff. These conflicts at the front-line are primarily due to the constraints and influence of marketization, therefore improvements in communication by themselves will not address the issues raised by respondents. Continued emphasis on targets, audits, value for money and policies by the government means that these will continue to be the focus of managers in the NHS as opposed to patient care and working conditions. This raised questions about the role of nurses themselves, their accountability and what constituted a good nurse.

Within the current economic climate, rather than more qualified nurses being employed, there is actually a reduction of registered nursing, meaning that workloads are growing, and unfortunately this does not look set to change in the near future. As we have moved into a sustained period of economic austerity since the time of this research, it is likely

that the issues and tensions that have been raised are likely to continue and possibly worsen due to the raised pressure that will be placed on the current front-line nursing staff, who will be expected to provide the same service despite fewer resources. There appears to be little consideration of what can reasonably be asked of front-line nurses during their working hours and a lack of acknowledgement from managers regarding the impact that policies, targets and audits have for them.

Much research focuses on the experiences of patients; however this thesis suggests that it is necessary to address the staff issues first to enable improvements to take place in patient experiences. It is important to understand the dynamics in relationships that are occurring at the front-line and the potential influences these will have on patient care and the implications for nursing generally in Scotland.

Methodological Issues

This study has used an interpretivist study grounded in the methodology of adaptive theory (c.f. Layder 1996; 1998a; 2006) to explore how NPM approaches influence and inform the working relationships of qualified nursing staff. It facilitated the need for the subject's individual perspectives and experiences to be understood. Adaptive theory has provided a conceptual framework which has used prior theoretical ideas to feed into and guide the design of the study and the analysis of the data, whilst allowing for the generation of new theory from the data.

This thesis is a qualitative study, which via semi-structured interviews, aimed to look at the individual views and experiences of the nursing staff. It has highlighted the

underlying structures which have caused or generated particular patterns, therefore allowing both objective and subjective aspects to be viewed. It is not possible to simply break the social world down into individual explanations, but rather we need to look at its broader and interwoven relations. However, it must be recognised that research cannot be all encompassing and so the use of domains (as highlighted by Layder and discussed in chapter 4, pages 111-115) has enabled a focus on separate elements for the purpose of the study design and analysis. A case study approach involving semi-structured interviews was an appropriate method for accessing in-depth and rich data from the respondents. The case study format allowed a relationship to form between myself as the researcher and the participants, allowing me to gain insights to better understand the actions and reactions of the participants.

Due to the focus of this thesis being specifically on front-line qualified nursing staff at the ward level, the potential solutions and reasons for tensions have largely been understood within this narrow context. Further research is needed to understand the tensions at a wider level. An exploration of the motivations of more powerful actors such as politicians, civil servants and senior managers, who ultimately control and define the broad environments under which the nursing staff work and policy function, would help to enhance understanding. Therefore, further research needs to be carried out in order to gain a fuller picture.

Further Areas for Research

The lack of understanding of the role of management and its differing goals is seen according to respondents as one of the significant causes for the tensions and animosity

which they report. Many of the respondents also reported that they believed that managers did not understand their work within the organisation, which led to misunderstandings and difficulties. It would therefore be interesting to explore how managers perceive their relationships with front-line staff and what factors influence their interactions. As part of this, how managers perceive the role of nursing within the NHS should be investigated. This has been done, for example by Evans (2010) with regard to managers within social work, which has allowed for a more nuanced understanding of the complexity of relationships which occur between practitioners and managers, and gives insight into local manager's roles in policy implementation.

Another area for further investigation is to examine the relationship between newly qualified (and junior) staff and health policy norms and objectives. During the interviews of this research study, there appeared to be a difference in the views of nurses with longer service compared with junior nurses. This could be because of the way nurses are now taught or nurses with longer experience having been nursing before some of the NPM approaches such as targets and audits were introduced. It would be beneficial to explore the extent to which nursing training encourages nurses to adopt a critical approach for example, in relation to the merits of targets and audits, or conversely, is it the experience of working within an organisation which means nurses are more likely to question changing practices and decisions?

The influence and issues of gender and ethnicity would be of interest to investigate. As was mentioned in chapter 4 (page 124), these were not a focus for this research. However, these are both potentially insightful areas for exploration. Nursing is a female dominated profession (White 2010) hence the development of nursing has been heavily

influenced by gender. There are now significant numbers of males entering the profession and it would be useful to explore in more depth whether gender plays a role in the relationships forged between the staff and their managers, and also whether male nurses experience different tensions in the workplace compared with their female counterparts.

Finally, as has been highlighted earlier in this chapter, the current research has been undertaken at a time of economic crisis, with fieldwork occurring in the summer of 2010 following the election of a new government into Westminster and while awaiting the budgetary decisions for Scotland. It therefore needs to be acknowledged that this could have influenced the views of the nursing staff. There was at the time much noise regarding the potential redundancies of nursing staff and cuts to the budget, especially within media reporting. It could be that these views were influencing the thoughts and concerns of the frontline nursing staff; therefore it would be interesting to interview staff on how they perceived their working relationships, interactions and the tensions in their role once there is less uncertainty in the Scottish NHS to determine if there are any differences.

Appendices

Appendix 1: Influence of NPM in Scotland and England

Key Features of NPM	Influence in England Today	Influence in Scotland Today
Hands-on professional management in the public sector	1983 Griffiths report: introduction of general management Introduction of internal markets Audits replace clinical expertise Skills must be observable and quantifiable	Unified health boards adopt a managerial role in relation to provision of health services More direct involvement from Scottish government through strategic plan approval, funding allocations, inspection and annual reporting
Standard-setting, performance measurement, and target setting, particularly where professionals are involved	Department of Health: national standard setting Accountability Audits (e.g. clinical, skills, quality assurance) Inspections Monitoring Targets (e.g. 4hours A&E targets) Increased performance indicators/monitoring/targeting Drive for quality improvement Evidence based clinical practice Held accountable for performance by UK Treasury (PSA) targets Lack of electoral accountability except at general elections to UK parliament	Audit Scotland –checks organisations spend public money properly, efficiently and effectively ‘value for money’ Performance management Accountability (political, professional, managerial, financial, market, legislative) ‘target driven’ Statutory performance indicators Audits (e.g. clinical, skills, quality assurance, ethical) Inspections Monitoring Targets (e.g. 4hours A&E targets) Increased performance indicators/monitoring/targeting Drive for quality improvement Evidence based clinical practice Performance management being refined, fewer but more focused targets for improvement about key priorities

		There are no PSA targets in place Held to account by their electorates
Emphasis on output controls linked to resource allocation	Accountability Competitive tendering/market testing Development of budgets and contracts Reducing length of stay in hospitals for patients Capped budgets Rationing/denial of certain treatments/care	'best value' policies linked to performance indicators, audits and assessment` Reducing length of stay in hospitals for patients Capped budgets Rationing/denial of certain treatments/care Performance management being refined, fewer but more focused targets for improvement about key priorities
The disaggregation or 'unbundling' of previously monolithic units into purchaser/provider functions, and the introduction of contracting	Introduction of concordat with private care in 2000 Abandonment of concordat in 2003; competition opened to international providers Cost-led competition Consumer input (consumer choice underpinning quasi-market relationships and purchaser/provider relationships (e.g. 'Citizen's Charter', The NHS Plan)	PCTs abolished but still allows local authority trading Internal market and GP fundholding abolished and replaced by a strategic/service divide Public private partnerships (e.g. PFI) (although SNP announced these would be abandoned in favour of Scottish Future trusts)
The shift to competition as the key to cutting costs and raising standards	Market-testing Competitive tendering Introduction of budgets and contracts Marketization Cost-led competition	Local authority trading 'best value policies' Internal market and GP fundholding abolished and replaced by a strategic/service divide
Stress on private sector management style and a move away from the public service	Accountability Increased market orientation Cost improvement plans Payment in exchange for services	Public private partnerships (e.g. PFI) Performance targeting and monitoring Consumer choice

<p>ethic</p>	<p>Financial accountability Marketization Cost-led competition (e.g. catering, cleaning, laundry farmed out) Performance targetting and monitoring Consumer choice Rationing/denial of some treatments/services Freedom to negotiate staff contracts, later abandoned in 1997 for ‘Agenda for Change’</p>	<p>Rationing/denial of some treatments/services Freedom to negotiate staff contracts, later abandoned in 1997 for ‘Agenda for Change’</p>
<p>Discipline and parsimony in resource use: cost cutting, ‘doing more for less’, controlling workforce demands</p>	<p>‘Agenda for change’ (new pay system and scale) Allowing for rewards for staff who are flexible and assist in job developments Emergence of new careers Flexible career frameworks Extended working roles Reducing length of patient stay Quality assurance audits Creation of new job posts Education of nurses outsourced to universities/colleges Students removed from staff rotas Increased skill mix dilution Ratio of qualified to unqualified nurses changing (increasing unqualified) Nurses assuming doctors roles Substitution of staff with those who have less skills and are cheaper Nurses overtime to fulfil job remits Staff pressured to learn new skills and be proficient quickly Training opportunities can be very individualistic, ignoring organisational deficiencies,</p>	<p>Audit Scotland –checks organisations spend public money properly, efficiently and effectively ‘value for money’ Accountability (political, professional, managerial, financial, market, legislative) ‘Agenda for change’ (new pay system and scale) Allowing for rewards for staff that are flexible and assist in job developments Emergence of new careers Flexible career frameworks Extended working roles Reducing length of patient stay Quality assurance audits Creation of new job posts Education of nurses outsourced to universities/colleges Students removed from staff rotas Increased skill mix dilution Ratio of qualified to unqualified nurses changing (increasing unqualified) Nurses assuming doctors roles Substitution of staff with those who have less skills and are cheaper</p>

	<p>passing responsibility to the individual (e.g. de-escalation training)</p>	<p>Nurses overtime to fulfil job remits Staff pressured to learn new skills and be proficient quickly Training opportunities can be very individualistic, ignoring organisational deficiencies, passing responsibility to the individual (e.g. de-escalation training)</p>
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Appendix 2: Discussion Guide

Discussion Guide (Version 2 – 01/09/09)

Remember when questioning think about probing questions

Silent probe: remaining silent and allowing respondent time to think and respond

Echo probe: repeating what has just been said and inviting them to continue or develop further

Uh-huh probe: respondents encouraged to continue by periodic and a non-committal indication of researcher's interest in what is being said:

uh-huh...

yes....

Ok...

I see...

Tell me more: explicit invitation to probe the respondent without repeating:

Can you tell me more about...

Can you explain a little more to me about...

Long question probe: Asking a longer question which hints that a full answer is sought:

What is it like telling...

Why do you think that...

Remember:

To clarify: tell me more.../can you explain a little more...

Seeking next stage: then what happened...

Seeking reasons: why do you think that...

Checking consistency: can you tell me more...you said that...but now you have said...can you explain...

Revising: let's go back to what you said about...in the light of what you said, can you tell me...

Opening the interview

Hi, thanks for taking the time to do this interview with me, I will try and be as quick as possible. As has been explained in the information sheets/consent form/ discussion we have had, this is for my PhD work at the University of Stirling. There are no correct or incorrect answers; this is simply about your views and opinions. Just to remind you that all the information will remain anonymous and confidential (as explained on the info sheet and consent form). Also just to remind you, that you are free to stop the interview at any point and to refuse to answer any questions you are not comfortable with. Different aspects of the research will be raised and different terminology used. Please feel free to ask me any questions at any time as we progress. Thanks.

*** The questions in bold are the questions to be asked to all participants. The questions in italics are for prompting if little information is given or if the question needs to be rephrased. ***

Nursing Questions

I am firstly going to ask some questions on how you see your role as a nurse and how this perception might have changed since qualifying.

Role of Nursing

Can you tell me what you think your roles as a nurse is now? Do you think this is different from what you expected when you qualified?

At present how would you describe your role within the organisation?

What aspects of your job do you enjoy the most/least and why is this?

How would you describe the challenges that you face in your day-to-day work and what influences these?

Which other members of staff are you most likely to interact with? How do you see their role within the organisation compared to yours?

In what ways if any, do you think that the NHS structure has change during your working life in the organisation or profession? Can you attribute these changes to anything?

More in-depth questions

We are now going to focus more specifically on the structure of the NHS, and what impacts on your working life and the relationships you have with other members of staff, managers and patients.

General

In general, when thinking about management what do you see as the positive features of the relationship between nursing staff and management?

What, if any, are the negative features of the relationships between staff and managers?

How would you describe the relationship staff in your area have with management? What influences this relationship?

What factors promote or undermine good communication between staff?

What if any, are the positive features of the relationship nursing staff have with other members of staff who they work with (e.g. medical staff, physios, OT, dietician)?

What if any, do you think are the negative features of the relationship nursing staff have with other members of staff that they work with?

What do you think can influence this relationship?

What are the positive features of the relationship nursing staff have with patients and their relatives?

What, if any, are the negative features of the relationship nursing staff have with patients and their relatives?

What influences this relationship?

Financial accountability efficiency, impact of targets, audits and monitoring:

In what ways, if any, has the running (or management) of the NHS changed since you qualified?

In your view, what factors have contributed to these changes?

What do you think is meant by accountability?

In what ways can accountability in your work environment be a positive thing?

In your view, in what ways can accountability in your work environment be a negative thing?

Can you think of any targets that have been introduced in your work areas?

In what ways can targets in your work environment be a positive thing?

In your view, in what ways can targets in your work environment be a negative thing?

Are you aware of auditing and monitoring procedures in your area?

In what ways can auditing or monitoring in your work environment be a positive thing?

In your view, in what ways can auditing and monitoring in your work environment be a negative thing?

Policies

What does the term policy mean to you?

In your view, to what extent can these policies have a positive impact on your day to day working life?

On the other hand, to what extent can these policies have a negative impact on your day to day working life?

Impact of consumerism:

What do you think is meant by the term consumerism? (This is where in more recent years, patients have been described as customers for the NHS)

In your view, how important is it that the views of people who use the NHS are taken into account?

What do you think is meant by management? Who are your managers?

In your view, in what ways, if any, does the NHS come under pressure by different levels of management (think about ward based, middle management)?

In your view, in what ways, if any, does the NHS comes under pressure from the Government?

In your view, in what ways, if any, does the NHS come under pressure by users of the service?

Working conditions

In your opinion, what factors can promote good working conditions and what influences these?

In your opinion, what factors can discourage good working conditions and what influences these?

Thank-you very much for you time and help with the research!

Appendix 3: Demographic Information

Could you please fill in this form asking for some information about you prior to commencing the interview³³. Please tick the appropriate box. Thanks.

About You

A. gender:

male

Female

B. Age:

21-30

31-40

41-50

51-65

66+

C. Ethnic Background³⁴

White

British

Irish

Any other white background

Mixed

White and Black Caribbean

White and Black African

White and Asian

Any other mixed background

Asian/Asian British

Indian

Pakistani

Bangladeshi

Any other Asian background

Black/Black British

Caribbean

African

Any other black background

Chinese and other ethnic background

Chinese

Any other ethnic background (*please specify*)

³³ This demographical information can either be given to the participant to fill out prior to the commencement of the interview or it can be incorporated into the interview process.

³⁴ This ethical classification is taken from the RCN Employment surveys (Ball & Pike 2005; Ball & Pike 2007).

D. How many years have you worked at this hospital?

- 1-2 years
- 3-5 years
- 6-10 years
- 11-15 years
- More than 15 years

E. How long have you been a qualified nurse?

- 2-3 years
- 4-5 years
- 6-10 years
- 11-15 years
- More than 15 years

F. What is your job title?

G. What speciality do you work in?

H. Are you a member of a nursing union?

Yes

No

Appendix 4: Consent Form



Louise Taylor
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Colin Bell Building
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Stirling FK9 4LA Scotland
Telephone: +44 (0) 1786 466307

E-mail: l.p.taylor@stir.ac.uk

CONSENT FORM

Title of Project: New Public Management and nursing relationships in the NHS

Name of Researcher: Louise Taylor

Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I am aware of what my participation involves, including the potential outcomes of the project, and what the information will be used for.

4. I understand that any information I provide is confidential, and that no information which could lead to the identification of any individual will be disclosed in any reports related to the project, or to any other parties.

5. I agree to the interview being recorded and anonymised transcripts being archived.

6. I agree to take part in the above study.

Name of Participant

Date

Signature

Researcher

Date

Signature

When completed: one copy for patient and one copy for researcher site file.

Appendix 5: Information Sheet



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Information Sheet for Research Project:

In what ways have the introduction of new public management approaches impacted on the working relationships of qualified nursing staff with managers, other staff members and patients?

An ESRC funded Project 2008-2011

This document is a research project summary which includes the relevant information for potential research participants. Your participation is greatly appreciated. Please read the following information carefully prior to signing the consent form on the final page.

What is the purpose of the study?

Within nursing there have been many changes to the management structures that impact on how nurses undertake their work. This study aims to examine how qualified nurses perceive their relationships with managers, with other members of staff and with patients, following management changes due to the introduction of New Public Management (NPM). NPM focuses on improving costs, efficiency, accountability, increased market orientation and competition within the NHS.

This research aims to investigate the impact that management structures and the managerial approaches of NPM have on nursing staff relationships in order to establish how these groups interact and work together. Participation in this study will include answering questions relating to your day-to-day work, the structure of the NHS, your role, issues of auditing, accountability and monitoring, and working conditions.

Who will be doing the research?

The research will be undertaken by myself, Louise Taylor (l.p.taylor@stir.ac.uk, 01786 466307). I qualified as a nurse from the University of Liverpool in 2004 and worked as a staff nurse within the NHS for several years in a variety of specialities. In 2006 I returned to university for an MSc and then began my PhD at the University of Stirling and my research is being funded by the Economic and Social Research Council (ESRC), for more information see: www.esrc.co.uk.

I am supervised by Dr Iain Ferguson (iain.ferguson@stir.ac.uk, 01786 467715) and Dr Ian McIntosh (ian.mcintosh@stir.ac.uk, 01786 467699) both from the University of Stirling.

What is involved?

If you agree to take part in the research then I will arrange a one-off meeting with you to talk about your views as a nurse and the nursing relationships my study focuses on. The questions are designed to help the researcher to understand your views, experiences and attitudes.

If at any point you feel uncomfortable about any of the issues raised, or do not wish to continue with the research, then you should immediately make this clear. It is your right **not** to discuss anything you are not comfortable with and you are free to withdraw from the research at any stage, without further explanation.

Interviews will be digitally recorded to ensure that the researcher does not miss anything important during the interview. The recordings will be transcribed and these transcriptions then used to identify the key points and findings raised in the discussion. Transcripts will be kept strictly confidential, and will be marked only with participant numbers, not with names or other personal information (see below: “what happens after the interviews?”). The interview should last no longer than an hour.

Do I have to take part?

No, it is up to you to decide if you wish to participate. The research is entirely voluntary and upon reading this information sheet you will then be asked to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

Confidentiality and anonymity

Confidentiality and anonymity will be maintained at all times except in cases where information is offered by a participant which raises concern, then in line with the NMC this information may be disclosed:

You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing (Talbot-Smith & Pollock 2006).

What happens after the interviews?

All information given in the interviews will be kept confidential and only used for research purposes. Also, all responses and other information will be kept anonymous (meaning no names will be disclosed). Quotations from the interviews may be used; however, no information that could lead to the identification of any individual will be disclosed in any report linked to this project, or any other projects or parties.

The information obtained from the research will be used in a PhD thesis for the department of Applied Social Science, University of Stirling as part of a three year research project. Furthermore, it may be published in academic journals and used in further academic papers.

All participants can opt for their information not to be used in further research projects if they so choose. Also, participants will be asked to agree to interview transcripts to be archived, and these will be anonymous. The actual audio recording will be destroyed at the end of the research project.

What if there is a problem or a complaint?

Any complaint about the way you have been dealt with during the study or and possible harm you might suffer will be addressed. If you have a concern about any aspect of the research, you should speak to the researcher (Louise Taylor l.p.taylor@stir.ac.uk, 01786 466307) who will do her best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this by contacting Dr Douglas Robertson (d.s.robertson@stir.ac.uk, 01786 467720).

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a research Ethics Committee to protect your safety, rights, wellbeing and dignity. This

study has been reviewed and given a favourable opinion by) the NHS Research Ethics Committee.

The research has also received ethical approval from The University of Stirling Department of Applied Social Science Ethics Committee.

Appendix 6: Letter of Invitation to Participate in Study



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E-mail: l.p.taylor@stir.ac.uk

Title of project: New Public Management and nursing relationships in the NHS
Name of researcher: Louise Taylor

To whom it concerns,

You are invited to participate in a research study. You have been approached and received this invitation because you are a registered staff nurse working within NHS Greater Glasgow and Clyde.

Before you agree to take part in this study, it is important that you understand the nature of the research, why it is being undertaken, and what it will involve. Please take some time to read the information on the attached information sheet. Also please feel free to talk to others about this study if you so wish.

If you require further information, or have any queries, please contact me either by phone or via email (details above). Alternatively, if you wish for further information from my academic supervisor, feel free to contact Dr Iain Ferguson on 01786 467715. The independent contact for this study is Dr Douglas Robertson (d.s.robertson@stir.ac.uk, 01786 467720). Dr Robertson will be able to talk to you about taking part in research in general: I myself and Dr Ferguson will be able to talk to you about this project specifically.

Thank-you for taking the time to consider taking part in this project.

Yours sincerely,

Louise Taylor
PhD Student
University of Stirling

Appendix 7: Checklist for going to the research site

- Inform people of where I am going to be (times/places/contact etc.)
- University ID card
- NHS Ethical approval letter
- R&D approval letter
- Research access letter
- Information sheet (multiple copies)
- Invitation to participate letter (multiple copies)
- Recruitment log for participants
- Consent forms (multiple copies)
- Helpline numbers for participants (multiple copies)
- Discussion topic guide (couple of copies)
- Demographic information questions (couple copies)
- Dictaphone
- Notebook

Appendix 9: Respondent Demographics

Age of Participants

Age Group	Frequency	Percent
21-30	10	32.3
31-40	9	29.0
41-50	6	19.4
51-65	6	19.4
Total	31	100.0

Nursing Band

Band	Frequency	Percent
5	20	64.5
6	4	12.9
7	7	22.6
Total	31	100.0

Length of Service

Years	Frequency	Percent
2-3	4	12.9
4-5	8	25.8
6-10	7	22.6
11-14	1	3.2
15+	11	35.5
Total	31	100.0

Member of a Union

Union	Frequency	Percent
Yes	31	100.0
No	0	0
Total	31	100.0

Speciality of Nurse

Speciality	Frequency	Percent
A&E/ Medical & Surgical Receiving Wards	11	35.5
Surgical Wards	11	35.5
Medical Wards	9	29.0
Total	31	100.0

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