Management Changes in the National Health Service: nursing and organisational theory in relation to the development of a new unit of health care.

by

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MANAGEMENT CHANGES IN THE NATIONAL HEALTH SERVICE; NURSING AND ORGANISATIONAL THEORY IN RELATION TO THE DEVELOPMENT OF A NEW UNIT OF HEALTH CARE.

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SUMMARY

This thesis gives an account of research into management changes in the English NHS following the implementation of the Griffiths' Report (1983). The research had three aims:

1. To describe and consider the effects of new management philosophies plans and practices by conducting a case study of one particular unit of health care.

2. To study theories of nursing and health care organisation.

3. To assess the relationship, if any, between experience and theory, suggesting ways to bring theory and practice closer together.

The academic perspective is multidisciplinary, drawing on literature from nursing, organisational theory and behaviour, health service management, social science, philosophy, history, economics and policy studies.

The thesis commences with a discussion of research methodology, arguing the appropriateness of an interpretive stance. An account of the development of the NHS and nursing's place within it is followed by a detailed case study of one unit, which lasted nine months and involved more than a hundred interviews. Particular characteristics of the case study are:-
Data analysis utilising grounded theory methodology
Inclusion of members of the organisational context
A system for participants to validate data pertaining to themselves.
The style is naturalistic, qualitative and processual.

Presentation of the results recognises the existence of multiple interpretations of organisational reality; a metaphor likens the development of the Unit to the weaving of a tapestry, where the backing is the structure of the unit, and the pattern the perceptions, values and aspirations of its staff, patients and context members.
Emerging themes in the thesis are:-
the complexity of the NHS
professional philosophies and their relationship to management
organising as a process
growth of a distinctive unit culture.

A deliberate choice is made to expose the conflicts and difficulties of naturalistic inquiry, by reflecting on research method throughout the thesis, which is written in the first person.

DEDICATION

"Whatever you do, work at it with all your heart, as working for the Lord not for men.".

St. Paul's Letter To The Colossians, chapter 3, Verse 23.

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LIST OF ABBREVIATIONS USED IN THE THESIS

AHA	Area Health Authority
AIDS	Acquired Immune Deficiency Syndrome
BMA	British Medical Association
CHC	Community Health Council
DGM	District General Manager
DH	Department Of Health
DHA	District Health Authority
DHSS	Department Of Health And Social Security
DMT	District Management Team
ECG	Electro Cardiogram
ENB	English National Board For Nursing, Midwifery And Health Visiting
ESRC	Economic And Social Research Council
FPC	Family Practitioner Committee
GNC	General Nursing Council
GP	General Practitioner (family doctor)
HVA	Health Visitors' Association
LMC	Local Medical Committee
NHS	National Health Service

RAWP	Resource Allocation Working Party
RCN	Royal College Of Nursing
RGM	Regional General Manager
RHA	Regional Health Authority
RTO	Regional Team Of Officers
UA	Unit Administrator
UGM	Unit General Manager
UKCC	United Kingdom Central Council For Nursing Midwifery And Health Visiting
UMO	Unit Medical Officer
UMT	Unit Management Team
UNM	Unit Nurse Manager
UPO	Unit Personnel Officer

CHAPTER ONE: INTRODUCTION - THE SUBJECT, STYLE AND PERSPECTIVE OF THE THESIS

1.0 Introduction

What is a thesis? The Shorter Oxford Dictionary says it is

> "A dissertation by a candidate for a degree"

Chambers's Twentieth Century Dictionary says it may also be

> "an essay on a theme."

This thesis fits both those definitions, but not the Shorter Oxford's second meaning,

> "a theme to be discussed and proved."

1.1 The Subject Of The Thesis

The theme at the centre of this dissertation is management change in the National Health Service in England, but no proof or refutation of any hypothesis is sought, because this is an exploratory piece of work. At the heart of the thesis is a case study of the development of one unit of health care, called for the sake of anonymity Western Unit. It is one person's attempt to follow McLachlan's suggestion (1985:2), made at a time when argument about the implementation of the Griffiths Report (1983) was at its height.

> "At the moment there is over-emphasis on the various slogans dominating health policy and the realities behind this must be studied. Managers in the NHS must become much more aware of the advantages of long-term inquiry."

The case study, trying to get at the realities behind the slogans, lasted for about eight months; this is by no means long-term inquiry, but it did take a processual, rather than a fixed view, a cine-film rather than a snapshot.

The whole thesis, however, covers a much longer period than eight months, because it aims to set the formation of this particular unit within a context that is historical, geographical, organisational, political and professional. The writing of the thesis has been just as much part of the research process as has the empirical work - I take the liberty of altering Karl Weick's (1980:19) aphorism slightly by asking

> "How can I know what I think until I see what I write?"

1.2 The Style of The Thesis

I realise that writing in the first person is not the usual style for a thesis. I felt I could do no other, partly because I have myself been the main research instrument. but mainly because I have taken a deliberate decision to expose the various stages in the intellectual, philosophical and ethical journey I have made through the world of research during the past ten years. Latour (1987:54) writes of the way the passive voice is used to define scientific style, denying that even technical literature can be totally impersonal. He says

> "the authors are everywhere, built into the text."

He compares the use of the passive voice with the choice of

a grey backdrop on a stage set; the active voice is compared to a coloured backdrop. He suggests that the choice depends on what effect one wishes to create for the audience. I would go further than Latour; I believe that use of a grey backdrop (the passive voice) in this thesis would create a false impression, and conceal the very real conflicts and dilemmas of naturalistic research in an organizational setting.

Writing in the context of history, but I believe equally applicable to case study, Abel-Smith (1960:240) says

> "Facts do not speak for themselves. By their selection and presentation the reader is influenced to accept the viewpoint of the writer. For this reason an author should at some point come into the open and expose his values to the criticisms of the reader."

I have chosen to "come into the open" right from the beginning of this thesis, seeking to show how I selected the facts for the case study, and demonstrating the constant interplay between events taking place in the NHS, the opinions and perceptions of the participants, and my own position and values as a researcher.

1.3 The Perspective Of The Thesis

Sir Geoffrey Vickers (1968:11) was a writer who encompassed many fields of study in his work and writings. He described how he had had to question sciences in which he was not professionally qualified, sometimes providing his own answers when the experts could not always help. He continued

> "I present the result with humility but without apology. Even the dogs may eat of the crumbs which fall from the rich man's table; and in these days, when the rich in knowledge eat such specialized food at separate tables, only the dogs have a chance of a balanced diet."
>
> Vickers 1968:11

I have already hinted at the multi-disciplinary and multi-perspectival nature of this research when referring to my effort to place the formation of the Unit within its wider context. There is a sense in which a management researcher needs to pick up the crumbs under a number of different tables, in order to eat a balanced diet.

Knights (1984:1) writes of the dilemmas faced by student researchers in management sciences, trying to choose between academic disciplines as well as theoretical perspectives. He cites economics, sociology, psychology and history as possible bases from which to start, as well as sub-disciplines within management such as marketing, production, personnel or industrial relations. His view is that too close a preoccupation with one of the academic social science disciplines may occlude any substantive practical purpose, and result in research that is insular and esoteric, resulting in neither theoretical development nor practical knowledge of management.

Conversely, Knights believes that too great pre-occupation with a functional aspect of management technique leads to research where academic and theoretical aspects are subordinated to prevailing management goals, and the managerial elite's intellectual myopia is reproduced.

Knights (1984:3) concludes

> "Clearly the polarisation of management research into either social science or one of the functional disciplines is unsatisfactory ..... In the one case, rarely does anything practical result from the research; in the other, the self-inflicted obligation to produce prescriptions renders the work theoretically immature or impotent."

I recognised that Knights's last point was true of my own recent work on nurse management roles (Read 1984) and so his advice acted as a further encouragement to me.

> "If only students were to survey in advance the theoretical and methodological possibilities of pursuing research into the management process, the final outcome might be more theoretically penetrating as well as of greater significance to practitioners."
>
> Knights (1984:3)

1.4 The Structure Of The Thesis

In Chapter Two I try to follow Knights's advice (1984), by surveying the theoretical and methodological possibilities, explaining the reasoning behind my choice of method and exploring its associated assumptions and implications for the conduct of research. Chapter Two also explains why the historical and organisational context of case studies are so important, preparing the way for the next two chapters. In Chapter Three I consider the development of the NHS and the place of nursing within it, including in that consideration an overview of relevant organisational and nursing theory. Having thus surveyed the background, in Chapter Four I move into the foreground, examining in some detail changes in the NHS from 1983 onwards at a national,

regional and local level.

Because the general scene in the NHS has been described, I believe the practical account of the progress of the case study can be better understood. This account is given in Chapter Five, beginning with the choice of research design, continuing with the conduct of the empirical work and concluding with a discussion of the problems of analysis. In Chapter Six I describe the District and Unit involved in the case study, recording the processes of Unit formation, the workings of the Unit Management Board and the perceptions of Unit staff; these are then related to aspects of organisation and management theory.

Chapter Seven analyses the working philosophies of Unit staff (mainly nurses) and their implications for management, relating these to differing approaches to nursing knowledge and practice as well as management theory. In Chapter Eight I consider the reactions of research participants to the Griffiths Report (1983) including the notions of quality improvement and increased consumer participation in the NHS. Perceptions on these topics are considered in the light of some of the literature on organisational value systems and culture. Chapter Nine concludes the thesis; in it I reflect on my research aims and whether they were fulfilled, on the research method and its problems and on implications for further research.

It would not be appropriate in this chapter to set out detailed reasons for choosing this particular framework for

the thesis. As Chapter Two explains, the chosen methodology leads to a processual view of research; and as already stated, writing the dissertation is as much part of the research process as is gathering the data. The shape of the dissertation therefore emerged as the writing progressed; each chapter grows out of its predecessor and earns its place in the overall structure.

CHAPTER TWO: THE RESEARCH PROCESS - IN THEORY

2.0 Introduction

I turn now to tracing my path through the maze that is research methodology, revealing as truthfully as I can the influences upon my thinking and planning from both literature and experience. It is necessary to do this before explaining the research context and background, or examining the literature surrounding the topic chosen, because the way these tasks were undertaken was guided by the principles of the research method adopted.

During the course of this chapter I suggest that most nursing research, including nurse management research, has been conducted in the positivist tradition, which influences the topics that can be studied and the kind of results obtained. I explore alternative approaches, and state my own preference and the influences that caused me to take up an interpretive stance. I then set out my research aims and intention of using case study to help achieve them. I further consider the constituent factors in naturalistic inquiry, including the use of grounded theory methodology. The chapter closes with a discussion of criteria for trustworthiness in naturalistic inquiry.

2.1 Similarities Between Researching Accounting And Researching Nursing

My initial area of interest for research on coming to Sheffield University was the development of criteria for measuring nurse management effectiveness; this was a natural progression from studying the roles of nurse

managers (Read 1984) and led to acceptance of academic supervision from those interested in management control related to accounting and organisational behaviour. Studying research methodology with accounting students soon revealed many similarities between the nursing and accounting professions - most notably, a much publicised concern about the conceptual gap between academics and theoreticians and the everyday practitioners of the profession (e.g. American Accounting Association 1978:28, Clarke 1986:3), and a growing awareness that theoretical pluralism is not necessarily a bad thing. (AAA 1977:49-52, Hopwood 1987; Chapman 1976:126, James and Dickoff 1984:72).

One common factor shared by nursing and accountancy is that both are practice disciplines

> "Whose practical wings predate their more theoretical endeavours by centuries." (Laughlin, Lowe and Puxty 1986:18).

Thus a majority of practitioners are largely concerned with professional practice and standards but not with the theoretical underpinning which is so necessary if practice is not to degenerate into mere ritual. Much of what is written about accounting research and the necessity of its relevance to professional practitioners is therefore applicable to nursing, and vice versa. For instance Morgan (1983a:385), commenting on an important article by Tomkins and Groves (1983), explains how accounting research developed by borrowing models and methods from the natural sciences, failing to question their appropriateness for studying the practice of accounting. Morgan argues that

whilst the technical manipulation of accounting data may be a suitable subject for a natural science approach, other aspects of accounting belong in the social world, and require different research strategies which are more sensitive to other realities than are at first apparent.

2.1.1 Developments in the Philosophy of Science

Morgan does, in fact overstate the appropriateness of generally accepted research strategies even for the natural sciences. Writers such as Chalmers (1982) Hacking (1983), Mitroff (1974) and Latour (1987) make it clear that there is not a single philosophical approach to natural science, but many. Chalmers (1982:xvi) tells how new developments in the philosophy of science have revealed difficulties with the idea that inference enables scientists to derive scientific theory from observation and experiment in a totally reliable way, He continues

> "There is just no method that enables scientific theories to be proven true or even probably true.... Attempts to give a simple and straightforward logical reconstruction of the "scientific method" encounter further difficulties when it is realized that there is no method that enables scientific theories to be conclusively disproved either."

Hacking (1983:127) outlines six distinguishable styles of scientific thinking, which provide a range of conceptual tools for scientists. He warns against a view of reality and objectivity that is dependent on just one style of reasoning, suspecting that the style of reasoning may determine the very nature of the knowledge produced.

Hacking continues his argument by referring to Hertz's Principles of Mechanics, in which three equally plausible explanations for certain phenomena were given. But at the end of the nineteenth century when Hertz was working, scientists could not accept multiple representations of reality. Hacking maintains that some modern philosophers of science, at least, now acknowledge that

> "There are no criteria for saying which representation of reality is the best. Representations get chosen by social pressures."
> Hacking (1983:144)

Mitroff (1974) and Latour (1987) both support this view of science.

2.1.2 Lack of Organisational Research By Nurses

Recalling my perception of similarities between accounting and nursing as practice disciplines, and bearing in mind Morgan's (1983a) tendency to over-simplify the contrast between natural and social science, Morgan's analysis of the situation in accounting may explain to some degree the paucity of research in the field of organisation and management in nursing. Most of the research that has been done has been at the rather mechanistic level of counting how many hours managers spend in different aspects of their role, and enumerating the number of different people with whom they have contact. (see Read 1984 for a review of this literature). Davies (1979:416) reviews research into the organization of health care from a medical sociologist's viewpoint, and makes a similar point to Hacking when she says

> "There is a growing awareness of the intimate relationship between the theoretical models and research methods used, on the one hand, and the kind of answers we tend to get, or not to get, on the other."

Davies writes about studies where "the organization" is viewed as a collectivity with a goal, and where rationality is taken for granted. She suggests that the use of new theoretical models of organizations, and new research methods may challenge this view, and even dispense with it. Davies (1979:415) continues

> "Dispensing with this means arguing that the organization does not equate with interests in an unproblematical way, that organizations which have come about as an alliance of interests are transformed as those interests change, and the interests themselves, as much as the concrete organizational forms in which they are embedded, must be subject to sustained analysis."

In nursing, there is a growing body of clinical knowledge tested by natural science methods, but these methods are not necessarily appropriate for research into the social and relational aspects of nursing. Once I had decided to study the impact of NHS management changes upon nursing, within its context of health care, it was plain that I would need to explore further the methodology of social research. I had abandoned the notion of searching for criteria for measuring nurse management effectiveness because I had learnt from management control literature (Ouchi 1979, Tiessen and Waterhouse 1983) that in conditions of uncertainty, control systems should rely more on professional values than on strict measurement. It was

obvious, early in 1985, that the NHS was entering yet another period of change and uncertainty.

2.2 Four Paradigms of Social Research

I referred at the beginning of this thesis to my decision to expose the different stages in my journey through the world of research. The stage I had reached in the spring of 1985 was the realisation that I wanted to study some aspect of NHS management change and its impact on nursing. I knew too that I did not want to look at nursing in isolation, but embedded in its context within the field of health care. My search amongst theoretical and methodological possibilities had already begun, because I was participating in a university course on research methodology in which a major text was "Sociological Paradigms and Organisational Analysis." by Burrell and Morgan (1979).

Stemming from the view that "all theories of organization are based upon a philosophy of science and a theory of society", Burrell and Morgan (1979:X) propose

> "That social theory can usefully be conceived in terms of four key paradigms based upon different sets of metatheoretical assumptions about the nature of society. The four paradigms are founded upon mutually exclusive views of the social world. Each stands in its own right and generates its own distinctive analyses of social life."

They explain that analysing social theory in that way exposes the underlying assumptions of the alternative approaches to social science, so that we realise how the researcher's frame of reference affects what he sees and

how he explains it. It is also vital that we recognise our own basic assumptions so that we may reflect more honestly on our own work, and understand alternative points of view with more insight. A paradigm literally means a model or pattern. But increasingly it is used as Burrell and Morgan use it here, in terms of world view, or a range of intellectual territory - a commonality of perspective, binding together the work of a group of theorists who share basic meta-theoretical assumptions and a frame of reference.

Burrell and Morgan's juxtaposition of the range of theories of social science (on a continuum from extreme objectivism to extreme subjectivism) with the range of theories on the nature of society (on a continuum from a sociology of regulation to that of radical change) offers the seeker a kind of intellectual map within which to locate theories and methodologies, and an heuristic device to aid in their analysis. This is shown below, in Figure 2.2.

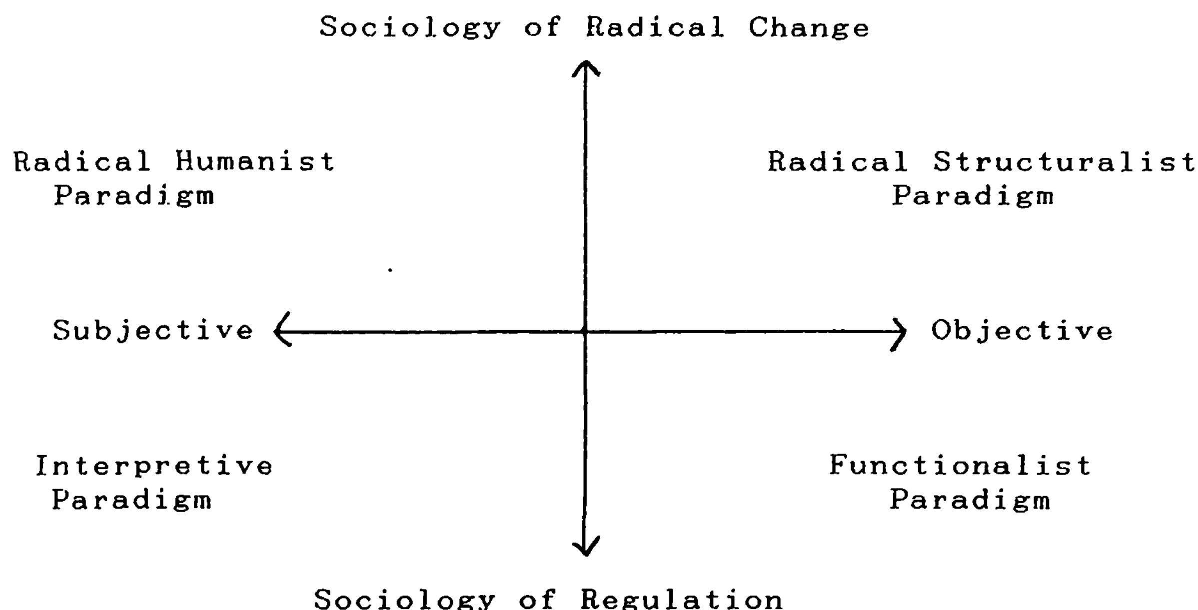

Figure 2.2 The Four Paradigms of Social Theory - from Burrell and Morgan (1979:22)

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2.2.1 Definitions of Philosophical Terms

Before describing Burrell and Morgan's classification in more detail, I will define what I take to be the meaning of some of the philosophical terms used.

ONTOLOGY

The science of being, the study of the essence of phenomena - whether reality is external to the individual, or the product of his consciousness.

REALISM

Belief that the social as well as the physical world has independent reality and concrete existence.

NOMINALISM

Belief that social entities or abstract concepts do not have absolute reality or meaning, but that naming them is a convenient way of describing them and making sense of the

world.

EPISTEMOLOGY

The study and science of the nature of, and grounds for knowledge, and how it can be obtained.

POSITIVISM

System of philosophy, articulated by Comte, recognizing only positive facts and observable phenomena together with the relations of these and the laws which determine them. Knowledge is only endorsed if it is obtained through scientific means, and refers to concrete objects experienced by the physical senses.

ANTI-POSITIVISM

System of philosophy recognizing the social world as essentially relativistic, understandable through the experiences of those involved.

POSITIVISTIC SOCIOLOGY

Adapts natural science methods to formulate law-like generalisations about the social world which are believed to be neutral in respect of values.

DETERMINISM

The belief that man is not free, but conditioned by his environment and circumstances. The doctrine that everything that happens is determined by a necessary chain of causation.

VOLUNTARISM

The belief that man has free will to change and be changed, that he is the creator of his own environment.

NOMOTHETIC METHODOLOGY

Research using natural science methods, based on systematic

protocols and techniques, using standardized instruments - treating the social world as if it were a hard, objective reality, searching for universal laws which explain and govern the reality observed.

IDEOGRAPHIC METHODOLOGY

Research using first hand knowledge and intuitive reflection, stressing the importance of the subjective experience of individuals in the creation of the social world. Emphasis is placed upon explanation and understanding of what is unique and particular to the individual rather than what is general and universal.

2.2.2 Key Variables In Social Science Theory

Burrell and Morgan classify social science theories according to four key variables as shown below.

Subjectivist Approach		Objectivist Approach
Nominalism	Ontology	Realism
Anti-positivism	Epistemology	Positivism
Voluntarism	Human Nature	Determinism
Ideographic	Methodology	Nomothetic

Figure 2.2.2 Assumptions about the nature of Social Science From Burrell and Morgan (1979:3)

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For social scientists, the basic ontological question is whether reality is external to the individual, assumed as "a given, out-there" (the position taken by realists) or

whether it is the product of individual consciousness, or cognition (the position taken by nominalists). The basic epistemological question centres on what counts as knowledge and how it can be acquired, whether reality can be observed, or can only be known by experience. Associated with these issues, but conceptually separate from them, is the question of the relationship between man and his environment - to what degree, if any, humans are conditioned by their external circumstances, (as determinists believe) or whether they have a more creative role and use their free will to exert control over their environment (as voluntarists believe).

Referring to Burrell and Morgan's framework, Hopper and Powell (1985:431) explain how the three sets of assumptions (about ontology, epistemology and human nature) have direct methodological implications. If the social world is treated as if it were the same as the physical world, then research methods such as standardized questionnaires are used, and analysed statistically. However, if the subjective experiences of individuals are recognized as contributing to the creation of a social world, then methods such as in-depth interviews and participant observation are used.

2.2.3 Characteristics Of The Four Paradigms

Burrell and Morgan (1979:23) maintain that each of their four paradigms has an underlying unity in its basic assumptions, so that groups of theorists clustered round each of those paradigms are separated from each other by

what they take for granted.

The functionalist approach assumes an ordered, independent world peopled by environmentally determined humanity needing only marginal change, in which research applies natural science models to social science, and seeks to provide an essentially rational explanation of social affairs. The radical structuralist paradigm sees a similar world but in need of radical change because its structures are seen as inherently dominating. Research in this approach seeks to expose conflict, contradiction and deprivation. Both these paradigms share a philosophy of positivism, realism and determinism and adopt a nomothetic approach to research.

An interpretive approach to social science assumes a world whose meaning is determined by insights of a free humanity who can change situations if they choose. The social world is seen as an emergent social process, and research seeks to understand the world as it is seen in subjective experience, and is participation-oriented. The radical humanist paradigm sees a society which needs emancipating from the limits of existing social arrangements and biases, and uses research modes such as critical theory to bring about change. Both these paradigms share a philosophy of anti-positivism, nominalism and voluntarism, and adopt an ideographic approach to research.

2.2.4 Most Nursing Research Is Functionalist

Here, then, was a range of theoretical and methodological

alternatives. I recognised that in nursing, as in accounting, the bulk of research studies had been conducted within the functionalist paradigm. One strong reason for this has been the traditional association of nursing with (if not dominance by) medicine, whose research tradition is strongly positivistic, and with whom the controlled experiment (e.g. double blind trials) is the favoured method. Not only does the medical profession exert theoretical influence over nursing research, but it also holds a strong position in the major funding bodies available to nurse researchers. How was I to choose a paradigm in which to work? Did I, in fact, have a choice or did my attitudes and beliefs mean that I was already committed?

2.3 Choice in Research Methodology

Factors involved in the choice process are illuminated by Laughlin, Lowe and Puxty (1986) in an article about the methodology course of which I had been a member. They model the choice process as follows:-

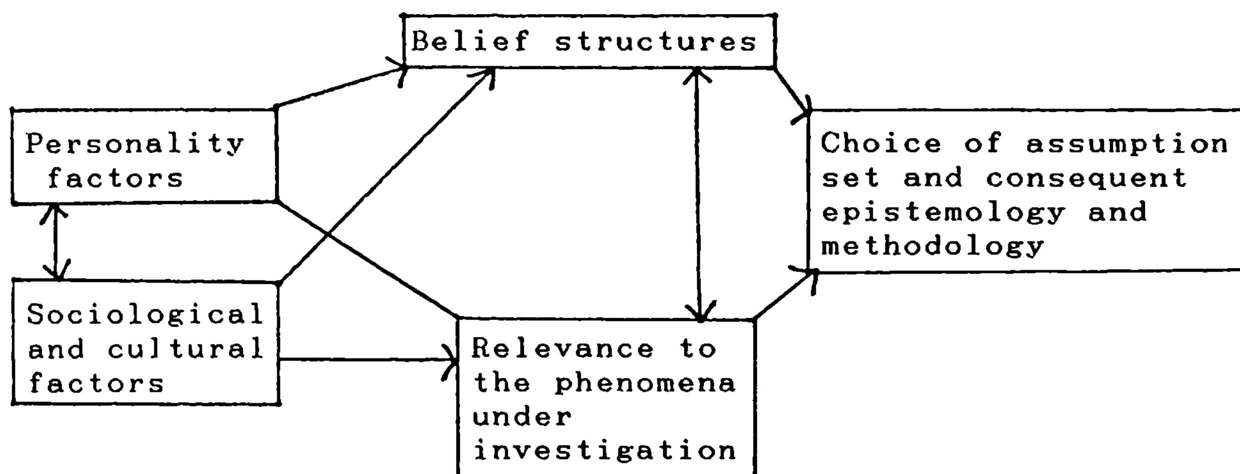

Figure 2.3 An insight into some postulated dynamics underlying methodological choice.
From Laughlin, Lowe and Puxty (1986:30)

The above authors suggest that:

> "particular choices are a function of either or both of a) beliefs about appropriateness b) some logical analysis concerning relevance to the phenomena under investigation. These two factors are dynamically interrelated, as they are also to more deep seated personal and social factors. What we believe to be "right" or "relevant" in methodological choice is related to who we are as people individually and collectively, which in turn is related to other sociological and/or cultural factors."
>
> Laughlin, Lowe and Puxty (1986:28)

<u>2.3.1 Stating My Own Position</u>

As I look back to the spring and summer of 1985 I can see more clearly now than I could then the factors at work in my choice of both the research topic and the methodology adopted. At the time I felt as though I was groping in the dark, and was very aware of external pressure in particular, the need for the research proposal to be accepted by the DHSS who were partly funding me.

First came my own position and assumptions about the nature of social science. It was plain that a study, however focused, within the general area of management changes and their effects, would require a social science rather than a natural science orientation. Taking the four key variables chosen by Burrell and Morgan for their importance in defining metatheoretical assumptions, I now state my own position in relation to them:-

On ontology - that social and organisational reality is not externally imposed, but largely internally created. As Schutz explains

> "The social world .... has a particular meaning and relevance structure for the human beings living, thinking and acting therein. They have preselected and preinterpreted this world by a series of commonsense constructs which determine their behaviour, define the goal of their actions, the means available for them - in brief, which help them find their bearings in their natural and socio-cultural environment and to come to terms with it."
>
> Schutz (1964:5-6)

I believe therefore that social and organisational reality means different things to different people and cannot be taken for granted.

On epistemology - that knowledge in social science is more than observable operations accessible to experience (Kolakawski 1972:16), and that inquirer and the "object" of inquiry interact to influence each other. (Lincoln and Guba 1985:98) I agree with Heron (1981:27) when he says that science involves more than just propositional knowledge and includes practical and experiential knowledge. He defines the latter as knowing a person, a place, or a process in face to face encounter and interaction. He believes that experiential knowledge of persons is most adequate when researcher and subject are in a relationship of reciprocal and open inquiry, and that researchers need to acquire the skill of making such relationships. I believe that the epistemology of nursing involves further kinds of knowledge in addition, as described by Carper (1978:22). These are scientific knowledge of human behaviour in health and illness, aesthetic perception of human experience, personal understanding of the uniqueness of individuals, and moral

and ethical concepts in order to appreciate values and make informed choices. Carper (1978:22) believes that each of these kinds of knowledge, which are separate but interrelated and interdependent in nursing, should be taught to nurses using appropriate methods and inculcating awareness of the limitations of each. The different criteria for evaluating the distinctive kinds of knowledge should also be understood.

Sarvimaki (1988:462) writes of nursing as a moral, practical, communicative and creative activity, whilst Tinkle and Beaton (1983:35) and Cull-Wilby and Pepin (1987:519) plead for research in other paradigms than functionalism to restore the balance in nursing. All these authors believe that logical empiricism, with its stress on value freedom, produces a very narrow kind of knowledge, and strips nursing of much of its meaning. Benner (1984:219) seeks to illuminate nursing expertise by interpretive research methods, saying

> "Our public language about nursing has grown too constricted and sterile as a result of monological theories and an attempt to develop a general, context free language to cover the local and individual contingencies in nursing..... We cannot afford to attend to and legitimize only what we learn from scientific experiments; the scope and complexity of our practice are too extensive for this."

My own view on the relationship between man and his environment is not an extreme one at either end of the determinism -voluntarism continuum. I do believe that man is endowed with free will and can exercise choice and effect change in his life and circumstances; but I would

also acknowledge the effect of both environmental pressures and hereditary characteristics on his life.

The fourth variable is methodology. My position on the other three reveals that I would be nearer to the subjective end of Burrell and Morgan's continuum than to the objective end - clearly anti-positivist in my epistemology, and tending towards nominalism and voluntarism. So, as expected, I would tend to choose a more ideographic research style involving in-depth study and personal encounter. My views on these four variables stem partly from intellectual consideration of the arguments involved during my period of acadmic study; but they have also been formed by experience in nursing and in research as well as influenced by my Christian beliefs and personal inclination to avoid conflict but to be as open and honest in relationships as possible, trying to understand and give due weight to other peoples' points of view.

My own position on the continuum between the sociology of regulation in society, and that of radical change, would again be fairly near the centre, but tending towards regulation. Consequently, I could indicate my own position within Burrell and Morgan's four paradigms as follows:-

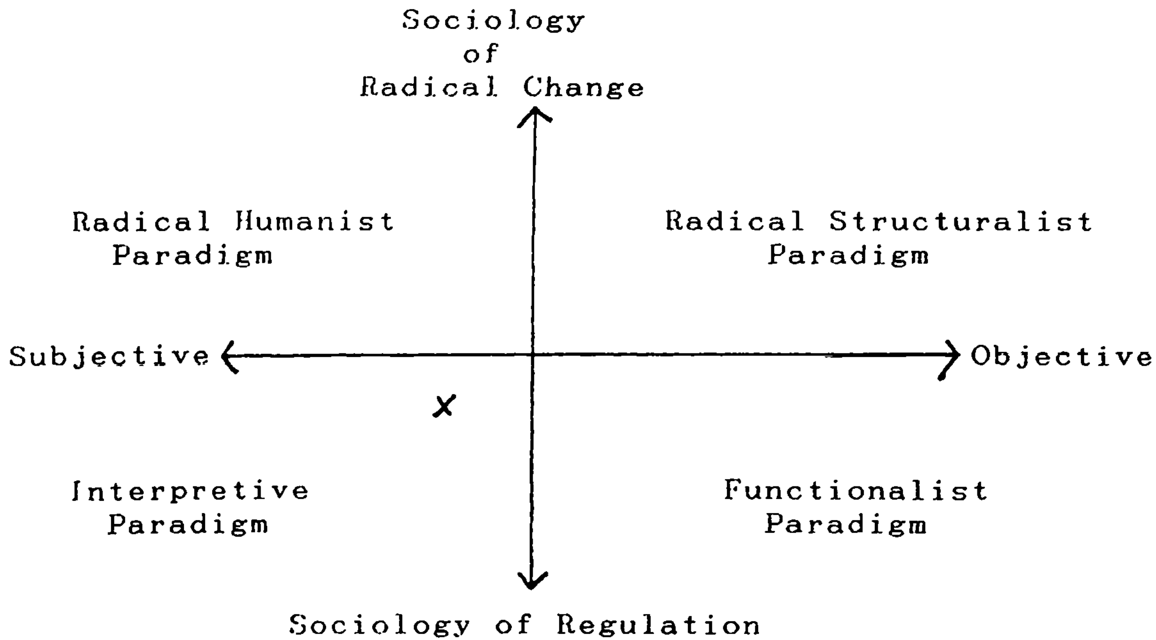

Figure 2.3.1 Marking my personal location within the Burrell and Morgan framework.

The remaining dynamic postulated by Laughlin et al (1986:30) to be of importance in methodological choice is relevance of methodology to the subject of the research. The interpretive paradigm views the world as an emergent social process; this was particularly appropriate to my area of research, that of the effects of management change on nursing within its environmental context of health care. Hopper and Powell (1985:446) state that

> "the form of inquiry adopted in any investigation should not be shaped simply by a commitment to particular research methods for their own sake, but should be logically consistent and appropriate, given the aims of the research and the values and assumptions that lie behind it."

They also say that interpretive research methods, by permitting research questions to emerge from the research process, rather than being predetermined at the outset, will raise issues that are more pertinent to the problems

of the subjects.

2.4 Other Ways Of Looking At Research Methodology

There are, of course, many ways of classifying research methodology, of which Burrell and Morgan's (1979) is just one example. However, the distinction between objective, mainly quantitative methodologies and subjective, mainly qualitative approaches seems to be universal and is a recurring subject for debate in many different disciplines, not least nursing. (see Orr 1979, Anderson 1982, Field 1983, Chinn 1983, Duffy 1985).

Another, earlier classification is made by Weeks (1973) and although the main distinction is between a deductive, deterministic approach and an inductive, voluntaristic one; the features in the framework do have many similarities with Burrell and Morgan's analysis, with the deductive features matching the objective side and the inductive features matching the subjective side of the dichotomy. Weeks (1973:379) makes three kinds of distinction when looking at literature on organisation theory. These are theoretical, which broadly correspond to Burrell and Morgan's ontological, epistemological and human nature variables, methodological, which correspond directly with Burrell and Morgan, and substantive, which relate to the empirical world by describing and categorising the social phenomena under study.

Weeks (1973:390) tabulates his distinctions as follows:-

Figure 2.4 Distinctions between approaches to organizations

From Weeks (1973:390). Copyright 1973 by Open University Press. Reprinted by permission.

Distinctions	Deductive, determinist approach	Inductive, voluntaristic approach
Theoretical	System Universalist Formal Unitary Structure	Action Particularist Informal Pluralist Process
Methodological	Functionalist Comparative analysis	Historical Case study
Substantive	Mechanistic High specificity of role prescription	Organismic Low specificity of role prescription

Space forbids detailed discussion of all the features of this table, but Weeks (1973:386) summarises the inductive side by saying that compared with the opposing, deductive approach,

> "the theoretical ideas themselves are grounded to a much greater extent, in the empirical phenomena under study ..... Much greater significance is attributed to the social actions of individuals in shaping society or the organization ..... depicting man as an innovator and creator of his social/organizational environment."

2.4.1 The Importance Of Seeing An Organisation In Its Context

It is also significant that a historical perspective is taken, seeing an organization in its developmental context. This is a view that is also stressed by Pettigrew

(1973:268) in his well-known study "The Politics of Organizational Decision Making" when he says

> "The emphasis has been on the organization as an ongoing system with a past, a present and a future. This view has implied that sound theory must take into account the history and the future of a system and relate them to the present."

2.5 From Methodology To Research Design

In progressing now to discussion of how the form of inquiry I adopted was consistent with the aims of the research, I hope to show that the values and assumptions lying behind that form of inquiry, whilst growing out of the soil of the interpretive paradigm, were also tempered by experience of health service research and nursing work, and consequently contributed positively to the development of the research design.

I referred earlier to the position I had reached in the spring of 1985; I knew I wanted to study some aspect of current NHS management change and its impact on nursing, but to do so in a way which did not isolate nursing from its context within health care. I was also by then interested in the relationship of health professionals' working philosophies to management objectives and practices. But as Miles and Huberman (1984:36) say,

> "Empirical research is often a matter of progressively lowering your aspirations. You begin by wanting to study all the facets of an important problem or a fascinating social phenomenon. But it soon becomes clear that choices must be made."

That process of choice is frequently glossed over in traditional research accounts, or treated as unproblematic.

The impression is often given that the topic of inquiry and the method of study were implanted in the researcher by revelation, and that the bulk of the research effort lay in carrying out the work and writing it up. Shipman (1976:147) says

> "Conventionalised reporting omits the brains, the heart and the strain during planning."

In this less than conventional report, I admit that the translation of generalised notions into a detailed research plan, and winning acceptance of the plan from funding agency and potential research subjects are tortuous and stressful processes, and more detail about this is given in Chapter Five. For now, I would say that there is a tension between desire for rigorousness in research design to satisfy sponsors, and flexibility to achieve acceptance by .research subjects. As Argyris (1968:185) says

> "Rigorousness is to a researcher what efficiency is to an executive: an ideal state that is always aspired to, never reached, and continually revered."

2.5.1 Choice Of Case Study Method

Following the rejection by the DHSS of my initial research plan, based on an action research philosophy, the idea emerged of conducting a case study of a newly constituted unit of NHS management. I gradually realised, after searching literature on case study method, (especially Yin 1984, and Mitchell 1983) that the insights of the interpretive paradigm could be applied within a case study

design. In particular, the attempt to obtain multiple perspectives on a problem or subject, which is central to case study method, should illuminate

> "the meanings and relevance structure of the social world experienced by human beings within it".
> (Schutz 1964:5)

Also the use of the person as the chief research instrument, in in-depth interviewing and in non-participant observation, again vital to case study method, is in accord with the view of knowledge outlined by Heron (1981:27). In this view, practical and experiential knowledge acquired by face-to-face encounter are valued equally with propositional knowledge. A third characteristic of case study, the recognition of participants' views of the study as an aid to achievement of validity, is congruent with the interpretive position on man and his environment, demonstrating that he may use his freewill to disagree and express an alternative view; provision needs to be made in the research design for recording such dissent in the final report.

2.5.2 The Research Proposal

Once I had discovered these characteristics of case study from a preliminary search of the literature, I was able to compile a research proposal which was duly approved by the funding body. I chose as the title of the study

> "Management Changes in the Health Service: an empirical and theoretical analysis of the formation and development of a new unit of health care."

Later this title was changed to

> "Management Changes in the NHS: nursing and organisation theory in relation to the development of a new unit of health care."

Consent was provisionally given for research access to one unit of NHS management, and more details of gaining access are given in Chapter Five.

The aims of the research were threefold:-

1. To describe and consider the effects of new management philosophies, plans and practices on nurses, nursing care, nurse managers and members of other health care disciplines and supporting staff within one unit of management, during a period of change.

2. To study existing theories and models of nursing, and of the organisation of health care, looking for any common features and relationships.

3. To assess what relationship exists between experience (as in "1") and theory (as in "2") and to suggest areas where either may need to change so that there is a closer correspondence between theory and practice.

Case study seemed to be the ideal method for fulfilling the first aim, and this is reported in Chapter Six. Chapters Three and Four attempt to fulfil the second aim, and Chapter Six onwards the third aim.

<u>2.5.3 Case Study Method</u>

Yin (1984:14) writes that the desire to understand complex

social phenomena may lead to the undertaking of case studies, because through that means of investigation the meaningful characteristics of organizational processes, as real-life events, are retained. Yin (1984:23) defines a case study as

> "an empirical enquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used."

Mitchell (1983:191) points to two particular characteristics of case study. The first is that the documentation of a set of events is undertaken explicitly for the purpose of drawing theoretical conclusions from it. This characteristic was relevant to me in my choice of research method, as I was intending to compare theories induced from my study with known theories of nursing and health care organisation. The second characteristic highlighted by Mitchell (1983:191) is that case study preserves the unitary character of the social object being studied. It does this by viewing the social unit as a whole, and studying its development as a process. He quotes Goode and Hatt (1952:339) in contrasting case study with survey analysis, where the person is replaced by the trait as the unit of analysis. They say

> "Attempting to organize the data around the unit of growth, or group structure, or life pattern, does force the researcher to think in these terms rather than fall back on trait analysis alone."

This does not mean that particular sub-groups within the unit may not be studied, or particular characteristics

focused upon; but care needs to be taken always to relate these parts of the study to the whole, and to see them in context.

2.5.4 The Influence of My Research Education and Experience

My conviction that case study method, adopting the values of the interpretive paradigm, was appropriate for the research aims I had set myself, was strengthened by my past experience of health service research. My initial research education, on a Sheffield University Diploma course for nurses, with much teaching in-put from the medical profession, prepared me to work within the functionalist paradigm, and to accept a positivist view of knowledge. Research was defined as a systematic search for answers to questions about facts, where

> "Facts are events that can be observed and agreed upon by others. Concepts are general ideas made from particular observable events where the events or facts fit together in a meaningful way."
> Chater 1975:2

On the research course a very structured and highly controlled type of research planning was encouraged, where every contingency was covered and problem anticipated, in order to facilitate validity, reliability and the avoidance of bias.

I accepted unquestioningly protestations about objectivity and value freedom, such as

> "Objectivity is an essential attitude in research. .....The research problem, methods and findings must be as free of personal prejudice and bias as

> possible. All of the decisions made in the entire research project are directed toward maximising objectivity."
>
> Chater 1975:5

It was several years later, having embarked upon a piece of management research (Read 1984 and 1987) that I discovered by painful experience that however much I as a researcher sought to be free of bias, the study was being used as a political instrument. I found to my cost that

> "evaluation research can easily be distorted for political ends.... can be used to procrastinate and avoid current disputes or to neutralise unpleasant political decisions by passing them to supposedly value neutral experts .... It is important to recognise the central place of subjective value judgments in such research, and the dangers inherent in assuming that if the research is carried out in a rigorous fashion then value-neutral, objective facts will emerge."
>
> (Clayton and Davies 1982:776)

I found this to be true also of research which was not overtly evaluative - much organisational research can be used evaluatively even when this is not the stated purpose.

Mitroff (1974:79) compiled a list of the conventional norms of science, and proposed counter norms, based on his view that for too long we have lived with the myth that science has to be devoid of passion if it is to be objective. Mitroff pointed out that many past scientific achievements had resulted from "passionate, if not biased enquires". My experience of health service research led me to identify strongly with Mitroff's list of counter-norms.

Figure 2.5.4 Some of Mitroff's Norms and Counter Norms about Science

From "The Subjective Side of Science" 1974:79, by I. Mitroff, published by Elsevier Science Publishers, reproduced by permission.

Conventional Norms	Counter Norms
Impartiality	Partiality
A scientist concerns himself only with the production of new knowledge and not with the consequences of its use.	A scientist must concern himself as much with the consequences of his discoveries as with their production - to do any less is to make the scientist into an immoral agent who has no concern for the moral consequences of his activities.
Suspension of judgment	Exercise of judgment
Scientific statements are made only on the basis of conclusive evidence	Scientific statements are always made in the face of inconclusive evidence; to be a scientist is to exercise expert judgment in the face of incomplete evidence.
Absence of bias	Presence of bias
The validity of scientific statement depends only on the operations by which evidence for it was obtained, and not upon the person who makes it.	In reality the validity of a scientific statement depends on both the operations by which evidence for it was obtained and by the person who makes it; the presence of bias forces the scientist to acknowledge the operation of bias and to attempt to control for it.

2.5.5 Can Research Be Value-Free?

Mitroff's statement on bias, as shown above, raises the question of whether research can ever be value-free as positivists claim. Heron (1981:33) gives the example of questionnaires and interview schedules which rest on the

norms and values of those who compiled the questions. Frequently it is assumed that these values and their frame of reference are consonant with those of the research respondents. If this is not so, the validity of the research findings may be questioned. Heron speaks of the manifold sub-cultures present within our society, each having its own value system, and concludes that research findings about people must take into account their particular sub-cultures and value systems. He goes so far as to say that

> "the idea that any science can be value-free is a delusion."
>
> Heron 1981:33

Lincoln and Guba (1985:161) echo this view. They maintain that inquiry is value-bound, being influenced by the values of the inquirer, by the assumptions of the underlying methodological paradigm and by the prevailing ethos of the research context. They also explain that all these influences may be in resonance with each other, which helps the inquiry forward, or in a state of dissonance which then hinders the research. (Lincoln and Guba 1985:178). They recommend that at the very least,

> "we should be prepared to admit that values do play a significant part in inquiry, to do our best in each case to expose and explicate them (largely a matter of reflexivity) and, finally, to take them into account to whatever extent we can."
>
> Lincoln and Guba 1985:186

Argyris (1968:191) describes a related problem to dissonance of values, that of the research process in a field setting tending to place the research subject in a

subordinate relationship to the researcher. He explains that the research encounter is not a neutral one, especially if conducted in work time and in the usual work-place. Argyris (1968:191-2) believes this factor contributes to a "double-bind" effect in organisational research. He describes the "spirit of inquiry" that motivates inquirers, with its connotations of exploration, experimentation, openness, a desire for knowledge for its own sake, and a wish to share that knowledge widely. He then says

> "If we compare these conditions with those found in the living systems of organizations we find that the organizations tend to create the opposite conditions. For example, it has been shown that interpersonal openness, experimentation and trust tend to be inhibited in organizations. The same may be said for the concern for truth for its own sake. The sharing of knowledge is not a living value since that could lead to one's organizational survival being threatened. Thus, the subject is in a double bind. He is expected to be open, manifest a spirit of inquiry, and take risks when he is placed in a situation that has many of the repressive characteristics of formal organizations, which he has long ago learned to adapt to by not being open or taking risks."

Argyris's (1968:193-5) solution to this problem is to take account of it in the research design, reducing the researcher's control over the subjects, giving the participants greater influence in the project and larger involvement in it, increasing meaningful feedback and generally making greater efforts to understand the point of view of the research subjects.

2.5.6 Naturalistic Inquiry

It will by now be clear that arriving at a research design was for me a long drawn out process, involving a deliberate search for a method that was consonant with my own values as well as approprate for the proposed research topic. The characteristics that I wished to feature in the design have been aggregated by Lincoln and Guba (1985:187-9) but I wish to make it clear that I decided on these features and planned the research before finding and reading their book:-

1. It is carried out in the natural setting, because reality cannot be understood apart from its context.

2. The researcher is the primary data-gathering instrument, rather than paper and pencil techniques.

3. Tacit or intuitive knowledge is legitimate, in addition to propositional knowledge.

4. Qualitative methods predominate, although some quantitative methods may be used in support.

5. Purposive or theoretical sampling is used rather than random or representative methods. (see below for further elucidation.)

6. Inductive data analysis is practised.

7. Theory is allowed to emerge from the data - this is known as grounded theory. (see below)

8. The research design unfolds gradually rather than being fixed totally in advance.

9. Meanings and interpretations are negotiated with the human sources of the information.

10. A case-study reporting mode is used.

11. The data is interpreted, and conclusions drawn, ideographically rather than nomothetically.

12. Only very tentative broad generalizations are made.

13. The focus and boundaries of the study depend on emerging realities rather than preconceived limits.

14. Special criteria for trustworthiness are set, such as credibility, transferability, dependability and confirmability; rather than conventional criteria such as validity, reliability and objectivity.

The relationship between these characteristics is shown graphically in Figure 2.5.6 (below).

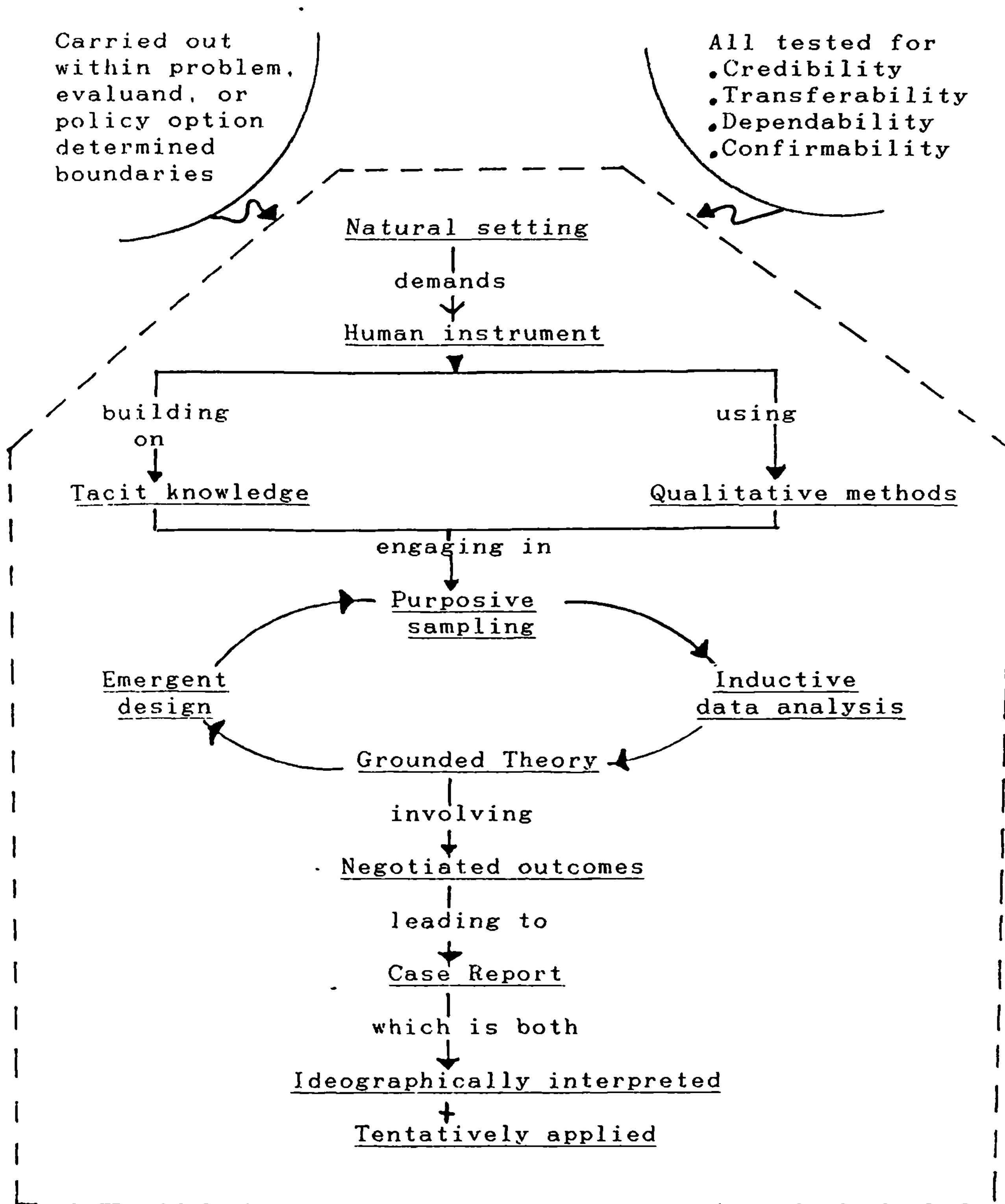

Figure 2.5.6 The flow of naturalistic inquiry

(From Y. Lincoln & E. Guba "Naturalistic Inquiry" p188 Copyright 1985 by Sage Publications.)

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I have already discussed the importance of the real-life context of the case study, of the researcher being the chief research instrument and of the admissibility of other kinds of knowledge than the purely propositional. All this presupposes the use of qualitative methods. The next four items on Lincoln and Guba's list, as shown in the diagram in Figure 2.5.6, all belong together, as they form steps necessary to the development of grounded theory. (see Glaser and Strauss 1967 and Glaser 1978).

2.6 Grounded Theory

Grounded theory is the term used by Glaser and Strauss for their approach to the handling of qualitative data and discovering theory implicit within it. (see Glaser and Strauss 1967, Glaser 1978 and Strauss 1987).

Many subsequent users of Glaser and Strauss's method have commented on their initial difficulty in penetrating the language of the original books. Some users state that workshops are the best way to teach the method, but as this facility was not available to me, I had to rely heavily on other authors to guide my understanding, and found Turner (1981 and 1983) particularly helpful. He states that

> "Grounded theory offers a way of attending in detail to qualitative material .... This approach promises the development of theoretical accounts which conform closely to the situations being observed, so that the theory is likely to be intelligible and usable by those in the situation observed, and is open to comment and correction by them."
>
> Turner 1983:333-4

He argues that descriptive accounts of our every day world

are full of theoretical implications. Making those implications visible and available to rigorous examination, and producing conceptual definitions for them, results in theory which is easily understood by people involved in that every day world and gives them a better understanding of their situation. (Turner 1983:347-8).

The descriptive account of the world to which Turner refers may be the text of in-depth interviews, or the contents of a field diary, or accounts of events observed by a participant or non-participant, or documents from the field under study - or a combination of some or all of these. The researcher should approach the field with as few pre-conceived ideas and theories as possible, having an open and sensitive mind. He should avoid filtering events through pre-existing hypotheses, as Colville (1981:-126) puts it.

The method of data analysis used to discover grounded theory is known as constant comparative analysis. In it, the analyst compares a number of incidents or statements in the raw data, comparing, classifying and categorizing them in different combinations, letting the data themselves suggest labels for the emerging concepts.

These conceptual labels are known as codes, but coding in the discovery of grounded theory is very different from coding in quantitative analysis. In the latter, the codes are pre-conceived categories, whereas in the former, the codes emerge from the data, and should posses one essential

property- that the code label should fit the phenomenon or ideas as exactly as possible. (Charmaz 1983:111, Turner 1981:232, Melia 1982:328).

In the pursuit of grounded theory,

> "rather than following a series of linear steps, the investigator works within a matrix in which several research processes are in operation at once. In other words, the investigator examines data as they arrive, and begins to code, categorize, conceptualize and to write the first few thoughts concerning the research report almost from the beginning of the study."
>
> Stern 1980:21

This is the reason for the four steps involved in the development of grounded theory being arranged in a circle in Lincoln and Guba's flow chart (see Figure 2.5.6, above). From the first tentative design a preliminary round of purposive sampling is undertaken. Miles and Huberman (1984:36-37) writing from a different research stand point from my own, (one they describe as "soft-nosed logical positivism") nevertheless describe this process well. They say that random sampling in the study of social processes reduces data to "uninterpretable sawdust" and that qualitative research is an investigative process which makes gradual sense of a social phenomenenon by contrasting, comparing, replicating, cataloguing and classifying features of it. As the categories become clearer, they help to guide the researcher towards other samples of persons to be interviewed or situations to be observed. This is known as theoretical sampling (Glaser and Strauss 1967:45). When theoretical sampling is followed, the researcher cannot say in advance how many

interviews or observations will be needed, or specify from exactly which groups of people responses will be sought. Data collection is brought to an end by what Glaser and Strauss (1967:70) call "saturation of categories". This is reached when nothing new is emerging from a particular situation or series of interviews.

In the pursuit of theory that is genuinely grounded in the data, the research process continually flows between interviews and observations, analysis, tentative theorising leading to further changes in design, further puposive sampling and so to more interviews and analysis. As Bechhofer (1974:73) puts it

> "The research process ... *is not* a clear cut sequence of procedures following a neat pattern but a messy interaction between the conceptual and empirical world, deduction and induction occurring at the same time."

Emerson (1983:95) speaks of the action of research as moving "back and forth" between data collection and analysis and Bulmer (1984:245) speaks of the interdependence of theory and observation. Baldamus (1982: 221) calls this process "double fitting", using the analogy of a carpenter fitting a new door into a frame, altering each in turn to obtain a better fit. He equates this to the process of informal theorising, restructuring the conceptual framework to fit the data, then going out to look for more data to confirm the concepts, or if the data denies the concepts, altering the framework again. The pursuit of grounded theory, which by its very nature involves a constant movement between data and concept

formation, should answer the quest highlighted by Knights (1984:3) for research that is theoretically penetrating as well as of practical significance.

I have endeavoured to explain some of the distinctive processes used to develop grounded theory, such as theoretical sampling, and to stress the constant interplay between data collection and analysis. These processes lead to hypothesizing about the relationships between categories, and finding links to existing theories and literature. One of the chief means stressed by Glaser and Strauss (1967:107) in the development of theory from the coding process is the writing of memos. These are usefully described by Charmaz (1983:120) as

> "written elaborations of ideas about the data and the coded categories. Memos represent the development of codes from which they are derived. An intermediate step between coding and writing the first draft of the analysis, memo writing then connects the barebones analytic framework that coding provides with the polished ideas developed in the finished draft."

Memos, when put together, form the basis for a tentative theoretical statement, which as Turner (1981:240) states, may not be very elegant but should have a closeness of fit so that participants in the world described may understand it. He also says that the statement should possess a degree of complexity reflective of the real world it represents, even thought it may not readily fall into a neat set of logical propositions.

I find this second attribute reassuring, because the

findings of my own study certainly did not fall readily into a set of logical propositions, yet seemed to the participants to reflect the complexities of their world. Had I only read Glaser and Strauss's works (1967, 1978, 1987) and not other writers on grounded theory, I would have felt I had totally failed to follow their method.

But I find this to be a common reaction. Charmaz (1983:125) says

> "Each researcher who adopts the approach likely develops his or her own variations of technique".

and Melia (1982:334) says that she had put emphasis on the spirit of grounded theory, rather than the letter. She continues

> "Glaser and Strauss's description of the procedures for generating theory, which at times tend to confuse rather than clarify, left the researcher with a sense of having fallen short of their ideals."

Another writer confessing to a "haunting sense of disappointment" with his experience of grounded theory methodology was Brown (1973:6). He had been hoping to gain insight into the role of social factors relating to schizophrenia but concluded that his type of data was unsuited to constant comparative analysis. He decided that the type of material best suited to it was material that was repetitive in character, involved short-term processes, or easily observable sequences of behaviour. Such material may be classified, mapped out and categorised, yielding taxonomies and descriptive theory. What Brown was really

looking for was explanatory theory (1973:2), which the grounded theory process did not produce. It would seem that Brown was working within a conventional positivistic framework of epistemology, where cause and effect are expected to be related in a linear way. Another well-known critic of grounded theory, Ford (1975:220) argued from a similar standpoint.

2.7 The Contrast Between Positivist And Naturalistic Viewpoints

My answer to these critics would be that the notion of mutual simultaneous shaping accounts more convincingly for real life than does a linear theory of cause and effect. One may indeed be left with a sense of disappointment at the untidy and complex picture of organisations revealed by naturalistic inquiry, but I believe that is due to the nature of the social world, not the failure of a research method. The complexity involved in naturalistic inqury is shown in Figure 2.7, contrasting assumptions of the two opposing paradigms.

Figure 2.7 Contrasting Positivist and Naturalistic Axioms

From "Naturalistic Inquiry" (Lincoln and Guba 1985:37)
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Axioms	Positivist Paradigm	Naturalist Paradigm
Nature of reality	Reality is single, tangible and fragmentable	Realities are multiple, constructed and holistic
Relationship knower to known	Knower and known are independent, a dualism	Knower and known are interactive, inseparable
The possibility of generalization	Time and context free generalizations (nomothetic statements) are possible	Only time and context bound working hypotheses (idiographic statements) are possible
The possibility of causal linkages	There are real causes, temporally precedent to or simultaneous with their effects	All entities are in a state of mutual simultaneous shaping so that it is impossible to distinguish causes from effects
The role of values	Inquiry is value-free	Inquiry is value-bound

In addition to cause and effect, another aspect of naturalistic inquiry where separation of two entities is difficult, is the relationship of the researcher with the people or phenomenon being researched. This relationship is described by Lincoln and Guba (1985:37) as interactive. (see Figure 2.7 above). This interaction is described in more detail by Turner, (1981:228) who believes that to develop grounded theory with integrity, there must be a willingness to disclose implicit or subconscious perceptual processes, through which some aspects of the research field

are given more detailed attention than others, and some topics pursued whilst others are assigned less notice. Turner concludes

> "The understanding which emerges from such research must thus be considered the product of an interaction between the researcher and the phenomena under study ... The competent development of grounded theory rests, in part, upon a sensitivity to these often tacit processes of perceiving and understanding, and upon a willingness and an ability to bring them out into the open for discussion."
>
> Turner 1981:228

2.8 Criteria For Trustworthiness In Naturalistic Research

The negotiation of outcomes, which involves the discussion of meanings and interpretations of the research with the human sources of information, is linked to the topic of criteria for trustworthiness which is the remaining subject of this chapter. Quantitative research, as Emerson (1983:100) reminds us, has well tested procedures for assessing validity and reliability which depend heavily on the researcher's unwavering adherence to the preset research design. The flexibility of field research makes such procedures impossible. There is, in addition, a deeper reason for rejecting conventional criteria for trustworthiness - they rest on the assumptions of conventional, positivistic science. As Morgan (1983b:15) points out, different research perspectives are formed in direct relation to their assumptions about what counts as significant knowledge, and to judge one perspective in terms of the assumptions of another quite different view is not feasible. He says later

> "In everyday life we would not normally dream of applying criteria for judging the quality of a cream cake in the assessment of a slice of roast beef. One wonders, therefore, why we engage in this kind of activity in social science."
> Morgan 1983b:393

As already shown on the flow chart (see figure 2.5.6) and on the list of characteristics of naturalistic inquiry, Lincoln and Guba (1985:42-43) suggest the replacement of such positivist criteria for research as validity, reliability and objectivity, by others more in keeping with the axioms of the naturalistic paradigm, such as credibility, transferability, dependability and confirmability.

2.8.1 Credibility

Becker (1970:39) writing on fieldwork methods, generally avoided the terms validity and reliability, asking instead about the credibility of the conclusions.

He proposed three particular aspects of importance in assessing credibility: whether a statement was volunteered rather than given in response to a question, the context of observation or interview, and truthfulness of the respondent. Becker (1970:29-30) believed that volunteered statements were more credible than direct responses to questions, as were observations made or answers given within the context of the respondent's normal working environment rather than in an artificial, "off-the-job" setting. His concern for the truthfulness of the informant stemmed, at least in part, from his positivist standpoint, according to Emerson (1983:103), who himself took a

different view, more in keeping with the interpretive paradigm.

> "In doing fieldwork, researchers are often more concerned with what a particular statement means for the social world in which it was made than simply whether it is true or false .... The lie, once detected, may be even more interesting than the truth, since it opens up a social phenomenon to be explored, understood and explained."

Within the interpretive paradigm, where reality is assumed to contain a multiplicity of constructions, the naturalistic researcher has different criteria for truthfulness. He or she must demonstrate adequate representation of those multiple constructions of reality to the satisfaction of their creators, the participants in the research study. The attainment of credibility, the naturalistic inquirer's substitute for the conventionalist's internal validity, thus requires great attention to feedback of research findings, as well as to the conduct of the project in such a way as to enhance credibility. (Lincoln and Guba 1985:301). One way of doing this is known as "prolonged engagement", the investing of sufficient time to learn the organisational culture and climate and to build trust.

Another is the technique of "triangulation", the use of different modes for data collection, such as interviews, observation and document analysis.

However, Lincoln and Guba (1985:314) believe that "member checking" is the most crucial technique for establishing credibility. This checking includes on-going feedback of

summaries of interviews to the interviewees, as well as reviews of the case-study report by groups within the unit under study. The on-going feedback gives respondents the opportunity to correct factual errors, and challenge interpretations, as well as to add further information. It also leads to an agreed record which makes it more difficult for respondents to claim investigator error or misunderstanding later.

Among sociologists recommending member validation are Douglas (1976:131) and Bloor (1983:172). Bloor found some disadvantages, particularly because the purposes of research participants frequently differed from those of the researcher, leading to differences reconciling accounts which were at variance. However he also highlighted advantages of the procedure: a promise of a member validation exercise may ease access to a research setting, and may reduce anxiety amongst participants. Bloor (1983:172) also acknowledges that some researchers may feel it is a matter of ethics to allow participants to see their account of their interaction. That is certainly true for me, as I aim to conduct research "with" rather than "on" people. For a member validation exercise to be effective, there needs to be an adequate level of involvement amongst participants; if they lack the necessary commitment, their evaluation of findings may be uncritical. (Bloor 1978:551) Finally, any additional material generated by the validation exercise should be treated as new data and subjected to analysis, and previous data re-analysed in the

light of it. The whole process may be a valuable spur to greater reflexivity on the part of the researcher. (Bloor 1983:172, Emerson 1983:107). The process of member validation is also used in grounded theory development, as a way of seeing whether the theory emerging from the data is relevant and earns recognition from the participants. (Turner (1983:347)

2.8.2 Transferability

Lincoln and Guba's second criterion of trustworthiness for naturalistic inquiry is transferability. They say

> "Naturalists make the assumption that at best only working hypotheses may be abstracted, the transferability of which is an empirical matter, depending on the degree of similarity between sending and receiving contexts. .... If there is to be transferability, the burden of proof lies less with the original investigator than with the person seeking to make an application elsewhere .... The best advice to give anyone seeking to make a transfer is to accumulate empirical evidence about contextual similarity; the responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgments possible."
> Lincoln and Guba 1985:292-8

Yin (1984:39) claims that case studies are generalizable in analytic terms, not statistical. By that he means that logical inference enables the analyst to see parallels between two or more situations because the same set of theoretical propositions apply to them both. (Statistical inference by contrast rests on sampling theory and the idea of a sample being representative of a wider population). The distinction between logical and statistical inference is helpfully illuminated by Mitchell (1983:197-200). He

also agrees with Lincoln and Guba about the importance of the inclusion of contextual description in case study.

> "All cases are necessarily contextualized and generalisations made from case studies must therefore be qualified with a ceteris paribus condition. It is incumbent on the observer to provide readers with a minimal account of the context to enable them to judge for themselves the validity of treating other things as equal in the instance."
>
> Mitchell 1983:206

2.8.3 Dependability And Confirmability

The dependability and confirmability of a naturalistic inquiry are closely linked together in Lincoln and Guba's (1985:317) argument. They suggest a process of audit by an external assessor rather in the manner of a fiscal audit by accountants of a firm's financial transactions. This seems similar to Yin's (1984:92) insistence on the maintenance of a meticulous data base of the case study, and following a "chain of evidence". This principle, according to Yin, is similar to that on which criminological investigations are based. The reader of the case study, as an external observer, follows the derivation of evidence from research questions to ultimate case study conclusions. Yin (1984:96) continues

> "As with criminological evidence, the process should be tight enough that evidence presented "in court" - the case study report - is assuredly the same evidence that was collected "at the scene of the crime", during the data collection process; conversely, no original evidence should have been lost, through carelessness or bias, and therefore fail to receive appropriate attention."

A final technique for enhancing credibility and

dependability in a naturalistic inquiry is suggested by Lincoln and Guba (1985:327). They suggest the keeping by the researcher of a reflexive journal which contains not only a day to day record of the study (who was seen, where and when) but also methodological rationales and discussions about decisions taken, and a personal diary revealing the interplay between the researcher's own values and the progress of research. Such a reflexive journal could be used by an external auditor to assess to what extent the fieldworker's own biases influenced the outcome. And even if not used in that way, such a journal is enormously useful to jog the memory during the analysis and writing-up of research.

In concluding this discussion of criteria for judging the credibility of naturalistic inquiry, I would have to agree with Lincoln and Guba (1985:329) that such criteria are open-ended. No amount of checking the reactions of participants, multiplying the kinds and sources of data used, prolonged observation or auditing of the data base can ever compel the reader to agree with the researcher - persuasion is as much as one can hope for. This contrasts with conventional inquiry, where within a closed, experimental system, all variables may be controlled, probability sampling ensures a population that is representative of a wider society, and computer analysis guarantees the accuracy of findings. However, despite the allure of such certainty, there are many areas which are not amenable to such tightly controlled research methods, and need the fresh approach that non-positivistic paradigm

resarch may bring, as Morgan (1983a:386-7) points out. He particularly mentions

> "The naturalistic approach ... may bring theory and practice much closer together than is currently the case, encouraging a theory of practice developed from the point of view of those involved in practice, rather than from that of the detached researcher - observer."

2.9 Conclusion

I began this chapter by highlighting the gap between theory and practice in professions such as nursing and accounting. It is appropriate that I should conclude it by suggesting a way of reducing that gap. In between I have tried to show how the adoption of social science methodology, particularly that associated with the interpretive paradigm, may help illuminate the changes in NHS management particularly as they affect nurses. I gave particular attention to the values and principles of naturalistic inquiry in the form of case study, utilizing grounded theory methodology. I have also discussed ways of establishing the credibility of qualitative research.

Later in the thesis I return in detail to the research process, and the case study, but in the next two chapters, I turn to the development of the NHS and nursing's place within it.

CHAPTER THREE: THE BACKGROUND - THE NATIONAL HEALTH SERVICE AND THE PLACE OF NURSING WITHIN IT

3.0 Introduction

I have mentioned several times already the importance of context in research, and this chapter and the next demonstrate my commitment to that belief. I trace the development of the NHS up to 1983, interweaving that narrative with observations about nursing. I then give an overview of organisation theory relating specifically to the NHS, followed by a brief survey of aspects of nursing that seemed particularly relevant to me in the light of conversations with nurses during the course of my research. I close by comparing insights from organisation theory with those gained from looking at nursing.

3.0.1 Literature Searching As An Aspect Of Naturalistic Inquiry

I deliberately left the writing of this chapter until after the composition of the methodology section, and the description and analysis of the case study material. (Many thesis writers compile their literature reviews before writing anything else.) So much has been written about the NHS and about nursing that rigorous selection is necessary. In keeping with the principles of inductive research and the search for theory grounded in empirical findings, the selection of literature is guided by the themes emerging from the empirical work, as well as its relevance to the whole subject of the case study.

The first aim of the research, as outlined in the previous chapter, was to conduct a case study of one unit of health

care, looking at the impact of management change on the Unit and particularly on nursing. The second aim was to study existing theories and models of nursing and health care organisation, to look for common features and relationships. I then intended to compare the working philosophies of members of the Unit, including their conceptual implications, with the theories expressed in the literature. However, as I read about health care organisation and the development of nursing in Great Britain I found the literature supported Laughlin et al's (1986:18) observation, that the practical aspects of a practice discipline predate theoretical endeavours by many years. History, with some policy analysis, is plentiful, but attempts at theorising are quite recent. The literature is also to some extent journalistic, *rather than* academic, particularly referring to recent events, because I have attempted to be consistent in applying methodological principles. I see the literature search as an aspect of naturalistic inquiry, conducted in the ideographic tradition, referring to subjective experience and making plain the values of participants.

3.0.2 The Importance Of The Research Context

It is my view that too much nursing research is stripped of its context in an attempt to be scientific. One of the underlying axioms of naturalistic inquiry (see Lincoln and Guba 1985:37) is the assumption of mutual simultaneous shaping. Because this study of the research context is an aspect of naturalistic inquiry, I try to show the

interdependence of nursing and its associated theories with the growth and development of health care provision in Britain. In keeping with the interpretive research paradigm, the background, the literature and the case study are seen as an emergent and ongoing process. As Watkin (1982:50) said

> "The N.H.S. as we have it today is the product of more than 200 years evolution. The legacy of the past is everywhere in the present."

3.1 The History Of Health Care And Nursing In England Up To 1948

Because of the need to allow adequate space for discussion of the most recent changes in the N.H.S., and for development of nursing theory, I set out in abbreviated form some historical events in nursing and health care. The figure below aims to bring us up to the inauguration of the N.H.S. with a little idea of the legacy of the past which may from time to time influence the present.

Figure 3.1 Selected features of the history of health care and nursing up to 1948

Middle Ages	Infirmaries and leprosaria attached to monasteries cared for sick poor. Some infirmaries survived the dissolution of the monasteries under Henry VIII (e.g. St. Thomas's, St. Bartholmew's). Most sick people cared for in their own homes.
1719	Foundation of first voluntary hospital (Westminster) by committee of concerned lay people. Others in London and provinces followed. Treatments in hospital given by "dressers" or "apothecaries" apprenticed to physicians and surgeons. Nursing care very rudimentary, not easily distinguished from domestic work, given by working class women.
1834	First acknowledgement of public responsibility for the sick - workhouses designated sick wards, care given by able-bodied paupers.
Mid nineteenth century	Some developments in religious nursing orders, both Catholic and Protestant, including provision of home nursing services in a few areas.
1854-6	Crimean War - Florence Nightingale took party of nurses to Scutari (some members of religious orders, some experienced working class hospital nurses, and some "ladies" - much dissension amongst party). Death rate amongst sick and wounded fell dramatically, Florence Nightingale became public heroine, £45,000 subscribed to Nightingale Fund.
1860	Nightingale Training School for Nurses set up at St. Thomas's Hospital with money from Nightingale Fund. Training regime described as more like religious novitiate than apprenticeship - resulted in unthinking obedience.
1867	Metropolitan Poor Act. Hospitals set up in London for infectious diseases and insanity.
1868	Similar provision for provincial cities and county areas.

Figure 3.1 continued.

Second half of nineteenth century	Steady improvements in public health through cleaner water supplies, better sanitation, housing and working conditions. Use of hospitals increased, especially after introduction of anaesthetics and antiseptic (later aseptic) techniques - but many sick still nursed at home by relatives and paid helpers (handywomen).
	Many hospitals set up Nurse Training Schools - some took "lady" pupils at their own expense - tended to become matrons and form elite group.
1867	Manchester and Salford Ladies' Sanitary Association employed first health visitor.
1887	British Nurses' Association founded, under leadership of Mrs. Bedford Fenwick, to press for statutory registration of nurses. Opposition from Florence Nightingale, much intergroup dissension over registration issue for next 30 years.
1889	Founding of Queen's Institute for District Nursing.
1900	Boer War revealed 48% recruits medically unfit for army service.
1900-10	Setting up of school health service and other preventive measures, and beginnings of availability of general medical practitioners for Friendly Society and Trades Union members.
1902	Midwives Act established Central Midwives Board, keeping roll of Certified Midwives, imposing rules etc.
1907	Notification of Births Act - resulted in increase in health visiting provision.
1911	National Health Insurance compulsory for lower wage earners. (families not covered).
1914-18	1st World War: shortage of trained nurses made up by VADs.

Figure 3.1 continued.

1919	Ministry of Health set up for first time.
1919	Importance of women's contribution to war effort recognised by granting franchise to women.
1919	College of Nursing founded (not granted Royal Charter till 1939).
1919	Nurses' Registration Act passed after Ministry of Health intervened to overrule disputes between factions in nursing. General Nursing Council (G.N.C.) created, Register of trained nurses set up.
1919	Minister of Health required all local authorities to set up maternity and child welfare services, thus increasing numbers of health visitors again.
1920	Dawson Report recommended nationally organised, comprehensive health service - no action taken.
1926	Royal Commission on National Health Insurance recommended separation of insurance provision from provision of medical care.
1929	Local Government Act - transferred responsibility for care of sick poor from Boards of Guardians to Local Authorities. From this date, some L.A.'s made good hospital provision, some did not.
1920's-1930's	Trades Union membership and activity grew amongst nurses in Local Authority hospitals and asylums. Recruitment and retention of staff were problems in all hospitals.
1932	Lancet Commission recommended improvements in nurses' living conditions to attract and retain recruits.

Figure 3.1 continued.

1939	Interim Report of Athlone Committee recommended better pay, shorter hours, improved superannuation and negotiating rights for nurses. Also recommended recognition of lower grade of trained nurse, State Enrolled Assistant Nurse - this initially opposed by Royal College of Nursing (RCN).
1939	On outbreak of war, government funded Emergency Medical Service took over administration of hospitals - voluntary and local government hospitals under one organisation for first time.
1941	Inquiry into state of hospital service revealed enormous inconsistencies of provision and standards.
1942	Beveridge Report recommended setting up comprehensive health care system, as part of welfare state.
1943	Nurses' Act authorised GNC to open roll for State Enrolled Assistant Nurses, and to regulate two year training for this purpose.
1943-8	Negotiations with medical profession, local authorities and voluntary hospitals, on health service organisation, remuneration, responsibilities etc.
1946	National Health Service Act passed.
1947	Wood Report on recruitment and training of nurses, in light of demands of NHS. Recommended training to be removed from control of matrons, under regional units with much greater academic emphasis and less repetitious nursing work, shorter working hours to allow time for study. Opposed by GNC and RCN because of reliance on student nurse labour to staff the hospitals. Not implemented.

Figure 3.1 continued

5.7.48. Appointed Day - the beginning of the N.H.S.

Sources of Information for Table

Abel-Smith (1960), Allan and Jolley (1982) Allsop (1984), Butler and Vaile (1984), Carpenter (1978), Davies (1977), Dingwall, Rafferty and Webster (1988), Ham (1985), Levitt and Wall (1984) Owen (1988), Williams (1978).

3.2 The Formative Years Of The N.H.S.

3.2.1 The Birth Of The N.H.S.

According to Rudolf Klein (1984:84), Britain's NHS is

> "the child of a marriage of convenience between social engineers and idealists, between the values of efficiency and equity."

Klein maintains that there was a consensus across the political spectrum, demanding that the nation's scientific and medical resources should be organised to increase the health and therefore the productivity of the people. There was also a growing agreement at the close of the war that social justice required the provision of a comprehensive health service, free at the point of use, so that equal medical needs should be met by equality of treatment available to all. Clark (1979:205) takes a more cynical view, saying that the NHS

> "took over, organised, fixed, formalized and some would say fossilized what was already there. And it did so in a manner which was determined, not on the basis of society's needs, but on the basis of accommodating the vested interests of those involved in operating it: a compromise package made up mainly of medical protectionism and political expediency."

Owen (1988) describes graphically how Aneurin Bevan negotiated, right up to the last minute before the NHS Act came into force, with the British Medical Association to ensure their co-operation. Bevan boasted later that he had "stuffed the doctors' mouths with gold." (Owen 1988:49).

Despite the justifiable note of cynicism in some quarters, there is no doubt that the establishment of the NHS did

demonstrate the government's firm commitment to developing and improving the health care system of the country. That commitment has been handed on through governments of both main political parties without any serious questioning until the present administration began to debate alternative means to reach the same end during the past nine years.

The NHS Act of 1946 defined the purpose of the NHS as securing improvement in the physical and mental health of the people, and preventing, diagnosing and treating illness. Allsop (1984:12-18) sums up the principles underlying the creation of the NHS as being those of collectivism (the state taking responsibility for its citizens), comprehensiveness (provision of all kinds of health care), universality (available freely to all), and equality (uniformly accessible throughout England and Wales). In addition, Allsop also recognizes that the principle of professional autonomy was enshrined in the foundations of the NHS. She quotes Bevan, in the House of Commons in 1946, saying

> "As I conceive it, the function of the Ministry of Health is to provide the medical profession with the best and most modern apparatus of medicine, and to enable them to freely use it, in accordance with their training, for the benefit of the people of this country. Every doctor must be free to use that apparatus without interference from secular organisations."
>
> Bevan (1946:52)

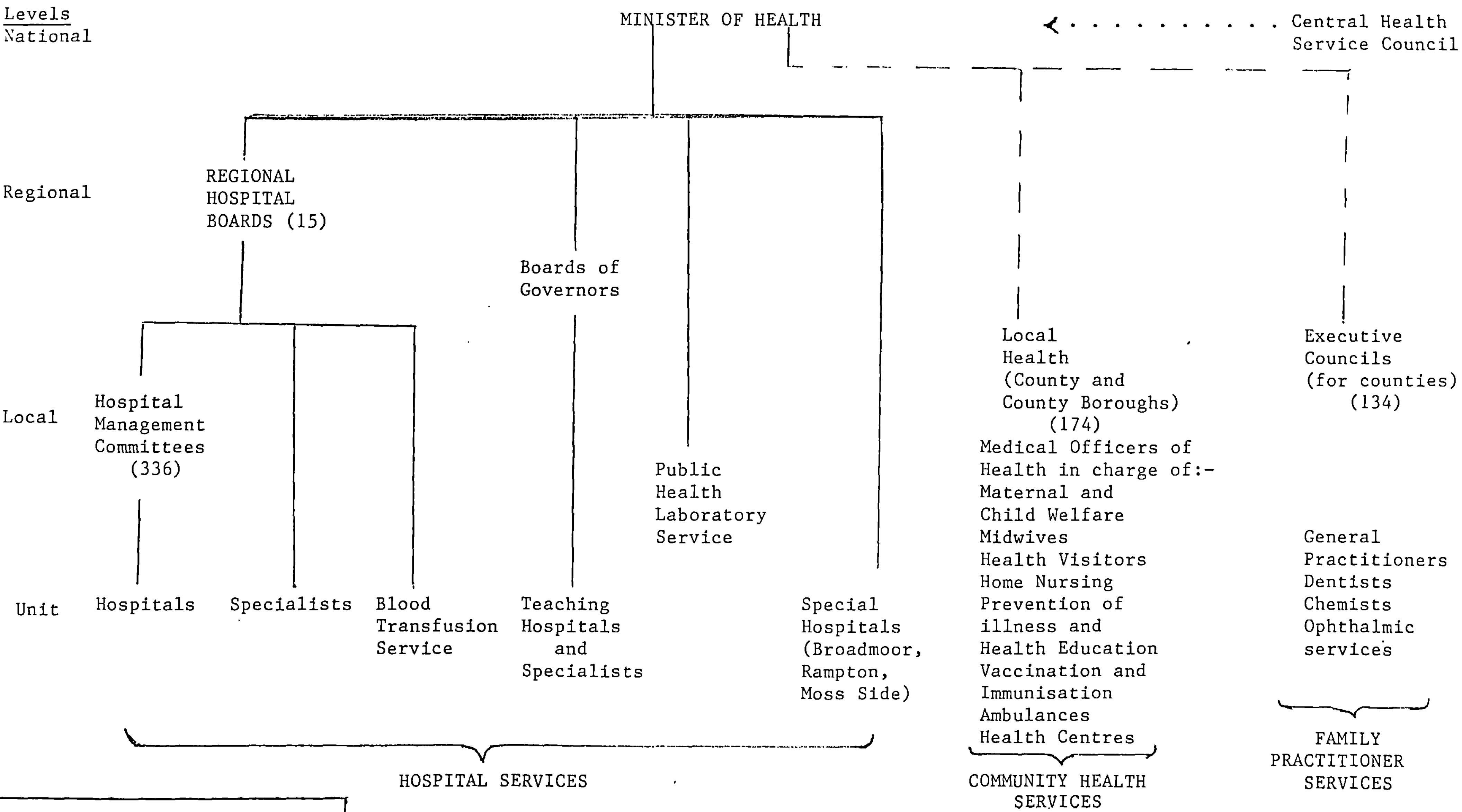
Allsop (1984:18) therefore concludes that Bevan accepted the implications of clinical autonomy - that decisions

about resource allocation in hospitals were the business of consultants, and in primary health were the business of general practitioners (GPs). However, Medical Officers of Health in local government had less scope for the operation of clinical autonomy. Because they were not concerned with individual ill-health, they had to operate within the financial constraints of local government, where decisions frequently had to be reached in competition with other services.

One basic assumption, which later proved false but went unchallenged at the time of the founding of the NHS, helped to soften the impact of the initial expense of the new service. That was the belief that when the reservoir of ill-health, left behind from the bad old pre NHS days, was cleared up it would be relatively simple and inexpensive to maintain the nation in good health. (Thwaites 1987:8).

Figure 3.2.1 shows the tripartite structure (hospital, community and general practitioner services) of the NHS in 1948. The community health services operated under a different frame of reference, organisational outlook and set of resource constraints from the other parts of the service. District nursing services were sometimes operated on an agency basis by nursing associations on behalf of the Medical Officer of Health.

Figure 3.2.1: Organisation of N.H.S. in England and Wales 1948-74.



In the early years of the NHS, services grew at an uneven rate, influenced by local decisions made by the "key service providers" as Allsop (1984:36) calls them - hospital consultants, G.P.s, and Medical Officers of Health. But because the administrative structure of the NHS was heavily biased towards acute hospital care, and hospital consultants wielded more power in those hospitals, especially in the teaching hospitals which were not constricted by so many administrative layers (see Figure 3.2.1), it was the acute specialities that experienced most growth at the expense of facilities for the chronically sick and disabled. As early as 1953, the rising cost of the NHS was causing concern, so much so that the Minister of Health set up a committee under C.W. Guillebaud, to inquire into the reasons (Ministry of Health 1956). The report exonerated the NHS from the charge of wasting resources and did not recommend any major change although one dissenting member, Sir John Maude, suggested that local authorities, if more efficient, could take over and unify the health service.

3.2.2 Nursing - Before And After The Coming Of The NHS

Few writers on nursing up to the middle of this century are remembered except for Florence Nightingale. Her "Notes on Nursing" originally published in 1859, and re-issued in 1974, are still much valued for their insight into the experience of being ill, as well as for the advice to would-be nurses. Nightingale's (1974:79) definition of a nurse was

> "any person in charge of the personal health of another."

She also defined the prime function of nursing

> "What nursing has to do .... is to put the patient in the best condition for nature to act upon him."
> Nightingale (1974:75)

Nightingale wrote of the characteristics needed to be a good nurse; she must be dependable, confidential, sober, honest, devotedly religious and aware of her vocation, extremely observant (and knowledgeable about what and how to observe, and how to report on those oberservations), good at organizing and delegating, sympathetic and able to apply the laws of health to person and environment. (Nightingale 1974:70-75).

Writers considering the legacy of Florence Nightingale to the nursing profession include Davies (1977:480-2), and Oakley (1984:24-5). Davies stresses Nightingale's insistence on discipline and obedience to doctors, sisters and particularly matron. Davies maintains (1977:479+491) that the prevailing professional strategy of nursing, involving deference to doctors, routinization of work and acceptance of a broad range of tasks, was handed on by Nightingale and was still persisting into the 1970's, supported by the hierarchical nature of nurse leadership, and the subordination of education to service needs. Oakley's article (1984:25) supports that view, adding evidence of gender influence to nurses' subservience to doctors, an opinion increasingly canvassed. (Salvage

1985:7, Clay 1987:113, Strong and Robinson 1988:xi).

I cannot find any evidence that any major shift of emphasis in nursing took place, from the time of nursing's recognition as an occupation in the second half of the nineteenth century, up until the early 1960's when I myself was in training, and can recognise the pattern described by Davies (1977). Abel-Smith (1960:247-9) confirms this. He describes the powerful influence of elite matrons in both the G.N.C., and the R.C.N. He also highlights the isolation of hospital nurses through their unsocial working hours and cloistered living quarters, and the lack of communication between nurses and social workers, so that nurses did not see their patients as belonging to the world outside hospital with all its probems and emotions. It would appear, then, that the birth of the NHS, with the associated changes in organisation, had little effect on nursing at the level of everyday practice. There was probably not very much effect at higher levels either, except that possibly the power of matrons in non-teaching hospitals declined somewhat, in that the group secretary became an important figure at the matron's expense.

In addition to the absence of evidence of any change in nursing taking place, it is certinly true that the most powerful influences in nursing at the time, the GNC and the RCN, strongly rejected the recommendations of the Wood Report (Ministry of Health 1947) (see Figure 3.1) thus losing the opportunity for more than a generation to change the whole pattern of nurse training which probably would

have affected nurses' thinking in very radical ways.

3.2.3 The 1960's - Managerialism

The label of "managerialism" has been applied to the period of the 1960's and early 1970's in the NHS by several writers, including Allsop (1984:53) - the managerialist approach culminated in the 1974 reorganisation. Allsop explains how the approach amounted to

> "a policy paradigm, a set of assumptions about the way the world works, and a guide to intervention."

These assumptions included belief in structural change as a means of improving organisational efficiency, with larger units bringing economies of scale, the application of principles of economic rationality, in terms of resource use and division of labour, and the utilisation of systematic planning as a neutral tool for achieving objectives. This rather mechanistic approach has its roots in the scientific management theories of earlier years, and tends to ignore the importance of organisational politics. One of the earliest manifestations of this managerialist thinking in the Ministry of Health was the Hospital Plan for England and Wales (Ministry of Health 1962). The plan paved the way for much new building and hospital modernisation based on estimated ratios of beds needed per head of the population for all the main specialities - a number of new district general hospitals were planned.

Influential voices in nursing began to realise that existing systems of nurse administration would not be

adequate for these new, larger, more complex hospitals. Also Revans's (1964) report on morale in hospitals suggested that management change might improve matters. (Carpenter 1978:95-6). The Ministry of Health set up an inquiry, under the chairmanship of Brian Salmon, with four aims as outlined by Jones et al (1981:4). These were to confirm professional status and coherence in nursing, to improve career structures and the image of intermediate grades, to increase effectiveness and improve patient care, and to bring up to date and democratise the nursing profession. The Salmon Report (Ministry of Health 1966) recommended the adoption of a new hierarchical management system, similar to those found in industry, in which top managers formulate policy, middle managers programme policy, and first line managers execute policy. There were to be clear lines of accountability and control; the new nursing officer level of middle management was intended to combine professional functions such as consultancy in clinical nursing and teaching responsibilities with the expected administrative and personnel functions. Rigorous selection and training for the new managers was proposed, and pilot schemes were to be set up in each region and evaluated. Within a few years, a similar system was proposed for the local authority nursing services in the Mayston Report. (DHSS 1969).

The RCN welcomed the new systems, because

> "they enabled influence to be brought to bear and a nursing voice to be heard at the highest levels of policy making."
>
> Davies 1977:488

Had the recommendations of the Salmon Committee been allowed to take their course, with adequate resources for training and time for learning from the pilot schemes then some of the criticism which followed might have been avoided. However, the National Nursing Staff Committee recommended assimilation of nurses in similar posts (i.e. the old assistant matrons, administrative sisters etc.) without further selection or training, and in 1968 the Prices and Incomes Board suggested immediate implementation of "Salmon" grades as part of a new pay award for nurses. (Jones et al 1981:7, Read 1984:6) This resulted in organisational structures being hastily pieced together with uneven spans of control, and staff with no clinical credibility taking on the new nursing officer posts without being able to fulfil the professional aspects of their new roles.

There is no doubt that the Salmon and Mayston Reports improved the career prospects for nurses, and gave them opportunity to manage resources at a senior level, especially when the 1974 reorganisation of the NHS took place, with its nurse management structures modelled on the Salmon pattern. It also made integration of hospital and community nursing structures easier at that time. (Rye 1982:285 and Carpenter 1978:98). The lack of management training was a serious disadvantage, however, from which the reputation of nurses may not yet have recovered (Strong and Robinson 1988:5). The new nurse management roles were frequently unpopular with the medical profession (Gibberd 1983:913, Watkin 1982:56). Carpenter (1978:89-90)

maintains that the adoption of an industrial model for nursing management involved the abandonment of the service ethic, a change of attitude which Carpenter claims then spread throughout the NHS. The implementation of Salmon certainly opened the way for the advancement of men in the nursing profession, as they were often more confident of their management abilities and also more mobile and could follow jobs across the country more easily than many women with family commitments. (Carpenter 1978:98,101).

Revans's hopes (1964) that changes in management structures would improve nurses' morale were soon dashed. Union membership amongst nurses increased dramatically in the 1960's, and the unions and the RCN both mounted major campaigns for better pay in 1969, threatening the Labour government's prices and incomes policy.

At this time there was also an attempt to create management consciousness in the medical profession through a working party which reported in 1967, colloquially known as the Cogwheel Report. (Ministry of Health 1967).

3.2.4 Preparations For Change In The NHS

In 1968 the Labour government brought the ministries dealing with health and social security together into one giant department, the Department of Health and Social Security, under a Secretary of State, Richard Crossman. Just prior to this, there had been a Green Paper suggesting changes in NHS structure (Ministry of Health 1968) and another followed in 1970 (DHSS 1970). Following a general

election in 1970, the new Conservative administration issued a consultative document (DHSS 1971) and a White Paper on NHS reorganisation (DHSS 1972a). Allsop (1984:61) observed that similarities of approach to problems in the NHS were greater than the differences between the two major political parties on this issue, partly because any proposed change had to be acceptable to the major interest groups within the service. Such a convergent approach proved invaluable because following publication of the management arrangements for the reorganisation (DHSS 1972(b)) and the passage of the NHS Reorganisation Act (1973) under the Conservatives, another election early in 1974 brought Labour back to power just before the appointed day in April when the reorganisation took effect. But before looking in more detail at the reorganisation, I would like to return for a closer view of nursing.

3.3 Nursing - Another Opportunity For Change?

One measure adopted by the Labour government in the late 1960's to try to soothe the unrest over pay amongst nurses was to appoint a committee, under the chairmanship of Professor Asa Briggs

> "to review the role of the nurse and the midwife in hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service."
>
> DHSS (1972(b):1)

Crossman's diary (Crossman 1977:759) for 23.12.1969 reveals the direct link between the pay dispute and the setting up

of the committee. Over half of the committee membership consisted of nurses; they met intensively for a two year period, receiving much oral and written evidence, and conducted their own research programme. Dingwall et al (1988:205-6) take the view that because of the constraints of available finance and manpower, which were strictly limited, the committee did not make detailed costings of its proposals, merely asserting the expected positive returns if they were carried out. It was almost as though defeat was admitted before publication - the managerial interests on the committee let the nurse educationists have their head, knowing that the proposals would inevitably be watered down because of resource implications.

Two main groups of proposal issued from the Briggs Report (DHSS 1972). The first was for a new central regulatory body for nursing, replacing the GNC, with separate national boards for the U.K. constituent countries feeding into it. The second group of proposals outlined a plan for a kind of comprehensive nurse education. There would be a common-core programme of eighteen months, at a fairly basic level, leading to certification; the more able students would continue training for another eighteen months to become registered nurses, and the most able could continue further still, for a higher certificate. Considerable integration of curative and preventive work was envisaged, and only midwifery, of all nursing's specialisms, received much attention to its separate requirements.

Consultation following publication was very long drawn out,

being complicated by NHS reorganisation in 1974, a change of government at the same time, and further unrest over pay which resulted in the Halsbury pay awards, incurring huge increases in NHS spending on staff. Many groups of nurses opposed Briggs's recommendations, especially health visitors, who feared the loss or dilution of their preventive role, and that their one year training course in institutes of higher education would be jeopardised. Eventually, after almost a decade of argument amongst nurses, the Nurses, Midwives and Health Visitors Act reached the statue book in 1979. The Act dealt with the professional regulation aspects of the Briggs Report, setting up the United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting, with its four constituent national boards. No further action was taken on the educational proposals of Briggs, and again, as in 1947-8, lack of unity within nursing meant that the opportunity to make fundamental changes in nurse education was lost. This could have had far-reaching effects on the whole profession.

3.3.1 Higher Education And The Growth Of Nursing Research

The first suggestion of university education for nurses had come from Mrs. Bedford Fenwick in 1898 (Hayward and Lelean 1982:197 and Chapman 1982:174). Despite the rejection of the Briggs proposals, there were some signs of a change in the intellectual climate of British nursing. Writing soon after the birth of the new academic nursing journal, the Journal of Advanced Nursing, Chapman (1976:111) celebrates

a decade of development in which several nursing departments had been set up in British universities, supplying an increasing number of graduate nurses who would not only care for patients but also question accepted methods, roles and attitudes amongst nurses and undertake research.

The Briggs Report (DHSS 1972C:108) contained a much quoted phrase

> "nursing should become a research - based profession."

The remark is immediately qualified by the statement that serious research would only be actively pursued by a minority, but that research awareness should be encouraged in all nurses. During the 1960's, the Ministry of Health (later DHSS) appointed their first nursing officer for research, (H.M. Simpson). Miss Simpson developed a strategy to encourage research education for nurses, better dissemination and implementation of research findings, and the provision of focal points for development of research programmes (Lelean 1980:5, Hayward and Lelean 1982:198). The DHSS set up nursing research liaison groups for nursing practice, education and service (management). The groups identified research needs, commissioned research and assessed the relationship of results to policy and practice. Several regional health authorities were encouraged to appoint nursing research liaison officers and the DHSS began a scheme of sponsoring nurses to take higher degrees. They also helped to finance the publication of

the first series of nursing research monographs by the RCN. (Lelean 1980:5-7). So, although the 1970's did not see the general adoption of change in nurse education, there was nevertheless a growing acceptance in some circles of a new outlook.

3.4 The 1974 Reorganisation And Its Aftermath

There were five main aims of the 1974 reorganisation of the NHS. (Allsop 1984:61 and Levitt and Wall 1984:18).

1. To improve co-operation and encourage continuity of care between hospital, community and G.P. services.

2. To enhance rational planning of health services by creating Area Health Authorities to coordinate strategic planning (fed downwards from DHSS and Regional Health Authorities) with delivery of care at District level. Area Health Authority boundaries were made co-terminous with local government boundaries to facilitate co-operation.

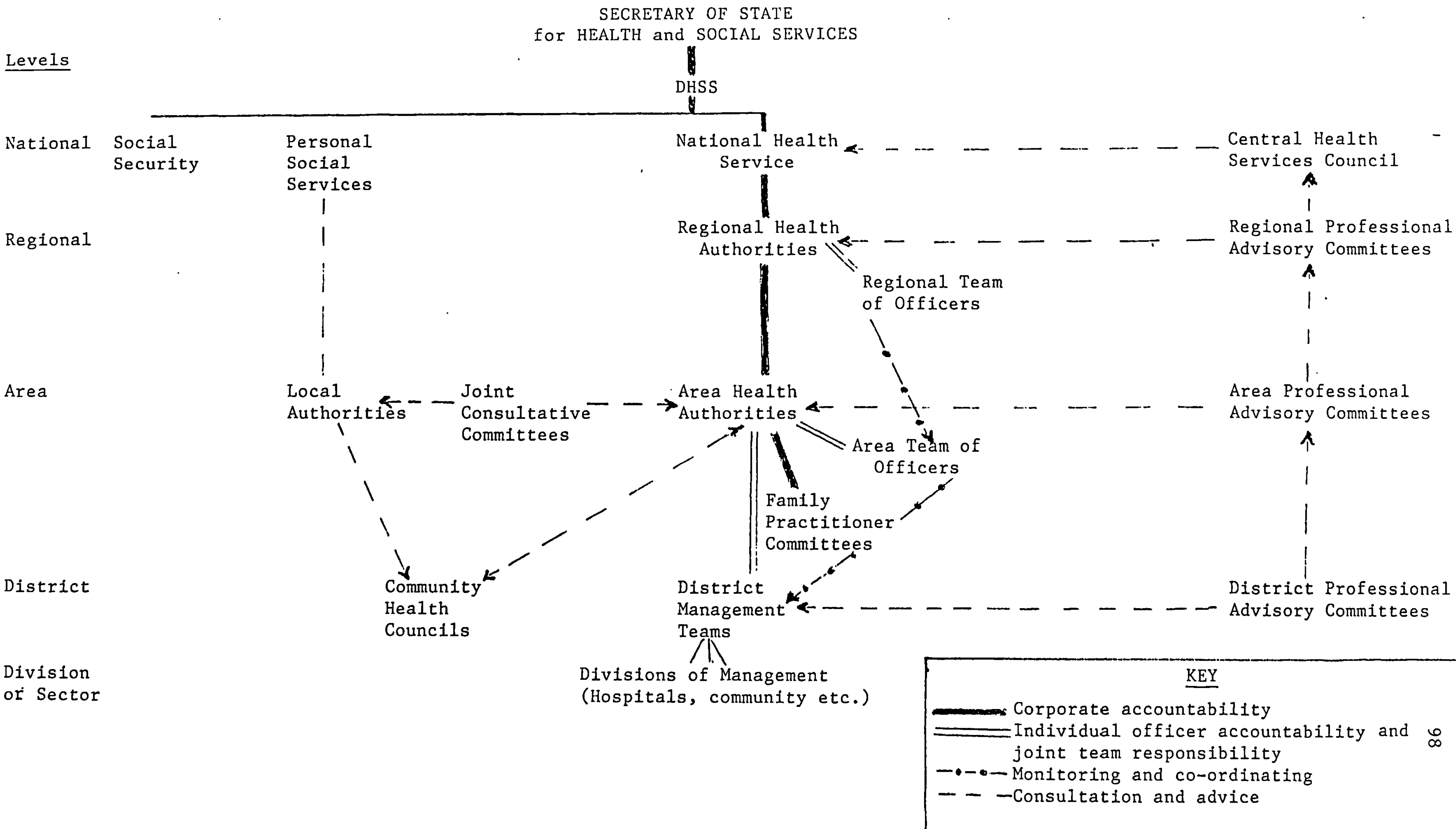
3. To enhance the implementation of central government policies on equalising access to care, and encouraging better care for the chronically sick, handicapped and elderly.

4. To strengthen management at all levels, encouraging "delegation of responsibility downwards, matched by accountability upwards."
   (DHSS 1972a)

5. To increase democratic decision making through consensus management by teams of officers at Region, Area and District, by the introduction of Regional and Area Health Authorities and the creation of Community Health Councils.

The planning systems and detailed management structures laid down by the DHSS (1972b) were typical of the rational management movement of the time and are represented diagrammatically in Figure 3.4.

Figure 3.4: Organisation of N.H.S. in England and Wales 1974-1982



However, in addition to managerialism other influences were also present in the 1974 reorganisation of the N.H.S. Clinical autonomy for the medical profession was still very much alive, even strengthened by the power of veto held by each member of the consensus teams at regional, area and district levels, and in right of access to regional and area health authorities by medical team members. Consultant medical staff contracts continued to be held at regional level.

Another influence perhaps intended as a balance to the professional and managerial mechanisms was the introduction of an element of democracy. Members of regional and area health authorities were still appointed by the Secretary of State, but included elected members of local authorities as well as health professionals and university staff. Community Health Councils were created to represent the public interest, and their membership included those concerned with particular groups such as the elderly and handicapped, as well as with ethnic groups and geographical areas. They could contribute to planning deliberations as well as acting as "watchdogs" for the public interest. A further democratic trend was representation of professional and trades union entities in professional advisory committees and staff councils, as well as the recognition of nurse managers as fully fledged officer team members at region, area and district level.

3.4.1 Problems Following The 1974 Reorganisation

It took more than two years for the very complex changes to work through the NHS. Even whilst the reorganisation was being completed, disquiet was growing over its consequences. Planning was a particular problem area; according to Levitt and Wall (1984:26) this was largely due to area health authorities postulating theoretical assumptions of need based on statistical analysis and the views of professional advisers which differed from the practical proposals of district teams of officers which were based on daily experience of managing the service. Allsop (1984:66) says

> "The planning system represented, par excellence, a belief in rationality. It was based on the assumption that problems could be analysed, future trends predicted, and a policy developed to provide for future contingencies. Planning was seen as a neutral tool, as a way of directing resources to identified priorities and needs."

But Allsop (1984:138) concludes that in practice, the planning process has been mainly an exercise of the bargaining and negotiating skills of the medical profession.

The second element in the disquiet over the 1974 reorganisation was management, and in particular relationships between area and district level, and also the growing strength of the different functional management hierarchies. Teams of officers at district level were not managerially accountable to officers at area level, but could be monitored by them, which caused resentment. Schofield (1985:6) describes the management structures of

1974 as resembling "a series of unrelated professional pyramids" He points to the large territories of the area authorities tending to make them remote from patient care. Levitt and Wall (1984:26) agree with this diagnosis, further explaining that the sense of remoteness from patient care was partly to do with the new boundaries, which though co-terminous with local government often bore no relation to catchment areas of district general hospitals. It seemed that the district management teams had the most satisfying role to play, and in fact the reorganisation worked quite well in areas which only comprised one district, so that area and district teams were one and the same. This tended to happen in fairly compact urban areas, rather than the large county areas. I observed this personally as I worked for part of this period in a single-district area and then moved to a multi-district area and sensed the loss of dynamic purpose in the management atmosphere.

The three areas of disquiet, planning, management and the area health authorities' remoteness from patient care, in conjunction with rising costs (partly due to the large increase in staff, estimated at 16,700, to service all the new departments) caused concern to the Labour government. When this concern coincided with industrial relations problems in the NHS in 1976, the government decided to set up a Royal Commission. (This was a favoured strategy of governments of this period). The Commission's (chaired by Sir Alec Merrison) terms of reference were

> "to consider, in the interests of both patients and staff, the best use and management of financial and manpower resources of the NHS".
> (Merrison 1979:1)

3.4.2 The Effect Of Economic Pressure On The NHS

Before considering the findings of the Commission, I wish to turn to wider contextual issues which were affecting the NHS in the 1970's, and which have been highlighted by Allsop (1984), Butler and Vaile (1984), Maxwell (1988) and Thwaites (1987). The oil crisis of 1974 precipitated most of the developed countries into revision of their economic assumptions, including how much government spending could continue to be directed towards health care. As the decade progressed, and inflation increased, advances in medical science and technology continued apace, raising public expectations and hopes that many more ills could be alleviated or cured. At the same time, demographic pressures became increasingly evident, in that the number of elderly people surviving to extreme old age as rising, and this group make very heavy demands on health care resources. Thwaites (1987:8) sums up the increased demand by speaking of "exponential expectation", and several means were used to try to resolve the lack of fit between the expectations and the resources available to meet them.

The Report of the Resource Allocation Working Party (RAWP for short) was published in 1976. It aimed

> "to provide a formula so that health resources could be distributed on the basis of need .... (to give) equal opportunity of access to health care for people at equal risk."
>
> Allsop (1984:93)

Nahapiet (1988:339) explains how different measures of need were combined and used for establishing "target" allocations of funds to the NHS regions. Similar calculations determined targets for individual areas and districts and these were then compared with existing levels of resource allocation in the various regions, areas and districts, thus revealing which were under and which over resourced.

The application of the RAWP formula to the allocation of resources in the NHS is now seen as a watershed in the life of the service (Thwaites 1987:9 and Schofield 1985:6).

> "For the first time health authorities were forced to recognise that the process of seeking to solve problems by pressing for more money had to stop. The formula could not hear them. Authorities thus began to spend less time in a position of supplication to the next level upwards and more time in focusing inwardly on tackling problems and making more effective use of resources."
>
> Schofield (1985:6)

Attention was focused on two particular approaches to problems, priority setting and cost saving. Two policy documents on priorities were issued (DHSS 1976 and 1977a) to try to improve services in the non-acute areas, but because both RAWP and the priorities approach involved "robbing Peter to pay Paul", there was also a search to find ways both "Peter" and "Paul" could save money. David Owen, then Minister of Health, suggested some possible

places to look - drug prescribing, procurement, space utilisation, maintenance, land disposal, and catering and domestic services. (Owen 1976).

3.4.3 The Royal Commission On The NHS (1979)

Whilst considerable progress was being made, at least in defining concepts as well as problems in the NHS, the Royal Commission (set up in 1976) had been gathering its evidence. It presented its report in 1979, shortly after the general election brought a new Conservative government to power. In the Commission's Report (Merrison 1979) the issues already discussed featured prominently. These were the need for greater efficiency and effectiveness, for redistribution of resources towards the "Cinderella" services and underprivileged areas, and the weaknesses of the 1974 reorganisation. Also highlighted was the need for better, more accurate information and statistics, and for more stress on health promotion and prevention of illness. Near the beginning of the Report (1979) the commissioners stated that politicians and public were broadly in agreement that the NHS should continue as a publicly funded service, but that the service lacked detailed and publicly declared principles and objectives, relying instead on policies which changed according to particular government priorities. The Commission therefore declared its belief that the principles of the NHS should be to:-

> "encourage and assist individuals to remain healthy; provide equality of entitlement to health services; provide a broad range of services of high standard; provide equality of access to these services; provide a service free at the time of

> use; satisfy the reasonable expectations of its users; remain a national service responsive to local needs.
>
> (Merrison 1979:9)

Thus the Commission restated commitment to the founding principles of the NHS, and whilst recommending simplification of management structures by cutting out the area tier, reinforced belief in the practice of consensus management provided that there was a clearly identified responsibility to implement team decisions.

One of the research papers accompanying the Commission's Report (Kogan 1978) criticized the mechanistic aspects of the 1974 system, particularly the rational assumptions of the planning system, and stressed the need for values to be openly discussed, and the political nature of planning to be recognised. The thrust of the Repot (1979) therefore was towards a more organic approach, whilst retaining a strong allegiance to what Klein (1982) calls the "social equity model" of health care. In this model

> "equal needs.... should get equal treatment. But while consumers may have requirements or make demands, it is experts who define needs."
>
> Klein (1982:395)

Klein calls this reliance on the expert opinion of service providers "technocratic paternalism," and argues that it is implicit in the social equity model of health care.

3.4.4 The Royal Commission's Views on Nursing

One member of the Commission, out of a total of sixteen, was a nurse-Professor (later Baroness) McFarlane, of

Manchester University, well known for her research and writing. The Commission (Merrison 1979 chapters 4 and 13) underlined the centrality of the caring role of nurses and the economic importance of the nursing workforce as the largest staff group within the NHS, whose pay accounted for one quarter of the service's current expenditure. RCN evidence to the Commission on concern over falling standards of care was taken seriously, and the Commission was disappointed that so little action had followed the Briggs Report (DHSS 1972c). They dispelled the myth that the number of nurse administrators had risen since the implementation of the Salmon Report (Ministry of Health 1966), depleting the wards of experienced sisters; they recommended the development of the role of clinical nursing officers, clinical nursing specialists, and joint appointees for teaching and clinical leadership. The Commission also recommended (Merrison 1979:206) a research programme on the use of unqualified nursing staff and on the composition of ward teams (incorporating a concern for role overlap between registered and enrolled nurses) more work on manpower planning and recruitment policies, and separate district budgets for the development of post-basic education for nurses.

In the years since the Commission reported, much change in the NHS has tended to overshadow its work, but events have reinforced the Commission's emphasis on the importance of nurses as the major carers within the NHS, and on concern over standards of care. Work has progressed on skill-mix in nursing teams (NHS Management Board 1986) and the

clinical career structure (Clinical Grading Review 1988), much attention is being given to recruitment and retention of nurses, and to changes in nurse training (UKCC 1986), and there is now widespread recognition within the nursing profession of the importance of post-basic and continuing education.

3.5 Accelerated Change In The NHS

The newly elected Conservative government quickly followed the Commission's Report with its own consultation document, "Patients First" (DHSS 1979), setting out its philosophy as follows:-

> "The needs of the patient must be paramount. Whatever structure and management arrangements are devised must be responsive to those needs. The closer decisions are taken to the local community, and to those working directly with patients, the more likely it is that patients' needs will be their prime objective."
>
> DHSS (1979:1)

The principal means of change proposed was abolition of the area tier of management, with district health authorities becoming the

> "key accountable body in the new structure, responsible for providing services as well as planning for them."
>
> Allsop (1984:128)

Each district would be based around one (or more) district general hospital(s), typically serving a population of between 200,000 and 500,000: management was to be in the hands of a team consisting of an administrator, a treasurer, a district medical officer (community physician), a nurse, a consultant and a general practitioner. The management team could decide their own structures below this level, as to how the units were to be planned, whether by geography or by care group; but each unit was to be managed by a team of administrator, nurse and medical representative, and was to have its own budget.

Consultation was followed by an Act of Parliament (1980) and a health circular (DHSS 1980) HC (80)8, "Health Service Development, Structure and Management" which followed the recommendations of "Patients First". Later, documents giving guidance on personnel aspects of re-organisation were issued to protect staff interests, especially for area authority staff. April 1982 was the date set for the changes, but "shadow" district authorities were set up early in 1981 and began making appointments to district teams of officers later that year, in readiness for the changeover.

In February 1981, the Secretary of State, Patrick Jenkin, sent out a handbook "Care in Action" (DHSS 1981) to chairmen and members of the new district health authorities. In his prefatory letter, he said

> "I am sure you do not need reminding that the Government's top priority must be to get the economy right; for that reason it cannot be

> assumed that more money will always be available to be spent on health care."

The Secretary of State stressed the need for each person to be responsible for his own health, and to be aware of the duty to help others, before highlighting the increase in local freedom to plan services, whilst observing national priorities for improvement in care for the elderly, mentally ill or handicapped, and the physically disabled. The handbook suggested a strategy for health promotion and illness prevention, and encouraged collaboration with social services, voluntary groups and the private sector; attention was particularly given to the possibility of fund raising through the voluntary and private sectors, and the expansion of community care for the priority groups mentioned above. The handbook also discussed monitoring and encouraging both quality and efficiency in the NHS, and the chapter on the statutory services was sandwiched between those on the voluntary and private sectors.

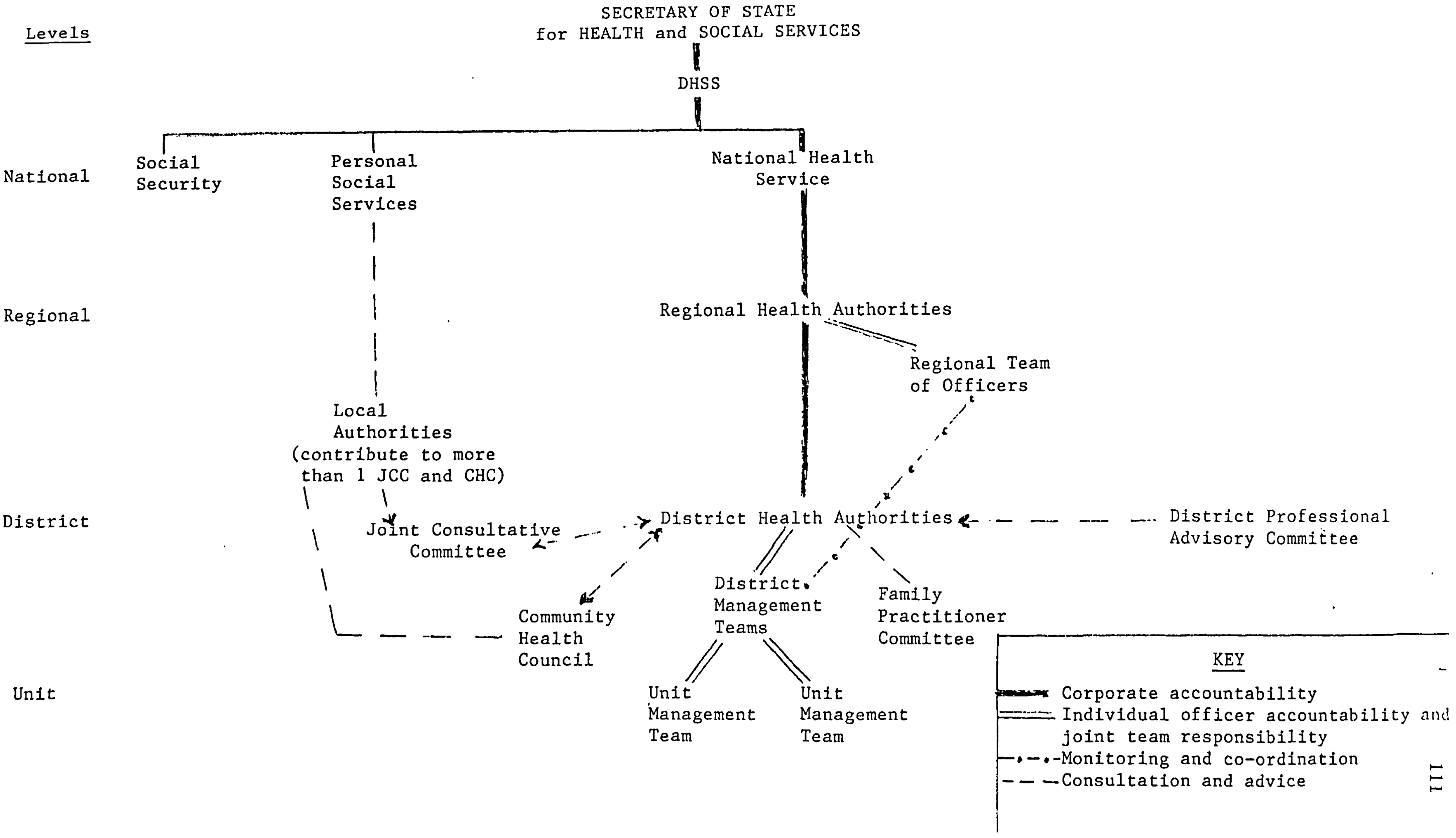
The significance of the "Care in Action" handbook is highlighted by Celia Davies (1987) who speaks of "a new conception of the D.H.A." whose role is to become more co-ordinative, more entrepreneurial, mixing public, private and voluntary services. She comments

> "If the task of the DHA was not so much to provide services, but to orchestrate them, then DHA's needed to experiment with different patterns of care. And what had to be demonstrated to the centre was not that health authorities had provided resources to a given level, but that the DHA had provided services that represented value for money."
>
> Davies (1987;307)

3.5.1 The 1982 Reorganisation Of The NHS

April 1982 ushered in the changes in NHS organisation set out in the circular HC(80)8 (DHSS 1980), with the new District Health Authorities as the key service providers and planners. (see Figure 3.5.1) Despite the stress and turbulence for many senior staff, particularly those who had worked at area level, there was generally more satisfaction with the new management arrangements than there had been with the 1974 structures. It was estimated that management costs had fallen from 5.12 percent of the total NHS budget in 1979-80 to 4.44 percent in 1982-3. (Ham 1985:31). However, relatively little has been written specifically about the effects of the 1982 reorganisation because it was so soon followed by further changes, even before some of the unit level appointments were made.

Figure 3.5.1: Organisation of NHS in England and Wales 1982



I will go on to discuss those changes in the following chapter, but first I want to try to go further to meet the second aim of my research endeavour, as outlined at the beginning of this chapter. This was to study existing theories and models of nursing and health care organisation, to look for any relationships, and to then be able to compare these theories with the empirical findings of the research project. So first I will try to give an overview of organisation theory specifically relating to public service organisations, and then look at theory developments in nursing.

3.6 Organisation Theory and the NHS - an overview

Organisational theorists who write about public service organisations often like to construct figures contrasting the differences between such organisations and their counterparts in the worlds of business or industry. Such lists have the danger of exaggerating one side or the other, and of over-simplification. However, I believe that a list may prove useful here, despite the drawbacks, because the next chapter will show how much recent health service policy rests on government assumptions that differences are vastly overstated, and that treating the NHS as if it were a business is the best strategy. Figure 3.6 shows some widely acknowledged differences between the NHS and business organisations.

Figure 3.6 Differences between the NHS and business organisations

Factor	NHS	Business
Motive	Service	Profit
Goals	Multiple, contradictory	Relatively clear
Aim	To encourage health and therefore reduce demand	To stimulate demand and increase product dependency
Resource base	Public taxes	Private capital
Beneficiaries	Patients	Shareholders/ owners
Rewards/ incentives	Increasing workload leads to increasing costs and possible financial crisis	Increasing workload leads to increasing income generation
Expansion limited by	Lack of funds and staff	Lack of consumer demand
Degree of public visibility	Enormous	Relatively slight
Orientation and loyalty of workers	Primarily to own profession and clients	Primarily to the firm
Transformation process	Staff/client interaction - depends on consent. Difficult to monitor Tends to paternalism	Employee/product interaction-easy to monitor. Employee/customer interaction - the customer is always right
Output	Relatively hard to measure. Cause and effect not always easy to identify	Relatively easy to measure
Awareness of need for value for money	Slow to develop	Well developed
Primary environmental influences	Political and professional communities	Economic and industrial factors

Sources Hasenfeld and English (1974) Kouzes and Mico (1979) Edmonstone (1982) Clark (1986) Williamson (1986)

3.6.1 Characteristics Of The N.H.S.

The characteristics of the NHS shown in Figure 3.6 are further accentuated by Rudolf Klein (1982:386) and shown below in Figure 3.6.1.

Figure 3.6.1 Characteristics Of NHS (derived from Klein 1982)

Characteristic	Demonstrated in:
Complexity	Health care requires co-operation of wide mix of skills - from doctors to porters. (141 occupational groups represented in DHSS)
Heterogeneity	Covers wide range of activities - from acute curative services to care of mentally handicapped.
Uncertainty	Of relationships between input and output. (No certainty that given input will result in regular quantity of health.)
Ambiguity	Of interpretation of statistics - e.g. number of patients treated maybe regarded as success or failure depending on objective - whether to provide treatment or to prevent ill health.
Dominated	By professional providers rather than consumer demand.
Clientele	Defined and selected by staff of organization.

Characteristics such as these are listed by Hasenfeld and English (1974:8) as barriers to rationality and would therefore demonstrate why efforts to impose rationality on the NHS in the 1960's and 1970's were largely unsuccessful. Butler and Vaile (1984:115-21) describe how many NHS

decisions are taken, not

> "in an ideal world of enlightened motivations, shared values and the ready access to relevant information. Rather, they are taken in the real world where information is limited, uncertainty abounds, time is in short supply, values conflict, and people are often struggling to maintain their own best interests. The context of decision-making is one of political awareness and conflict, in which people are often more concerned to avoid mistakes than to create possibilities."
> Butler and Vaile (1984:116)

The world of the NHS, as described above, has much in common with the "organized anarchies" as depicted by Cohen, March and Olsen (1972) and Cooper, Hayes and Wolf (1981), which are often said to be "loosely coupled", a term much used by Weick (1976). Hasenfeld (1983:176) explains how public (or human) service organisations have problems with their internal structure and management controls which differ from business organisations. Their work units appear to be only weakly connected to each other and the centre - such structures evolve in response to their turbulent environment, their way of working through client encounters and their combinations of professional and managerial staff. To a casual observer the organisation may appear to be in disarray and slow to respond to public pressure. Hasenfeld (1983:176) comments that efforts to make public service organisations more efficient often concentrate on designing more centralised and tightly-coupled structures and procedures but that such solutions are often counter-productive because they ignore the dilemmas and particular needs of these organisations. He warns of the danger of substituting measures of

efficiency and productivity in place of the more elusive measures of effectiveness and quality, leading to steady, if unobtrusive debasement of services. Typical methods used would be offering services on a group, rather than individual basis, substituting para-professionals or agency staff paid out of a different budget from regular staff, or forcing professional staff to handle their own clerical and routine work, thus reducing their time spent with clients. Such measures are commonplace in today's NHS.

3.6.2 Domain Theory And Its Implications For The NHS

The writings of theorists concerned with the characteristics of human service organizations helped Kouzes and Mico, two American consultants in organzational development, to go further, and test out the proposition that human service organisations are made up of three distinct domains - a domain being defined as

> "a sphere of influence or control claimed by a social entity"
>
> Kouzes and Mico (1979:456)

The three domains are the Policy Domain, the Management Domain, and the Service Domain. Each operates by different principles and work methods and has different measures of success, and the interactions between them create conflict and discord. Kouzes and Mico's (1979) work has been augmented by Edmonstone (1982) and Smith (1984b) in the U.K., and the following figure, Figure 3.6.2 draws on all four authors' ideas.

Figure 3.6.2 Domain Theory

	Domains		
	Management	Service	Policy
Principles and orientation	Bureaucracy Hierarchy	Collegiality Autonomy Profession	Democracy Representation
Measures of Success	Efficiency Effectiveness Cost-saving	Quality of care Professional standards	Equity Fairness of decisions
Mode of work	Rule following	Problem solving	Negotiating

Edmonstone (1982:293) maintains that the differences between the domains tend to reinforce their separate identities and

> "inhibit the development of a common vision for the organisation .... People in each domain collect information needed to perform their own roles and selectively ignore or discount information from other sources, and thus frequently arrive at incompatible conclusions."

Similar analyses of health care systems have led to very similar classifications by other writers. Alford (1975) writes of "structural interests" in health care - these are the professionals, who are dominant, (in other words, the doctors), the corporate rationalisers (administrators), who are challenging that dominance, and the community, whose interests are repressed. Alford's ideas are quoted by both Ham (1985:195) and Allsop (1984:8). Williams (1985:3) suggests a very similar classification, but bases it on the work of Hultin (1984). However, Williams adds a fourth domain, that of accounting, whose principles and success measures mirror those of the management domain, but whose

working mode is budgeting and auditing.

Edmonstone (1982), Smith (1984b) and Williams (1985) all suggest that the conflicting interests of the domains may be at least partly resolved by attempts of each to understand the other domains' assumptions, objectives and principles, and the pressures that each put upon the other. Smith (1984b:6) proposes,

> "people in the various domains need to be given the skills likely to produce change in the other domains. These include role analysis and negotiation; influencing skills; individual change techniques; team building etc."

Williams (1985:6) goes further, and speaks of "interpenetration of territory" by the representatives of the different domains, lessening the areas of exclusive control over parts of the system by recognised experts such as accountants. He pleads for more flexible and imaginative organisational structures, styles of behaviour and management training and development. The organisational image he projects would have much in common with Morgan's (1986:104) metaphor of the organisation as a hologram; each part of the system contains all the information belonging to the whole of it - everything is enfolded or encoded in all the parts. It is interesting that Morgan (1986:104) sees likenesses between the characteristics of self-management and learning through action, that are exhibited in the innovative firms described by Peters and Waterman (1982), and the characteristics of holographic organisation. Many

commentators on the NHS see the influence of Peters and Waterman's book, "In Search of Excellence", as playing a great part in changing the structure and culture of the NHS after 1983, which will be the topic of the next chapter. But first, I must fulfil one other objective of this present chapter, to look at recent developments, particularly theoretical ones, in nursing.

3.7 Recent Nursing Developments - an overview

In the opening chapters of this thesis I explained how the insights of a number of different academic disciplines were involved in studying the NHS and nursing's place within it - history, politics, economics, sociology, philosophy, organisational theory and behaviour all play their part. Because of the breadth of these different perspectives, it is difficult to achieve depth at the same time; so inevitably this overview, which includes an attempt to examine recent developments in nursing theory, is rather shallow. I make no further apology for this because I have stressed the importance of seeing recent changes in the NHS within their historical and organisational context and most of this chapter has been devoted to that purpose. I put forward the view earlier that nursing knowledge encompassed aspects of science, aesthetics, morals, personal relationships, practical skills and communication. All of these features will become apparent in the following pages: often they are closely intertwined and cannot be separated, as I discuss such topics as the role and function of the nurse, her philosophies and values, her education and the

theories that underpin all these. There has been a tremendous proliferation of literature on all these topics since the early 1970's, some of it of transatlantic origin. For this reason, there will often be a number of references for any given point, but I feel that even a brief overview will increase awareness of the position of nurses in the mid 1980's as they face further organisational change. The period covered by the overview will range from the 1970's until 1988, thus encompassing the time of greatest turbulence (so far) within the NHS.

3.7.1 The Role And Function Of The Nurse

There has been discussion and disagreement over the role and function of the nurse ever since Florence Nightingale sub-titled her famous "Notes on Nursing" (1859 and 1974) "What it is and what it is not". Two of the early titles in the RCN's Research Series "The Study of Nursing Care" tried to find some agreement on the role of the nurse, with little success. Lamond (1974:10) wrote

> "No source tapped could give the writer a uniform conceptualisation of nursing, and she found little evidence of a uniform, basic philosophy of nursing."

However, she did find some consensus that nursing is composed of three aspects, task performance, interpersonal relationships and commitment to nursing values (Lamond 1974:83). A year earlier, in the same series, Anderson (1973:27) described the nursing role in terms of a list of activities such as carrying out treatments, making observations, giving basic care, talking to patients and

relatives and assisting doctors. Neither of these authors mentioned the definition given by Briggs (DHSS 1972(C) : 44)

> "The central role of the nurse is to ensure the care and comfort of the person being nursed, to maintain oversight and co-ordination of that care and to integrate the whole - both preventative and curative - into an appropriate social context."

Briggs, in his turn, did not quote Virginia Henderson, an American nurse, whose definition is now very widely accepted amongst nurses, which appeared initially in 1961, and again in 1966.

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work ... she initiates and controls; of this she is master. In addition she helps the patient to carry out the therapeutic plan as initiated by the physician."
> Henderson (1966:15)

The English writers' of the early 1970's neglect of this definition is probably symptomatic of the slowness with which nursing ideas crossed cultural barriers then, in comparison with today's rapid dissemination through international journals and conferences.

Slightly later definitions of the nursing role stressed the importance of the nurse-patient relationship (Chapman 1976:112 and Allen 1977), and an official prescription (DHSS 1977 b) declared that nursing involved the promotion of health, the prevention of illness, the care of the sick

and rehabilitation, with caring for people being the essence of the professional role. Despite the growing discussion of the nurse's function. Clark (1982:131) still lamented that

> "Many people (including some nurses) still see nursing merely as a collection of tasks undertaken on the initiation of, and under the direction of doctors for the sole purpose of assisting the medical function."

Wilson-Barnett's "Key Functions in Nursing" (1984:p6-12) reflects the notion of nursing knowledge having scientific, aesthetic, personal, moral, practical and communicative aspects. She gives five functions - understanding illness from the patient's viewpoint, provision of continuous psychological care, helping the patient to cope (but not encroaching on his own ability to care for himself), providing comfort and co-ordinating treatments.

As early as 1972, Briggs reported that nurses and midwives found systems of task allocation and a "production line concept of care" frustrating, and stressed the need for patient-centred systems of care. (DHSS 1972C:41). This emphasis has continued to be made - see for instance Rye (1982:292), Melia (1987:29 and 45) and Wright (1986:65) amongst others. One of the harmful aspects of task allocation systems of nursing, as seen by McFarlane (1976:191) Williams (1978:41), Pembrey (1985:48) and Clay (1987:87) has been the division of nursing work into basic and technical care, terms first used by Goddard (1953) in

research using work-study methodology. Williams (1978:41) particularly, in studying the ideology of professionalism and of vocation, draws attention to the need for recognition of the personal worth of helpless patients. In that light bedside nursing becomes

> "a complex compound of actions and tasks performed in a context of social relations,"

and not just a job to be assigned to an untrained helper whose custodial attitude may damage personal dignity.

3.7.2 Nursing Values

Thus, almost imperceptibly, the discussion has moved from consideration of the nurse's role and function to questions of values and professional philosophies. I am aware that my use of the term philosophy would be classified by serious nurse philosophers such as Schrock (1981:171) as colloquial rather than rigorous. I use it in the simple way described by Hewitt (1985:55) of philosophy referring to the underlying assumptions of a person's work or lifestyle. Hewitt (1985:56) argues that the knowledge and skill involved in technical procedures are not crucial issues in nursing, rather it is beliefs and values underlying practice that are of utmost importance. That is the way Schurr and Turner (1982:3) use the term philosophy when they say

> "Nursing is concerned with caring for people throughout the span of life. It is founded on the belief that every person merits equal care and attention, has individual rights, preferences, needs, beliefs, emotions and problems unique to him/her."

The RCN (1981) refers to the value - system of nursing having the patient at the centre.

Three writers on caring in nursing acknowledge a debt to Heidegger in their understanding of what it means to care. (Griffin 1980 and 1983, Kitson 1985 and Dunlop 1986). Griffin (1980:265) writes

> "I see the concept of caring in a nursing context as referring to acts and related attitudes, predominantly the moral attitude of respect for persons. These caring acts of innumerable different kinds have in common that they are all performed under the moral emotion of respecting the dignity (and perhaps temporarily relinquished) autonomy of another human being."

In her later article Griffin (1983:289) writes of caring involving the giving of prolonged and reliable attention to the patient's clinical, cognitive, moral and emotional needs. In order to give this attention, the care-giver needs a certain amount of maturity, together with a freedom from self-centredness. (Griffin 1983:292). Kitson (1985:13) agrees, and is concerned that so little is done to prepare student nurses for this responsibility. She argues that the need for nurses to meet the personal and emotional needs of patients is like a hidden curriculum in nursing, referred to euphemisticallly as nurse - patient communication, or "good bedside nursing." Kitson (1985:15) believes that caring in nursing involves commitment to provide support, possession of appropriate knowledge and skill, and respect for the dignity and independence (actual or potential) of the patient or client.

Kitson also explores the relationship of lay carers to

professional carers, showing how professional carers may take over when there is a deficit of either commitment, skill or respect in the care given by the family member, friend or untrained carer. (Kitson 1985:15 and 1987:159). This relationship of lay and professional carers is also discussed by McFarlane (1976:189), Pembrey (1985:49) and Dingwall et al (1988:116).

3.7.3 Accountability In Nursing

The kind of caring portrayed by Kitson (see above) inevitably involves the concept of accountability. According to Rhodes (1983:66) nurses up to the late 1970's were sheltered from the need to be fully accountable for their own professional practice by firstly, the medical profession, and secondly, their employing organisation, usually (in Britain) the N.H.S. Historically nurses were regarded as acting on the authority of doctors, who as late as 1978 were classified by Rowbottom (1978:87) as their "encompassing profession". The hierarchical structure of the N.H.S., particularly in the format laid down for the 1974 reorganisation, was designed to allow for vicarious liability for nursing staff to be held at health authority level, provided that the nurse kept carefully to the rules and guidelines dictated by her nurse managers. However, changing views of nursing, touched on in the previous pages, and which will be more fully developed shortly, led to the inclusion of the concept of professional accountability for the first time in the nursing syllabus in 1977 (Rhodes 1983:66), and for accountability to become

legally required of nurses in the Nurses, Midwives and Health Visitors Act of 1979. (Bowman 1986:115). The new statutory body set up in the 1979 Act, the UKCC, consulted widely on the subject of accountability, and issued for the first time in 1983 a "Code of Professional Conduct" for nurses, midwives and health visitors. The second edition (UKCC 1984) enjoins each member of the profession to justify public confidence, to enhance the reputation of the profession, to act in the interests of society, but

> "above all to safeguard the interests of individual patients and clients."

No less than fourteen areas are given in which professional accountability shall be exercised; these include the responsibility to maintain and improve personal professional competence, to refuse to accept delegated tasks in which the person is not competent, and to take account of the environment of care, adequacy of resources and workload of colleagues and subordinates. Where any of these may put patients at risk, the professional nurse has the duty to report the circumstances to the appropriate authority.

The RCN's working committee on standards (RCN 1981) publicised the need for nurses to accept accountability for meeting patients' needs through the use of "the nursing process", a problem solving approach to individualised nursing care, which was coming to the forefront of nurses' attention at that time. The RCN not only encouraged clinical nurses to adopt the process, but made explicit

nurse managers' responsibility for providing resources for this purpose, and nurse teachers' accountability for imparting appropriate knowledge and skills. A member of RCN staff, writing later about the work of the standards' committee, stressed the need for nurses to have enough authority to control change from a system of task allocation to one of individualised care. (Rye 1983:64). Rye continues

> "Part of the current concern about standards arises from the fear of the individual nurse, of groups of nurses and even the profession as a whole, that they can no longer control the circumstances or provide the necessary conditions to ensure good nursing care."

It was this fear that nurses were losing the authority to control conditions in which patient care was given that caused such a strong reaction amongst nurses to the introduction of general management, which is discussed in the following chapter.

3.7.4 The Nursing Process

No overview of recent nursing developments would be complete without reference to the introduction of "the nursing process" approach to individualised patient care. As mentioned previously, the RCN promoted it in Great Britain, as did the Nursing Department of Manchester University under Professor Baroness McFarlane, but perhaps more importantly it was introduced into the general nursing syllabus in the revision of 1977 by the G.N.C. (Walton 1986:1). As Walton explains (1986:v), enthusiasts for the

process claim that its use improves nursing care by its systematic, individualised approach. (McFarlane 1982:110) But it can be understood at a number of different levels; possibly as a system of paperwork, albeit with spin-offs for quality control and manpower planning (Dingwall et al 1988:22b, Walton 1986:5), alternatively as an organisational tool, the antidote to task-allocation nursing (McGilloway 1980:87, Rowden 1984:220). It may also be seen as an educational instrument to bring theory and practice closer to each other (de la Cuesta 1983:367, Walton 1986:4), or as an ideology associated with professional aspirations for identity, status and autonomy (Walton 1986:3, Dingwall et al 1988:213-7, de la Cuesta 1983:367).

The nursing process may briefly be defined as the application of a systematic cycle of problem-solving steps to each individual patient's needs for nursing care. These steps are the familiar ones of assessment by means of observation and history-taking, planning in collaboration with the patient and his family, implementation of the care-plan, and evaluation of the care and the patient's response to it, leading to further cycles. The idea originated in the nurse education sector of the U.S., in the late 1950's and early 1960's, and by the early 1970's its use was an essential pre-requisite for accreditation of hospitals by major insurance schemes in the U.S.A. (de la Cuesta 1983:366-7, McGilloway 1980:80). The cultural origins of the nursing process in the very different organisational, economic and political milieu of health care

in the United States are now seen as a problem which was perhaps not acknowledged soon enough in the U.K. (de la Cuesta 1983:370, Dingwall et al 1988:216). However, Walton (1986:2 and 68) recognises that the process was widely welcomed by nurses in the U.K. and in Europe because it seemed to answer some of the common problems in health services worldwide - trends towards dehumanization and depersonalization, pre-occupation with technology, the need to evaluate patterns of care, yet a desire for closer involvement of patients in their own treatment, and the growth of the consumer movement more generally.

There have been continuing debates over the implementation of the nursing process in some areas of nursing. Its focus on problems, and on the individual are not always helpful, particularly in community nursing where more importance is attached to communal and political perspectives and to people's strengths rather than their weaknesses. (Walton 1986:70 and 85). In places where patient turnover is very rapid (minor surgery, for instance) the relevance of the nursing process is questioned (McFarlane and Castledine 1982:5). Salvage (1985:67 and 173) accentuates the greater stressfulness to the staff of giving more personalised nursing care, thus requiring more counselling help and sensitive management. (Menzies' well known study, published in 1960, shows how task-allocation systems in nursing are a defence against anxiety.)

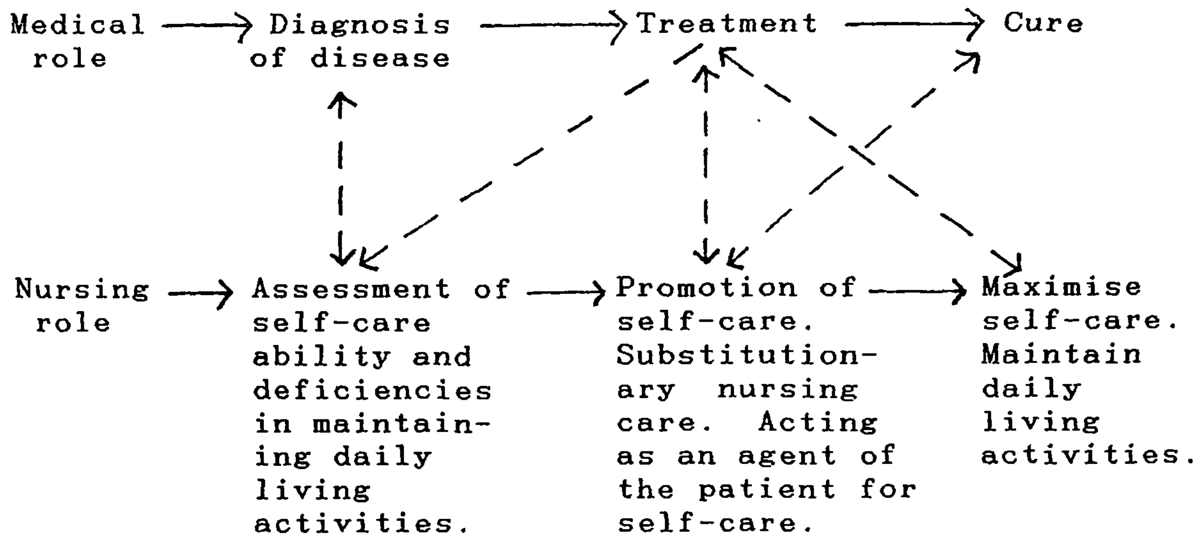
Most authors are agreed that evaluation of the benefits or otherwise of the introduction of the nursing process has

been a problem. (Walton 1986:36 and 75, de la Cuesta 1983:370, McGilloway 1980:88, Berry and Metcalf 1986:590). In particular, the quality of ward management exercised by ward sisters and charge nurses is of vital importance. If the ward sister provides the right example and sets up a facilitating environment, then a patient centred, problem solving approach may flourish. (Walton 1986:40, McGilloway 1980:86, Pembrey 1980).

Despite the fact that similar problem-solving approaches have been tried in medicine and social work (Walton 1986:55 and 64) doctors have often been antagonistic to the introduction of the nursing process, seeing it as a bid for nursing to establish professional autonomy. (Mitchell 1984:217) Several authors have appealed for better attempts to explain and publicize the nursing process, particularly between members of multi-disciplinary teams. (Walton 1986:11, de la Cuesta 1983:370, Rowden 1984:220) McFarlane and Castledine's (1982:3) diagram of the relationship between medical and nursing roles is helpful in this respect.

Figure 3.7.4 Complementary Nature of Nursing and medical roles

(from McFarlane and Castledine 1982, published by CV Mosby Co., St. Louis, U.S.A. reproduced by permission.)



McFarlane and Castledine (1982:12) say

> "Nursing provides the environment for maintenance of life which makes all other health functions possible."

3.7.5 Nursing Models And Theories

The diagram does more than just show the relationship between medical and nursing roles and processes. It als demonstrates how, in order to make sense, the nursing process needs to be based on a nursing model. In this case McFarlane and Castledine make clear (1982:3-7) without actually using the term "model", what their view of nursing is, and what it involves. They base their views on the theories of Henderson (1966) and Orem (1971) which have the notion of self-care, and nursing acting in place of self-care, as their key features. The diagram demonstrates how the use of a model acts as a guide to nurses, so they know

what to assess and how to plan care for their patients. This point has been stressed in more recent writing on the use of the nursing process (Roper et al 1983:17, Aggleton and Chalmers 1984a:24, Wright 1986:1) The diagram also differentiates between the medical model of care, diagnosing disease by means of signs and symptoms, proceeding to treatment and hopefully cure, and nursing models, which may have different goals as well as different modes of activity. (Schurr and Turner 1982:4, Aggleton and Chalmers 1985d:38). Cull-Wilby and Pepin (1987:516) point out that although Florence Nightingale explicitly identified nursing knowledge as distinct from medical knowledge, her successors did not follow her example. Up until the 1960's in America, and much later in the U.K., most nurses were taught along medical lines - nursing textbooks for instance were structured according to diseases and separate body systems.

A similar pattern of dissemination of ideas has occurred in the study of nursing models and theories as with the nursing process; there has been perhaps a ten year time lag between the USA and UK, with university nursing departments becoming interested first, then articles in academic nursing journals, followed by interest in the more popular nursing press, the RCN and the statutory body. (The English National Board first made a requirement that schools of nursing should base their curricula on an explicit model of nursing in 1985, at the same time suggesting that the underlying concepts should be founded

on health not disease. (ENB 1985).

There has been considerable confusion in the nursing literature on terminology surrounding theory formation. I would follow McFarlane (1986:3) and Kristjanson et al (1987:524) in saying that a model is a representation of reality which may assist in analysis and specify relationships or processes. Most nursing models are, as McFarlane (1986:3) puts it, pretheoretical - or at the conceptual level, in that they do not provide the level of specificity required to derive principles. Kristjanson et al (1987:524-5), drawing on Miller (1985) deplore the tendency in some academic nursing circles to label conceptual models as theories, when they lack operational definitions, empirical testing and are

> "so all-purpose, so all-inclusive and so abstract that in trying to explain everything they explain nothing."
>
> Miller (1985:420)

3.7.5.1 Criticisms Of Theories And Models

There is a healthy scepticism evident in the British literature on nursing theory and models. Criticisms include charges that theories are often built on speculation and idealism rather than reality, that they are treated as a kind of trial of orthodoxy, almost in a religious sense, rather than being subjected to rigorous testing, and that their creators, in their use of specialised jargon, engage in a kind of academic "one-upmanship." (Johson 1986:44, Johnson 1983:26, Crow

1982:113, Hardy 1986:104, Wright 1986:4, Lister 1987:40, Kershaw 1985:27). Another group of criticisms is gathered round the view that nursing models should relate specifically to the context in which they are to be used; factors to be considered include culture, organisation, politics and the understanding of the language and terminology used. (Miller 1985:420 and 423, Luker 1988:28, Wright 1986:3-4, Kershaw and Salvage 1986:xiii). However, this view is often used to support the identification and use of nursing models, but models which are inductively derived, context specific and acknowledge their differing philosophical perspectives - a pluralistic approach. (James and Dickoff 1984:72, McFarlane 1976b:449, Hardy 1986:107, McFarlane 1986:113). If one accepts, as I do, that many of the above criticisms of nursing theory are accurate, it is no surprise that writers still claim that there is a large gap between the perceptions of everyday practitioners of nursing and the ideas of theoreticians. (Miller 1985:417, Clarke 1986:5, Melia 1987:129).

3.7.5.2 Benefits Of Theory-Based Nursing

The closure or reduction of the gap between theory and practice is actually one of the benefits claimed for the use of nursing models by Baroness McFarlane (1986:2) who says

> "Models may have a value for practice ... They may
>
> 1. Serve as a tool which links theory and practice;
> 2. Clarify our thinking about the elements of a practice situation and their relationship to each other;

3. Help practitioners of nursing to communicate with each other more meaningfully;

4. Serve as a guide to practice, education and research".

Wright (1986v) says

> "A model of nursing has no valid purpose unless it serves nurses to help make their nursing better,"

and Pearson (1986:47-53) is convinced of the value of model-based practice for nurses working in multi-disciplinary teams and for nurses learning to exercise accountability for their own professional standards. Several writers acknowledge that most nurses do have their own personal concept of nursing, an informal model, even if they would not be able to express it in theoretical terms. (Clark 1982:129, McFarlane 1986:3-6, Luker 1987:27). There seems to be a growing acceptance, at least amongst UK proponents of nursing models, that the best way forward is for nurses who work together, in a ward or community team, expressing their own personal concepts to each other, should either choose a known model and implement it from the bottom upwards, or decide even to build their own. (Pearson 1986:51, Roper et al 1983:19, Walton 1986:86, Wright 1986:148). This should ensure commitment from all concerned, rather than the situation which arose in the early days of the introduction of the nursing process, which was imposed from above and aroused much antagonism and resistance amongst ward-level nurses. (Walton 1986:86) However, in advocating a "bottom-up" process rather than "top-down" it is still important to remember the need for

agreement and consistency between nurse practitioners, managers, educators and researchers. (Stevens 1983:711-7, Stevens 1984:120-5, Chaska 1983:723, Wright 1986:121-138, Farmer 1986:13). The situations described by Wright (1986:v) and Pearson (1986: 51-53) are probably the ideal - where a whole clinical department, nurses, nurse-teachers and nurse-managers, all deliberate together and come to a joint decision to adopt and implement a conceptual model for their nursing practice.

3.7.5.3 Classifications Of Theories And Models

The literature on nursing models and theory, particularly that originating in the USA abounds in different schemes to classify, describe, analyse and evaluate the different models. In the UK, Aggleton and Chalmers (1986) have particularly tried to make these classifications and evaluative frameworks accessible to the ordinary nurse. They suggest that in deciding which model might be appropriate for an area of practice, the following questions might be useful:-

1. What assumptions are made about people and their health - related needs? Do these match the nurse's assumptions?
2. What values does a model work with?
3. What are the key concepts of the model? What is their derivation (e.g. from nursing research or other disciplines?) Are they likely to be useful to nurses?
4. What relationships between concepts are suggested? Are they supported by research? Do they seem reasonable in the light of nursing experience?
5. What role for the nurse does the model describe? Is

this role acceptable to practising nurses?

6. Is the model parsimonious yet not simplistic?

7. Does the model have something of generality to say about nursing in the context in which its use is being considered?

8. Is the use of the model likely to lead to better standards of care?

Derived from Aggleton and Chalmers 1986:104-105.

The same authors suggest that following the use of a particular nursing model, nurses might evaluate its utility by asking four questions, based on the stages of the nursing process.

1. Did the model give guidelines for assessment which enabled the patient's problems to be clearly identified?

2. Did the care-planning and goal-setting match the patient's expectations?

3. Did the model suggest an appropriate range of nursing interventions for the particular setting?

4. Did the planned care meet standards acceptable to the patient and the nurse?

Derived from Aggleton and Chalmers 1986:105

Following the English National Board's requirement (1985) for schools of nursing and post-basic courses to develop their curricula around a model of nursing, books, journal articles, conferences and courses on this topic have proliferated. Many institutions in England have chosen models which broadly have developed from Virginia Henderson's definition of the role of the nurse quoted earlier in this chapter, based on the concept of the nurse enabling the patient to carry out activities of daily living. The best known of these are the models of Roper,

Logan and Tierney (1985) and Orem (1971), probably because the ideas expressed are quite familiar to British nurses, and the language used is easy to understand. Other models used occasionally in the UK and more widely in the USA may be based on symbolic interactionism (eg Riehl 1980) developmental theory (eg Thibodeau 1983) systems theory (eg Johnson 1980) or holistic ideas (eg Rogers 1980). It would seem that nursing in the UK is managing to develop an awareness of theory without going to some of the extremes of incomprehensibility seen in the USA. This may be due in no small measure to the efforts of nurses like Wright who remain in clinical practice. He writes

> "The opportunity exists to expand on home - grown ideas about what nursing is and how to give patients a better deal, to do it in a language that is accessible to all and to incorporate within it the many possible models for practice."
> Wright 1985:20

Wright does warn that theorising in nursing may be used to increase the status of the theorists and the profession rather than to serve the needs of the patient, and others join him in this warning. (Wright 1985:20, Hardy 1986:106, Melia 1987:158). He also speaks out strongly about the seeming indifference of American nurse theorists to the inequalities in their health care systems and asks

> "Does this mean that all the supportive, growing relationships between nurse and patient which they describe are only available if you can afford to pay for them? Does theorising about nursing have any value if there is a great well of unmet need in the population .... because they simply do not have the resources to pay for a nurse, and therefore never have a nurse-patient relationship?"
> Wright (1985:19)

These arguments about professional status and the willingness of nurse theorists to think politically lead to further discussion on these two points which will close this overview of recent developments in nursing.

3.7.6 The Concept Of Profession In Nursing

The concept of a profession is one that is much disputed; indeed a complete branch of sociology, that of occupational sociology, has made a special study of it. Melia (1987) covers the area helpfully from a nursing viewpoint, and I could not possibly even begin to deal with the concept of profession adequately here. My use of the term equates very much with the way I used the word "philosophy" earlier in this chapter - in a simple, almost colloquial way. I believe this is similar to the way in which Becker (1962:91-93) refers to profession as a "folk concept", understanding it in the way society uses it, symbolizing a morally praiseworthy kind of occupational organisation. Salvage adds to this the notions of independence and autonomy, together with a desire for the occupation to control its own work and standards. (Salvage 1985:90) Salvage argues that a strategy of professionalisation has been uncritically adopted in nursing, and that it is used not just as a means to reach desired goals, but also to enforce submission of new entrants to the nursing establishment's moral and behavioural code. (Salvage 1985:94). She further claims that such a strategy divides the nursing workforce, alienating unqualified staff, tries to enforce a spurious unity, stresses individual

accountability at the expense of collective responsibility to take political action, and thus supports the status quo rather than challenging it. (Salvage 1985:95-101).

Salvage also highlights throughout her book (1985) the impending shortage of nurses due to a declining number of eighteen year olds, and the present high wastage in nursing due to lack of flexibility by employers unsympathetic to women's particular needs. These issues are also stressed by Strong and Robinson (1988), Dingwall et al (1988), Hudson (1986) and Clay (1987). Salvage, in a later article (1988) suggests that Project 2000 (UKCC 1986), the latest attempt to reform nurse education and ensure a good supply of nurses for the future, is part of a struggle for professional survival in the face of loss of power for nursing resulting from Griffiths' (1983) changes to NHS management.

The Project 2000 document (UKCC 1986) does make clear the benefits to nursing of the introduction of the nursing process and the increasing awareness of the need for theoretical frameworks.

> "There was now a new basis for unity, one which was simply not available at the time when Briggs reported. Health needs models of various kinds, stressing an holistic approach to care and offering classifications of client or patient needs are widely used in the different areas of nursing, midwifery and health visiting .... It is thus clear that the professions of nursing, midwifery and health visiting are now united under a new statutory umbrella; they are ready to stand in a new and closer relationship to each other."
>
> UKCC 1986:34

A few pages further on, the report emphasises the aspects

of art, science and caring in nursing (UKCC 1986:41) reinforcing my argument for epistemology in nursing to include aesthetics, morals and personal relationships in its compass. The project argues for the supernumerary status of the student nurse. It suggests a form of education intended to lead to the emergence of practitioners who take responsibility for their own professional development and will be flexible, ready for change and able to work in a variety of settings in the community and in institutions. There would in future be only one grade of registered practitioner, assisted by a new helper grade. Some commentators have gone even further, and argued for all nursing care to be given by qualified staff (Clay 1987:107) whilst others argue that despite the professionalisers' attempts to squeeze out less qualified nurses, there will always be a place for several different levels of qualification or training in nursing. (Dingwall et al 1988:228, Melia 1987:185).

3.7.7 Nurses And Politics

There have already been some references in this chapter to nurses' willingness to make political statements, or to understand the political significance of happenings within the NHS. Salvage's (1985) book which refers frequently to the issue of professionalism is actually entitled "The Politics of Nursing." It is written from an avowedly radical and feminist standpoint, often criticizing the Royal College of Nursing, seeking to put trades union views fairly, and urging nurses to look behind government

policies on value for money and efficiency to see the underlying threat to the NHS as we have known it. In many ways Clay's (1987) "Nurses: Power and Politics" appears to be the Royal College's answer to Salvage's criticisms, in conjunction with the RCN's own "Manifesto for Nursing and Health" issued in 1986 to challenge all the political parties in preparation for the 1987 general election. Although differing in their approach, all these publications share one message - that nurses have to be prepared to think and act politically. Back in 1975, this would have been viewed as a revolutionary statement. Schrock (1977:41) quotes from a Nursing Times editorial in 1975

> "Nurses on the whole are not political animals and the profession itself has, by its attitude, ensured that this has been so."

However, the difficult financial situation of the 1970's and early 1980's ensured that NHS cuts and reorganisations forced nurses at last to realise that, in Schrock's words,

> "health care without politics is simply not possible"
>
> Schrock 1977:49

Several attempts were made in the ensuing years to draw the government's attention to the effects of cuts on the NHS (RCN 1978, 1984a), and in 1987 the RCN joined forces with the British Medical Association and the Institute of Health Service Managers to draw attention to the need for better funding for the NHS. (Alleway 1987) Above all, the nursing profession's reaction to the Griffiths Report (1983), to be

discussed in the next chapter, demonstrates just how much nurses had taken Schrock's advice to heart.

3.8 Is There Any Benefit In Considering Nursing And Organisation Theory Side By Side?

It only remains in this chapter to consider whether there are any observations to be made concerning the ideas expressed about nursing, and organisation theory related to the N.H.S. - in other words, is there any common ground? Certainly, some of the characteristics of the NHS such as complexity, heterogeneity and goal multiplicity apply equally to nursing and increase understanding of why rational, bureaucratic systems of management are not always suitable. This increases the pressure for self-management which becomes more realistic now that personal accountability in nursing is recognised, and efforts are being made to use models of nursing which are consistently applied to staff relationships as well as staff/patient relationships. Add to this the hopes that Project 2000 will give rise to a new generation of nurses, flexible, always learning and prepared to work in a variety of settings, and perhaps the metaphor of the hologram may apply to nursing as well as health service organisation.

One last point - I referred to a healthy scepticism amongst many British nurses regarding the more abstract and speculative nursing models and their use. This has led to an insistence in many quarters that models used are context-specific and stand or fall by whether or not they improve patient care. It is to be hoped that similar

scepticism will be evident in health service policy makers and managers as they consider the various solutions for the NHS's problems put forward by so many people over recent years. These proposals are often based on practices occurring in the USA or European countries whose philosophy and context of health care is totally different from our own. I believe there has to be a freedom for different health authorities to adopt their own solutions to their problems, whilst maintaining adherence to the basic principles of the NHS as re-stated in the Royal Commission's Report (Merrison 1979).

3.9 Conclusion

This chapter has covered a very long time-span, becoming more and more detailed as we approach the 1980's. I have interrupted the narrative about the NHS as an organisation at various points to focus more closely on developments in nursing. Section 3.6 will be seen to have particular relevance as the latest changes in the NHS are unfolded in Chapter Four, and Section 3.7 will be of value when considering the perceptions of nurses in the case study unit in Chapters Six, Seven and Eight.

CHAPTER FOUR: THE FOREGROUND - THE QUICKENING PACE OF CHANGE IN THE NHS FROM 1983 ONWARDS

4.0 Introduction

I now take up the story of the NHS from where I left it at the end of Section 3.5. However, consideration of the implementation of the Griffiths Report (1983) will be enlightened by the discussion of organisation theory in Section 3.6. In this chapter I consider both the initial reactions to the implementation of the Griffiths Report and longer term issues raised by it, such as the position of nurse management, the power of the medical profession, the possibility of political pressure and the influence of the DHSS. (now D of H). The chapter closes with discussion of the balancing role of general management in the many conflicts of interest in the NHS.

4.1 The Griffiths Report

In the previous chapter I described the development of the NHS up to the 1982 reorganisation, including specific discussion of nursing and its theoretical base. The new district health authorities took on their full responsibilities in April 1982, and began to appoint staff to manage their new units, which were to be responsible for all day-to-day decisions. However, early in 1983, the Secretary of State for Social Services asked Roy Griffiths, Managing Director of Sainsbury's the supermarket chain, to head a small team of prominent managers from business and nationalised industries

> "to give advice on the effective use and management of manpower and related resources in the NHS."
> Griffiths (1983:1)

Griffiths's Report, in the form of an extended letter to the Secretary of State, was published in October 1983 and was notable for its brevity (just seven pages of recommendations, and seventeen pages of explanation and comment) and its sense of urgency.

> "It was emphasized that we had not been asked to prepare a report, but that we should go straight for recommendations on management action ... Speed of implementation is essential .... All our recommendations are designed to be implemented without undue delay; none of them calls for legislation nor for additional staff overall; and all of them are completely consistent with present initiatives to reduce costs."
>
> Griffiths (1983:1-2)

Another characteristic of the Report was the way that all its recommendations were clearly made the responsibility of particular individuals rather than being generally addressed. Its main directives are set out in Figure 4.1 and are followed by a summary of some of Griffiths's explanatory comments. I have given them in this order, rather than in the form of "diagnosis and prescription" adopted by Harrison et al (1988:27-28) because that is the order used by Griffiths himself, and emphasises his insistence on necessary action rather than reflection. In fact he closes his letter to the Secretary of State by saying

> "There have been over the years many working party reports on, and much discussion about, many of the areas we have considered. The point is that action is now badly needed and the Health Service can ill afford to indulge in any lengthy self-imposed Hamlet-like solioquy as a precursor or alternative to the required action."
>
> Griffiths 1983:24

Figure 4.1 Main Recommendations of Griffiths Report (1983)

Person responsible	Action to be taken
Secretary of State	To set up, within DHSS a) Health Services Supervisory Board - chaired by Secretary of State, consisting of Minister of Health, Permanent Secretary, Chief Medical Officer, Chair of NHS Management Board plus 2 or 3 non executive members. - role would be to give direction and purpose to NHS, to make strategic decisions, to approve budget and resource allocations, and to receive evaluations of performance. b) N.H.S. Management Board - chaired by new General Manager of NHS (probably from outside NHS and Civil Service), membership all full-time officers, specialising in finance, personnel, technology, planning, procurement and property. - role would be to plan implementation of policies, give leadership, control performance, achieve consistency and long-term drive.
Regional and District Chairmen of Health Authorities	a) Should extend accountability reviews from district to unit level. b) Should identify a general manager to be responsible for achieving objectives set by the authority - at regional and district levels. c) Should have greater freedom to organise management structures to suit local needs. d) Should clarify roles of Chief Officers, reduce functional management, ensuring all reporting is to General Manager. e) Should clarify role of Health Authority members, and place in decision-making. f) Should initiate cost improvement programmes to be implemented by General Managers.

Figure 4.1 continued.

Person responsible	Action to be taken
District Health Authority Chairmen	a) Plan for all day-to-day decisions to be taken within units of management. b) Involve clinicians in management, consistent with clinical freedom, using "Cogwheel" structures and management budgeting approach. c) Identify General Manager for each Unit. d) See that each Unit has a total budget, proper detailed financial procedures, and develops management budgeting approach.
Personnel Director, Member of NHS Management Board	Should a) Co-ordinate evidence to pay review bodies and Whitley Councils. b) Look for ways to bring in incentives and rewards and sanctions to management system. c) Stimulate management training, performance review and career development, reviewing personnel policies and ensuring devolution. d) carry forward DHSS work on nurse manpower levels, and instigate similar work for other staff groups.
Chairman of NHS Management Board	Should a) Ensure property function handled in more commercial manner, streamlining and devolving capital schemes and property disposal. b) Review and simplify decision making and consultation procedures in NHS. c) Ensure that management ascertains perceptions of patients and communities about service standards, responding to, and acting on those perceptions, promoting realistic public and professional views of what the NHS can provide within available resources.

In giving his reasons for his recommendations, Griffiths (1983:10) countered the expected objections that managing the NHS is very different from managing a business by saying that the similarities are much more important. He claimed that for private sector managers below Board level, levels of service, product quality, productivity, staff motivation, cost improvement and meeting budgets were key objectives, rather than making a profit. All these were managerial concerns to which Parliament was urging the NHS to give priority. Griffiths found the NHS lacking in five particular respects, summarised by Harrison et al (1988:27-28).

1. A lack of strategic central direction - DHSS give numerous, trivial directions to health authorities, but make little attempt to set specific policy objectives.

2. A lack of individual managerial responsibility - leading to "lowest common denominator decisions". (Griffiths 1983:12)

3. A failure to use objectives as guide to managerial action, with a consequent absence of drive to implement plans and policies.

4. A lack of orientation towards performance or concern with productivity - a disinclination to undertake economic or clinical evaluation or collect the right kinds of data.

5. A lack of orientation towards the consumer, shown by absence of information about views of NHS users.

Griffiths's own definition of the general management function was

> "the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance."
>
> Griffiths Report (1983:11)

In several places in the Report, and at other times when interviewed, Griffiths stressed the need for the NHS to balance the interests of the patient, the community, the taxpayer and the employees. When asked how the NHS might look in a few years time if his report was implemented, he hoped that the patients would notice the difference in the way they were treated, and in finding that the process of referral from G.P. to hospital was smoother and speedier. He also hoped that the staff would be better motivated and enjoy better personnel management, and that managers and authority members would be less frustrated and better informed. (House of Commons 1984:141).

Commentators on Griffiths have pointed out the influence of two particular books on management in his thinking. Dimmock (1985:30) and many others have seen the advice of Peters and Waterman (1982) ensconced in the Griffiths Report. Several of their principles for excellence in business are echoed - particularly a bias for action, staying close to the customer, being value-driven, having simple forms and lean staffing, and having simultaneous loose-tight properties (retaining strong central control of values and goals but devolving most decisions to local level.) Strong and Robinson (1988;7) trace the influence of Drucker (1979) in Griffiths' thinking. They stress particularly the emphasis on performance and results, and most of all, effectiveness.

The Griffiths' Report reached health authorities in late October 1983, and on 18 November 1983 the Secretary of

State wrote to regional and district chairmen to say that the Government had accepted "the main thrust of the Report", and were to set up the NHS Supervisory Board straight away. Authorities were requested to comment on the parts of the Report relating to their work by January 9th 1984, so that improvements could be set in motion by the beginning of the new financial year in April. It was clear from the tone of the letter that the Government were determined to carry through Griffiths's proposals in full.

4.2 Initial Responses To The Griffiths Report

Health service management and professional journals were full of articles about the Report and its implications throughout the consultation period, and I shall make some quotations from these; but one of the more considered vehicles of response came in the Report of the House of Commons Social Services Committee, who took written and oral evidence from many professional and academic bodies and published their deliberations in March 1984. The Committee welcomed certain aspects of the Report - the insistence that patients matter, the stress on an effective management process, the need for flexibility and devolution in the NHS. They recognised that the critique of NHS management found in the Report was accurate, and commanded fairly general assent from every one concerned - but disputed some of the recommendations, and requested a full parliamentary debate and delay in implementing the disputed points until a matching level of agreement could be reached on action to be taken.

The Committee deplored the short consultation period and the lack of any consultation on the changes at the centre, in the D.H.S.S. They also found it surprising that such sweeping changes could follow such an "impressionistic" report. They quoted the remark of the National Association of Health Service Personnel Officers,

> "If the Sainsbury organisation were to receive recommendations for such significant management changes from an external consultant, much more evidence and investigation would be demanded before such recommendations would be acceptable."
> House of Commons Social Service Committee (1984:vii)

This point had previously been made by Carruthers (1983:10). The Committee claimed (with some justification),

> "The reaction to the Report has not been very enthusiastic. It has been interpreted as an attack on NHS staff, as a threat to clinical freedom, a blow to nurse management. Whether or not the proposals amount to a reorganisation, they do represent for those involved the third attempt in a decade to put NHS management to rights. There is a tone of genuine and understandable weariness at such a prospect running through the responses to the Report."
> House of Commons Social Service Committee (1984:vii)

Many of the Committee's misgivings about the Griffiths Report followed from their view that the Report did not always seem to appreciate the "peculiar nature of the NHS." (House of Commons 1984:viii). The Committee believed that that peculiarity was not just a consequence of the lack of a profit motive, nor of the immense size of the NHS, nor that it had to be concerned with people rather than things, but that the management and professional levels within the NHS do not coincide. In managerial terms, a senior

consultant may be below unit management level, but still be independent in his use of resources, not accountable to management for his clinical decisions yet earn more than the Secretary of State. This strong sense of difference between the NHS and other organisations is echoed by many commentators, for instance Ennals (1984:230) and Harrison (1984:17).

The Committee asked particularly for further consideration to be given to the implications of the changes in the DHSS on ministerial accountability to Parliament and relationships with regional and district chairmen, to the implications of management budgeting on clinical freedom and professional responsibility, and the likely effects on nurse management - asking at the same time for the Chief Nursing Officer at the DHSS to be on the Supervisory Board. All these issues have continued to be central to argument about Griffiths' implementation up to the time of writing. The Committee wondered whether the general management function at district level could not be achieved by removing the power of veto from officers, and sharpening the role of team chairmen - but suggested separate and delayed consideration for general management at unit level, to give the newly created (1 year old) units time to develop their management capability. This plea had previously been made by Carruthers (1983:10).

Two other points from the House of Commons Social Services Committee's Report (1984) are worth mentioning. One was optimistic - the King's Fund (1984:184) emphasised just how

good the NHS is at providing value for money and a fair system for health care for everyone in the U.K. The other was pessimistic. The Health Services Management Centre of Birmingham University (1984:181) pointed out how difficult it is for Government to prescribe a model to fit every local community, saying that it is easier to get it wrong everywhere then to get it right everywhere.

> "If a mistake is made, it tends to be a massive one. It takes the resources of government to create an organisational catastrophe."

4.3 The Implementation Of Griffiths - 1984 Onwards

That warning, and many other expressions of disagreement or caution, did not deflect the Government in their determination to press through the Griffiths' changes. The chorus of argument and counter argument continued, and I will return to some of the issues shortly, but in June 1984 the DHSS issued Health Circular (84) 13 which required action by health authorities in no uncertain terms.

> "RHAs and DHAs must identify a general manager - at region, district and unit level - to take personal and visible responsibility for carrying out the general management function."
>
> DHSS (1984:2)

Eighteen months was to be allowed for the establishment of the general management function right down to unit level, and contrary to the pleas of the Social Services Committee of the House of Commons (1984:xxix) the DHSS circular (1984:2) identified the unit as the most important level of all, because that is where observable improvements would be seen by patients and the community at large. The DHSS

stressed the need for all health care professions, particularly doctors and nurses, to be fully committed to the principles of general management, and to be involved at unit level. The circular explained how the clinicians' decisions about the clinical care of individual patients determined the level of resources needed, and how these resources were not unlimited. The DHSS continued by suggesting that clinicians should be given relevant and timely information and administrative support. They also recommended that doctors should be given management training early in their careers. Both the improvement in professional advisory machinery for doctors and nurses, and the implementation of management budgets were seen as part of the process of closer involvement by clinicians in unit management.

The next two years during which, of course, my case study was planned and implemented, saw more management activity and change than had ever been seen before in the NHS.

> "Griffiths is the single most important change in the structure of the NHS since the service first began ... It is a revolution, though a revolution that has only just begun."
>
> Strong and Robinson (1988:xi)

General managers were sought and appointed at regional and district levels, often after long delays whilst the DHSS deliberated over their approval. But the real revolutionary factor was what happened next, when district chairmen and general managers, as Parston (1988:23) explains, took advantage of the freedom suggested by

Griffiths (1983)

> "to organise the management structure of (their) authorities in the way best suited to local requirements and management potential."

They followed advice given by Tom Evans, then Director of the King's Fund College (who has since died) at an early conference to discuss the implications of the Griffiths Report; often deciding to form an executive board at district level, with directors of finance, personnel, planning, operations and others - with no-one gaining a seat on the board by nature of their professional status alone. Parston (1988:24) describes how many health authorities took the opportunity to redesign the structures only recently assembled for the 1982 reorganisation, appreciating for the first time a sense of discretion and real local control. No longer did all health authority structures and job titles have to be the same, and there even began to be consideration about future change, if local circumstances should make that necessary.

Only time will tell whether this very real revolution, with many health authorities changing their unit structures out of all recognition, and the creation of a multiplicity of new job titles such as "patient care manager" or "quality assurance director", will turn out to be beneficial to the NHS, or whether it is, in fact, the organisational catastrophe that the University of Birmingham Health Services Management Centre (1984:181) so gloomily predicted. At the time of writing (autumn 1988) some health authorities are changing unit structures again,

having done so only two or three years ago. Bennis's prophecy, made originally in 1964 (but re-published later) about businesses in the U.S.A., seems to be coming true in the N.H.S. Speaking of the 1990's and beyond, he said

> "The key word will be temporary: organizations will become adaptive, rapidly changing temporary systems ... They will be organized around problems to be solved ... by relative groups of strangers who represent a diverse set of professional skills ... The groups will be conducted on organic rather than mechanical lines; they will emerge and adapt to the problems rather than to programmed role expectations."
>
> Bennis (1973:766)

Bennis said that such a system would gradually replace the theory and practice of bureaucracy.

4.4 Other Management Initiatives

Before looking in a more focused way at analysis and comment on the Griffiths changes, I believe it is important to see that those changes were just a part of a wider process - part of what a team from Brunel University (1985:5) called "a procession of management interventions." Day and Klein (1985:1677) explain that the transformation of the administrative style of the NHS reflects more general changes that have affected all government departments and public services, especially since a 1982 report on efficiency and effectiveness in the Civil Service. (Prime Minister 1982). This report urged all departments to measure outputs in relation to objectives, and to have constant regard for value for money. Day and Klein (1985:1677) comment

> "Economic scarcity has made the vocabulary of management the universal language of Whitehall."

Figure 4.4 lists the principal management interventions in the NHS between 1980 and 1983. Sources for this list include Brunel University (1985), DHSS (1984), Peat Marwick (1986) and Harrison et al (1988).

Figure 4.4 Principal Management Interventions in NHS 1980-83

Year	Month	Intervention
1980		Steering group on health service information set up under chairmanship of Mrs. E. Korner
1980		Management Advisory Service set up - to encourage good management practice.
1981	February	"Care in Action" handbook sent out by DHSS to chairmen and members of D.H.A.s.
1982	January	Annual review system set up - for DHSS to monitor R.H.A.s.
1982	January	Work began on devising performance indicators.
1982	March	Inquiry into disposal of surplus NHS land.
1982	March	Experimental use of private accounting firms to audit H.A.'s accounts.
1982	April	Reorganisation of NHS in England and Wales.

Figure 4.4 continued

Year	Month	Intervention
1982	April	Rayner scrutinies extended to NHS - inquiries into transport, supplies, recruitment advertising and residential staff accommodation followed.
1982	later	Review of NHS audit function.
1982	later	Inquiry into budgetary arrangements of Family Practitioner Committees.
1983	January	Strict manpower limits in N.H.S. set.
1983	February	Plans to restrict doctors' prescribing rights first discussed.
1983	February	Griffiths team commissioned.
1983	Autumn	Instructions issued to H.A.s to put out to tender laundry, domestic and catering services.
1983	Autumn	Proposal to restrict G.P.'s use of deputising services.
1983	October	Griffiths' Report issued.

Klein and Scrivens (1985:14-15) explain that almost from the beginning of the NHS, the lack of an efficient information system was a perennial problem. Yet it was only in 1980 that any real attempt to deal with it in a planned way was inaugurated - the Korner Steering Group was set-up to advise on minimum data sets to be collected at district level, which could then be aggregated at regional and national levels, on activities in all branches of the NHS. Klein and Scrivens (1985) maintain that although such a system had been needed for years, the factor that precipitated it was a change in the political and economic environment. Their view is that of itself, information is of little value, but as a tool it aids both decision making and monitoring, and becomes a basis for accountability. The Korner exercise therefore becomes much more than a neutral and technocratic process, it is one means of reconciling the tension between central control and local responsibility in the NHS. In a time of economic stringency, the Government has to be sure that value for money is being obtained in public services. Yet the Conservative administration was committed to a philosophy of devolved responsibility in the NHS.

Klein and Scrivens (1985:19) explain how better information can transform the nature of the relationship between the centre and the periphery. Whilst the centre is routinely and unobtrusively informed of the actions of the periphery, it can still allow devolved decision making. Better information may therefore reconcile the conflict between the NHS being accountable to Parliament, and the

need for decentralisation of decision-making. There are, of course, other interpretations of the uses of information which will be considered later in the chapter when the increased politicization of the NHS is discussed. The argument is also augmented by Day and Klein (1985) and Hunter (1984).

4.4.1 Management Budgeting And Resource Management

One other aspect of the "procession" of management interventions should be mentioned here, and that is management budgeting. In the Griffiths Report (1983) it is clear that new initiatives on this were already beginning, in four demonstration districts (see Coles 1988). However, these four projects ran into severe difficulties, partly from an unrealistically short time scale, partly from lack of appropriate computer hardware and software, and partly from lack of involvement of clinicians at anything other than a superficial level, because they were inadequately trained in the necessary skills, and not part of the management structure. Further work is continuing, under the title of "resource management" under the guidance of the NHS Finance Director, Ian Mills, (see Coles 1988, Jones 1987, Smith 1988 and Mills 1988 and numerous articles in Health Service Journal.) It is now recognised by serious commentators, but possibly not by the DHSS, that management budgeting, for proper implementation, requires financial resources for extra, better qualified staff, more training, and better computer facilities. (Social Services Committee 1984:xviii, Strong and Robinson 1988:127).

The implementation of the Griffiths Report does raise some particular issues which deserve detailed discussion but in focusing on these issues I would wish to keep the wider picture of management interventions in view. The introduction of general management is not an isolated event, but part of a process, and later I will discuss some critiques of that process which are now emerging.

4.5 Issues Raised By The Implemention Of The Griffiths Report

Many commentators agree (see King's Fund (1984:184) and Parston (1988:22) among others) that the initial debates about Griffiths were largely meaningless and concentrated solely on the question of who should be general manager, rather than on the process of general management. Carruthers (1983:9) said

> "Of course each profession is defensive. The doctors agree with the advice, provided always that the general managers appointed are doctors ... The treasurers have openly stated that they see themselves as the only group trained in management by experience and by their qualification ... The administrators ... assume that the job is a natural extension of their present role anyway ... The nurses seem to be defending a position before it has happened and reacting on the assumption that general manager posts will not be given to nurses."

Crail (1987:9) called this kind of reaction "tribalism", especially when professionals sought to retain their own management position outside the general management framework. The Social Services Committee Report (House of Commons 1984:xxviii) illustrates this situation. Crail (1987:9) did warn, however, that a general manager should

seek to understand the reactions of professionals, because what may appear as unreasonable prejudice may conceal a vital component in the maintenance of high standards of care.

4.5.1 The Position Of Nurse Management After Griffiths

The vociferous and persistent objections of the nursing profession to the Griffiths Report might at first have seemed to be prejudice and even pique at hardly being mentioned in the Report. Whereas most other occupational groups settled down to an acceptance of the situation, if not welcoming it, the voice of nursing, chiefly articulated by the Royal College of Nursing (RCN), grew louder and clearer in its opposition. Harrison (1988:146) sums up Griffiths as being seen as "a collective threat" to nursing - threatening the loss of the right to be managed only by nurses, the loss of promotion opportunities, the loss of equal status with other professions in health care management, and ignoring the profession's role in determining health care policies and controlling research into manpower (or womanpower) and quality within its own boundaries. The RCN, in its evidence to the Commons Social Service Committee (1984b:16-17) stressed that nurses needed to be managed by nurses because professional accountability for standards of nursing care and education was not just due to health authorities but also to their statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. The RCN objected very strongly to the omission of the Chief Nursing Officer

at the DHSS from the NHS Supervisory Board; the Committee's Report (1984) took up this objection successfully on their behalf.

As implementation of the Griffiths Report proceeded at district and unit levels throughout 1984 and 1985, the nursing profession's worst fears were seen to be well founded. Many health authorities' new management structures had no place for nurse managers at senior level except in an advisory capacity, often as part of another job such as quality control, or directing nurse education. In a few authorities, there were no nursing management posts as such above ward level. That nursing was suffering more than any other group was recognized by many commentators. (Strong and Robinson 1988:13-15, Owen 1988:41, RCN 1985b.). Rowden (1985:25-26) particularly expresses the widespread bitterness felt by the profession that although the DHSS stated that the implementation of Griffiths was not a reorganisation, and therefore laid down no personnel guidelines or ground rules, many very senior nurses were being "frozen out of management" and the whole NHS was

> "living through the most traumatic and wholesale restructuring that the NHS has witnessed since ... 1948."

However, pressure was beginning to be felt, and the Secretary of State reassured the RCN that he had made it clear to health authorities that in preparing their new management arrangements they must ensure adequate provision of professional advice, including nursing. The Secretary of State told the RCN that he expected authorities to require a nurse adviser at senior management level whose main responsibility would be the giving of that advice, although other duties in support of the general manager might also be allocated. The nurse adviser would have right of access to the health authority on nursing matters, and be accountable to it on professional nursing issues. (RCN 1985a). Later that year, in a written answer to a question in the House of Lords, the government health spokeswoman strengthened that statement:

> "All health authorities' must have a senior nurse accountable for professional matters and with direct access to the authority. The title of the post will vary between authorities dependent on the post holder's other responsibilities. On matters of day-to-day management the nursing officers will be accountable to the general manager."
>
> Trumpington (1985)

The RCN however, were so alarmed at the proposed management structures at unit level in many authorities that they increased their support to their branches by sending out "Action Packs" in September 1985 (RCN 1985c) giving advice on how to fight for nursing's place in management. The reasons they suggest that nurse managers matter are as follows:

1. To be patients' advocate at the point where resource priorities are set.

2. To counter balance the power of the acute medical sector representing care rather than cure, so that priority groups (elderly, mentally ill and handicapped, and patients in the community) get a fairer share of resources.

3. To argue the case for ward sisters when non-nursing managers try to change shift patterns or staff level mix in a way that threatens safe standards of care.

4. To represent educational needs of student nurses when service needs threaten them.

5. To protect standards where value for money becomes the over-riding philosophy, by utilising and stimulating research into quality, and educating general managers on nursing developments affecting standards of care.

The RCN followed up the "Action Packs" by a national press campaign in January 1986, with the intention of ensuring that every single unit in the country had a director of nursing with authority to act as head of the nursing services in that unit. (Dunn 1986:100). Despite criticism of the campaign for being exaggerated, poorly timed and irrelevant (Hunt and Jarrold 1986:101, Randall 1987:41) there have been signs that it has helped, combined with eloquent pleas from Baroness Cox, a nurse on the Government front bench in the House of Lords, to at least partly restore nursing's place in management circles. (Naughtie 1986:22, Parston 1988:27, Owen 1988:41).

Nevertheless, the pressures on senior nurses are greater than they have ever been; often a combination of advisory and managerial work is demanded. It is not unknown, for instance, for one senior nurse to be expected to offer professional nursing advice to a health authority, develop standards for use in quality assurance and run a unit or a

large institution in need of huge managerial input. (Buchan 1985:25). As Strong and Robinson (1988:112) say

> "How far real advice and serious quality could be developed under those circumstances was not clear."

Research into the effects of Griffiths' implementation is just beginning to be published (Robinson and Strong (1987), Strong and Robinson (1988), Glennerster et al (1986), Owens et al (1987)) and reveals just how great the effects have been on morale amongst nurses and in the reduction of numbers of nurse managers. Hancock, one of the few nurses to become a district general manager, writes of the need to identify in each ward, department or clinic the one person with the authority to get things done, but then continues

> "We don't just need to identify who can get things done, in some health authorities we just need to identify who is there at all!"
>
> Hancock (1987:2-3)

Clark (1986:10) recounts how nurses have borne the brunt of efficiency measures in Oxfordshire Health Authority by taking over duties previously undertaken by other staff, rather than see patients suffer. The effect on nursing staff has been devastating and the authority's own Nursing Review Panel declared that the pressure was quite unacceptable. Instances such as this underline the necessity for strengthening professional advisory machinery at district level, and making sure that this is separate and independent of management structures. (Robinson and Strong 1987:xi, RCN 1985c, Rowden and Slack 1986:20, Bolger

1986:22).

Whilst the position of nurse management has suffered such strong assaults in many districts, it must be remembered how the study of nursing theory has flourished during the same period, particularly from 1984 to 1987, as described in the previous chapter. It is as though while nursing's influence and position in the management domain has diminished, it has gained strength and confidence in the professional domain.

4.5.2 The Possibility Of Political Pressure

Despite the seriousness and importance of the position of nurse management following the implementation of the Griffiths Report (1983), there are even more fundamental issues at stake. In a debate at RCN Representative Body Meeting in 1985, Jo Plant said

> "The main danger to the NHS from the Griffiths Report is the creation of a clear line through which political pressure can be exerted, extending from the health departments to the regional, district and unit general managers, and then to areas of clinical activity."
>
> RCN 1985(b)

The question of political pressure had already been raised by Ride (1983:10) and Hunter (1984:93). This clear line had been created through the power of the Secretary of state to appoint regional and district chairmen of health authorities. These chairmen, it will be remembered, were given the duty of identifying regional, district and unit general managers. Obviously, decisions on appointments were made after consultation with health authorities at

each level, but all such appointments were scrutinised the DHSS, and sometimes delayed or vetoed, so that possibility of political influence cannot be ruled (Nicholson 1985;30).

4.5.2.1 The Constitutional Position Of The Secretary State

Another aspect of this issue is the effect of gene management on the constitutional position of the Secret of State in his accountability to Parliament for the NH and in his relationship to regional and district heal authorities. Hunter (1984:93) believed that if th Secretary's responsibility was to remain intact, then th Supervisory Board could only be advisory. However, if that was the case, then how could there be responsibility to it from the Management Board for the present departmental management functions? The uncertainty extended to the role of health authorities vis-a-vis their chairmen and the respective general managers. These matters were raised in some detail by the Social Services Committee (House of Commons 1984:xv), Day and Klein (1983:1814, 1985:1678) Wall (1987:51) and Strong and Robinson (1988:95). There has been an example of the complex nature of these problems in the short-lived appointment of a businessman, Victor Paige, to the Chairmanship of the NHS Management Board. Over a year elapsed between the announcement by the Secretary of state of his intention to set up the Board, in November 1983, to Victor Paige taking up his duties in January 1985. Nicholson (1985:30) prophesied that unless Paige was allowed to really lead the NHS, without too much

ministerial pressure, and in a manner broadly acceptable to the service providers, then his time as chairman was likely to be unhappy and unproductive. There were persistent rumours of civil service interference and Parston (1988;28-9) concludes the story

> "The small, strong centre with a sense of leadership, initiative, urgency and vitality never emerged from the inner struggles of the Department ... In June 1986, halfway through his three year contract, Paige resigned, citing incompatibilities between political and managerial objectives and priorities."

After several months, the Government showed that in its eyes (as Parston 1988 puts it) the political and managerial objectives were the same, and appointed the Minister of Health as Management Board Chairman, with Sir Roy Griffiths as his deputy, and Len Peach, previously Personnel Director, as Chief Executive Officer. These events confirmed early suspicions about political influence in the NHS after Griffiths, and have been the cause of resignation from the service of a number of general managers who come in from the business world, and who have expressed amazement at how NHS decisions may be reversed following even a whisper from a minister, whether the new decisions make economic sense or not. (Sherman 1986:18).

4.5.2.2 DHSS Involvement In Day-To-Day Management

Griffiths himself (1983:16) complained that the DHSS were often too involved in unnecessary trivialities, and too little involved in things that were really important. Parston wrote (1988:20) of the "stream of central

directives" that poured out form the DHSS without any consistent pattern and interfered with day to day NHS management in the early 1980's. McLachlan (1985:2) thought that the Griffiths' changes at the centre had actually intensified this problem.

> "Use of the new arrangements for greater arbitrary and superficial political instruction to the service, rather than less, seems to be an emerging problem."

This is corroborated by Cain (1987:1291), Strong and Robinson (1988:89), Day and Klein (1985:1676) and Best (1987:7) who says

> "a number of developments suggest that the DHSS - consciously or otherwise - is engaged in a process of 'repossesing' general management .... (which) is seen as little more than a means for giving effect to top-down line management"

This process of "watering down" could perhaps be described as the "Yes, Minister" factor, explained by Butler and Vaile (1984:100) as

> "the capacity of the civil service machinery to limit the effectiveness of the political heads of departments, particularly in issues that seem likely to be decided in ways contrary to established departmental ways of thinking."

It is possible, therefore, to see present trends in the NHS either as a sign that the Griffiths changes have brought about increased political control of the service, including the introduction of new values stemming from the market oriented policies of the Conservative government, or as an indication that civil service bureaucracy is actually

"watering down" the urgency and innovativeness that Griffiths wanted to see develop.

4.6 A longer-term view of Griffiths implementation

Hunter (1988), describing the ESRC funded research on the impact of general management in the NHS, said it had been crucial

> "to distinguish between the form and substance of management. Merely designating an officer as general manager does not necessarily mean that other changes will flow from this formal act."

When the Griffiths Report (1983) was first being discussed, Smith (1984a) had observed that structural reorganisation was a cumbersome and painful way to bring about policy change, which ignored the reality of organisational life. He maintained that anything other than incremental change was rare, because of the complexity of the NHS, and that renewal of management processes rather than structures would be more likely to make real differences. Parston (1988:17) reported that Griffiths himself recognised the long term nature of the change process; he referred to the structural and personnel alterations as being steps in the evolution of the managerial and organisational culture of the NHS. Other writers agreeing with this view are Best (1985:21), Hancock (1987:5) and Crail (1987:8). One of Strong and Robinson's (1988:81) research respondents refers to the changes having the nature of "a marathon, not a sprint." Thornton (1984:1352) wrote that changes were required in attitudes, expectations and understanding. Parston (1988:31-2) has emphasized the part that new

management practices such as individual performance review, performance related pay and short term contracts are playing, as well as better management training and the realisation by managers that they never stop learning.

4.6.1 General Management And Leadership

Best (1987) has put on record that in his view, the effect of the introduction of general management has been immense. He believes that already, the NHS has been

> "transformed from a classic example of an administered, public sector bureaucracy into one that increasingly is exhibiting the qualities that reflect positive, purposeful management."
> Best (1987:3-4)

So what are the qualities Best refers to? A number of writers are agreed that leadership, as opposed to dictatorship, is a much needed quality in an NHS general manager. (Crail 1987:7. Strong and Robinson 1988:59, Peat Marwick 1986) Hancock (1987:10), herself a general manager, wrote of managers seeing themselves as leaders, and as custodians of organisational values and standards. That concept of leadership reflects the ideas of Smircich and Morgan (1982:260) who describe successful corporate leaders giving strategic direction to an organization by providing an image or pattern of thinking which gives a sense of meaning to those involved.

An example of leaders providing such a pattern of thinking is given by Alan Randall, District General Manager of Worthing Health Authority.

> "The new management board grappled with the idea of trying to define our style of managing, indeed our own values of management. .... Individually and then collectively the board struggled to put into words what we all felt about the need to set and improve standards, the need to define management attitudes to clients and staff and the need to translate those ideals into personal behaviour. Self-consciously these thoughts were put down ... in a slim document entitled. "The Worthing Way" ... The first stage of seeking commitment to the ideas within "The Worthing Way" has gone well. The reaction of managers and staff has been warm and encouraging. The big challenge now is to convert those ideals into behaviour that permeates the total management structure."
>
> Randall (1987:42-3)

Randall's mention of the need for commitment to corporate values is echoed by Hancock (1987:6) Best (1987:9) and Busk (1985:810). Writing in the context of an article about conflicting values and interests within the NHS, which as a newcomer to district general management from the world of business he found to be quite destructive, Busk spoke of the need for mutual respect and understanding, better communication and multi-disciplinary co-operation, the raising of morale and a commitment to a corporate philosophy.

4.6.2 General Managers As Mediators

Klein (1985:62) believes that given the political and economic pressures surrounding the NHS in the 1980's, conflicts of values are inevitable. He therefore proposes that the manager's role is that of an "entrepreneurial broker " - trying to reconcile the demands of technical innovation, professional and career self-interest, and value for money efficiency and effectiveness. Klein continues

> "In determining his strategic aims, the manager may well be a technocrat ... but in shaping the tactics for moving towards his aims, he will have to be both an opportunist and a politician."

This view of the manager mediating between groups is shared by Albrow (1973:407) and the evidence of the Nuffield Institute to the Social Services Committee (House of Commons 1984:130) who stressed that NHS managers need behavioural and diplomatic skills in conjunction with ability to use quantitative methods in the technical aspects of management.

It is important for the general manager to be able to impart his or her set of organisational values in a way that staff can accept and affirm, so that shared meanings form a basis for understanding. If the manager fails in this, there could be severe problems. Some years ago, Albrow (1973:409) wrote

> "Organisations are social units where individuals are conscious of their membership and legitimise their co-operative activities primarily by reference to the attainment of impersonal goals rather than to moral standards .... All members contribute to conceptions of legitimacy. For example, if in an organisation service to the community has hitherto been regarded as the legitimising principle par excellence, managerial efforts to set up profitability as the prime objective may well be regarded by most members as illegitimate."

Because the implementation of Griffiths' Report has been accompanied by so many other measures to obtain value for money, and surrounded, particularly during the winter of 1987-88, by public and political discussion about shortage of resources in the NHS, it is no surprise that Strong and

Robinson (1988:49) report

> "Money, rather than anything else, was the first priority for every general manager."

It seems likely, therefore, that much of the opposition to Griffiths' reforms, however it is expressed, grows out of a feeling shared by many NHS staff that the goals and values being pressed upon them by top management are illegitimate.

4.6.3 General Management As A Symbol Of Pluralism In The Welfare State

These new goals and values are part of what Davies (1987) sees as "a major transformation" of the NHS, first articulated in "Care in Action" (DHSS 1981) already discussed in this chapter. Davies (1987:303) writes

> "What is being advocated, and indeed, what is well under way in the health sector, is a variant of welfare pluralism, a mixed economy of welfare, a new public/private mix of services."

Allsop (1984:216) sees the inspiration for this transformation as the policies of the radical, new right, who seek to change the system of health care funding by introducing a combination of private and state insurance schemes, and increasing the role of the private sector. The arguments of the new right rest on their assumption that health care consumers are rational, intelligent, well-endowed and healthy, and thus are able to protect their health and avoid illness by their own foresight. The argument takes no account of social and economic factors in the causation of disease, nor does it weigh up the collective benefits of a healthier population.

Davies (1987:309) sees the implementation of the Griffiths Report as closely linked with the introduction of a new, pluralistic approach. The appointment of authority chairmen likely to agree with Government policy, and the chairmen's role in appointing general managers subject to DHSS approval, bringing in outsiders wherever possible, has contributed to much new thinking. The newcomers have possibly accepted more easily than traditional NHS administrators the concepts of limited statutory obligations, and a new mixture of public, private and voluntary provision.

New thinking brings with it new retoric. Davies (1987) describes the way that non-statutory services are increasingly seen as flexible, responsive and innovative, where as statutory services are seen as monolithic and unresponsive.

> "A consumer-led range of services is a vision beginning to be set against a profession-led care delivery system. In this juxtaposition, the professionals are cast as both careless of resources and as deaf to questions of patient and client choice. Pluralism in welfare is allied with freedom and choice."

However, there are signs that even those who are enthusiastic about general management, recognise the dangers of "unmanaged marketisation" as Best (1987:6) calls it. He warns against the danger of allowing market forces to improve efficiency to such an extent that geographical and social equity are forgotten as basic principles of the NHS.

Much stronger criticism of the way that the thinking of the radical right has permeated health policy and management is now beginning to emerge. Groups like "NHS Unlimited - a committee to combat private medicine" (1988) have been set up within the House of Commons, and a few lone voices from the world of medicine (e.g. Shuster 1986) have spoken out. Christine Cousins's (1987) book "Controlling Social Welfare" gives a left-wing and feminist perspective on recent changes in welfare provision and the NHS. She highlights the contradiction for managers in introducing market rationality into the public sector in order to relieve financial pressure on the government, whilst still needing to maintain the legitimizing aspects of welfare services which help preserve mass loyalty to state authority. Cousins undertook case studies of Griffiths' implementation in several district health authorities in the home counties. She observed that

> "There was a tendency for managers to treat the health service as a set of commodities, of plant, equipment and manpower, which they had the right to manage as they saw fit, rather than as being held in trust for the public. This was accompanied by a technocratic rhetoric .... the effect of this was to objectify labour, and the production and nature of health care, damaging .... the moral commitment of employees to health care work."
> Cousins (1987:168)

Cousins particularly studied the effects of domestic and other services being contracted out to commercial companies, which although generating some savings to health authorities, also involved hidden costs in terms of monitoring compliance with contracts, extra work for

others, particularly nurses, who took on work not covered by the contracts, and loss of morale and commitment amongst lower-level workers. Cousins (1987:172) believed that contracting out was politically attractive to the Government as well as economically, because it weakened the strength of public sector unions.

Cousins (1987:167) also argued that gender issues are important in present trends in health policy and management, a view that is shared by Allsop (1984:120) Strong and Robinson (1988:47) and Owen (1988:43) but which there is not space to discuss here.

4.6.4 General Management As A Challenge To Medical Dominance

Another issue which is embedded deeply in the development of the NHS and has been brought into sharp focus by the implementation of the Griffiths Report is that of medical dominance. As long ago as 1979 Clark was putting forward the case for abandoning

> "the overwhelming dominance of medicine and the medical model of illness in health services, replacing it with a model based on prevention and care, in which care is a partnership between family, community and a multi-professional team."
> Clark 1979:208-210

The work of Freidson (1970 and 1986), Illich (1976) and Kennedy (1983) is well known in this field and Allsop (1984:117, 208, 226) points to the medical profession as a barrier to change at various points in the history of the NHS. Bradshaw (1985:42) expresses the opinion that the Griffiths Report was mainly about control. Basing his

argument on the ideas of Edmonstone (1982) and others regarding domain theory, which I discussed in the previous chapter, Bradshaw explains that NHS managers do not have the same degree of control as their industrial and commercial counterparts, chiefly because of the autonomy of the medical profession. He concludes

> "all the indicators suggest that the district general managers will exert powerful control over nursing, paramedical and ancillary staff. The chief test will be whether or not DGMs can control the doctors."
>
> Bradshaw 1985:42

Recently the question of medical dominance has been raised again by Strong and Robinson (1988:6) who like Allsop (1984) trace back through the history of the NHS and find many points where the power of the medical lobby has frustrated change. Writing about the 1974 reorganisation, they doubt the capability of consensus management to have welded together the many disparate elements of the NHS, even supposing that the balance of power had been equal between the different groups, which was not the case. They say

> "Consensus management was hardly a negotiation between equals. Managers were weak because doctors were strong, nurses were ignorant because doctors were educated."
>
> Strong and Robinson (1988:6)

However, the authors of this detailed ethnography do not reach any conclusion on whether the Griffiths changes have had any effect on medical dominance. Perhaps it is too soon to tell.

4.6.5 General Management As A Balance Between Individual And Community Needs

I suspect that giving so much attention to the question of medical power obscures the debate that could lead to a way to resolve some of the most acute problems of resource allocation and priority determination. That debate is centred around the moral and ethical questions raised by the need to use health resources more effectively and efficiently. The questions include a fundamental one, as Allsop (1984:225) points out, of whose interests prevail, the individual or the collectivity? Health professionals in clinical practice tend to think in terms of individual need, whereas health care managers or planners take a more detached view, looking at the needs of the community as a whole. A number of commentators on Griffiths' implementation see this dichotomy as a central issue - particularly Glennerster et al (1986:5-6), Owens et al (1987:87), Wall (1987:52) and Hunter (1984:94). Culyer (1984:preface) writes

> "An unfortunate division of responsibility seems to have grown up whereby costs are the business of administrators and treasurers, while benefits are the business of doctors and nurses ... some doctors even claim it is unethical for them to be concerned about costs."

Continuing the argument, Williams (1984:3) considers three roles that many senior doctors carry simultaneously, those of clinician, practice manager and membership of a management team or executive board. Even in the one-to-one situation of the clinician, Williams argues, the doctor may

have to consider, with the patient, the relative benefits of different forms of treatment in terms of quality or quantity of life, which may include economic considerations. Also, because the doctor is not a perfect agent, he inevitably weighs up the costs and benefits for himself, in terms of time to be spent in particular. So all doctors cannot help but be involved in health economics, is Williams (1984:8) conclusion. He claims that the economist's method of counting costs as well as benefits when making decisions, even clinical decisions, is therefore not unethical, and that anyone acting totally without regard to costs is not ethical, but fanatical.

Seen in this light, Griffiths' attempt to involve clinicians in management, combined with the initiatives in management budgeting, may not be capitulation to medical dominance, nor an attempt to impose rationality on the irrational, but a quest for balance between the interests of the individual and the community.

4.6.6 General Management As A Balance Between Many Other Conflicting Interests.

To conclude this chapter I want to expand on an idea suggested by Strong and Robinson (1988:85). They characterised general management as a series of "overlapping pairs of opposite dimensions". I would suggest that the NHS itself is permeated at all levels by pairs of opposites - in one sense they are conflicting dimensions, but in another sense they are continua. One might picture the whole edifice continually balancing on a

number of see-saws, all tilted at different angles. A list of some of these pairs of opposites, suggested in this chapter and the previous one, is shown in Figure 4.6.6(a). It is followed by a similar list (Figure 4.6.6(b)) which applies specifically to nursing, although I believe there are strong links between the two lists, because the practice of nursing is embedded within the NHS and therefore takes on many of its characteristics, as shown in the previous chapter.

Figure 4.6.6(a) Some Of The Opposing Dimensions Present In The NHS

Central Control	Devolution
Tighter Structure	Flexibility
Authority	Democracy
Mechanistic Systems	Organic Systems
Systematic Review	Personal Responsibility
Efficiency	Equity
Rationality	Bargaining
Value for Money	Pursuit of Quality
Productivity	Personal Service
Cost Containment	Individualized Care
General Management	Specialist Advice
Political Expediency	Social Justice
Needs of Community and Organisation	Needs of Individual
Public Accountability	Professional Autonomy
Statutory Services - profession led	Non-Statutory Services - consumer led
Cure	Care
Acute Specialties	'Cinderella' Services
Treating illness now	Promoting health in future

Figure 4.6.6(b) Some Opposing Dimensions Present In Nursing

Nursing as a professional activity	Nursing as a lay caring activity
The nurse as technician cum medical helper	The nurse as patient advocate
The nurse as theoretician	The nurse as everyday practitioner
The nurse as practitioner in her own right	The nurse as therapeutic team member
The nurse as member of a professional association - searching for status	The nurse as member of trades union - feeling solidarity with other NHS workers
'Nurse managers' "macro" approach	Nurse practitioners' "micro" approach
Student nurses with educational needs	Student nurses used as "pairs of hands"

One way of looking at general management in the NHS is to see it as a way of achieving a balance between the conflicting dimensions. The writers of a Peat Marwick (1986:53) handbook aimed at public sector managers suggested that the test would come in three to five years time from the introduction of general management.

> "If the momentum can be maintained, if there is a balance drawn between achievement of performance and sensitivity to patient needs, and if care is taken to listen to the views of consumers, then the NHS should be improved significantly."

Evidence so far indicates that the balancing act continues - but precariously. A number of factors put extra weight on one side or another at regular intervals - political interference, economic changes such as sudden alterations in financial allocations or pay awards and changes in disease patterns such as increases in the number of

A.I.D.S. cases. The NHS will continue to change; even as I write the publication is expected of the long awaited White paper resulting from the Prime Minister's Review of the NHS.

4.7 Conclusion

Turning back, however, from the future, it is time to focus on the case study of the development of one NHS unit, created in the aftermath of the Griffiths Report. The issues raised in this chapter - nurse management, medical dominance, political pressure and the "procession of management interventions" (of which "Griffiths" was just a part) all appear later in the thesis as concerns of the research participants. The idea of general management's balancing role in the midst of conflicting interests in the NHS is also relevant later, especially when considering the role of the Unit Management Board and the Unit General Manager.

CHAPTER FIVE: THE RESEARCH PROCESS - IN PRACTICE

5.0 Introduction

In this chapter I seek to fulfil the undertaking given in the first Chapter (section 1.2) to expose the stages in my journey through the world of research. I begin by describing the business of gaining access to a research site and arriving at an acceptable research design. After a frustrating period of waiting the research process gets underway and many aspects of this are discussed. Considerable space is devoted to data analysis in all its stages, which began, as it should, whilst the research was still in progress, and seems to have continued right up to finalising the last draft of the thesis. I particularly consider the use of metaphor in organisational analysis, and conclude by recognising the problem resulting from lack of perseverance with the "memo-writing" stage of discovering grounded theory.

5.1 From General Ideas To Research Design - Choices And Constraints

In Chapter Two I observed that it is usual in some research traditions to gloss over the process of choice involved in making a detailed research plan out of a mass of possibilities, giving the impression that this is not a potentially difficult stage. Not describing the choice process often contributes support to the myth of value freedom beloved by positivists - in reality a number of factors constrain the researcher in translating generalised notions into a detailed research plan, and in getting that

plan accepted by the funding agency and the intended participants. Constraining factors include the depth and breadth of the researcher's knowledge of the relevant areas of theory and literature, the extent and nature of her experience of research and of the substantive area to be studied, her own goals and values, and her intellectual and personal attributes and limitations. Add to this the practical considerations of time and resources available, the likelihood or otherwise of acceptance of the plan by the funding agency and intended participants and the fact that events do not stand still and wait to be captured - and the possibility of an ordered, rational choice process recedes. The situation begins to resemble the "garbage can" model of organisational decision making described by Cohen, March and Olsen (1972) where organizations are seen as

> "contexts (or garbage cans) into which pour problems, solutions, participants and choice opportunities."
>
> (Pfeffer 1982:235)

Decisions may result from resolution (a matching of problems and solutions) flight (problems avoided but solved by another, unrelated choice) or oversight (they are seen as part of another problem and resolved along with it). The originators of the model prescribe a "technology of foolishness" to be applied in such situations, where amongst other things creativity and experimental behaviour are encouraged, and intuition is valued. Experience, in these circumstances, can be treated as theory, but theory

which is constantly growing, changing and being rewritten. Looking back on the choice process I faced, I see similarities between it and the "garbage can" model.

Commenting on Knorr-Cetina's (1981) work on "The Manufacture of Knowledge", Sunesson (1985) describes how Knorr-Cetina concluded that a scientific paper had been written in a setting more determined by power than by scientific ethics. Sunesson writes that such a paper may give

> "a false picture of the research process. It tries to make us think that the research started out from problems that in fact were invented much later: it depicts a mess of contingencies and random events as a logically planned research process, and interprets the research findings in several opportunistic ways. The actual writing of the paper takes place in a process that has almost nothing to do with rationality. Instead, it is determined by the power of institutions and individuals."
>
> Sunesson (1985:230)

I am not saying that the research process described in this thesis has nothing to do with rationality, but I do not want to gloss over the points where opportunity played a greater part than I would have liked, and where influences of people or institutions had some effect.

In Chapter Two I briefly alluded to one of the tenets of the grounded theory approach, which is the desirability of the researcher being able to approach the data without first filtering it through pre-existing hypotheses and theories. (Colville 1981:126) (sometimes referred to as having a "tabula rasa"). I suppose young, inexperienced sociology students might sometimes be able to approach a

possible research topic in this way, but I certainly could not do this. I had spent very many years working at field level in health care organisations, including some time in the locality in question (5 years previously). More recently I had been studying theories of nursing and organisation. However, I believe that I had not committed myself to any one particular approach, other than to realise that professional philosophies are inevitably reflected in the management of health care. As Stevens (1984:125) says

> "The nurse executive theorises, whether she intends to or not, by virtue of the structures she employs to place patients and staff, to distribute the work to be done and to tell how it is to be accomplished."

At the time I was struggling to produce and negotiate acceptance of a research plan (during the spring of 1985) it was not by any means certain that nurse executives would actually continue to function in an executive capacity, at least in the case-study district. The situation nationally is described in Chapter Four. This uncertainty about future management patterns explained my inability to specify an action research strategy in my original proposal which was rejected by the DHSS. The suggestion that I undertook a case study of a unit of management came initially from a nursing officer at the DHSS; this solution to my problem of what research to do fitted my own values, goals, personality and resources, as I have already described in Chapter Two. I also realised that I could still investigate the interface between professional values

and management, whether or not there was a nurse executive in post in the Unit.

5.1.1 Gaining Access To A Research Site

In order for the case study research plan to be accepted by my sponsors, the DHSS, I had to find a unit willing for such a study, which would also be accessible to me at minimum expense, and of a size to make it possible for a single researcher to investigate it at some depth. Fortunately unit general managers were just being appointed by Stoneyshire D.H.A., following approval by the DHSS of their restructuring plan. One of the Stoneyshire units, Western Unit, met my criteria, and the UGM was sympathetic to the idea of a case study and gave outline consent for research access in July 1985.

5.1.2 The Research Design

The purposes for the entire research project have already been listed in Chapter Two. The case study itself was described as exploratory, and therefore built around research questions, rather than a hypothesis - which would, in any case, have been contradictory to the idea of inductive theory building and naturalistic design. The questions posed in the original plan, submitted to the DHSS for approval, were as follows:-

1. What staff and services make up the new unit?

2. a) How have the staff been managed and supported in the past, and b) what changes are they expecting and experiencing under the new arrangements?

3. What beliefs about the nature of their work and its place within a system of health care do the various professional groups hold?

4. What are the implications of these beliefs for management structures and practice and for quality and quantity of care?

5. How does a unit, and its subsidiary sub-units form goals or objectives? Are these goals congruent with each other?

By the time the research began, another question had been added:-

6. What difference to members of the Unit, clients of the Unit (e.g. patients, G.P.s, local authority services) will it make, or has it made, by forming a separate Western Unit, rather than being managed from District HQ?

Whilst acknowledging in the research plan that the grounded theory approach demanded flexibility and continuous modification of the design, I had to map out in some detail the expected methods of data collection and analysis, the anticipated participants, and the boundaries and time-scale of the project, in order to gain approval from the DHSS. The tension between the need for official approval and the aspiration to follow a rather unconventional path of research remained with me throughout. I envisaged the investigation beginning in September 1985 and continuing till June 1986; the new U.G.M. was to take up his duties in September, and the Unit was meant to be fully operational by April '86. A full description of the Unit is given in the next chapter. I viewed the Unit as being all staff and services accountable to the UGM - the principal sub-units being staff groupings such as nursing (the major component of the Unit) medical staff (very few) paramedical staff (various therapists), administrative and secretarial staff and support services (technical, maintenance, domestic and

catering). The context of the Unit was spelt out in some detail in the research design as I felt that this was a crucial consideration. The context was seen as the organisations, departments and individuals with whom the Unit would relate - in particular:-

Other units of management within the D.H.A.,

District-based departments of D.H.A. e.g. personnel, planning, finance, research,

Neighbouring D.H.A.s providing services to the Unit, on an agency basis,

Relevant Local Authority departments e.g. Social Services, Education,

Consumers of health services (including G.P.s) voluntary organisations and the Community Health Council.

I planned to use several different methods of data collection. These were:-

1. In-depth, focused interviews with UGM, his support staff, and key members of sub-units, also key members of context groups.

It was initially planned to tape-record these interviews, to provide a complete record for analysis.

2. Group discussions with staff - possibly using Group Feedback Analysis (Heller 1969).

3. Non-participant observation of meetings within Unit - policy, planning, staff meetings etc.

4. Document analysis e.g. Griffiths Report (1983) DHSS circulars, Health Authority, DGM's and UGM's reports and plans relating to the Unit.

5. Collect any available statistics on staff turnover, absence, grievances, complaints, performance indicators etc.

In the research plan I also specified that data analysis would proceed concurrently with data collection, according to the grounded theory method, and that I would feedback

relevant data to participants, giving them opportunity to comment on my interpretations, and using their comments as further data. I made no claims to generalisability of the findings of the case study, but expressed the belief that because the study as a whole was to compare theories of nursing and health care organisation with practical reality as seen in the case study, the ideas expressed would have value and interest beyond the confines of the Unit concerned. The research plan was eventually accepted by the DHSS in late August 1985 - but it was to be several months before I could actually begin the research.

5.2 From Acceptance To Beginning The Research

This part of the research record is based on the journal I kept from March 1985 onwards. I did not list it in the research plan as a data collection instrument but it has served as such as I have used it to reflect on the process of research as well as to record actual events.

In September 1985 I drafted an introductory letter (see Appendix 1) to be used in various forms throughout the research to different groups of participants. In it I explained the nature and format of research reports and issues of confidentiality as well as explaining the perspective and scope of the project. Although agreeing to the conditions set out in this letter, the UGM asked me not to go any further until he was able to consult his management team which would not be until the end of the year. The DGM also intervened at this point, wanting me to

consult the new District Research Officer who would be taking up office in October 1985, and then to write a paper for the Health Authority, before beginning the research.

5.2.1 Problems With Tape-Recording

At this point I began to have doubts about using a tape recorder for the interviews. The UGM felt it would be a barrier to acceptance, and it was becoming clear to me that I would not have secretarial support for transcribing tapes to the level that would be required. (The methods I had chosen demanded immediate access to interview records both for member validation and constant comparative analysis). In addition, there are other arguments against mechanical recording which I found later in "Naturalistic Inquiry" (Lincoln and Guba 1985:272) and endorse from experience. Hand note-taking is not as threatening as tape-recording, keeps the investigator alert, and is not subject to technical difficulties such as machine, tape or electric failure. It is easier, using notes, to summarise back to the participant at the close of the interview, or to flag important issues to return to later, and to insert observations on the interviewee's non-verbal behaviour, or other comments. The process of analysis is also enhanced by hand-recording interviews, because the discipline of writing up a full interview script using the notes as a basis, whenever possible within twenty-four hours of the interview for best recall, serves at least as a preliminary opportunity for analysis,

> "at least to the extent that the next day's work can be refashioned on the basis of today's insights."
> (Lincoln and Guba 1985:273)

I decided therefore to abandon the idea of tape-recording interviews.

5.2.2 Delays In Beginning The Research

Following the arrival of the new Research Officer in the District, the DGM agreed that a paper need not go to the D.H.A., provided the Research Officer agreed on my research plan. I wrote and delivered a seminar paper in the Research Department in November '85, which clarified some of my ideas and strengthened my resolve that the case study should be conducted in a collaborative, participative style. The UGM for Western Unit was invited but to my disappointment did not attend. The seminar was a useful forum for discussion of the ethical aspects of the project, but still the permission to begin was delayed.

At this time the RCN and Health Visitors Association held an open meeting in Cobbletown where Stoneyshire DHA had its headquarters. At the meeting national officers spoke in support of local members who were protesting about lack of consultation over unit restructuring and especially over roles for senior nurses in the new units. The national officers encouraged local members to make greater use of the nurse member on the Stoneyshire District H.A., as well as the professional adviser at district level. The latter was in fact in an anomalous position. The former Chief Nursing Officer for the District had not been formally

recognised as Chief Nurse Adviser, and soon after this was seconded to work outside the District. It was to be many months, in fact after the case study was over, before the Director of Nurse Education at Cobbletown was recognised as Chief Nurse Adviser in addition to her existing role. So for almost a year there was no effective voice for nursing at a high level in Stoneyshire DHA.

Returning to November 1985, a few days after the RCN/HVA protest meeting, the plans for higher levels of management in the three new units were published and a short period of consultation ensued, including the holding of open meetings for staff to question the UGMs. The unit plans varied considerably between the three new units, both in terms of actual structures, especially over specified positions for senior nurses, and in terms of making unit philosophy explicit. The long-stay unit document was clearest over a philosophy of care, whilst Western Unit was the only one to specify a senior nurse as a unit board member. Nationally this was the time when concern about the position of nurses in the new management arrangements was reaching a peak, culminating in the RCN's press campaign in January 1986, referred to in Chapter Four (Section 4.5.1).

At the end of November, the UGM for Western Unit gave me permission to make preliminary contact with the Uppertown Administrator and Senior Nurse who were quite possibly going to apply for positions on the Unit Management Board. (Their appointments, as Deputy Unit General Manager and Unit Nurse Manager respectively, were confirmed in

February, 1986). Both of them agreed to co-operate in the case study, although expressing concern about the many issues they faced in addition to the creation of the new Unit. These included:-

competitive tendering for cleaning and catering

building of a new maternity wing and closure of the existing maternity unit

developments at the Geriatric Hospital including possible building alterations for the provision of a psycho-geriatric unit

nurse recruitment problems in view of new developments

possible provision of local psychiatric and mental handicap services.

The Senior Nurse suggested I make informal contact with the nursing officers to ascertain their willingness to take part in the case-study. All gave their support but I had to wait until 10 December '85 for the formal permission to proceed from the UGM.

5.3 Doing The Case Study

As Unit Board appointments were not yet made, I decided to start my research at the level of field staff - in particular, with nurses, as my strongest contacts were with that group. I made appointments to meet groups of staff informally at health centres and hospitals early in the New Year. (it was too close to Christmas to start meetings in December.) In the intervening time I obtained staff lists and sent out introductory letters to all trained nurses in the Unit (S.R.N.s and S.E.N.s, midwives and health visitors and school nurses.) Later in the

project I had informal discussions with a few nursing auxiliaries but found little response amongst them to any of the issues at stake. I made preliminary site visits to all the major centres in the Unit, (hospitals and health centres), delivering letters and talking informally to members of staff - in some cases, renewing old acquaintances, as I had worked in the area some years previously.

5.3.1 The Interview Process

I had been gathering, over the months of preparation, a list of topics round which to focus the interviews, whilst allowing other issues to surface as well. The topics included all the items on the list of research questions given earlier in this chapter, which were applicable to staff working in the Unit. Later in the project, when I began interviewing people belonging to the Unit context, I concentrated more on the question of expectations of the Unit and its services, and patterns of communication and relationship, and later still, when talking to members of the Unit Board, found issues of role and identity within the Board, and its relationships both internal and external, assuming importance.

I adopted a conversational, informal interviewing style, aiming to put the interviewee at ease. My models for this style of interviewing were those described by Schatzman and Strauss (1973:73) and Melia in her thesis (1981) and later in her book (1987:190-195). The interviewer has an agenda of topics, but these are introduced in such a way that the

subject feels free to say whatever he wishes and to introduce new ideas which the interviewer may then explore.

Knowing that the transcript of the interview was to be sent to them for review and comment was reassuring to many participants, and I believe gave them greater freedom of expression.

I conducted the very first interview the week before Christmas, with a Community Nursing Officer. The interview lasted over one and half hours, which was on the long side, but I found that most interviews took between forty-five and seventy-five minutes. They usually took place near the person's working base, but preferably not in their own office because of the likelihood of interruptions.

5.3.2 Writing Up Interviews And Seeking Validation

Within twenty-four hours of the first interview I wrote up my account of it as near verbatim as I could, using my scribbled notes as the "skeleton", marking my questions and remarks Q and the response A in the margin. I wrote (in my own handwriting which fortunately most people can read) the scripts in a series of duplicate books with numbered, perforated pages, heading each page with the date of the interview and a reference to enable me to distinguish that person's job and location at a glance. The key to these references was kept at all times safely secluded, and recorded the page and book numbers beside the reference key for each interview - each book had one hundred pages and fifteen books were filled with interview scripts. The top

copy was detached from the book, photocopied and the photocopy was then sent to the interviewee for review, with the request that they make any additions, deletions or alterations they wished, then return it to me as soon as possible. Of over one hundred interview scripts, only one was not returned eventually, although some needed a little chasing. The one not returned was regretfully abandoned as data. Very few people made any changes, endorsing the script as an acceptable record of the interview; of the two who did make substantial changes, one had the beginnings of influenza at the time of the interview, and probably did not quite know what she was saying!

5.3.3 Keeping The Data-Base Intact

The reason I chose the rather complex system of recording, referencing and copying the scripts was that I needed to keep a safe copy untouched, of every script, as the "meticulous data-base" referred to by Yin (1984:92-4), whilst having two copies available for analysis. Grounded theory methodology may require the cutting up of scripts into separate parts (maybe even of a couple of lines) for sorting of concepts. In the event, I adopted a different system of analysis, writing concepts onto 3" x 5" cards as suggested by Turner (1981:232 and 1983:334) but when I planned the system I was not sure how to proceed, so allowed for an extra copy.

5.3.4 Interviewing Nurses And Other Unit Staff

Early in the New Year I met with small groups of community

staff and explained the background and implications of the research to them. I then booked appointments to interview as many as I could, finding very few who refused to take part. During January I conducted twenty interviews, usually managing to write up the scripts on the same day, except for one day when by over-enthusiasm I booked five interviews. I found it could take up to two hours to write the transcript for one interview. The problem was fitting the interviews in when people could be spared from their clinical duties (for community staff often in the middle of the day) and trying to rationalise the travelling a little by doing several interviews in one place on one day. Whenever possible I mixed with staff at coffee and lunch times in the staff room to try to imbibe the atmosphere.

In February 1986 I began to make contact with midwifery and paramedical staff, whilst continuing community staff interviews. At this time, the appointments of Deputy UGM, Unit Nurse Manager and Unit Medical Officer were confirmed. I had found little organised response to my suggestion that hospital staff should invite me to speak to them at a staff meeting - so I began to go into the hospitals when the opportunity arose and "buttonhole" people and try to arrange interviews. My arrival in the Maternity Home seemed to act as a signal for women to go into labour, and in the Casualty Department as a trigger for accident victims to come pouring through the doors! It was very difficult to find suitable times to interview hospital staff - almost all were part-time and shift overlaps had

been pared to the minimum to save money on staffing - so when a trained nurse was on duty, she was usually "in charge" of the ward, and could not spare time to talk to me. I interviewed twenty-seven people in February, because a considerable number were going to be on holiday in March, making the remaining staff extra busy; consequently I had a back-log of interview scripts to write and only interviewed ten people in March. (I also needed to write an interim report for my academic supervisors towards the end of March which took time away from interviewing, but acted as a useful and necessary opportunity to stand back from the research process and realise that I had become unbalanced - I was rushing on with data collection and not giving time for analysis, and so not fully entering into the grounded theory approach.)

I was beginning to find that among nurses I was not discovering anything new - my questioning was beginning to become routinised - and I realised I might be approaching what Glaser and Strauss (1967:70) call "saturation of categories." So apart from making arrangements to do some night-time interviews with nurses in April, I wrote to the remaining trained staff, mostly in hospital but a few in community, asking them if they had a particular contribution to make to the research, to get in touch with me either personally or in writing, otherwise I would be moving on to different staff groups and context organisations. No further nurses contacted me.

5.3.5 Interviews In the Unit's Context

By early April I had obtained permission from the UGM to contact general practitioners in the area, also to contact local authority senior officers and neighbouring health authority U.G.M.s, and I began interviews with these influential groups. It was important that I should not step outside the limits of access given to me by the UGM - as the process of Unit formation moved slowly forward, he had progressively to build relationships first with staff groups, and then context organizations. He, quite reasonably, wanted at least to make his first contacts before I approached people with questions about the Unit. Making arrangements to see G.P.s was even more difficult than meeting hospital nurses - usually because the receptionists acted as a buffer. Despite my having sent an explanatory letter warning of an impending telephone call, frequently I would be greeted by a claim to know nothing about me, and even had to send duplicate information on one occasion. However, by dint of persistence I did eventually manage to interview, either singly, or in groups, nineteen G.P.s, or to receive written observations from them. Only one practice on the fringe of the unit area was totally uninvolved, with all the rest taking part in some way.

I was received warmly by representatives of local authority education and social service departments, and obtained their differing perceptions of the N.H.S. Yet another perspective came with the interviews with two U.G.M.s of the neighbouring Health Authority (belonging to a different

region); their two units provided many services for Western Unit on an agency basis, so their contribution was vital. During this period (April - May '86) I was continuing to interview Unit staff, especially support service managers and medical and paramedical staff, and investigating possible consumer contacts. Eventually I settled for representatives of voluntary organisations whose members would be likely to use the health services more than the average - such as clubs or projects for disabled or handicapped children or adults, and, of course members of the Community Health Council. I did approach the Hospitals' Leagues of Friends, but received no replies from them. Contact was made with members of District Headquarters departments and a representative of the other Unit within Stoneyshire chiefly relating to Western Unit: they were seen informally and the conversations written up in my field diary - they preferred their comments to be "off the record". Their views became part of my store of "tacit" knowledge about the Unit.

I concluded the interview process by talking with members of the Unit Board, some of whom did not take up their duties until June '86, despite the intention for the unit to be "up and running" from April 1st.

5.3.6 Other Data Sources

I received written comments from one member of Stoneyshire Health Authority who was particularly concerned with the Western Unit. Altogether I interviewed one hundred and fifteen people, but because some of these spoke

to me in small groups, the number of interview scripts was one hundred and seven. For analysis I added to these eight scripts of meetings I attended as non-participant observer - two of which were Unit Board meetings, and the rest were meetings in different locations around the Unit, held from early April onwards, giving staff of all grades the opportunity to meet the UGM and other Board members and to question them and express their views. I treated these observations similarly to the interviews, writing scribbled notes at the time, and writing a full script within twenty-four hours. These, however, were not submitted for member validation.

5.3.7 Summary Of Interview And Observation Scripts

Table 5.3.7 shows the number and designation of people interviewed. I explained earlier in this chapter the difficulty of finding suitable times to interview hospital nurses because they could seldom be spared from the wards. This explains the discrepancy in proportions of hospital and community nurses interviewed. However, even when interviewing hospital nurses later in the project, I was conscious of a sense that saturation of categories was being achieved, as little new material was uncovered.

Appendix 2 gives a more detailed list of interview scripts and personal records of meetings I attended, in order that quotations cited in later chapters of this thesis may be traced to their source.

Table 5.3.7: Summary of interviews and scripts used in analysis

Designation	Number inter-viewed	Total no. in category (if known)	Percentage of category	Number scripts
Health Visitors and School Nurses (including Nurse Manager)	17			17
District Nurses (R.G.N. + S.E.N.) (including Nurse Manager)	17			17
Community Midwives	4			4
Total Community Nurses	38	44	86%	
Hospital Midwives (including Nurse Manager)	7			7
Cottage Hospital Nurses (RGN and SEN) - includes Nurse Manager	8 1 did not return script			7
Geriatric Hospital Nurses (RGN and SEN) - includes Nurse Manager	7			7
Total Qualified Hospital Nurses	22	58	38%	
Paramedics and Clinical Medical Officers	12 included a group interview	*		10
Service Managers and Secretaries	5	*		5
Management Board	7	8	87%	7
General Practitioners (only 1 practice not represented at all)	19 (included several groups)	28	68%	12
Consumer Representatives - (from voluntary societies, C.H.C., and H.A. member)	8			8
Context Representatives - (Social Services, Education, UGMs from neighbouring H.A.)	6			6
Meetings Observed (Unit Board x2 and 6 UGM/staff meetings)	8			8
			Total scripts	115

* Because Unit boundary arrangements not fully resolved, impossible to calculate number of Paramedical and support workers belonging to Unit.

5.3.8 Documentary Data

Documents collected included, of course, the Griffiths Report (1983) itself, and the later DHSS circulars that followed it, the papers put out by the DGM and UGM about management plans and structures, and a small number of minutes of meetings held as the Unit developed. Surprisingly little had appeared as written communication within the Unit by the time I concluded the case study - perhaps because of its small size, most communication was done personally either face to face or by telephone. A full list of documents can be found in Appendix 3.

5.3.9 Data Not Available

Two sources of data included in the original research plan did not become available. Group discussions with staff using Heller's (1969) technique of group feed-back analysis were not possible because of the difficulty of gathering groups together for long enough. This was due to already mentioned problems of lack of shift overlap, part-time working, and the scattered nature of community facilities in this largely rural area. Statistics of any meaning or relevance were not available either, because of the previously disparate management of the different staff groups involved, and the gradual nature of the handover of management responsibility to the Unit itself. It was particularly impressed on me by the Personnel Department at District that statistics on absence, turnover and so on should be looked at over a considerable period to have any meaning - two years being a minimum - and the way these

statistics had been recorded made it impossible to separate out Western Unit from the other units until after April '86, the date for full operational responsibility for the Unit.

5.4 Data Analysis

I have already referred to the sense of falling short of Glaser and Strauss's ideals that I felt, in common with other researchers. This feeling was particularly strong when I was so bogged down in interviews and writing scripts in February 1986, and again when writing Chapter Two and re-reading Glaser and Strauss's enthusiastic encouragements to follow their method. However, as I look again at my interview scripts and the concept cards generated from them, I realise that perhaps I had too lofty a view of the theory I was looking for. The concepts distilled from the interview scripts are indeed

> "the commonsense constructs which determine (the participants') behaviour, define the goal of their actions .... in brief, which help them find their bearings in their natural and socio-cultural environment and to come to terms with it."

as Schutz (1964:5-6) explains in his writing on social reality. Linking these concepts together does produce a "theoretical account of a small fragment of the world", as Turner (1983:347) put it.

5.4.1 Preparing Data Summary Cards

My first task in the analysis process (other than the mental assimilation of the ideas expressed whilst writing

the interview scripts) was, on receipt of the script back from participant review, to prepare a summary card for each script (on a 8" by 5" index card). On this I listed the main points expressed - and later, on the back, was able to add the reference numbers of all the concept cards to which this person's ideas had subscribed. This was a useful way to follow through the implications and consequences of certain professional philosophies to the remainder of the issues discussed.

5.4.2 Comparative Analysis

Eventually, but rather later in the research process than was desirable, I began to work on the real comparative analysis. As I read through a script I used a highlighting pen to illuminate the key phrases that encapsulated that person's ideas - immediately as each concept was isolated I wrote it in pencil on a 5" by 3" card in as concise form as I could, one thought to each card. Towards the bottom of the card I wrote the reference number of the script and the page where the concept appeared in coloured ink - a different colour for each professional group involved. By the time I had found a concept repeated on a number of scripts, I would have a number of references, perhaps six or seven, and I could tell at a glance if they were all the same group (e.g. midwives, or health visitors) by the colour of inks on the card.

Having exhausted the first script, I spread the concept cards out around me and began highlighting the next script.

Each time I isolated an idea, I scanned the existing cards to see if a similar concept was already expressed. If it was, I added the reference to that card. If not, I made a new card. Occasionally, a word or two needed to be added to a card to fully incorporate the new idea. Much thought was required when comparing ideas to identify similarities and differences, and obviously personal interpretation does play a part in such a process.

Having read about Macintyre's (1979) attempts to use a computer to aid qualitative analysis, I did consider whether I might be able to do something similar; but I rejected the idea chiefly because a computer programme can only recognise the words you ask it to, and is not sensitive to the way in which those words are used. Also I would have had to enter the entire data base myself, not having any secretarial help. Spending a number of weeks immersed in analysis produces a great familiarity with the data and the concepts expressed, and I found the small cards easy to handle. Had I followed Glaser's suggestion of cutting up the scripts, rather than Turner's, of using cards, I think the process would have been harder and slower.

5.4.3 Discerning Patterns In The Data

When I had worked through all the scripts, the next stage began. That involved reading and re-reading all the concept cards, making attempts to classify them in various ways. Cards which were similar in meaning were combined at this stage, but even so I had over 500 cards to organise. I

think this is the stage where I was most conscious of falling short of Glaser and Strauss's method. The process of writing memos did not flow well - I would have felt happier if I had built up a larger and deeper collection of writings linking the varying conceptual categories. Possibly this is something that works better when you are part of a research team and write memos for other members of the team to explain your ideas.

Eventually after much sorting and re-sorting, some patterns and themes began to appear, and I was able to discern twelve main subject headings under which to sub-divide the cards. Each subdivision heading spelt out the conditions for inclusion, being the chief of a family of codes - each code being, as Charmaz (1983:111) put it

> "a shorthand device to label, separate, compile and organize data."

A summary of the analytic framework is given in Appendix 4.

5.4.4 Including Nurse Managers' Responses With Their Staff's Responses, Not Making Them A Separate Group

It is obvious that a good deal of emphasis has been placed on nurses' views; this is because much of the work of the unit is nursing work. After much consideration I decided to include the clinical nurse managers' responses together with the nurses they managed, for the purposes of analysis, rather than as a separate group. I came to this conclusion because although the nurse manager interviews tended to be longer, and yielded more concepts for analysis than did the

nursing staff interviews, the actual nature of their response did not seem qualitatively very different. Apart from making this judgment intuitively, I also calculated for each nursing discipline the mean number of concepts relating to purely nursing issues, and the mean number relating to wider issues of N.H.S. organization and philosophy. Expressing wider issues as a percentage of total concepts expressed, I compared these figures for nursing staff with the figures for their respective nurse managers which resulted in the following table.

TABLE 5.4.4 Comparing Clinical Nurse Manager Responses with Nursing Staff Responses

Discipline	Nurse manager	N.M's total concepts	N.M's wider issues No.	N.M's wider issues %	Staff No. in group	Staff's mean total concepts	Staff's wider issues Mean No.	Staff's wider issues Mean %
Health Visitors	1	43	20	46.51	16	28	13	46.43
District Nurses	1	37	21	56.76	16	25	11	44
Midwives	1	33	16	48.48	10	25	14	56
Geriatric hospital nurses	1	37	19	51.35	6	22	10	45.45
Cottage hospital nurses	1	36	16	44.44	6	22	11	50
Total	5	37 (mean)	18 (mean)	48.65 (mean)	54	24	12	50

I took advice from the Statistical Services Unit of Sheffield University but was advised that statistical tests were not appropriate in comparing these figures. However, it can be seen that for health visitors, the manager and staff's mention of wider issues was similar in proportion. For district nurses and geriatric hospital nurses, the managers expressed proportionately more organizational issues than did the staff, and for midwives and cottage hospital nurses the opposite was the case. Taken as a whole, the managers' and staff's proportions of wider issues were very close, therefore on the grounds of qualitative similarity of response I included nurse managers' responses with their staff's.

5.5 The Unit Report

Once I had completed the framework of the analysis, and assigned all the subdivisions and codes to their places within that framework, I produced a short report for the Unit itself, as time was already slipping by, and if the work was to be of any use to the participants, they needed to see the report. The report (which was sent to participants in May 1987) became the "tentative theoretical statement" referred to by Turner (1981:240) which

> "should reflect, as faithfully as the researcher can manage, the complexities of that portion of the world which has been studied."

The report was sent initially to the members of the Unit Board, who after some delay wrote an enthusiastic response, (see Appendix 5) stating their intention to build on the

findings and to take heed of the areas where problems were demonstrated. I then circulated the report widely so that each participant was able to see a copy - I particularly asked for reactions and responses but have had very few replies and comments. This was disappointing, in view of Bloor's comments (1978:551) quoted in Chapter Two, that uncritical evaluation of findings by participants may indicate a lack of a sense of involvement in the research on their part. I received a handful of accepting comments from nurses in the Unit, and one criticism from a school nurse that I had not indicated school nurse responses separately from health visitors. I have been informed, however, that in all the different parts of the Unit, work is going on which uses parts of the report, so it does appear to have been adopted and used. So although my initial action research strategy was not acceptable to the DHSS, the Case Study Report has been used as a piece of action research by the members of the Unit themselves. With that I am well satisfied.

5.6 Further Data Analysis

When preparing to write about the findings of the case study for this thesis, I reflected further on the lack of memos generated, and my dissatisfaction with the level of analysis. In the case report for the unit, I had accepted as "core categories" in the analysis the different emphases within professional philosophies expressed by nurses, and followed the implications for management of these philosophies as they appeared to differentiate between

management styles. Glaser and Strauss recommend (1967, 1978, 1987) basing a research monograph on one, or at the most two, core categories. They suggest that later monographs may be written using the same data, but adopting another perspective by emphasising another core category. This is illustrated by their work on sickness and death in American hospitals, which produced two monographs with different emphases, "Awareness of Dying" and "Time for Dying" (Glaser and Strauss 1965 and 1968).

This separation of monographs may be suitable for dissemination of medico-sociological theory (although I suspect that separation of concepts there may lead to damaging consequences if medico-social professionals apply part of the theory to their practice in an unbalanced way). But I realised that by concentrating on one core category (professional philosophies) at the expense of others, I was in danger of destroying the unitary nature of the case study, as described by Goode and Hatt (1952:339), and treating the core category variations as traits. I would lose much of the richness of the data by doing this.

5.6.1 Using Metaphor In Organisational Analysis

In Chapter Three (Section 3.6.2) I alluded briefly to Morgan's (1986) use of metaphor as a way of understanding organisations. He seeks to show how many common ideas about management depend on a number of taken-for-granted images of organisation, which are often mechanical or biological in character (for instance the well known contrast between mechanistic and organic systems described

by Burns and Stalker in 1961.) Morgan (1986:12) writes

> "Our theories and explanations of organizational life are based on metaphors that lead us to see and understand organizations in distinctive yet partial ways. Metaphor is often just regarded as a device for embellishing discourse, but its significance is much greater than this. For the use of metaphor implies a way of thinking and a way of seeing that pervade how we see our world generally."

Morgan (1986:13-17) continues by drawing attention to the complex, ambiguous and paradoxical nature of many organisations. In Chapters Three and Four of this thesis I believe I have shown that these characteristics are certainly present in the NHS. Morgan's argument is that no one metaphor can capture the entirety of an organisation, but that the use of a number of different metaphors may

> "enhance our capacity for creative yet disciplined thought, in a way that allows us to grasp and deal with the many - sided character of organizational life."
>
> Morgan 1986:17

5.6.2 Using The Metaphor Of A Tapestry In This Analysis

As I considered my Case Study Report with its emphasis on the core category of professional philosophies, and reflected on the dearth of patterns of response related to those philosophies in some of the subject areas included in the study, it seemed as though my analysis lacked cohesion and strength. It reminded me of one of those curtains in a doorway made of strips of plastic, or strings of beads - you could push through it at any point. I sensed that in reality, there were a number of core categories which

interlocked at various points in the analysis. It was then that the metaphor of a tapestry occurred to me. The canvas on which the tapestry is worked is the structure of the health service in Western Unit; it is a loose-grained fabric made up of small hospitals, health centres, and the health and illness related activities carried out within them and within peoples' homes and community premises within a rather distinctive geographical area. This "canvas" is described in the chapter following this one.

The threads making the design on the canvas are the concepts, philosophies, values, goals and perceptions of the staff working in the Unit both as field workers and managers, interwoven with perceptions of groups representing actual and potential patients, and of general practitioners who work closely with Unit staff and use unit facilities whilst not actually belonging to the Unit. The borders of the tapestry are the ideas and expectations of key people and organizations who relate to the unit and belong to its context, such as local authority staff and managers of the neighbouring health authority who provide many services on an agency basis. As I pursued the analysis further, on the basis of the tapestry idea, I could see that certain ideas were visible in certain groups, and then disappeared, only to re-emerge later, rather like threads being taken through to the back of the canvas and then being brought to the surface in another part of the tapestry.

To discern patterns made by the threads of ideas, concepts

and groups of participants I had to concentrate attention to some extent on commonly expressed ideas. I could not take note of every single opinion expressed in the case study, it would have made the analysis impossibly complicated. But bearing in mind the interpretive view that organisational realities are multiple and conflicting, I set the threshold at which I would take notice of ideas quite low - if twenty percent or more of a group expressed an idea, I noted it. Using the colour coded references on my concept cards, I compiled profiles of views on all the major research questions of many different groups within and in the context of the unit. I present these profiles and patterns in later chapters of this thesis, attempting to show how concepts and philosophies are interwoven and hold the unit together. A summary of all these profiles is given in Appendix 4.

As the idea of the tapestry came alive to me, I began to see it, not as I originally did, as a neat rather domesticated work of art, like a firescreen or a cushion cover, but as a continuous process, telling a story - like a latter-day Bayeux tapestry in the making.

5.6.3 Defective Memo-Writing Recognised As A Problem

At the beginning of this thesis I announced my intention to be as frank as possible about the path I have followed and the influences upon me whilst carrying out this research study. At a late stage in writing I still felt dissatisfied with the level of analysis, even though

adopting the tapestry metaphor had helped my understanding. Using the grounded theory method had resulted in a number of topics which were to have been the subject of short chapters in the thesis - on nursing philosophies, management philosophies, on reactions to the Griffiths Report, on Unit formation, on consumerism and quality assurance, and on the Unit Management Board. As I began to write conclusions for these chapters, I found I was repeating arguments and constantly referring back to earlier statements. The sense of discomfort eventually forced me to reconsider the structuring of these chapters, to re-group research evidence, and to use some ideas from nursing and organisational literature to supplement the conceptual framework in the places where it was weak.

At first I felt as though I had abandoned the grounded theory approach, but then I realised that the *comparison of* the grounded theory with existing conceptual frameworks is acknowledged as a late stage in Glaser and Strauss's methodology. (Turner 1981:239) Probably had I persevered at an earlier stage with the memo writing I would have reached the same conclusions without the stress of making last-minute changes in the thesis.

5.7 Conclusion

This has been quite a painful chapter to write, because I have had to face up to the realisation that my attempts to discover grounded theory have not always been "according to the book". (see Glaser and Strauss 1967, 1978, 1987) However, as stated earlier (section 2.6) I am not alone in

this. It has also been a painful experience to re-live the uncertainties and frustrations of taking part in naturalistic inquiry, with all its constraints and delays, its disappointments and adjustments. Yet writing the chapter has also reminded me of the pleasures of research involving face-to-face encounter with participants - the satisfaction of being a sounding board for peoples' ideas, the excitement of being allowed to witness important events, the fulfilment of at last reaching a framework for expressing ideas that seems to hold together and make sense.

CHAPTER SIX: THE CASE STUDY - LOOKING AT THE PROCESS OF UNIT FORMATION

6.0 Introduction

The first part of this chapter describes the background to the formation of the case study Unit, giving details of its history, geography, demography and health care services. These structures make up the canvas backing, on which the patterns of the tapestry are worked, as we follow the metaphor outlined in the previous chapter. The description also provides parameters and key features to guide anyone wishing to consider transferring conclusions from this study to another area of health care. The necessity for case studies to include contextual detail to enable comparability is argued by both Lincoln and Guba (1985:297-8) and Mitchell (1983:206).

The aim of the case study was stated in Chapter Two, but I will repeat it here. It was "to describe and consider the effects of new management philosophies, plans and practices on nurses, nursing care, nurse managers and members of other health care disciplines and supporting staff within one unit of management, during a period of change." It is helpful, when trying to trace the effects of new practices, to have some understanding of what was being replaced or superseded, and so some of the management history of the services comprising the new Unit is given. It might also help to think back to Chapters Three and Four, to remember that in the early 1970's rational management ideas were paramount. Later in the 1970's and early 1980's the

effects of economic recession and increasing politicisation were felt in the NHS, as well as the introduction of greater devolution and pluralism of provision. The Griffiths' Report (1983), which was discussed in some detail in Chapter Four, aimed to bring in general management principles at every level of the NHS, increasing managers' responsibility for planning, implementation and control of performance, in order to fulfil specific objectives. The later part of this chapter tells the story of how the introduction of general management principles was carried out in Western Unit.

In telling this story in Section 6.3, I also examine staff perceptions of management, past, present and future, and their views on the creation of the Unit and the expected effects. Section 6.4 looks at the Unit Management Board, its roles, relationships and responsibilities, and the chapter ends with a discussion of the process of organising as it occurred in the Unit.

6.1 Stoneyshire District

In order to understand the rationale for the formation of the Unit studied, it is necessary to describe the "parent" district of which that unit is a part. From 1974-1982 Stoneyshire District was one of three districts making up a county-wide area health authority. On the dismantling of the area tier of authorities in 1982, the newly autonomous Stoneyshire District Health Authority formed five units as shown in Figure 6.1, covering acute, maternity, mental illness, mental handicap and community services. Each unit

was managed by a team of officers reflecting the organisation at district level, consisting of an administrator, a nurse and an accountant. Each of these three officers headed a functional hierarchy in the unit, and was, in their turn, accountable to a senior officer at district level. Each unit team of managers was joined by a doctor, who represented other medical staff, but was not accountable to anyone in a managerial sense. The teams at both district and unit level operated on a consensus model of decision making, with each member having the right of veto. The District had only recently begun to enjoy improved funding, altering its position as the worst funded district in the worst funded region, according to the Resource Allocation Working Party's calculations. It serves a population of 360,000, the majority of whom live in the more industrial eastern end of the District, in urban or semi-rural conditions. By contrast, the western part of the District is quite sparsely populated upland, supporting hill farming, quarrying, a little light industry, and tourism. Natural patient flow at this western end is towards Millbridge's acute hospital facilities (see fig. 6.1(b)). Millbridge D.H.A. belongs to a different regional health authority, and in fact provides a number of services for the small hospitals in the western part of Stoneyshire's district, on an agency basis.

From 1982, most of the services in the western part of Stoneyshire District were managed by the Community Unit, except for the maternity services. No services for the

mentally ill or handicapped were based in this part of the District at all. A separate planning team for this western area was set up in April 1983 because in all the care-group based planning teams, exceptions were constantly having to be made for this part of the District.

6.1.1 Implementation Of Change In The District, 1985

At the beginning of 1985, the newly appointed District General Manager (previously the District Administrator) produced his plans for improving the efficiency and effectiveness of the District. He proposed altering the existing five - unit structure by dividing off the western end of the District, with all its peculiar problems, to be a separate unit, and creating just two units for the remainder, divided along functional lines (acute/community and long stay) See fig. 6.1(a), 6.1.1(a) and 6.1.1(b). These plans were eventually approved by the DHSS in the early summer of 1985, and the three Unit General Managers took up their positions in September of that year.

FIGURE 6.1(a)

Structure of NHS after 1982 Reorganisation showing Unit structure of Case Study District.

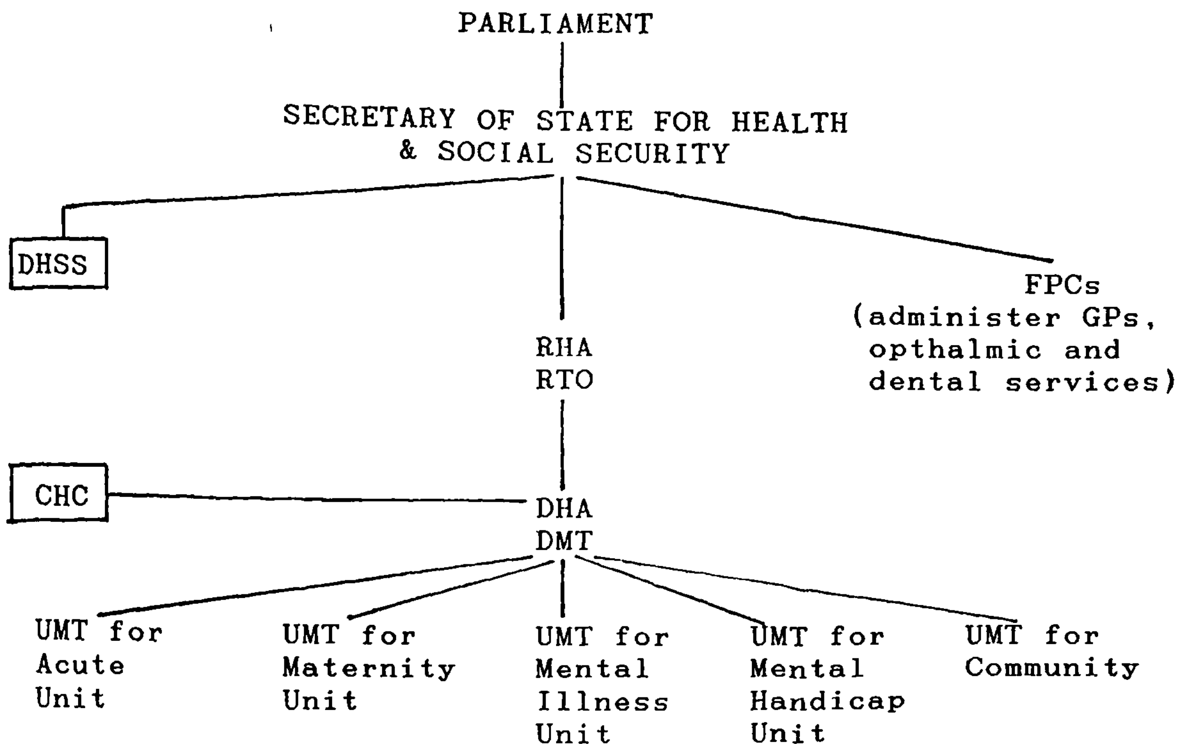
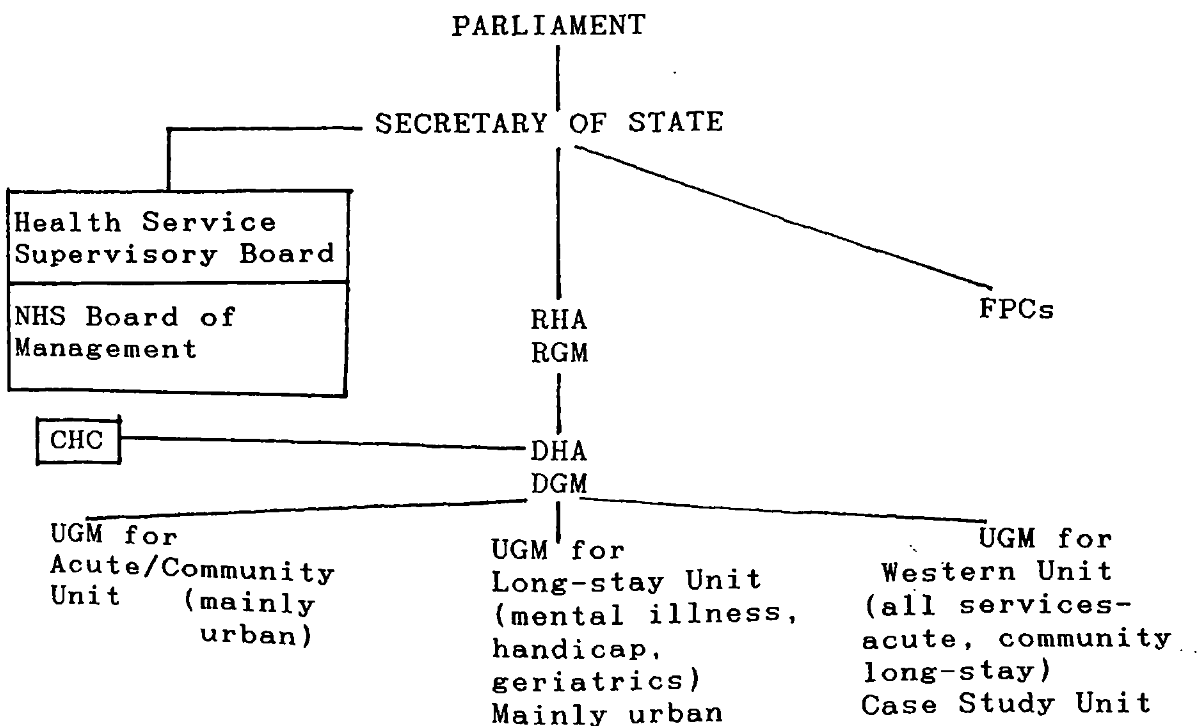


FIGURE 6.1.1(a)

Structure of NHS post Griffiths implementation, showing revised Unit structure of Case Study District.



SCALE approx. 1 inch to 4./5 miles

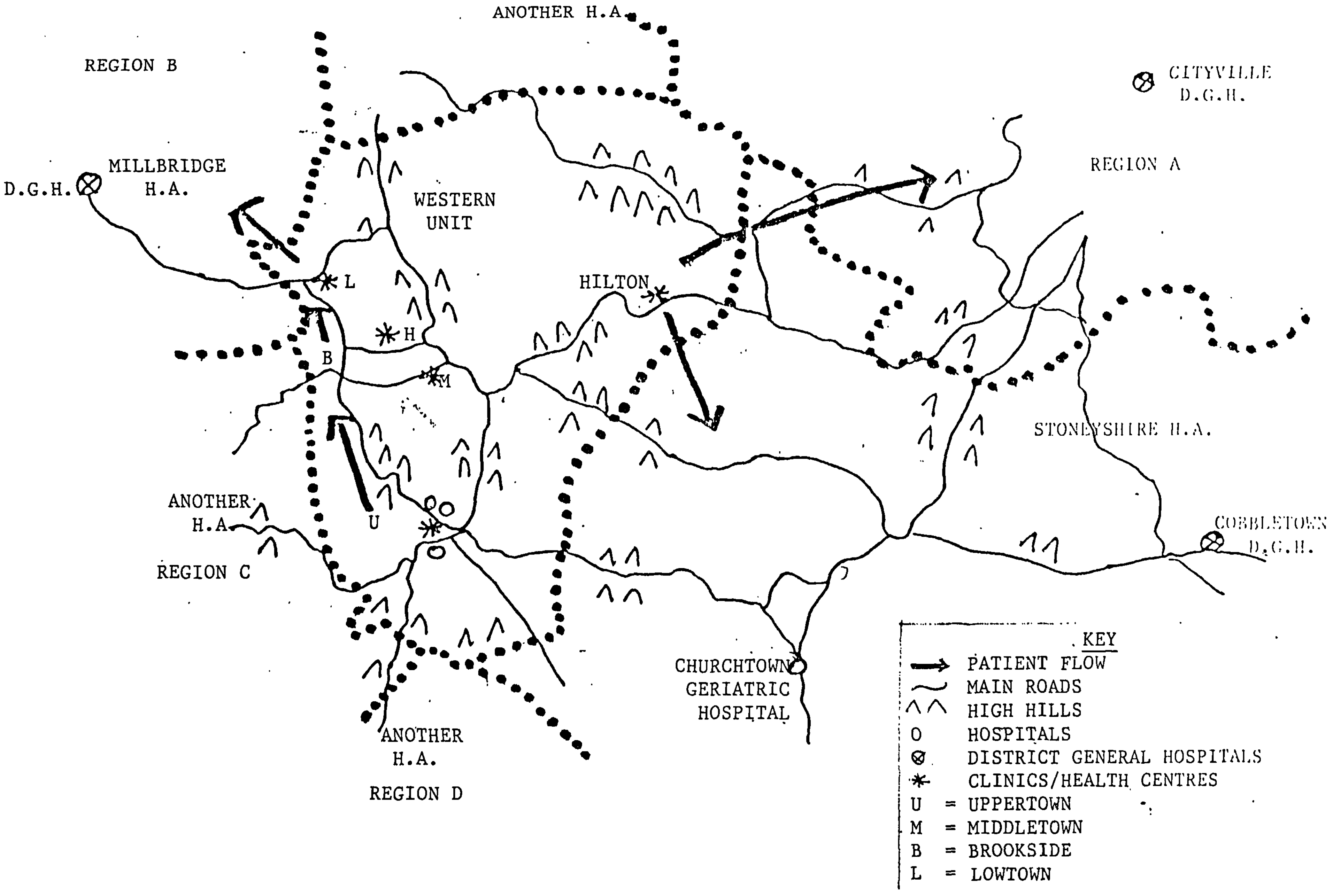
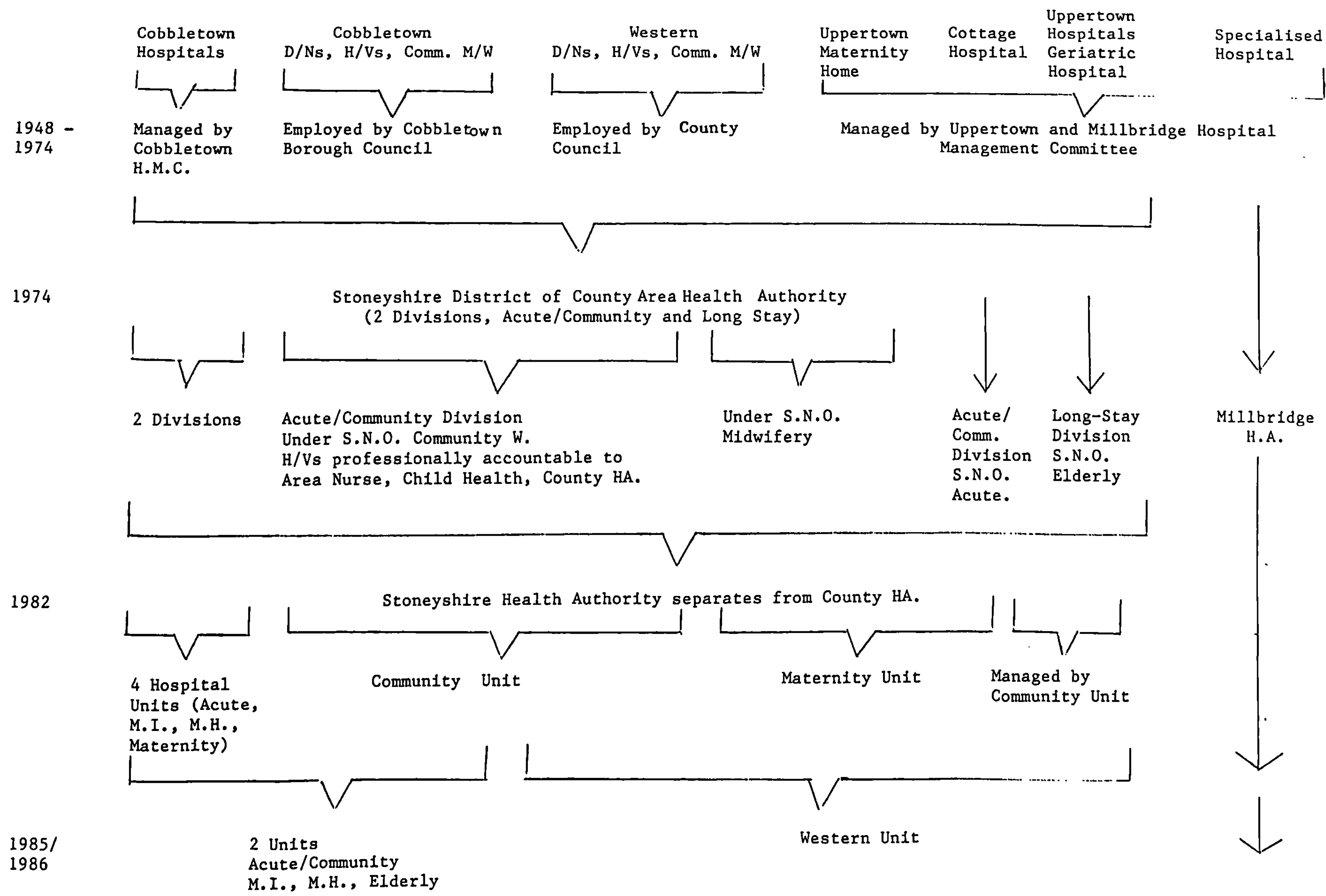


FIGURE 6.1.1(b): Chart to show Management History of Stoneyshire Health Services



6.2 The Creation Of Western Unit

The Western Unit was created to cope with the special problems arising from its sparsely populated area and its remoteness from the District General Hospital at Cobbletown - so stated the District's Annual Report for 1985-6, acknowledging that the Unit's development would require continuing discussion with Millbridge Health Authority and its parent region. No part of Western Unit is nearer than twenty miles from District Headquarters at Cobbletown, and Lowtown is more than thirty miles away from it. The Unit serves a population of about 52,000, distributed as follows:

Uppertown	20,000	approx.
Lowtown	9,000	approx.
Middletown	6,000	approx.
Brookside	5,500	approx.

with the remainder in scattered villages, hamlets and farmsteads.

6.2.1 Western Unit's Health Care Facilities

At the time of the case study, Uppertown Cottage Hospital had 44 beds, Uppertown Geriatric Hospital had 52 beds (with plans for a further 16 beds for elderly severely mentally ill patients) and the Maternity Home at Uppertown 14 beds, although this was preparing for close-down and transfer of staff to a newly built wing at the Cottage Hospital which would accommodate eight mothers. Millbridge Health Authority provides many technical and support services for

the Western Unit on an agency basis -pathology, radiology, pharmacy, sterile supplies and laundry. All the consultant physicians and surgeons (except for mental handicap services) covering services in Western Unit are contracted to Region B, and work part-time in Millbridge and part-time in Western Unit. (The consultant for mental handicap is contracted to Region A, and works mostly in Cobbletown and the rest of Stoneyshire H.A.)

Western Unit has two health centres (in Uppertown and Middletown) and three clinic premises (in Lowtown, Hilton and Hillside) which serve as bases for health visitors, community nurses, midwives, paramedical and school health staff, and where many preventive health activities take place such as child health clinics, immunisation, ante-natal teaching and chiropody. In the health centres, family doctors lease surgery premises from the Health Authority. In addition, some health visitors and district nurses are based in premises belonging exclusively to general practitioners, and run clinics in those premises, and also a number of child health clinics are held in rented premises (such as village halls) in the Western Unit.

6.2.2 The Unit's Geography

Geographical influences have contributed to the development of service patterns in Western Unit. Staff based at Hilton, separated from the rest of the Unit by a high range of hills, have traditionally had more links with staff

based between Hilton and Churchtown, and with hospitals in Cityville, despite being in the same local government area as Uppertown. Public transport from the Hilton area is easy to Cityville, very sporadic to Cobbletown and Churchtown, and extremely difficult to Uppertown. Staff based at Lowtown tend to feel more affinity with Millbridge rather than Uppertown, again because of ease of transport northwards, and in winter it is easier to travel downhill to Millbridge than uphill to Uppertown because of the persistent threat of snow over the hilly areas. The reluctance of Cobbletown based staff to venture up to the Western Unit, especially in winter, has contributed to the pervasive sense of isolation commonly expressed by Unit staff.

6.2.3 The Unit's Management History

Historically, the different components of the new Western Unit do not share a common management history (see fig. 6.1.1(b)). Up till 1974, district nurses, health visitors and community midwives were employed by the County Council; with headquarters in the south of the county and a nursing officer at Uppertown. From 1974 to 1982 they were managed from the Acute and Community Service Division of Stoneyshire District in Cobbletown, with evolving and changing emphases over time, but with health visitors' professional leadership (as opposed to managerial) coming from Area Health Headquarters in the south of the county. In practice, that often meant no leadership was given. Up till 1974, hospital services in Uppertown were managed by

Millbridge and Uppertown Hospital Management Committee, and then until 1982 nurses at the three Uppertown hospitals were managed by different divisional teams from Cobbletown. However, hotel and support services for the Uppertown hospitals continued to be managed locally, utilising many of Millbridge's facilities as happens now. Many Western Unit staff have been in post sinc before 1974, and so have seen four different management systems in operation. (I have already referred to the management of most of Western Unit's staff by the Community Unit from 1982 until the Griffiths' changes brought the new Unit to birth.)

It should be remembered that following each major management change, in 1974 and 1982, it took a period of years rather than months for effects to work right through the organisation, because appointments were not all made at once, and so when plans to change Unit structures were revealed in 1985, there had been little time for feelings of stability or identity to grow or develop.

6.2.4 Western Planning Group

Possibly the factor which most influenced the District General Manager towards setting up the Western Unit as a separate entity was the existence of the Western Planning Group which produced a strategic plan for the area in February 1985. Encouraged by Region A's strategic planning guidelines, the Planning Group suggested that Western Unit should be responsible for all community services for all the Unit's 52,000 population - that means all domiciliary nursing services and health visiting, and domiciliary

paramedical services. However, because of "patient drift" as it is called, the area round Hilton would be excluded from hospital plans for Western Unit; acutely ill people from there tend to be treated in Cityville, partly because of ease of transport and traditional referral practices by general practitioners. I suspect that acute cases from outside Cityville's own district continue to be accepted willingly because of the existence of a medical school in Cityville. Chronically ill and geriatric patients from the Hilton area are not generally so welcome in Cityville, and mostly are treated in Churchtown or Cobbletown.

The Western Planning Group's strategy suggested that it would not ever be feasible to provide a District General Hospital in Uppertown, the numbers would not make such a proposition viable. Most acute services would continue to be offered in Millbridge, but plans were to be made to increase out-patient clinics in Uppertown, to cater for the population of that town itself, and for those of Middletown and Brookside. Out-patients from Lowtown would continue to go to Millbridge. The strategy highlighted the need to make better use of surgical facilities at Uppertown Cottage Hospital for minor and day-case surgery, and to develop the role of that hospital in giving acute medical care, and terminal care to local patients.

The role of Uppertown's Geriatric Hospital was planned to be enhanced by putting more emphasis on assessment and rehabiitation; the range of care offered would increase with the development of the ward for elderly severely

mentally ill patients. The planning group's strategy stressed the need to develop community teams for the mentally ill and mentally handicapped, and to encourage greater commitment to joint planning for the Western area, involving the local authority Social Services, Education and Housing departments, the voluntary organisations and the private sector (such as nursing home proprietors), and especially, general practitioners.

6.2.5 Transferability - Key Characteristics Of The Unit

At the beginning of this description of Western Unit, I referred to the need for anyone wanting to apply theories discovered in the case study to another unit, to be able to use certain parameters or key features as markers, to judge whether the theory might be transferable to their own circumstances. Obviously no other Unit will exist which matches the Western Unit exactly on all points, so which factors might seem to be the important ones? One way of highlighting features which could be considered relevant is to look at structural contingency theory. This arises from a body of management research conducted mainly in the 1960's and 1970's which claims that there is not one best way of managing all enterprises, but that different management styles are more or less appropriate depending on the characteristics of the organisation concerned. Pfeffer (1982:149) summarises much of the literature surrounding structural contingency theory, and in doing this sets out the elements both within and relating to the structure of the organisation, in its way of operating and in its

resources, which have been considered important by researchers in that field. Figure 6.2.5 sets out the characteristics of Western Unit expressed in these terms.

Figure 6.2.5 Key Characteristics Of Western Unit

as at 1.4.86

Size - expressed by number of employees* 270
expressed by size of annual budget £2,421,000
expressed by population served 52,000
expressed by number of hospital beds (not a good reflection) 114
(*head count, not whole time equivalents)

Technology employed - In production - relatively simple, but very individualized, not routine.
In information processing and dispersion - mainly face to face or by telephone, not computed; hand compiled and analysed.
Not heavily bureaucratized.

Resources available - Finance strictly limited and future resources uncertain.

Environment - Changing, developing uncertainly.

Competition - Private facilities make up for shortfall rather than competing.

Structure of Unit - Not highly formalized at time of study.
Vertical and horizontal differentiation - see figure 6.2.5(a)
Not centralized but localized services.

Complexity high, due to interdependence with
neighbouring health authority and region
local authority departments
voluntary organisations
private sector (nursing homes etc.)
See Figure 6.2.5(b)

In addition to these factors highlighted by structural contingency theory, I would add the isolation of the unit, the fact that it is newly created from pre-existing services, and that it was not a nurse training area (except for fieldwork teaching of health visitor students and

district nurses in training) during the period of the study. Having, therefore, a number of different parameters by which to make comparisons, anyone wishing to consider the transferability of the theory expressed in this study may make their own judgments.

FIGURE 6.2.5(a): Structure of Western Unit During Research Period.

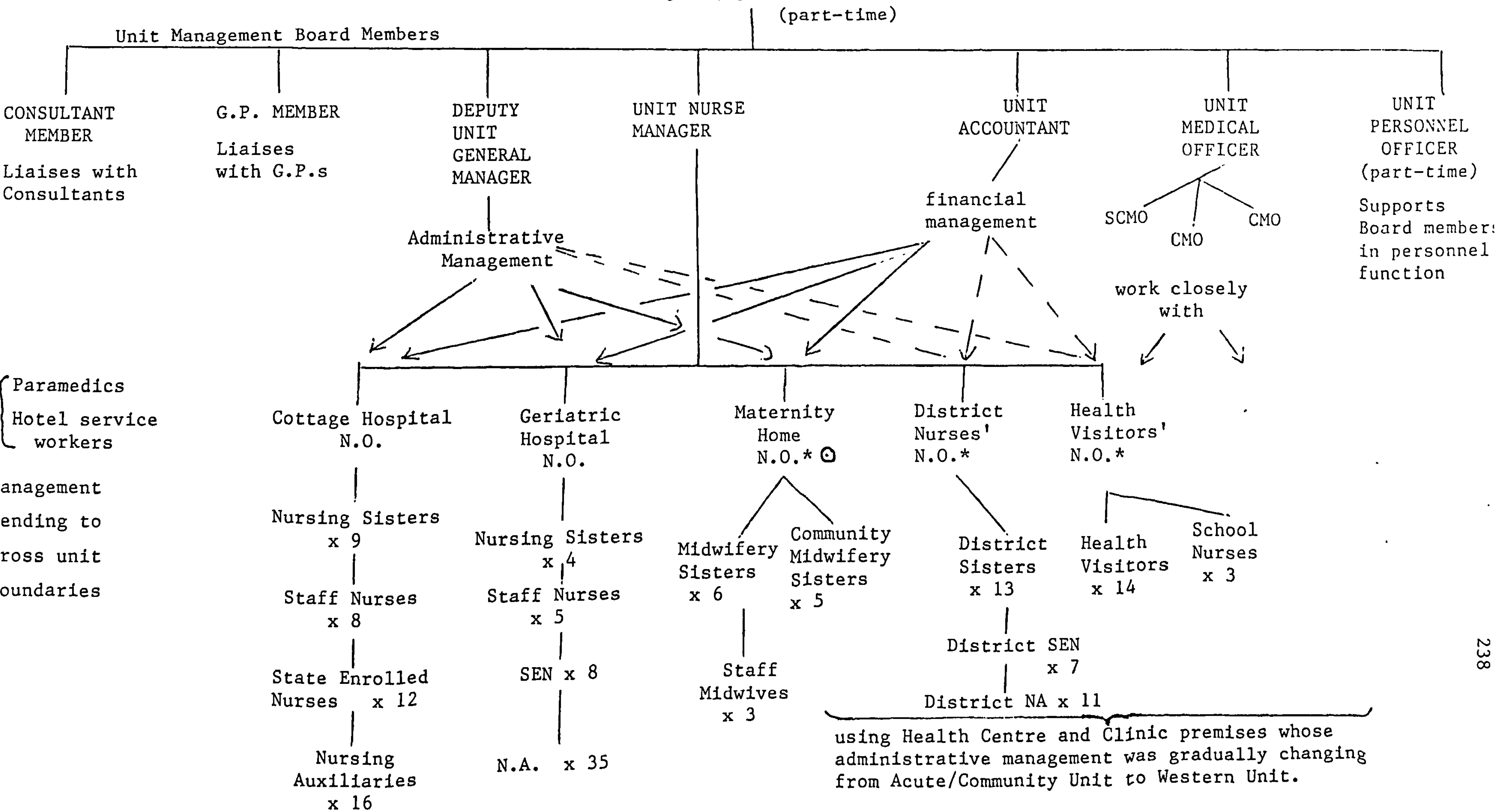
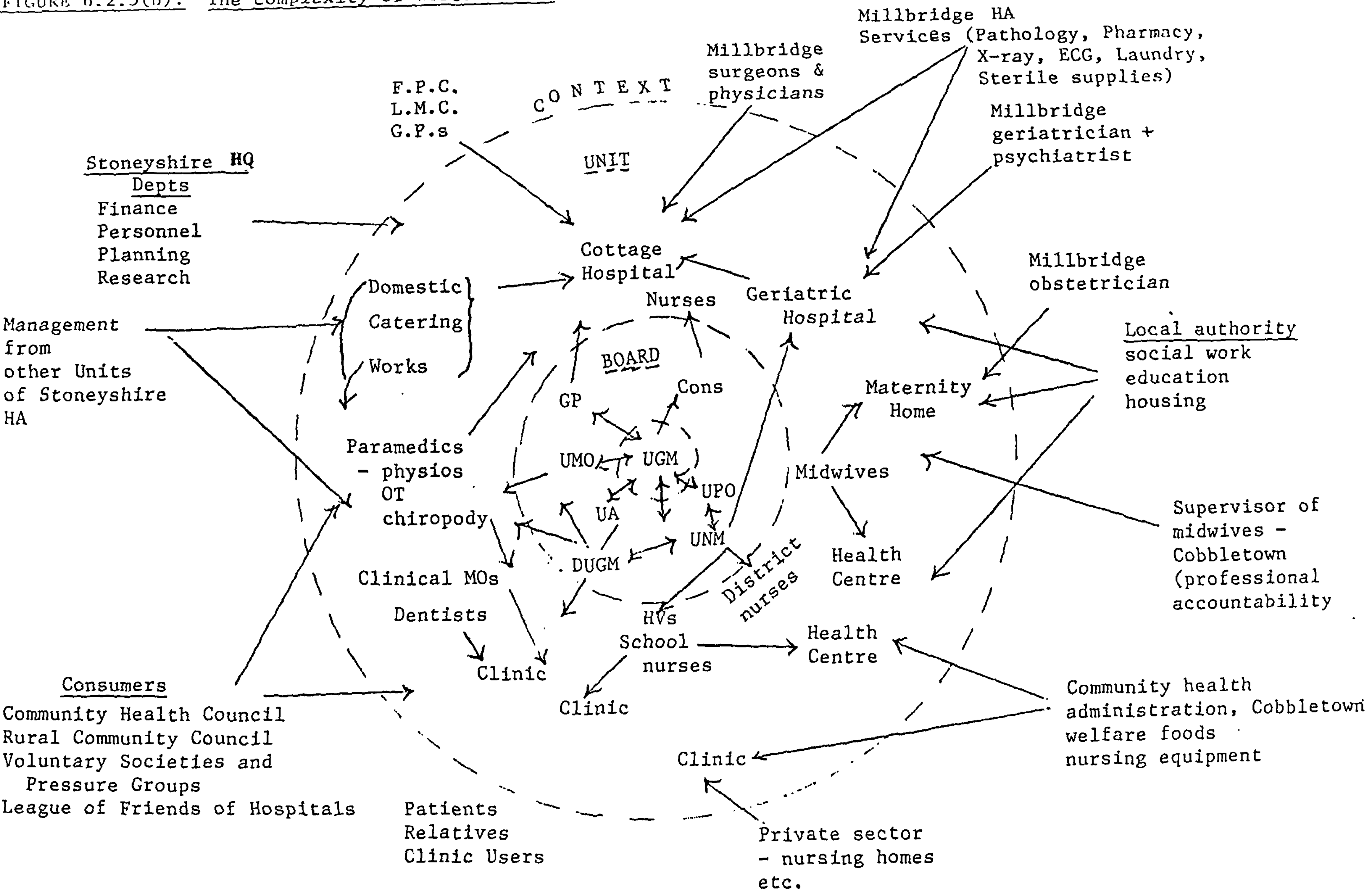


FIGURE 6.2.5(b): The complexity of Western Unit



6.3 The Process Of Unit Formation

This description of Western Unit and its characteristics forms the canvas back cloth on which the tapestry of philosophies, perceptions, goals and values of staff, clients and related organisations is worked. I begin now to look at the development of the tapestry by studying some of the processes that were at work right from the announcement of the DGM's plans in January 1985 till after the close of the case study in the second half of 1986. This acount is based on interviews, (see Appendices 2 & 4) documents received (see Appendix 3) and my research journal. Figure 6.3 sets the case study timetable in its organisational context.

FIGURE 6.3 CHRONOLOGY OF WESTERN UNIT DEVELOPMENT AND CASE STUDY

Jan	1985	DGM publishes Unit reorganisation plans and general management strategy
Feb	1985	Western Area planning team reports, suggesting extension of services.
June	1985	DHSS approves Unit plans, UGM posts advertised.
July	1985	Case Study research proposal sent to DHSS for approval, following granting of outline consent to access to Western Unit by UGM designate
August	1985	DHSS approve case study proposal
Sept	1985	UGMs take up posts
Nov	1985	Unit Board structures published by UGMs, consultation follows
Dec	1985	Case study officially begins
Feb	1986	Unit Board structures approved by DHA. Deputy UGM, UMO & UNM appointed in Western Unit
March/ April	1986	Unit management sub-structures submitted to DHQ for costing & approval
April	1986	Unit officially up & running (first Unit Board meeting held) UGM meets with staff in 6 locations between 9.4.86. & 19.5.86.
May/ June	1986	Unit accountant, personnel officer, consultant member & GP member appointed & gradually take up duties.
July/ August	1986	Case Study officially ends. First Unit Review by DHA.
September	1986	Unit management sub-structures agreed with some changes from original plans. Nursing officer duties re-aligned.

6.3.1 Western Unit - Gestation, Birth And Early Life

The news of the planned creation of a separate Western Unit received a mixed welcome from those most affected. GPs and patients liked the idea, for the most part, as did some hospital nurses, but many community nurses felt they had benefited enormously from being part of the Community Unit created in the 1982 reorganisation, and so the early months of 1985 saw a number of protests to the new DGM and the DHA and many reasons being put forward for keeping the existing unit structure. These protests were not successful, however, and the circulation of the Western Area Planning strategy began to disseminate encouragement to think of the new unit as a separate entity, at least among the most senior staff. It also focused attention on the major developments already described earlier in this chapter, and the Administrator and Senior Nurse in Uppertown were already working closely together with planners from District Headquarters and the Community Unit to further these developments.

Later in 1985, as already mentioned in the previous chapter, members of the RCN and HVA, including some from Western area, organised a meeting to express concern over lack of consultation on the management structures for the new units. So there was considerable relief, when the structures were made public in November, that at least Western Unit was to have a designated Unit Nurse Manager at board level. There was also to be a deputy UGM to deal with administration, as the UGM was part-time, keeping his

clinician's role at district level. The structure of the Unit is shown in Figure 6.2.5(a). The afore-mentioned Uppertown Administrator and Senior Nurse, who bore the brunt of day-to-day management in the Western area, were appointed Deputy UGM and Unit Nurse Manager respectively, in February 1986. However, this was only after they had experienced a great deal of anxiety over their situations, partly caused by the RHA lowering the salary gradings agreed by the DHA, due to the small size of the unit, and partly caused by the appointment procedures adopted by the DHA. Also at this time another member of the Board was appointed, a senior clinical medical officer who knew the area well, and had good contacts with local authority departments. These board appointments ensured continuity in the new Unit.

In the meantime, of course, the day to day work of the hospitals, clinics and community health services continued uninterruptedly. From February 1986 the three Board Members worked closely with the UGM to prepare for the Unit's inauguration two months later, liaising closely with the old Community Unit, and the newly appointed managers of the reconstructed units over boundary issues, particularly as they affected Hilton. These issues were not finally settled until after the case study was over in the autumn of 1986. The Board Members of Western Unit also had to work very closely with the District Finance Department and the Personnel Department because appointments of Unit Accountant and Unit Personnel Officer were not taken up till May and June 1986 respectively. There was much work to

be done to separate the Unit's finances from the other units' accounting systems, and the personnel records and systems pertaining to Western Unit's staff from those of the other units.

The UGM and his first three Board Members began to make closer contact with general practitioners, in readiness for the nomination of a G.P. to the Board. They also began to liaise fruitfully with hospital medical consultants from Millbridge H.A. in preparation for their election of a representative to the Board, and to negotiate with the UGMs of the two Millbridge units which provide services to Western Unit on an agency basis. In addition to all this there were building alterations at both Uppertown Cottage Hospital and Geriatric Hospital to be supervised in preparation for expanding services at each; these services also needed planning, including the recruitment of staff. Then the first stages of a community mental illness service had to be inaugurated, and a community mental handicap programme to be planned. Add to this negotiations over competitive tendering for both catering and cleaning in the Uppertown hospitals and the complexity of change is seen to be formidable.

Many aspects of management change were still not worked out by March 1986. Relationships between district heads of services such as physiotherapy and occupational therapy and the new Unit had not been thought through fully at this stage. Indeed the district head of one paramedical service had not even seen the whole text of the UGM's management

document when I spoke to her in February 1986, even though it had been issued in November 1985.

The future of nurse middle managers (clinical nursing officers) remained uncertain throughout the case study period. The Unit Nurse Manager submitted her plans for middle management to District Headquarters for costing and approval in April 1986, but was not authorized to confirm appointments (with some modification from her original wishes) until September 1986. These factors led to a certain degree of dislocation in the unit - although paramedical and nursing managers continued to function, there was an air of uncertainty hanging over the Unit, and communications did not always work well.

6.3.2 Perceptions Of Staff About Management

In the midst of all this uncertainty, I conducted interviews with nurses of all disciplines, paramedical and support service staff. I asked them what had been their experience of management support in the past, and Table 6.3.2(a) summarises their replies. Sixty two percent of those who responded to this question (some chose not to answer this particular query) felt they had received as much support as they had needed in the past.

TABLE 6.3.2(a) Staff Experiences Of Past Management Support

(not all staff responded to this question)

		Support has been adequate with tendency to improve in recent years	Support has fluctuated, with some problem areas	Support has been too distant, and lacking over closure of maternity home
Health visitors/ school nurses 17 in group 14 responded		11	3	
District nurses 17 in group 16 responded		7	9	
Midwives - 11 in group 11 responded		5		6
Geriatric Hospital Nurses 7 in group 6 responded		4	2	
Cottage Hospital Nurses 7 in group 6 responded		5	1	
Paramedicals 7 in group (clinical MO's not included) 4 responded		3	1	
Support service Managers and Secretaries 5 in group 4 responded		3	1	
Total Responses	61	38	17	6
Out Of Total possible	71	62% basically satisfied	38% basically dissatisfied	

A smaller number were dissatisfied to some degree, including a number of midwives who felt unsupported by senior management over the closure of the Maternity Home. Only a vociferous local campaign, when staff and ex-patients had lobbied a health authority meeting, had gained the concession of a new maternity wing at the Cottage Hospital, instead of all patients having to go to Millbridge. Now the staff grading plans for the new wing were causing controversy and again the staff felt unsupported by senior management in Cobbletown, who still held responsibility for midwives.

Table 6.3.2(b) summarises replies to my question relating to the level of management support staff were experiencing at that time, which was in the early months of 1986. Sixty per cent of those who responded (and again, some chose not to express an opinion) were satisfied with the support received, but some (mainly community and midwifery staff) felt that their managers' preoccupation with impending change had altered the normal balance, so that support was now mutual, or even lacking significantly.

TABLE 6.3.2(b) Staff Experience of present management support (not all staff responded to this question)

	Support adequate or more than adequate	Support mutual between staff & management	Manager too preoccupied to support staff
Health Visitors/ school nurses (17 in group) all responded	10	6	1
District nurses (17 in group) all responded	7	5	5
Midwives (11 in group) 7 responded	2	4	1
Geriatric Hosp. Nurses (7 in group) 6 responded	6		
Cottage Hosp. Nurses (7 in group) 5 responded	5		
Paramedicals, (7 in group) 4 responded	4		
(no response from support services etc, 5 in group)			
TOTAL Responses 56 (Out of Total possible 71)	34 (60%)	15 (27%)	7 (13%)

Most participants expressed uncertainty about future management support, although over a half of these thought that if each discipline retained its own manager, eventually matters would resolve. The remainder, which included most of the midwives, were more pessimistic. (see Table 6.3.2(c)).

TABLE 6.3.2(c) Staff expectation of future management support

	Optimistic, providing keep manager for own discipline	Unsure but pessimistic	Situation needs clarifying particularly over district/unit management relations
Health Visitors/ school nurses (17 in group) 15 responded	11	4	
District nurses (17 in group) all responded	11	6	
Midwives (11 in group) all responded	2	9	
Geriatric Hosp. Nurses (7 in group) all responded	6	1	
Cottage Hosp. Nurses (7 in group) all responded	3	4	
Paramedicals (7 in group) 5 responded	-	2	3
Support managers and Secretaries (5 in group) 1 responded		1	
TOTAL 63	33 (52%)	27 (42%)	3 (5%)

Total possible responses 71

From these tables it can be seen that midwifery and district nursing staff were least satisfied with past, present and possible future management arrangements. The clinical nurse managers for these disciplines each had

responsibilities for small hospitals outside Western Unit and for staff over a wider area and so were less accessible to staff in Uppertown and points north than the managers in other disciplines. The staff understood the reasons, and felt sympathy for the managers' position, whilst still expressing their dissatisfaction.

These interviews took place between January and April 1986; staff and managers had to wait until September 1986 to know that each nursing discipline was to retain its own nurse manager, except district nurses. They were to be managerially accountable to the nurse manager for health visitors, but to retain access on professional matters to their former nurse manager, who was transferred wholly to the Acute/Community Unit which covered the less rural part of Stoneyshire Health Authority. Midwives were to have their own local manager, and were reassured that none would be downgraded on moving to the new wing of the Cottage Hospital.

6.3.3 Morale In Western Unit

(Note:- Where quotations from interview scripts are given, the number in brackets refers to the script number in Appendix 2).

The months of uncertainty about middle management structures and boundary issues took their toll in terms of nursing staff morale. Thirty four per cent of nurses interviewed felt that morale was low; these were mainly community and midwifery staff. (See appendix 4, sections

EFGH.) Midwives, support service managers, geriatric hospital staff and some health visitors felt that the management changes were particularly stressful because they coincided with the other major changes already described - rebuilding, competitive tendering, staff grading issues and for health visitors, the expected release of the government's Community Nursing Review (Cumberlege 1986). District nurses, midwives, paramedicals and some members of the Management Board were particularly aware of disruption in the normal management process. A district nurse said

> "There's such a lot of uncertainty, it sometimes feels as though people have forgotten we exist - we're in a kind of "limbo". The management changes seem to go round in circles, so we just think "Let them get on with it!"
> District Nurse, Middletown (12)

Another district nurse, this time at Hilton, which is on the periphery of Western Unit, and where staff were particularly anxious about whether they would be managed as part of Western Unit or not (they preferred to be managed from Churchtown rather than Uppertown) said

> "The lack of information about our relationship with Western Unit has tended to make us suspicious and negative and allowed resentment about the uncertainty to build up. It's especially difficult for our manager, because she has no information to give us."
> District Nurse, Hilton (54)

The Nurse Manager for District Nurses echoed that feeling

> "I'm disillusioned with the D.G.M. and District Personnel Officer for allowing managers to be subjected to such a long period of uncertainty and major upheaval with minimal consultation

> and information."
>
> District Nurse Manager(2)

Some nurses spelt out their awareness that the Griffiths' principles and their outworking showed inconsistencies.

> "It seems to me that the way they've implemented Griffiths is not how it was originally intended. It was meant to speed up decision making, but we've got a part-time UGM and it seems that decisions are slower than ever."
>
> Community Midwife(71)

Another midwife also expressed the effect of Griffiths' implementation being confused with other changes.

> "It's difficult to sort out how much the uncertainty over future staffing levels is due to Griffiths, and how much just to the move to the new building. I think the delay is because the UGM has to take the final decision, but because his management board is incomplete, he's been putting it off."
>
> Hospital Midwife (39)

The issues raised in these last two quotations about the UGM being part time and about the formation of the Unit Board are discussed later in this chapter, but first I want to explore in more detail the perceptions of both Unit staff and others about Unit creation, because they reveal the conflicting realities present at the time of the case study.

6.3.4 Perceptions On Unit Creation

(See Appendix 4 G and H)

One of the most striking things about doing the case study of Western Unit was the constant recurrence of the idea

that the area had been isolated, neglected and deprived of health service resources over a very long period. The only staff groups who did not give much support to this theme were district nurses and health visitors, who tend to feel that all community services suffer similarly in comparison with acute services. Some comments were:-

> "Geographically and demographically, Western Unit's area is on its own anyway."
> Nurse Manager, Cottage Hospital(42)

> "Uppertown has always been out on a limb - we've seen different management systems come and go. We're unique, geographically."
> Midwife, Uppertown(37)

> "Western area was really a neglected area".
> Clinical Medical Officer, Lowtown(81)

> "We suffer from isolation out here, and a lack of information and stimulation."
> Health Centre Secretary(32)

> "In the past, Western area was very much "the poor relation."
> Hospital Engineer, Uppertown(101)

> "In the past, Western area had to learn to be self-sufficient, and frequently had to put up with a second-rate service compared with the rest of the district."
> Unit Personnel Officer(112)

> "This area tended to be rather forgotten and under-provided."
> G.P., Uppertown(98)

> "This area has always been a "no-man's land" between Cobbletown and Millbridge."
> Consumers' Representative(108)

> "This area has been rather a Cinderella for some time, as though for health purposes it doesn't belong fully to either Cobbletown or Millbridge."
> Consumers' Representative(109)

Other expressions used in this connection were unwanted, wilderness, cut-off, white elephant, and second best.

It is no surprise therefore, that the idea of creating a separate unit met with a great deal of approval, particularly amongst G.P.s, consumers and members of context organisations, some of whom had unhappy memories of trying to negotiate service improvements with Cobbletown based managers.

> "Even the Western Area Planning Team ... was rather a Cobbletown oriented body, and the knowledge base of some members about the reality of health services in Western Area was weak, and their understanding limited."
> County Council Local Social Service Manager(83)

However, it must be acknowledged that amongst the representatives of Local Authority departments that I interviewed particularly on planning matters, there were marked differences in perception between County Offices based staff and local managers out in Western area. County Offices based staff viewed the creation of the Western Unit as a complication; they preferred to liaise and negotiate with one representative of the whole Stoneyshire district, not to have to give separate consideration to a Unit within it.

6.3.5 Expectations Of The Effects Of Creating The Unit

Many Unit staff agreed that the creation of the new unit recognised the separate identity of the area, and should have its own policies. The Unit would have the right to be heard at District level, and draw attention to the poverty

of provision in the area. Staff expected that the localisation of management would lead to quicker decision making and better communications, and the establishing of a more personalised health service. (particularly voiced by hospital nurses and paramedical staff.) Consumer and context representatives felt that the Unit had potential for greater effectiveness because of the goodwill of voluntary organisations, the lack of large institutions, the existence of the Cottage Hospital where G.P.s could admit their own patients, and the considerable staff continuity. The Deputy U.G.M. (87) said

> "I think because we are a localised unit, we will be able to identify the specific needs and requirements of the area, including consulting with voluntary societies etc."

The small size of the Unit in numerical terms was an asset, in the opinion of several Unit staff and G.P.s, in that the U.G.M. would be able to have direct contact with almost everyone in the Unit, and Board Members thought staff would get more involved in decision making. Lastly, in this list of the Unit's advantages, was the thought that the creation of the Unit would be likely to bring hospital and community staff together, improving partnership and integration, and also bring managers and staff closer.

> "It may lead to building a better network of contacts for staff."
> Health Visitor, Lowtown(10)

> "There should be more working together of professionals, we should be closer-knit."
> Health Visitor, Uppertown(23)

> "There's a better chance of people getting to know each other - the personal touch."
> District Nurse, Uppertown(26)

> "There should be a sense of unity - we won't be "out on a limb" any more".
> Midwife, Uppertown(37)

Inevitably the creation of the new Unit also had its opponents, particularly amongst health visitors, and staff based at Hilton.

> "We tend to be isolated and cut off from the rest of Stoneyshire - this just formalises the difference. Our real ties are with Millbridge."
> Health Visitor, Middletown(4)

> "We might be more isolated - cut off from Cobbletown. I'm afraid we might miss out on training and up-dating. Western area, with its rural atmosphere, is all for keeping the status quo. Cobbletown, being a big town, is more dynamic. There's a danger of stagnation."
> Health Visitor, Uppertown(24)

Hilton staff expressed their views very strongly.

> "It could certainly produce problems if we are part of Western Unit. We belong on this side of the hill emotionally, geographically, socially."
> District Nurse, Hilton(14)

> "For us here at Hilton, the unit could cause greater isolation, and there could be liaison problems. We've always been in no-man's land here, and if our contacts with Cobbletown decline because of the new unit, we shall be worse off. There are transport problems here, the only place you can get to on public transport is Cityville."
> District Nurse, Hilton(54)

> "I feel we belong to each other here at Hilton, but the hills get in the way between here and Uppertown! ..... We'll be no better off in the new Unit than we are now - we will still be at a distance from our manager - Churchtown or Uppertown, it makes no difference."
> Health Visitor, Hilton(56)

> "To me, Western area is "over the hill" ..... Not that I'm not willing to play my part if they've decided we are part of Western Unit - but I hope they don't want us to stick to hard and fast boundaries, because we're talking about people - you can't just draw a line down the road and say one side can have service and the other can't ..... I want to keep my area as it is - part in Western area, and part in Unit 1. If they try to separate the two parts to streamline the management, it wouldn't make sense."
> School Nurse, Hilton(53)

> "I fear it may mean an increase in paperwork, if separate records have to be kept for work done in Western Unit and Unit 1 - and a wider number of contacts may have to be made within both units."
> Clinical Medical Officer, Hilton(66)

> "It would be very difficult if you had to keep making distinctions between patients who were in Western Unit and those who weren't. The main part of Western area relates to Millbridge, whereas different parts of the Hilton valley relate to Cityville, Cobbletown or Churchtown, especially for geriatric care."
> Speech Therapist, Hilton(29)

The Unit Management Board recognised the importance of boundary relationships both within and without the Stoneyshire District.

> "I think relationships will be the crux of the Western Unit, especially with Millbridge, and the continuing communication with Cobbletown. Lines of communication with Cobbletown will be difficult because of Western Unit being geographical, whereas the other units are divided functionally."
> Medical Member of Unit Board(48)

Other problems resulting from Unit creation stem from worries about the adequacy of the budget, particularly as it is difficult to make economies of scale in a small unit, a great amount of the finance is committed in staff salaries, and management costs tend to be higher,

proportionately.

Some community nurses, as well as paramedicals, G.P.s, consumers and Board Members expressed concern about finance, particularly in view of the fact that several services needed to be started from scratch, such as community mental handicap and mental illness services. As the Unit Accountant (111) put it

> "Unfortunately, the number of problems in the unit is not proportionate to the size of the budget - it is a very complex unit."

A number of people observed that the small size of the budget was a reflection of the lack of importance accorded to Western Unit in Cobbletown. Looking at the N.H.S. as an outsider, the Social Services Manager for Western area (83) said

> "Resources in the NHS tend to flow to where the consultants' power base is strongest - and as Western Unit is served by Millbridge consultants, who do not regard Western area as important, resources tend to be low."

In a staff meeting, the Deputy UGM (63) observed

> "Because consultants from Millbridge work at Uppertown in a part-time capacity, they put up with conditions for themselves and their patients which they would not tolerate if they were using the facilities full-time. They don't pester the D.H.A. for improvements as they would if it were their own authority and region."

This attitude was also reflected in a comment from a Superintendent Radiographer (107) at Uppertown Cottage Hospital.

> "I get the impression that Uppertown sessions are more readily cancelled than Millbridge sessions if consultants are away."

Not everyone interviewed felt strongly about the creation of the Unit, either positively or negatively. Quite a few nurses and G.P.s were prepared to wait and see what happened before expressing an opinion, and others, particularly district nurses and G.P.s did not expect the Unit's formation to make much difference at all. (see Appendix 4 GD1 and GD2).

6.3.6 Western Unit - Up And Running?

The unofficial "birth notification" of the new Unit was circulated to staff members in the last week of March 1986, in the form of the Western Unit Newsletter. (Appendix 3, D7). The Deputy UGM introduced it, suggesting it would be published on a three monthly basis, and asked for volunteers to assist him in editing it. The remainder of the first edition was a letter from the U.G.M., informing staff of recent appointments to the Unit Board (Deputy UGM, Unit Nurse Manager and Unit Medical Officer) and announcing a series of meetings in various locations around the Unit where staff could come to meet the UGM and other Board Members. The UGM reassured staff that the Griffiths' reforms were mainly a matter for senior managers, and so they need not expect much effect on their everyday work. However, despite the intention to publish the newsletter regularly, it never appeared again.

I attended each of the six meetings mentioned in the

previous paragraph, where the UGM met field staff at various locations in Uppertown, Middletown, Lowtown and Hilton during April and May 1986. (Appendix 2, scripts 63, 68, 69, 78, 79, 95). These were arranged as an opportunity for two way communication between the UGM and unit staff as the Unit became operational. Some drew a very good attendance with representation of every staff group whilst others were less well attended. The UGM took a different Board Member with him to each meeting, and usually one of the district heads of service of the paramedical professions, and these were invited to give their particular view of Unit development. At every meeting the UGM brought people up to date with the latest Board appointments and current developments in services, in line with the operational strategy for the Unit. He usually spoke of the role of the Western Unit Newsletter (see above) in keeping people informed, explained the planning process for the Unit, and bemoaned the way District Headquarters still had too much power over Unit affairs. The UGM generally listened to problems specific to the location of the meeting, often promising to take action (later staff complained that he had not done so.) At several meetings uncertainty over boundary issues and middle management structures were mentioned as a source of anxiety for staff.

One meeting was particularly difficult because the UGM made a statement about the management of the particular location where the meeting was being held that did not accord with staff perceptions of how it was managed, and caused offence

and bewilderment to several people present. What the UGM had taken to be already the case was only one possible future option for the management of this location, which needed very careful and tactful introduction. This incident damaged relationships between Board Members and other senior staff in the Unit for some time.

6.4 The Unit Management Board

(This section draws on material listed in Appendix 2, 104 and 113, Appendix 3, numbers 9 to 24, and Appendix 4, section L).

The first Unit Board meeting was held on 4th April 1986, but the first time the complete Board met was 3rd June, following the appointments of the G.P. member, the Consultant Member, the Unit Accountant and the Unit Personnel Officer during May. At the April and May board meetings, accounting and personnel functions were represented by District Headquarters' officers. Although April 1st 1986 was the official date for Unit inauguration, and marked the separation of accounts and management information, in reality the beginning of the Unit was a long drawn out process lasting many months, while the boundary and management issues were negotiated. With hindsight, the case study should have continued at least until the end of 1986, rather than finishing in the summer; this is one disadvantage of research done in pursuit of a higher degree, that time scales have to fit the academic timetable rather than organisational demands.

I was allowed access to the Unit Board meetings on two occasions, in June and July, but not to any planning group meetings or meetings between management and staff (except for the U.G.M.'s "getting to know you" meetings just described). I received minutes of the Board meetings from April till late July (there were five in all) and was aware that if the meetings I attended were typical, then the minutes did not fully reflect the character of the meetings; conflicts and pressures which were very real were not reflected in the minutes.

Figures 6.4(a) and 6.4(b) show the composition of the Unit's Management Board and the key responsibilities, philosophy, personal objectives and mode of working of each member, as revealed to me during interviews.

Because of the short period available to watch the Board at work, it would be invidious to make a detailed analysis of its functioning. So what follows must not be taken as by any means a true or whole picture of the Board, but purely as tentative ideas towards a very partial view.

FIGURE 6.4(a): Management Board Composition in Western Unit

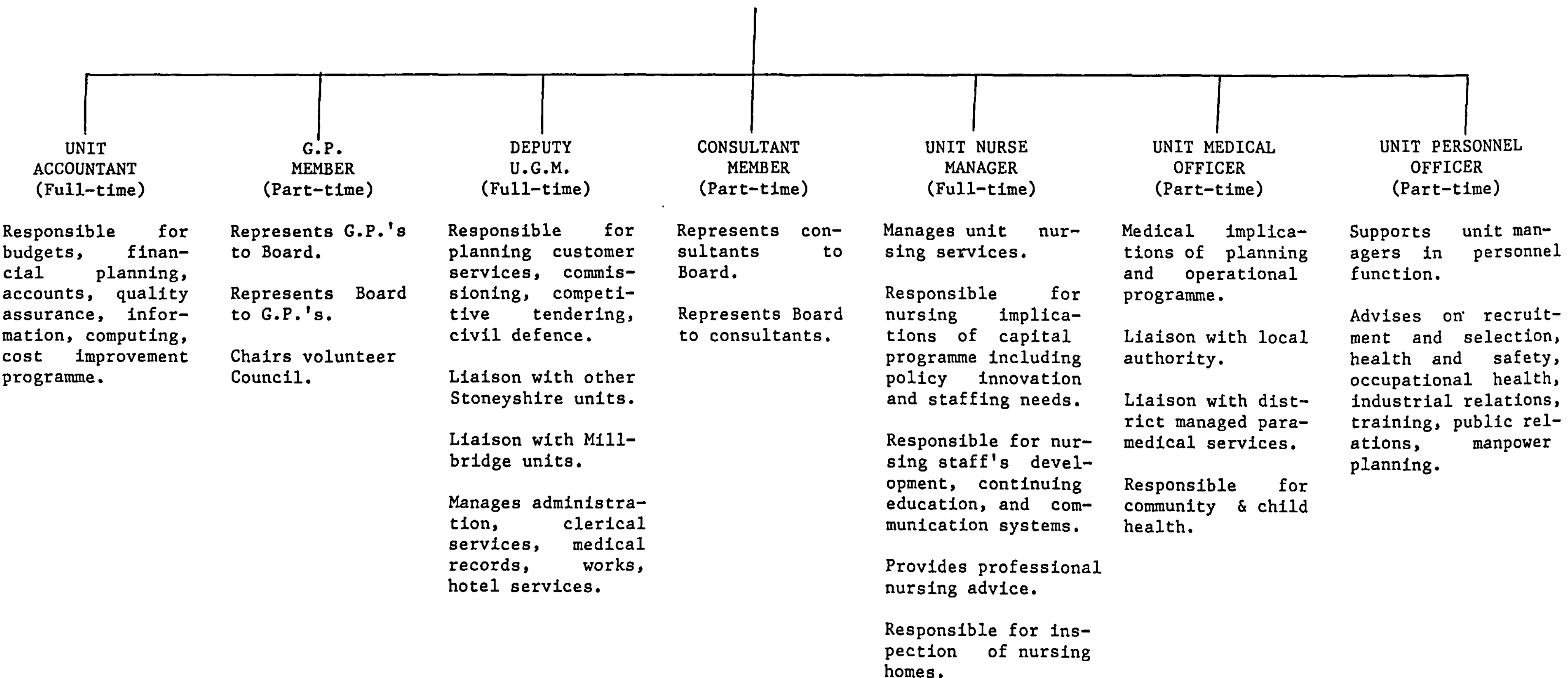


Figure 6.4(b): Summary of Management Board Interviews
(to be read in conjunction with chart of board composition)

See Appendix 2
Script numbers 106, 87, 90, 112, 111, 48, 114, 155.

	UNIT GENERAL MANAGER	DEPUTY UNIT GENERAL MANAGER	UNIT NURSE MANAGER	UNIT PERSONNEL MANAGER	UNIT ACCOUNTANT	MEDICAL MEMBERS x 3
Key Responsibilities	Appoint right people to right posts. Maintain enthusiasm and commitment of senior staff, and morale of all.	Oversight of Unit planning, including commissioning developments. Direct management of Unit administration. Co-operating with Unit Accountant to produce financial information for Managers.	Develop nursing implications of operational programme and capital development - especially policies & staffing. Communicate broad philosophy rather than getting bogged down in detail.	Support Managers in their personnel function. Offer skill in manpower planning, recruitment, training and public relations.	Provide financial information to Unit General Manager and Board, to enable them to keep within budget. Look for cost improvements. Implement quality assurance strategy.	Medical implications of planning. Two-way liaison with Millbridge Consultants, G.P.'s and Local Authority. G.P. member - establish volunteer council
Philosophy for Unit	Utilise resources with maximum efficiency for benefit of patients. Involve clinicians in innovation and planning.	Identify specific needs of the area, by consultation with staff and local communities. Make realistic plans to meet needs.	Put patients first, providing total health care in a collaborative way, in partnership with Social Services.	Create and maintain an equitable working environment - this then has positive effect on delivery of care.	Utilise resources to best possible advantage for patient. Approach issues from patient view point.	Improve patient care, get local people involved, increase efficiency and cost effectiveness.
Personal Objectives	Increase team spirit. Break down inter-disciplinary barriers. Encourage innovation. Involve all staff in process of quality assurance. Regard field workers as experts.	Increase activity levels in Unit. Improve morale. Avoid letting short-term work crowd out longer term.	To encourage a sense of unity, belonging and pride in the Unit, with flexibility. To develop a 24 hour home nursing service, with terminal care on hospice lines.	To provide a first-rate personnel service for the Unit. To recruit the right staff for the ESMI Unit. To set up a Unit Staff Council.	Keep budget under control. Make best use of resources. Make strong case for increased Unit budget - under resourced at present.	Improve clinical services, avoid total pre-occupation of the Board with finance, protect medical interest.
Preferred mode of working	Delegation. Reliance on team. Apply clinician's perspective.	Encouraging participation of staff. Developing realistic planning mechanisms.	Co-operation with Unit Board Members, especially Personnel Officer, to manage change.	Face-to-face communication rather than writing. Informal meetings supplementing formal ones.	Teaching and enabling staff at patient level about budgeting and quality assurance so that they can be involved.	Improving co-operation with G.P.'s and consultants by better communication.

6.4.1 The Board's Responsibilities

Amongst the Board's duties (according to information given by Board members) are the giving of leadership to the Unit, the making of policy, consultation with staff and the giving of advice to the UGM. The overall purpose of the Board is to fulfil the objectives of the Operational Programme, derived from the strategy of the Western Planning Team published in February 1985, and the Board's success or failure will be measured by its ability to see these objectives through to completion. The main items on the Operational Programme are listed below:

Relating to Uppertown Cottage Hospital -

Greater throughput in beds, operating theatre and Accident and Emergency Department

Reduce waiting times
- before receiving initial Outpatient appointment
- between consultation and surgery
- in Outpatient clinics

Make more use of community health premises.

Get major developments up and running -

Transfer maternity services to new premises
Open Ward for elderly mentally infirm
Develop Community psychiatric nursing service
Start Community mental handicap nursing service

Develop joint planning with Local Authority and Millbridge H.A.

Develop day and respite care for elderly.

6.4.2 The Board's Relationships

The terms of reference for the Management Board were outlined by the U.G.M. at the inaugural meeting in April 1986. Stress was laid on the difference between the old system of consensus management by Unit teams, and the "post Griffiths" arrangements where individual accountability and responsibility were the keywords. Apart from the specific task of implementing the Operational Programme, the Board's purpose was declared to be the identification, setting forth and monitoring of objectives, targets and standards for the Unit. Processes agreed to be vital for the fulfilment of these purposes include planning, involving staff at all levels within the Unit, G.P.s, members of different Local Authority departments, representatives of voluntary bodies and Millbridge Health Authority. Communication was seen to be of utmost importance throughout the Unit and all its many boundary relationships.

The need for better communication, even between Board members, was stressed to me by two of their members during July 1986.

> "We do not have enough time to hammer things out informally, so too much is dealt with formally, in meetings."
>
> Board Member(112)

Another said

> "There are problems in the development of a corporate identity - there is very little opportunity for informal interaction between Board

> Members, especially as the UGM and Unit Personnel Officer are part-time. So there is a sense of fragmentation about the Board at present."
>
> Board Member(111)

There were clearly a great many relationships in the making during the summer of 1986 - the obvious ones already mentioned elsewhere in this chapter such as with the other units within Stoneyshire, and the neighbouring units of Millbridge H.A., and also with consumer and context organisations. Paramedical staff in the Unit felt that clarification was needed in the position of the Unit vis-a-vis the district heads of the paramedical professions. At the late July meeting of the Unit Management Board, the Deputy UGM had to urge the UGM to attend the next meeting of the working group convened to deal with boundary issues between Western and the other two Stoneyshire units - progress had been held up previously because of his lack of attendance, as only the UGM had authority to take certain decisions. Until these issues were settled, staff at Hilton would remain dogged by a sense of conflicting interests.

Two particular sets of relationships were already beginning to bear fruit in the Unit - the appointment of both G.P. and consultant medical representatives to the Board had met with almost universal approval, and communication was beginning to flow through those channels in both directions to everyone's benefit.

6.4.3 The Role Of The UGM

There have been several references in this chapter to the role of the UGM being part-time; a number of people felt this to be a problem, and one which made further difficulties for the Deputy U.G.M.

> "A great deal of strain falls on the deputy UGM because he is on the spot all the time, but he has not got the power to make the necessary decisions. The UGM cannot commit enough time to the Unit to ease the process, and he is actually quite reluctant to take any decision without the backing of the management team."
>
> Unit Board Member(111)

This observation was supported by several other Board members, and by my own observations in Board meetings. In fact, most of the time the UGM acted as chairman of a consensus - seeking team, and on a few occasions when he wanted to postpone a decision or make it in opposition to the rest of the Board, he was very strongly opposed until he came into line with the rest of the Board.

6.4.4 Unit Planning Processes

The operation of the planning system was only just beginning in the summer of 1986 - many hours were being spent by different members of the Unit Board in consultation with Unit staff, District Headquarters staff, Local Authority and voluntary body representatives, and staff of Millbridge H.A. It is hard to give a clear picture of the way the process worked because I was not given access to the meetings, though I received some minutes. The core planning team for the Unit was the UGM,

his Deputy, the Unit Accountant and Unit Personnel Officer who met almost every week. The Unit Nurse Manager and Medical Officer and the other two medical representatives were co-opted as necessary, as were the various "outsiders" mentioned above. But there was also a more formalised, larger Joint Care Planning Group which met less often. One of the acknowledged problems was the transformation of planning into implementation, when those involved in the planning do not have total control over that implementation, due to the links with Millbridge H.A., which did not seem to give priority to any issue involving the Western Unit.

The local Social Services Manager (83) welcomed the stimulation to planning issuing from the establishment of the Unit.

But he warned

> "We really need to be very clear about the "ownership" of different projects, and to know who does what in terms of responsibility and implementation. In the past, this whole planning area has been like a minefield."

<u>6.4.5 The Unit Board And Its Budget</u>

The general opinion of respondents throughout the research that Griffiths' reforms were chiefly about saving money (see Chapter Eight for more detail), was certainly supported by my experience at Board meetings - much of the time was spent talking about finance, despite the Consultant Member (114) of the Board's taking as his personal objective

> "to avoid thinking of financial aspects constantly, and spending all board meetings talking about money."

Progress on some issues could not be made because *decisions* had not been made at District level about the substructures of Unit management, and whether the Unit itself would have to bear all the costs of these. There were also problems over the training budget, so a number of matters connected with improving quality in the Unit were hampered by lack of finance or uncertainty about it, and slowness of decisions making at District level. This served to restrict the desired autonomy of the Unit to tackle its problems in its own way.

6.5 Discussion Of Issues Raised By The Case Study Of Unit Formation

This short account of the workings of the Unit Management Board closes my general observations of the early life of Western Unit. I referred earlier to my realisation that the case study should have continued until the end of 1986 at least; I should have conducted at least one more round of interviews with field level staff, because the initial round took place before the Unit was up and running, to all intents and purposes. The tapestry continued to grow and become more complex, but out of my sight. In later chapters I return to certain aspects of the pattern, and look at them in more detail.

6.5.1 Were The Aims Of The Case Study Fulfilled?

First, however, I must consider whether the general account of the Unit's workings, given in this chapter, does actually enable us to see the effects of new management philosophies, plans and practices on the unit and its staff, which was the avowed intention of the case study. I have to admit that the study was too short to fulfil this aim; by the end of the study period, many staff were barely aware of new philosophies, and new management plans and practices were scarcely established. Nevertheless, I do not believe the study was wasted, because much has been revealed about the processes of change in the NHS.

Although Griffiths had said his plans for NHS reform did not amount to a reorganisation (Griffiths 1983:23), NHS staff certainly perceived them as such. No national guidelines or personnel policies for coping with organisational or job changes were issued; this lack of accepted rules, combined with the pressure of other changes such as competitive tendering, financial cut-backs and increased computerisation produced widespread anxiety and also cynicism amongst staff. This has been demonstrated in quotations in this chapter, and was seen in many other districts throughout England. (Cox 1986, Cousins 1986, Allen 1986:494).

The sense of uncertainty, even bewilderment, experienced by staff would not have pleased Griffiths himself, who, in the introduction to his recommendations (Griffiths 1983:2) said

> "Staff within the Health Services have to be assured that when changes are being made, demands made on them will as far as possible be part of an orderly management process."

6.5.2 Organising As A Process

Griffiths' reference to management as a process leads me to an approach to the analysis of the case study outlined in this chapter, based on the idea of organising as a process, rather than organisation as a static entity. (see Hosking 1988:147). This approach grows out of research in the interpretive paradigm, and is consistent too with the work of Pettigrew et al (1988) who are studying change in the NHS more widely. Hosking's view is that the process of organising can be seen to comprise structural, cognitive, political and social aspects (Hosking 1988:151). Pettigrew et al (1988:302) see the process of change as *having* rational, political and cultural elements. There are, therefore, parallels between the two analytic schemes; structural approaches are generally rational and culture encompasses social and cognitive aspects, even though needing other connotations to give it its full meaning. (e.g. shared values and beliefs - see Smircich 1983:345). The concept of organisational culture is dealt with more fully in Chapter Eight.

I referred in Chapter Five to the difficulty I had in moving from the "bare bones" of the analytic framework demonstrated in Appendix Four, reached by the use of grounded theory methodology, to writing substantive theory. I felt this was at least in part due to a failure to pursue the memo-writing stage. Eventual progress towards raising

the conceptual level from the everyday statements of Appendix 4 towards a more abiding perspective on the process of change in the NHS has been helped by considering the ideas of Hosking (1988) and Pettigrew (1988) discussed above.

Looking back at the formation of Western Unit, the structural process stands out most clearly. This originated with the DGM, aided by his District Officers for Personnel, Planning and Accountancy. Following acceptance of the restructuring plans for the District, they transferred control, altered accountability mechanisms and delegated authority for Western Unit to the UGM and his Management Board. The UGM and Board set up a new office base in Uppertown, and set in motion new systems and services throughout 1986 as described in this chapter, but with certain delays over middle management structures and boundary issues. This caused the feeling of dislocation described so graphically by some of the respondents.

The cognitive process of organising the new Unit is also clearly visible. The DGM explained his rationale for the reorganisation of the units in a paper issued in January 1985, and this was followed in the November by the UGM's plans for Western Unit. In between, there had been at least two editions of the District's Newsletter, which was circulated widely to all staff, and contained articles explaining the changes. The open meetings for staff to hear the three UGMs in Cobbletown in November 1985, the Western Unit Newsletter in March 1986 and the series of

"getting to know you" meetings in Western Unit in April and May 1986 continued the process. I was not given access to meetings between middle managers and field staff, but one must assume that information about Unit development must have being given at these also. Despite these various aspects of the cognitive process, I found many staff ill-informed about the changes. At least two members of staff claimed that my invitation letter to them, to take part in the research project, was their first intimation of impending change.

Len Peach, then Chief Executive of the NHS Management Board, acknowledged in 1988 (p43) that communication in the NHS was not all it might be.

> "I am occasionally surprised and worried about the ignorance displayed at local level of what is happening at district and region levels. If people do not know what is going on and are not involved, they fill the vacuum with misconceptions and rumours, generating problems that consume vast amounts of management time and effort. Every good manager recognises that putting half that time and effort into establishing good communications will be a sound investment."

Similar views on the importance of the cognitive process in NHS reorganisation were expressed earlier by Hodgkinson et al. (1985:23).

Because of the link between the cognitive process and the social or cultural process, expressed by Peach above, (in that lack of information can result in unnecessary anxiety and misconceptions) I shall turn to the social process next. This link between lack of information and stress in change situations is also highlighted by Jick (1987:266).

The social process of unit organisation should have involved the welding together of different parts of Western Unit - hospital and community staffs, perhaps, or staffs of the different hospitals in Uppertown. Despite a suggestion that the Unit Newsletter should become a vehicle for "family" news, this never materialised, and the "getting to know you" meetings did not often bring staff together who would not normally meet. The intention to hold a staff party at an Uppertown hotel was continually postponed in 1986, and it did not take place until 1988, under a new UGM. A number of different emotions were expressed by participants in the research interviews and contributed to the growing culture of the Unit. Anxiety has already been mentioned a number of times, and sometimes this was coupled with hostility, as in the case of most staff at Hilton. Apathy or cynicism due to the seemingly constant reorganisations was also a common reaction. Some enthusiasm was voiced, but chiefly by potential consumers, G.P.s, and others belonging to the Unit's context such as neighbouring UGMs. It appeared that little was done to support staff through these emotions, probably because the nurse middle managers, who would have been most likely to see the need, were themselves subject to greater problems than their staff.

The last of the organising processes, the political aspect, was certainly taking place throughout the period of the case study, but largely unobserved by me. Minutes of meetings were my chief source of information on this

process, which involved negotiation, persuasion, and liaison over boundary issues, the personnel training budget, nursing equipment loan services and welfare foods sales between Western Unit and Cobbletown. The political process also covered meetings with Millbridge representatives over agency services such as laundry and laboratory facilities, and over consultants' sessions at Uppertown. The main questions in these negotiations were "Who does what?" and "Who pays the bill?" The boundary issues took longer than they should have done to be settled, because the UGM sometimes sent his deputy to meetings, but the deputy did not have the authority to take the necessary decisions. A further aspect of the political process was the setting up of advisory committees, from April 1986 onwards, such as Medical and Planning groups, also the Staff Council (for trades union and professional association representatives) and the Volunteer Council to represent Consumer groups.

6.5.3 Leadership In The Process Of Organising

Writing in the context of organisational innovation, Bouwen and Fry (1988:156) maintain that successful organisational revival and development require continuity as well as novelty, and careful transformation from the old to the new. Western Unit were fortunate in that three Board Members, the Deputy UGM, the Unit Nurse Manager and the Unit Medical Officer, were already familiar with the Unit, as were the G.P. and Consultant Members who were appointed later. Bouwen and Fry (1988:166) go on to say.

> "Many organisations struggling with revival or innovation experience the need for what we call "common script": a shared understanding ... of what the innovation is about and where it is headed. Leaders of organisations need to be about the business of making commonsense or shared meaning out of all the individual perceptions and interpretations of events that have already occurred, related to the change, and of all their intentions about what will occur next."

The role of leaders in giving meaning and a shared image to their staff in times of change is emphasised by a number of writers on organisation, particularly Smircich and Morgan (1982:260), Sproull (1981:215) and Pettigrew (1979:577). The need for leadership was actually expressed by one of the clinical nurse managers in a research interview.

> "I expect the Board to make some clear policies. I also expect them to actually ask us what our problems are, and to help clarify them. I suppose what I'm looking for from them is leadership."
> Nurse Manager, Cottage Hospital (42)

I believe the research evidence given in this chapter reveals that the Board as a whole did give a measure of leadership to the Unit, and the Deputy UGM and Unit Nurse Manager were more prominent in this by virtue of their familiarity with the Unit, and the fact that they were usually on the spot and available. But the UGM himself, partly because he was part-time, partly through unfamiliarity, and partly because he seemed to deliberately take the role of chairman rather than manager, did not emerge as a leader. In evidence to the House of Commons Social Services Committee, representatives of the King's

Fund (1984:187) said

"The nominal general manager would be a disaster."

This view is supported by Banyard (1988:824) after a recent survey of the state of general management in the NHS. I am not saying that Western Unit experienced a disaster - they clearly did not; but had the Management Board not been so familiar with the Unit and its staff and services, it might have been a different story.

6.5.4 Partial Fulfilment Of The Organising Process

I believe the evidence in this chapter also reveals that the processes of organising were only partially recognized and fulfilled in the Unit. The structural process was interrupted due to the delay over middle management structures and boundary issues, the cognitive process did not seem to reach all the staff, the social process was hardly used, and the political process again suffered delays, partly through the UGM being part-time. The effect of this, in metaphorical terms, was as if the canvas was prepared for the tapestry, but the working of the pattern was left largely to chance, rather than being designed, directed and encouraged by a master craftsman.

6.6 Conclusion

Conducting a case study from within the interpretive paradigm has, I believe, highlighted aspects of the organizing process that might have been overlooked according to a functionalist perspective.

Such a perspective would have concentrated almost exclusively on the structural process, and on describing the canvas backing for the tapestry, if we return to the metaphor; the pattern on the tapestry would have been largely missing. Instead, by the use of ideographic and grounded theory methodology, the multiple realities of Unit members, consumers and context organisation representatives have been demonstrated.

In this chapter I have described the history, geography and services provided by the unit, and discussed the organising processes involved in setting it up. In addition I have explored staff perceptions about management and Unit identity and the Unit Board's perceptions of their responsibilities and relationships. I have tried latterly to begin to set these perceptions into a wider context of organisational analysis, and pursue these thoughts further in Chapter Eight. In the intervening chapter, however, we look in more detail at attitudes of professionl staff, especially nurses, because any overall analysis of a health care organisation must take professional attitudes into account.

CHAPTER SEVEN: PROFESSIONAL PHILOSOPHIES AND VALUES AND THEIR RELATIONSHIP TO MANAGEMENT

7.0 Introduction

Having looked, in Chapter Six, at the organisational background and the developing patterns of the tapestry depicting Western Unit, and having concluded that some of those patterns arose almost spontaneously, rather than being guided by a master craftsman, we now look in more detail at certain aspects of the pattern.

This chapter begins by examining the professional philosophies of nurses in Western Unit. (See Appendix 4A) First of all I analyse them according to professional discipline, and then I take a different perspective, looking at the principal emphasis expressed in the philosophies, and searching for possible explanations of the differing views. I then draw together the points of similarity between them, suggesting that a basis exists for building a distinctive nursing philosophy for the unit. After a short section on teamwork, I turn to the question of whether the variations in philosophy affect staff's expectations of management, whether analysed according to professional discipline, or according to principal emphasis. The scheme for analysing professional philosophies is influenced by the insights of nurse theorists, particularly McFarlane (1986). By contrast, the analytic framework for staff expectations of management arose entirely from the data, by the use of constant comparative analysis as discussed in Chapter Two (2.6) and Chapter Five (5.4.2) (see also Appendix 4C) I then build a

synthesis of the different expectations, and the chapter closes with a discussion of the distinctive features of health care management and the necessary managerial roles.

7.1 Disciplinary Expressions Of Professional Philosophy

To a certain extent, each healthcare discipline (e.g. each different branch of nursing) holds particular ideas and values in common. I asked each participant who worked in the Unit

> "Can you explain to me your professional philosophy? In other words, what is at the heart of the job for you?"

Sometimes I needed to probe a little more, or illustrate my request more fully, in keeping with the conversational nature of the interviews. My use of the term philosophy, as a kind of "folk concept" is explained in Chapter 3.7.2. First of all I present quotations from the interview scripts, Each quotation represents similar ideas expressed by at least twenty per cent of the group in question, in accordance with my self-imposed rule explained in Chapter Five (5.6.2); the bracketed number after the reference refers to script numbers in Appendix 2. (Occasionally quotations are single statements not following this rule; these exceptions are clearly indicated.) A full list of concepts derived from the interviews can be seen in Appendix 4, section A. These excerpts are followed by a figure summarising the nurses' responses in terms of categories commonly used in classifications of nursing models. (e.g. McFarlane 1986:3)

7.1.1 Health Visitors And School Nurses

> "Health visiting is the preventive arm and nursing the caring and curing arm of health care. Health visitors need to shift from a curing and caring view to a preventive view, and see things in the long term rather than the short term"
>
> Health Visitor Manager(1)

> "Health Visiting is trying to achieve a healthier society - in an individual and family sense, but also thinking of the community in which they live, working through groups of various kinds."
>
> Health Visitor, Lowtown(20)

> "We are helping people to improve their quality of life, from the cradle to the grave."
>
> Health Visitor, Uppertown(24)

> "The main thrust is towards prevention of ill-health and disability, being involved in health education..... The end in view is self-care, that families should be able to take responsibility for their own health."
>
> Health Visitor, Hilton(56)

> "Health visiting is being there, at the grass roots, influencing people towards well-being ... hoping they will make choices that lead to physical and mental wholeness."
>
> Health Visitor, Lowtown(10)

> "School nursing is promoting the health and welfare of children within the school setting, extending out to reach the whole family. Screening is part of our work, through school medicals and vision testing ... then there's immunisation and health education...."
>
> School Nurse, Middletown(33)

Finally, a statement only made by one H.V., but which I found illuminating

> "Health visiting actually grows, in the sense that the more you do in an area, the more you need to do - it generates its own impetus."
>
> Health Visitor, Middletown(31)

7.1.2 District Nurses

"District nursing is taking care of people in their, own homes, so they don't have to go into hospital. I'm in a supportive role to the patient's family, I teach them to cope and look after the patient - and of course teach the patient himself."
District Nurse, Uppertown(7)

"Hospital is an unnatural environment, it can make people feel worse, it frightens them."
District Nurse, Uppertown(26)

"I try to support the patient and family, and keep relationships going - so that when I have to do more for them we won't be strangers. For instance, when a patient is terminally ill, they might not need much care at first, but I keep popping in so they get to know me."
District Nurse, Middletown(6)

"Patients like to have one particular nurse that they get to know well and can confide in .... the thing I like about district nursing is to be able to follow a patient right through."
District Nurse, Uppertown(26)

"We need to think of the patient as a whole person, with social background and needs included. We nurse him as a whole, whether in hospital or at home, not cutting him off from his environment".
District Nurse Manager(2)

"I think caring is the most important part of the job - but giving care using professional knowledge and involving the family .... It's important to be seen to be competent and knowledgeable - it gives the patient confidence in you, and helps to build up trust."
District Nurse, Uppertown(17)

"District nursing is working with the patient in his own surroundings, taking into account his family and social conditions. This makes you very aware of the precipitating factors of the illness, so you may teach him how to avoid the problem in the future. You feel aware of the patient's own knowledge about, and perception of, disease. Because the district nurse understands the patient's view, she can give tailor-made education

about illness and care for the patient in a realistic way."

District Nurse, Hilton(54)

7.1.3 Midwives - Hospital And Community

"The distinctive thing about midwifery is that you are a practitioner in your own right - you make the decisions, using your own professional judgment, about the delivery and care of the patient."

Midwifery Sister, Maternity Home(65)

"The midwife's aim is to ensure a safe delivery in as natural a way as possible - to have happy mothers and healthy babies .... so that the whole experience of childbirth becomes something a mother can look back on with happiness and satisfaction."

Midwifery Sister, Maternity Home(34)

"In a small unit like this you are often able to follow a patient right through - you see her ante-natally, then deliver her, and look after her and the baby for several days - you get continuity of care."

Midwifery Sister, Maternity Home(65)

"The midwife becomes a real friend and counsellor to the family..."

Midwifery Nurse Manager(16)

"We use a system of individualised care, where a patient care plan is discussed before labour begins, and the patient can express her wishes about pain relief, birth position and so on..."

Midwifery Sister, Maternity Home(34)

"I try to respect the mother's wishes, not force her to accept things she does not want. But when it comes to a life-threatening moment I have to draw the line and insist on the safest course to follow."

Midwifery Sister, Maternity Home(39)

"The most important thing is to recognise the needs of the patient - to find out what she is wanting from the pregnancy."

Community Midwifery Sister(38)

7.1.4 Cottage Hospital Nurses

"The important thing about nursing for me is caring for the comfort and well being of the patients, looking after their needs... I enjoy my contact with the patients."
Enrolled Nurse, Cottage Hospital(64)

"Caring for and comforting patients are the most important aspects - making personal relationships with them."
Sister, Cottage Hospital(52)

"It is important for the patient's voice to be heard... The nurse should try to persuade but not force compliance with treatment... Nurses should seek to protect a patient's emotional state as much as the physical."
Cottage Hospital Nurse Manager(42)

"I contribute as much as I can to the patient's quality of life whilst in my care."
Enrolled Nurse, Cottage Hospital(64)

"I think we are here in Casualty to give a good, efficient service; we also need to be kind and understanding and pay attention to individual worries otherwise the patients will not benefit from our treatment."
Sister, Cottage Hospital(50)

7.1.5 Geriatric Hospital Nurses

"I like caring for people, and seeing they're happy. I like to work with the more dependent patients, using my basic nursing skills ...making people as comfortable and peaceful as possible."
Enrolled Nurse, Geriatric Hospital(36)

"Caring is the main theme for most nurses ...I'm a nurse because I like caring for people."
Night Sister, Geriatric Hospital(61)

"I assess the patient soon after admission, finding out everything I can about him as an individual, his likes and dislikes and habits. Then I do whatever possible to improve his condition, rehabilitating as much as possible, maintaining existing abilities. If death is inevitable, I try to make sure that physical care is excellent ...

> and that patient and relatives are prepared and helped to adjust to the situation."
>
> Sister, Geriatric Hospital(27)

> "My job is to ensure that the people in my care are given the kind of care, both physical and mental, that is right for their needs - looking at them as whole people, helping to educate them and their relatives so that their needs are recognised."
>
> Nurse Manager, Geriatric Hospital(22)

> "All the staff here share the idea that this is the patients' home - so we try to see that things are done to make them happy".
>
> Enrolled nurse, Geriatric Hospital(43)

> "Because of the emphasis on rehabilitation, it is important for night staff to know how patients are treated in the day. We interpret the patients' needs and are much more flexible."
>
> Night Sister, Geriatric Hospital(57)

> "Whenever it won't be detrimental to their condition, we leave them to sleep undisturbed - then they are more alert in the day, to co-operate with treatment"
>
> Night Staff Nurse, Geriatric Hospital(59)

7.1.6 Summary And Discussion Of Disciplinary Differences In Nursing Philosophies

These quotations demonstrate the truth of McFarlane's (1986:3) assertion that most nurses carry with them an image of nursing which includes ideas about the role of patients and nurses, the health care environment, the nature of and processes involved in nursing actions, and nursing goals. These parameters, which I used to draw up figure 7.1.6 as a means of analysing the nurses professional philosophies, correspond to an earlier list compiled by Dickoff, James and Wiedenbach (1968:420) which is much used by American nurse theorists, comprising:-

Agency - who performs the activity? i.e. the role of the nurse.

Patiency - who is the recipient? i.e. the rôle of the patient.

Framework - what is the context? i.e. the environment.

Terminus - what is the end point? i.e. the goal.

Procedure - what are the techniques? i.e. the process.

Dynamics - what is the energy source? i.e. attributes needed.

Figure 7.1.6 summarises the working philosophies of nurses in this study.

Figure 7.1.6: Summary of working philosophies of different disciplines in nursing.

	HV + School Nurses	District Nurses	Midwives	Cottage Hospital Nurses	Geriatric Hospital Nurses
Recipients of Care	Families: parents, mothers babies, under 5's, school-children, teachers, elderly, handicapped, community groups.	Anyone who needs nursing at home. Whole person, not just physical part, family included.	Mothers Babies The family as a whole unit.	People as individuals - whole person, not just physical part.	People as individuals - whole person, not just physical part. Include family.
View of environment	Long-term view. Families seen in context of community. Health service seen in its political environ-ment.	Patient's home is best place for him, hospital is unnatural environment. Important for nurse to understand patient's background.	Birth in context of family life. Want congenial environ-ment for birth, with continuity of care.	Hospital environment needs to be patient-oriented, not institutionalised.	Hospital is patients' home. Need to relate present care to patients' past and future. Integrated 24 hr care.
Role of nurse	Offering, not forcing advice, changing attitudes, meeting needs.	Caring. Supporting. Attitude changing.	Practitioner in her own right. Almost one of the family - friend and counsellor.	Patients' advocate. Offering, not forcing advice. Enabling. Persuading.	Professional carer. Agent for rehabilitation.
Process involved	Health education. Contacts with wide range of people and groups. Screening. Supporting. Helping, liaising.	Use of "nursing process". Comforting, explaining. Rehabilitating. Building relationships. Educating patient and family.	Use of "midwifery process". Use of professional judgement in decisions. Building relationships.	Caring for comfort and wellbeing. Making personal relation-ships. Teaching patients and relatives.	Use of "nursing process". Making people comfortable and peaceful. Educating patient and family to recognise own needs.
Goal of nursing	A healthier society. Improvement in quality of life. Families to take respons-ibility for their own health.	Individualised care to whole people. Prevention of hospital-isation. Enabling to cope. Improving quality of life.	Safe delivery as naturally as possible. Happy mothers. Healthy babies. Patient centred service.	Individualised care to whole people. Healthier society, improving quality of life. Protection of emotional state of patient, thinking how he feels.	Individualised care to whole people. Rehabilitation. Making life for patients as normal as possible. Giving best possible care, causing no harm.
Attributes needed by nurse	Availability. Accessibility. Adaptability. Objectivity. Respect for peoples' autonomy.	Caring attitude. Competence. Skill, knowledge. Experience. Realism.	Respect for mothers' wishes. Reliability. Flexibility. Availability.	Kindness. Understanding. Efficiency. Flexibility. Persuasiveness.	Knowledge, skill, experience. Flexibility. Imagination. Humour.

The nurses I interviewed were not used to presenting their professional philosophies in any structured form, but nevertheless did possess their own images of nursing. It seems likely that they assume that their personal image is like everyone else's; the differences only seem to emerge when perhaps two nurses are sharing the care of one patient, and some crisis precipitates a breakdown of *relationships caused* by the differences.

Figure 7.1.6 provides supporting evidence for the UKCC's (1986:34) assertion, quoted in Chapter Three (3.7.6) that there is a new basis for unity shared by nursing, midwifery and health visiting professions. This unity grows from the widespread acceptance of holistic models of health care which are often taken as part and parcel of the "nursing process" approach. Individuals in all nursing disciplines in Western Unit stressed individualized care, seeing a patient in his environmental context, allowing choice and teaching healthy lifestyles. It should not be difficult, given this background, for a common philosophy, even an explicit model, to be built up for nursing within the Unit.

7.1.7 Paramedical Staff and Clinical Medical Officers

A number of this group described their work as consisting of several dimensions - one-to-one therapy or treatment, advice or education to carers, parents or teachers to enable them to carry out remedial activity, and screening or preventive work to detect or forestall problems. A speech therapist, physiotherapists, a chiropodist, a dental

officer and clinical medical officers all referred to this multi-faceted approach in their work, which has similarities to modern approaches to nursing. In this approach, assumptions are made that families or other carers have an important part to play in the treatment of patients, and that healthcare clients are ready to take responsibility for their own, and their families' health.

> "There used to be almost entirely a one-to-one relationship between the speech therapist and the patient. But recently the role has changed to a more advisory one."
>
> Speech Therapist(29)

> "I assess, advise and support teachers, parents and children. We take a preventive approach, trying to spot incipient problems and treating them before serious trouble occurs. We aim to teach parents or teachers to teach the child, rather than giving a lot of treatment ourselves".
>
> Paediatric Community Physiotherapist(51)

> "I'm involved in screening for health problems, and immunisation... I hope to help school staff appreciate the effect of health problems, to raise their awareness of health as a possible cause of behaviour changes in pupils."
>
> Clinical Medical Officer(66)

7.1.8

Service Managers and Secretaries

The common theme running through this group is the sense that the service they provide or supervise enables the clinical work of the unit to go on unhindered.

> "I'm responsible for the smooth running of the whole place."
>
> Health Centre Secretary(32)

> "I'm responsible for mechanical and electrical maintenance in all Health Service properties."
>
> Senior Engineer(101)

> "I'm responsible for the provision of all domestic services (everything to do with cleaning) in all the unit's premises."
> Domestic Services Manager(100)

Other staff interviewed in this group, who expressed similar ideas were a catering manager and a family planning clinic secretary.

7.2 Another Perspective on Professional Philosophies

The first part of this chapter classifies professional philosophies in the most obvious way, by separating out the different disciplinary groups within nursing. I have already stressed the many similarities between the groups, largely based on holistic values and the use of the nursing process. However, as I used the grounded theory method, comparing concepts held by nurses of all kinds, I discerned some disparities between nurses of the same disciplinary group, contrasting with agreement across the disciplinary divide over some issues. Eventually several coherent themes emerged, which seemed to focus on the role of the nurse; further analysis revealed that most nurses in the study clearly put emphasis on one or other of these roles, and on the goals associated with them. This analysis is discussed more fully in Chapter 5.4.3, 5.6.2 and Appendix 4.

The largest group, labelled group A, forty two per cent of all respondents, was made up of representatives of all the disciplines in nursing. (See Figure 7.2.4 and Appendix 4A). Group A saw nursing as being primarily a professional response to need. Another important group, labelled group

B, comprised thirty seven per cent of respondents, again from all the different disciplines. Group B saw nursing primarily as relationship building. The last group, group C, comprised the remaining twenty per cent, who were mainly health visitors and school nurses, but included two district nurses. Their view of nursing was of promoting health and preventing illness.

To discover the allegiance of nurses to these different emphases on professional philosophies, I used the cards on which I had summarised each person's views. (see Chapter Five, 5.4.1). I could tell from the code classification system (see Appendix 4) which group emphasis was predominant in each person's thinking in all but a few cases. In those cases where responses seemed at a glance to straddle all three groups, or two of them, rather than appearing clear-cut, I examined the original scripts again. This re-reading scripts in their entirety did reveal in each case a bias towards one particular emphasis, enabling me to make a clear categorisation.

In illustrating the emphases of the different groups I follow the same pattern as in the previous section, using quotations which represent at least twenty per cent of the group's membership. I then summarise the positions held in Figure 7.2.4, expressing the ideas according to components taken to be important in classifying nursing models. The figure also gives the exact composition of the groups. This is followed by further discussion.

7.2.1 Nursing As Professional Response To Need (Group A)

"In a nutshell, I think health visiting is meeting peoples' needs - of all ages, as individuals and as groups."

Health Visitor, Hilton(55)

"The health visitor is an independent practitioner in her own right, who manages her case load and should establish her own priorities."

Health Visitor, Uppertown(5)

"District nurses are there to give skilled nursing care to everyone *in the community* that needs it."

District Nurse, Middletown(11)

"An essential aspect of district nursing is effective provision of competent nursing skills where needed by anyone in the community, the range of these being flexible to accommodate the varied needs of patients."

District Nurse, Hilton(14)

"As a midwife, I think the most important thing is to recognise the needs of the patient - to find out what she is wanting for the pregnancy."

Community Midwife, Uppertown(38)

"Midwives are practitioners in their own right - they should have professional autonomy. Their duty is to women and their babies."

Community Midwife, Uppertown(45)

"We teach patients to recognise their own individual needs."

Nurse manager, Geriatric Hospital(22)

"The night staff carry out the nursing process with the patients according to their own discretion. There used to be rigid routines ... but now we may interpret the patient's needs and be much more flexible."

Night Sister, Geriatric Hospital(57)

7.2.2 Nursing as Relationship Building (Group B)

"The health visitor is the friend of the family - in a long term sense, and accessible to them."
Health Visitor, Uppertown(24)

"In District Nursing, getting on with patients is the most important aspect - you try to advise them and support them through any problems. You really become one of the family."
District Nurse, Uppertown(18)

"A Community midwife has a relationship with families as wholes, as well as with the Mothers.... It takes time to build good relationships."
Community Midwife, Lowtown(46)

"Caring for people who are unable to care for themselves is the most important thing - and I include in the caring the families of patients .... When I was in training, sisters excluded families from the wards as much as they could.... I vowed I would do things differently when I became a Sister."
Sister, Cottage Hospital(49)

7.2.3 Nursing As Promoting Health (Group C)

"Health Visitors are home visitors -using our basic nursing knowledge for prevention, looking beyond the curing and caring in a wider way. We use screening techniques and search for health needs."
Health Visitor, Uppertown(21)

"I act as a kind of clearing house for information for people who need help of various kinds. I start with advice on basic healthy living, in the home and for all the family."
Health Visitor, Lowtown(9)

"School nursing has changed from being concerned with hygiene, to a stress on health education and prevention of illness."
School Nurse, Hilton(53)

"I see myself as caring for and educating about the health of patients and their relatives. I try to

> see people as a whole, and to think of prevention of illness."
>
> District Nurse, Middletown(12)

7.2.4 Summary And Discussion Of Differences In Professional Philosophies

Although the "promoting health" group was made up largely of health visitors and school nurses, health visitors were also included in both other groups as were district nurses. Midwives and geriatric hospital nurses were predominantly in the "professional response" group, whilst cottage hospital nurses were predominantly in the relationship - based group, along with a large number of district nurses and a few of the other disciplines. The exact composition of the groups, together with a compilation of their values and attitudes classified as in the previous figure, is given in Figure 7.2.4.

FIGURE 7.2.4 Summary of working philosophies of different groups of nurses, classified by principal emphasis.

Nursing seen as	Group A "professional response to need"	Group B "relationship building"	Group C "promoting health and preventing illness"
Professional discipline of staff holding concept	District Nurses (incl.NO) 4 (23% all DN) Health Visitors (incl.NO) 5 (29% all HV) Midwives (incl. NO) 9 (82% all MW) Cottage Hospital Nurses 1 (14% all CHN) Geriatric Hospital Nurses (incl. NO) 6 (86% all GHN) 25 (42% all N)	District Nurses 11 (65% all DN) Health Visitors 2 (12% all HV) Midwives 2 (18% all MV) Cottage Hospital Nurses (incl. NO) 6 (86% all CHN), Geriatric Hospital Nurses 1 (14% all GHN) 22 (37% all N)	District Nurses 2 (12 % of all DN) Health Visitors and School Nurses 10 (59% of all HV and SN) 12 (20% of all nurses)
Recipients of care	People as individuals, seen as whole persons, not just the physical part. Families of patients cared for.	People as individuals, seen as whole persons, not just the physical part. Families of patients cared for.	Families, parents, mothers, babies, children under 5, school children, teachers; the elderly, the handi-capped; community groups.
View of environment	Patients or clients seen in context of their family or social background. Birth seen in context of family life. Elderly in hospital - needs seen in relation to past and future.	Knowledge of patients' home environ-ment very important. Hospital environment needs to be patient oriented, not institutional.	Families seen in context of community. Health service seen in context of political environment.
Role of nurse	Professional carer. Practitioner in own right.	Almost one of the family. Patient's advocate.	Presenter of choices to help in achieve-ment of healthy lifestyle. Disseminator of information.
Process involved	The nursing process - Assessment, planning Implementation, evaluation Individualised care to the whole person. Using skill, knowledge.	Building relationships over time. Supporting and teaching patient and his family. Giving people-centred, individualised care to whole person and his family.	Influencing, guiding. Persuading, educating. Supporting. Offering options. Screening, preventing.
Goal of nursing	To meet patient's need, using professional skills to care. To enable patients to live life as normally as possible. To deliver healthy babies as normally as possible.	To give continuity of care, improving the quality of life, enabling self-care at home whenever possible. To do the patient good, not harm.	Families to take responsibility for their own health, and be able to cope. Improvement in quality of people's lives, through changing attitudes.
Attributes needed by nurse	Sound knowledge base. Skill, competence, experience. Good powers of observation. Adaptability.	Caring attitude accompanied by knowledge and skill. Aptitude for teaching patients and relatives.	Sound knowledge base. Objectivity. Availability. Respect for individual freedom of choice.

7.2.4.1 Possible Explanations For Differences

I looked for possible explanations to account for the varying emphases in professional philosophy; a number of hospital and district nurses had participated in courses on "the nursing process" in the recent past, held locally, based on an Open University (1984) teaching package. Some nurses actually said "Now we do this and that..... we used to do ....." The pivotal point for change in practice was this particular course, which had made a practical reality of an approach to care which had previously seemed to them no more than a paper exercise. Of the five clinical nurse managers, four seemed to belong to the group emphasizing nursing as professional response to need. A fairly small percentage (See Figure 7.2.4) of health visitors and district nurses shared the approach of their nurse managers - this is not surprising as they do not work in close proximity to each other, where they would be likely to be influenced strongly. Also both groups of nurses experience extra academic education to obtain their community nursing qualifications; they are therefore trained to think more critically than most nurses, and exhibit a good deal of independence. The Nurse Manager for the Geriatric Hospital (22) explicitly stated her intention of inculcating her own model of nursing in her staff.

> "We try to look at our patients as whole people, and to educate them and their relatives to recognise their own needs ... I believe I need to lead staff into accepting this model by my own example."

She appeared to be successful, in that all her staff

interviewed, except one, shared her orientation towards viewing nursing as professional response to need. The situation was similar amongst midwives, with nearly all joining their nurse manager in the "professional response to need" group.

The Nurse Manager at the Cottage Hospital (42) was very clearly in the "relationship building" group, as were most of her staff. She said

> "I think the whole idea of a patient-oriented health service should be adopted by all disciplines, not just nursing. That includes the G.P.s who will sometimes put a patient in hospital, not because the patient wants to go, but because it saves trouble for the doctor or district nurse."

I looked at geograhical relationships (See Figure 7.2.4.1) of nurses holding the various professional philosophies, but apart from the influence of nurse managers on the institutional groups described above, there seemed to be no pattern. Why community nurses held their particular views was a mystery.

LOWTOWN
Clinic
and
G.P. Surgeries

Group A x 1 HV
Group B x 2 DN
Group B x 1 HV
Group B x 1 Community Midwife
Group C x 2 HV

MIDDLETOWN
Health Centre and
G. P. Surgery

Group A x 1 HV
Group A x 1 DN
Group B x 3 DN
Group B x 1 Community Midwife
Group C x 2 HV
Group C x 1 SN
Group C x 1 DN

HILTON
Clinic and
G. P. Surgery

Group A x 1 HV
Group A x 1 DN
Group C x 1 SN
Group C x 1 DN
Group C x 1 HV

Geriatric
Hospital

Group A x 6
Group B x 1

Maternity
Home

Group A x 7 Hospital midwives
Group A x 2 Community midwives

UPPERTOWN

G.P. Surgeries
and
Health Centre

Group A x 2 HV
Group A x 2 DN
Group B x 1 HV
Group B x 6 DN
Group C x 3 HV

Cottage Hospital

Group A x 1
Group B x 6

FIGURE 7.2.4.1 Geographical Relationships Of Nurses Holding Various Professional Philosophies

From my own tacit knowledge of nursing staff in the unit, there did not appear to be a connection between length of time in the profession, or even since post-basic education, and the professional values and attitudes of staff.

7.2.4.2 Similarities Between Philosophies

Looking again at Figure 7.2.4, the similarities in approach are just as marked as the differences, as they were in the previous figure where views were classified according to professional discipline rather than predominant emphasis. The differences seem to occur particularly in the choice of role adopted, and consequently in the process used to fulfil that role. As I recall Griffin's (1983:289), classification of patients' needs into clinical, cognitive, emotional and moral, which I discussed in the section on the philosophy of caring in Chapter Three (3.7.2) I speculate whether nurses' emphases on different roles depend on how they perceive patient needs. Health visitors seem to interpret their clients' needs as being chiefly for information. Many midwives, Geriatric Hospital nurses and some others perceive their patients' needs as being mainly clinical, and many district nurses, Cottage Hospital nurses and a few others respond largely to the need for emotional support which they perceive in their patients.

As the questions about working philosophies were only a part of the wider interview process, it would be unwise to place too much stress on the differences between groups. It seems reasonable to suppose that if I were to go back and talk to the same nurses again, this time concentrating

exclusively on their roles and the processes they adopted, they might say that they do vary their approach depending on their perception of patient need. They would probably agree that nurses need to be professional carers, relationship builders and educators, all at the same time. The different aspects relate closely to the different kinds of knowledge needed in nursing, referred to in Chapter Two, (2.3.1) as described by Carper (1978:22) and Sarvimaki (1988:462). The knowledge needed to be a professional carer is both practical and moral, to be a relationship builder requires creativity and personal understanding, and to be an educator demands scientific knowledge and communicative ability. There are links, too, to the kinds of process at work during the creation of the Western Unit, as depicted at the end of Chapter Six. Educators employ predominantly cognitive processes, relationship builders social and emotional processes, and professional carers a combination of all three.

I have already concluded that the similarities in approach between the different disciplines in nursing, and between those whose principal emphasis differs, are just as marked as the differences. It is therefore possible to synthesise these features using the same categories as for the previous figures (7.1.6 and 7.2.4). This I have done in Figure 7.2.4.2.

FIGURE 7.2.4.2 Synthesis - Working Philosophy of Nurses in Western Unit

Elements for consideration	Assumptions and Values
Recipients of care	Individuals viewed holistically - physical, mental, spiritual, emotional, social factors considered. Family unit often recipient of care.
View of environment	Patients seen in context of family and community rather than hospital, and in terms of their past, present and future. Hospital must be patient-oriented.
Role of Nurse	Professional carer, Relationship builder, patient advocate Disseminator of information, Changer of attitudes.
Process involved	The Nursing Process-assessing, planning, implementing and evaluating care for individual patients. Use of professional judgment and skill. Making relationships, comforting, supporting. Educating, guiding, preventing illness.
Goal of nursing	Improvement of quality of life for patients/clients. A healthier society. Enabling people to cope with their own health needs and take responsibility for them. To give individualised care, including meeting emotional needs. To prevent hospital admission.
Attributes needed by nurses	Caring attitude, kindness Competence, skill, knowledge, experience Ability to observe accurately Ability to teach Availability, accessibility, adaptability Objectivity, realism, reliability, efficiency. Respect for autonomy of individuals. Understanding, humour, imagination.

7.2.4.3 A Basis For A Nursing Model?

This synthesised philosophy could very easily become a foundation for the nurses in Western Unit to use, on which they might build a model for nursing care, as did the nurses described in Wright's unit in Tameside. (Wright 1986). Many aspects of the synthesis are similar to some of the role statements dealt with in Chapter Three, especially that of Briggs (DHSS 1972C:44) the DHSS (DHSS 1977b) and Wilson-Barnett (1984:6-12). Although it did not appear that any nurses in the unit were basing their practice on any of the recognised nursing models such as Roper et al's (1985) or Orem's (1971), there were also no indications that they were working to a medical model either. Nurses no longer view themselves as hand-maidens to doctors; the nurses I interviewed saw doctors as colleagues, working alongside them rather than directing them.

7.3 Participants' Views On Teamwork

Most community nurses saw themselves as belonging to a team of some kind, usually including the general practitioner to whom they are attached, together with district nurses and health visitors attached to the same practice. Some felt that social service personnel, and other health service workers such as paramedicals were also in the team, but some excluded them, and there did not appear to be any pattern to the responses. A few community nurses felt a strong sense of reltionship with the local hospitals, but most did not.

Hospital nurses generally felt that for them, the team included staff on their ward, and also paramedicals and support workers directly involved with their patients.

A few hospital staff mentioned community nurses spontaneously in their assessment of who they related to, and several more when specifically asked did agree that there was more contact between hospital and community nurses recently, especially at educational events. But a number of hospital staff commented on the isolation of their hospitals from the outside world of the NHS in general.

Several paramedical staff commented that they were members of several teams; firstly they belonged to their *own* professional service, whatever it might be - chiropody, speech therapy etc. But they also felt allegiance to staff at the hospitals, clinics or special schools where they spent parts of their time.

7.4 Implications of Professional Philosophies For The Management Of Health Professionals

In the first part of this chapter I have analysed nurses' expressions of their working philosophies according to their discipline and also according to their principal emphasis. I have suggested areas of consensus, and other aspects where there is variation. The nursing literature had implied that model-based nursing practice is very much the business and concern of nurse managers (Stevens 1984:120-5, Chaska 1983:723, Farmer 1986:13). Accordingly, in my interviews with staff in Western Unit, having

elicited each respondent's own working philosophy, I then asked "Does your view of nursing have implications for the way nursing is managed?" Later in each interview I also asked what each member of staff expected from their manager in the way of support.

If we return to the metaphor of the tapestry, staff expectations of management are another example of a part of the pattern where many threads run together, and where they separate, the distinctions may be rather subtle. Figure 7.4.1 classifies staff expectations of management by professional discipline, and Figure 7.4.3 by predominant professional philosophy. The five target areas for support listed at the left hand side of these figures, sharing of professional values, innovation and *inspiration*, *staff* support, meeting of educational needs and general management, are conceptual categories derived from the interview responses by grounded theory methodology, not a pre-conceived set of codes. (See Appendix 4C). They are an example of how a start is made to building a substantive theory of the perceived needs of clinical nurses for management support.

Figure 7.4.1 is followed by quotations from staff which spell out in more detail their expectations of managers, and then by a brief discussion. Figure 7.4.2 sets out clinical nurse managers' own perceptions of their role. Figure 7.4.3 is also followed by quotations and discussion.

Figure 7.4.1: Expectations of management classified by professional discipline

Subject area	HV's and School Nurses want manager	District Nurses want manager	Midwives want manager	Cottage Hospital Nurses want manager	Geriatric Hospital Nurses want manager
Sharing of professional values and knowledge	Who recognises staff's professionalism and facilitates them to do their job in their own way	(spans HV's to Midwives)	(spans HV's to Midwives)	Who shares caring values and values sisters' role in taking responsibility for staff and keeping good relationships with them.	(spans Cottage and Geriatric)
	Trained in own discipline	(spans HV's and District) Who shares caring values	(spans District and Midwives) Who lets staff look after individuals whilst management deals with systems		And who facilitates staff to do job in their own way.
Innovation and Inspiration	With vision for service, is prepared to innovate and take risks; who will be strong voice at top management level, and not get bogged down in administration but will motivate and lead.				With vision for the service, is prepared to innovate and take risks.
Support for staff	Who will solve problems	(spans all)	(spans all)	(spans all)	(spans all)
	who is accessible, available, approachable	(spans HV's to Midwives)	(spans HV's to Midwives)	who is a good listener	(spans Cottage and Geriatric)
	who gives clinical advice. who is a good listener	(spans HV's and District)	who gives definite answers, especially on staffing problems.	and who is on the spot, clinically involved and gives clinical advice	and takes a personal interest in them
	who takes personal interest in them, and supports in problems with primary care team and with legal implications.				
Meeting educational needs	who will arrange continuing education, keeps up to date, updates staff, monitors and assesses training needs	(spans HV's and District)	who is also supervisor of midwives, monitors standards and assesses training needs	who will arrange continuing education	(spans Cottage and Geriatric)
		and inducts and re-orients staff and gives career counselling			who keeps up to date and up-dates staff
General management	who negotiates boundary problems and acts as public relations officer	(spans HV's to Midwives)	(spans HV's to Midwives)	who sees to smooth running of service	(spans Cottage and Geriatric)
	and who takes a wider view, sees significance of social trends, recognises interdependence with other units and environment	and sees to smooth running of service including supplies and equipment		and who takes a wider view, sees significance of social trends, recognises interdependence with other units and environment	and who has worked way up through nursing hierarchy and has good theoretical training

7.4.1 Staff Expectations of Management - According To Professional Discipline

7.4.1.1 Health Visitors and School Nurses

> "Health visitors need a manager who understands their work - who will listen and take action - who will put their case strongly."
>
> Health Visitor, Lowtown(28)

> "It's important to have the back-up of experienced nursing management, because of the possible legal implications, and especially if there's a difference or problem between the H.V. and the G.P. she's attached to."
>
> Health Visitor, Lowtown(9)

> "So often, the practicalities of management are incompatible with the philosophy - managers seem to get so bogged down in the organisation, they don't have time or energy left to co-ordinate aims for health visiting, and motivating staff, and putting plans into action."
>
> Health Visitor, Lowtown(10)

> "Management concentrates on our work with individuals, it doesn't recognise the community aspects ..... Our manager is restricted by her remit - management have certain things they have to be concerned with, and H.V. involvement in the community doesn't come into it."
>
> Health Visitor Lowtown(20)

> "It's important for the manger to really understand what school nursing is all about."
>
> School Nurse, Middletown(33)

7.4.1.2 District Nurses

> "An efficient service needs efficient and adequate delivery of supplies and equipment - the manager oversees that. She's also responsible for ensuring continuous training, up-dating and access to modern treatments ... There has to be flexibility so that practitioners in different areas can adapt to varying conditions - for instance, urban and rural areas require and dictate different work patterns. The manager needs to encourage district nurses to emerge from their isolation - to feel part of the organisation

as a whole .... I do feel that the manager, while giving support and being available .... should not breathe down the necks of her staff."

District Nurse, Hilton(14)

"We are all individually accountable, nursing officers are there to support us, to enable us to get on with nursing, not to take the responsibility."

District Nurse, Middletown(13)

"We need a manager for legal problems, any problems between staff, to give advice on patient problems (especially with relatives) and even personal problems."

District Nurse, Uppertown(7)

7.4.1.3 Midwives

"Midwives' chief management need is for statutory midwifery supervision, to ensure that our practice is always safe. Apart from that, we need a nurse manager to liaise with other managers, and with medical staff if there are any problems with them ... and to deal with other issues, like supplies."

Midwifery Sister, Maternity Home(65)

"Management policies sometimes lose sight of the individual. The midwifery management system should give the sister flexibility to act in the way she thinks appropriate."

Midwifery Sister, Maternity Home(37)

"Midwives need management who will understand their reasons for certain actions, and will be able to give support in any legal problems that may arise ... We also look to management for up-dating, information and continuing education."

Community Midwife, Uppertown(38)

7.4.1.4 Cottage Hospital Nurses

"We need a manager to help solve problems when they occur, someone who knows what resources are available - also for co-ordinating staff cover, and for arranging training and assessing training needs."

Sister, Cottage Hospital(52)

> "Management looks at facilities and services, but not at individuals - nurses look more at individuals and their needs ... Nurses need a manger who is a nurse, who is approachable, so that they can discuss patients' problems; also for conflict situations between staff, or difficulties over ill-health. You need someone who can take a broader approach than you can from ward level."
>
> Sister, Cottage Hospital(44)

7.4.1.5 Geriatric Hospital Nurses

> "Managers should understand what goes on at ward level ... Nurses need to know that decisions that are beyond the scope of the individual ward sister will be made quickly, that management will have sufficient authority."
>
> Sister, Geriatric Hospital(27)

> "The main thing expected of the management is the smooth running of the hospital - and the provision of a working environment that will keep the staff happy."
>
> Staff Nurse, Geriatric Hospital(59)

> "We chiefly need someone to sort things out when there are problems - but also someone to give in-service training and run courses for up-dating".
>
> State Enrolled Nurse, Geriatric Hospital(43)

> "I think one important job for a nurse manager is to take notice of new pieces of equipment ... and try to arrange trials - in fact generally to keep us up to date and introduce new ideas."
>
> State Enrolled Nurse, Geriatric Hospital (36)

7.4.1.6 Other Unit Staff

Paramedical staff of various disciplines (speech therapy, chiropody, physiotherapy) seemed to view management rather as medical staff would, stressing the need to preserve their own clinical freedom. They took the view that they largely managed themselves, that some form of district management was necessary to provide resources and expertise

on occasional rare conditions, but that management must respect the professional judgement of practitioners. Paramedical staff and managers of support services such as catering and domestic services all agreed that management guidelines were far from clear, and that detailed discussions and decisions were needed on the relationship of district-managed and cross boundary services to unit management.

7.4.1.7 Discussion Of Similarities And Differences

As in the case of staff philosophies of care, there are more similarities between groups than differences. Staff want managers who share their values, facilitate them by solving problems and seeing that the service runs smoothly, and look after their educational needs. Health visitors seemed to articulate their hopes for management more readily than other groups, though followed fairly closely by Geriatric Hospital nurses. District nurses and midwives had least to say - these were the groups who were least satisfied with present management and more pessimistic about the future. (See Chapter 6.3.2). It may be that their dissatisfaction gave them less incentive to express ideas about what they sought from managers, almost as if they were suffering from a collective sense of depression.

7.4.2 Clinical Nurse Managers' Perceptions Of Their Roles

Before discussing staff expectations of management in more detail, I want briefly to look at how the clinical nurse managers for the various disciplines in nursing perceived their own roles. Figure 7.4.2 sets these perceptions out, using the same parameters as in the previous figure. This is then followed by Figure 7.4.3, which summarises how nursing staff's predominant philosophical emphasis affected their expectations of management. Subsequently quotations illustrate these expectations.

Figure 7.4.2: Clinical Nurse Managers' perceptions of their role.

Subject Area	CNM for HVs and School Nurses	CNM for District Nurses	CNM for Midwives	CNM for Cottage Hospital	CNM for Geriatric Hospital
Sharing of professional values and knowledge	Facilitate staff to be flexible Recognise professionalism of staff Monitor standards	Influence staff towards holistic approach to patient care Monitor standards	Accept staff as practitioners in own right Exercise statutory professional supervision	Give leadership to staff to become patients' advocates	Lead staff by own example to give care that meets patients' needs, and makes their lives as normal as possble Facilitate staff to do this
Innovation and Inspiration	Encourage innovation	Motivate staff		Be involved in planning	Initiate Take risks
Support for Staff	Give support	Be counsellor	Be counsellor, friend to staff Mediate in disputes	Be a sounding board for ideas Support staff	Help staff feel secure
Meeting Educational Needs	Provide information Assess staff training needs	Teach Advise	Assess staff training needs Up-date staff	Educate staff	
General Management	Liaise Maintain services	Organise staff-cover	Organise staff-cover Integrate staff into wider service	Solve problems Take a wider view Exercise discipline Negotiate resources Be public relations officer	Take decisions

Figure 7.4.3:
Expectations of management, classified by professional philosophy.

<table>
<tr><th>Subject Area</th><th>A
Nurses emphasising professional response to need want manager</th><th>B
Nurses emphasising relationship building want manager</th><th>C
Nurses emphasising health and prevention of illness want manager</th></tr>
<tr><td rowspan="2">Sharing of professional values and knowledge</td><td colspan="3">trained in own discipline who facilitates them to do the job in their own way</td></tr>
<tr><td colspan="2">and who shares caring values and recognises staff's professionalism</td><td></td></tr>
<tr><td>Innovation and inspiration</td><td>who has vision for the service, is prepared to innovate and take risks.</td><td></td><td>who has vision for the service, is prepared to innovate and take risks, will be a strong voice on behalf of staff at top management level, and who will not get bogged down in administration, but will motivate and lead.</td></tr>
<tr><td rowspan="3">Support for staff</td><td colspan="3">who will solve problems, take a personal interest in them, give clinical advice and be a good listener</td></tr>
<tr><td rowspan="2"></td><td colspan="2">and who is accessible, available, approachable</td></tr>
<tr><td></td><td>and who supports staff in problems with primary care team and in problems with legal implications</td></tr>
<tr><td rowspan="2">Meeting educational needs</td><td colspan="3">who will arrange continuing education, keeps up to date and updates staff,</td></tr>
<tr><td>monitors staff and assesses training needs</td><td></td><td>monitors staff and assesses training needs</td></tr>
<tr><td rowspan="2">General management</td><td colspan="2">who sees to smooth running of service</td><td rowspan="2">who takes a wider view, sees significance of social trends and recognises interdependence with other units and environment, and will negotiate boundary problems and act as public relations officer</td></tr>
<tr><td>and who will negotiate boundary problems and act as public relations officer</td><td></td></tr>
</table>

7.4.3 Expectations Of Management According To Professional Philosophy

Here are some expectations of management for staff seeing nursing predominantly as:

7.4.3.1 Professional Response To Need (Group A)

> "Health visitors are independent practitioners in their own right .... They should largely manage themselves, they do not need several layers of management between themselves and the nursing director. They do need some support though ... One of the most important things for a manager to provide is a two way flow of information between staff and management .... We sometimes need help with planning new initiatives."
>
> Health Visitor, Uppertown(5)

> "Management should enable you to get on with the job, and back you up - to look after the staff. They need to monitor that the job is being done properly, and see that people get training and up-dating. They need to be good at organising equipment and supplies, and to keep the staff informed of what's going on."
>
> District Nurse, Middletown(11)

> "Every midwife is herself a manager of her own work, and she needs the freedom to adapt to people - so the management system should allow that flexibility and not be full of rigid rules and laws."
>
> Midwifery Sister, Maternity Home(34)

> "Managing people who are practitioners in their own right is different from other kinds of management .... It makes it difficult to agree and implement common policy, because they all feel their own ideas are right."
>
> Midwifery Nurse Manager (16)

> "As nurses care for people, they tend just to think in terms of the patient in the bed in front of them - they don't think in terms of costs and overall management patterns. So although I think ideally nursing should be managed by nurses, they should take a wider view and not just think of the individual patient."
>
> Night Sister, Geriatric Hospital(61)

7.4.3.2 Relationship Building (Group B)

"I like having a nursing officer. It means someone actually takes notice of me, and is available to help with problems. Ten or more years ago, when we didn't have nursing officers, we were very isolated and I wondered if anybody cared about us and our work."

Health Visitor, Uppertown(24)

"Nursing should be managed in such a way that the nurses can actually get on with the caring ... I want a manger who understands and supports me."

District Nurse, Uppertown(17)

"Management needs to understand the importance of relationships - and the difference between hospital and community midwifery practice."

Community Midwife, Lowtown(46)

"Nursing should be managed by nurses who recognise the value of nursing, and the importance of nurses spending time with patients and not always being boggeddown with paperwork."

Sister, Cottage Hospital(41)

7.4.3.3 Health Promotion (Group C)

"Anyone managing health visiting needs to understand what health visitors do and why .... They need to realise that H.V. s have to adapt themselves to the different circumstances they find themselves in ... H.V. s need support at times like case conferences, especially when there might be legal implications. They need someone who can intervene when there are problems getting equipment ..."

Health Visitor, Uppertown(23)

"District Nurses need to be managed by a nurse who has practised as a district nurse who has expert knowledge and who understands the reality of it. Someone who is hospital based tends to have a standardized view, and not understand the social implications of living in various places - you need intimate geographical knowledge of the area managed ... District nurses need a manager who is accessible - out here, they won't need to make contact very often, but when they do it is usually something serious."

District Nurse, Hilton(54)

> "The nursing officer for health visiting should be a channel for communication upwards to unit management, and outwards to other units and services - and a source of advice from a wider viewpoint."
>
> Health Visitor, Middletown(30)

> "Health visitors need a manager who is up-to-date and can impart knowledge - someone instructive who is also approachable and available."
>
> Health Visitor, Uppertown(21)

7.4.3.4 Discussion Of Expectations Of Management

First of all I want to comment on some of the points arising from the quotations from interviews, then continue by discussing in more general terms the problems of managing professional people, and the relationships of their philosophies of care to the way they are managed.

Although the differences between the three groups of nurses with varying emphases in their professional philosophies are not very marked, it is noticeable that those who stress the importance of personal relationships seem to have less to say about their expectations of management than other groups. (See Figure 7.4.3) It is as though they are concentrating so hard on the personal perspective that the organisational aspect is neglected.

Insistence on self-management emerges very clearly from the responses of nurses who see their role as professionals meeting patient need. Indeed the midwifery manager pointed out how difficult it is to achieve agreement over policies when each member of staff sees herself as a "practitioner in her own right". This highlights the need for manager

and staff to get together to discuss underlying beliefs and values, and to work towards agreeing a model for care which might provide a basis for unity.

A number of nurses expressed concern that their managers get "bogged down" in the administrative system, thus reducing their capacity for leadership and innovation. A similar complaint especially from nurses in the community, was that managers are forced to pay much attention to statistical returns, which only tend to reflect one aspect of work, work with individuals, rather than activities in community groups, or other influencing roles which are hard to measure. These concerns may be a sign that staff are aware of the conflict between managerial and professional domains, and see their clinical managers as really representing the management domain. (See Chapter 3.6.2). The managers' responses did not reveal that they themselves felt any such conflict - if anything, more sense of conflicting demands was evident in the next level of manager, those on the Unit Management Board.

7.4.4 Synthesis Of Staff Expectations Of Management

To sum up the detailed evidence, it seems that all nursing staff share certain expectations of their managers, but some stress one aspect more than another for reasons of professional philosophy or disciplinary role. All staff want a manager who shares their caring values and gives leadership, solves problems and exercises a general management role. At the same time they want the manager to allow them space to act as true professionals, whilst still

offering support and educational opportunities.

Following the pattern of analysis of the first part of this chapter, I have compiled a synthesis of nurses' expectations of their managers, according to the same parameters used in Figures 7.4.1, 7.4.2 and 7.4.3. The synthesis is presented in Figure 7.4.4.

Figure 7.4.4 Synthesis - Nurses' Expectations Of Management In Western Unit

Subject Area	Nurses Want Manager Who:-
Sharing of professional values and knowledge	Is trained in their own discipline, Facilitates them to do the job in their own way, Shares their caring values Recognises their professionalism
Innovation Inspiration	Has vision for the service, Is prepared to innovate and take risks
Support for Staff	Will solve problems, Take a personal interest in them, Gives clinical advice Is a good listener Is accessible, available, approachable
Meeting educational needs	Keeps up-to-date, and up-dates staff, Arranges continuing education,
General Management	Sees to smooth-running of service , Takes a wider view

7.5 Distinctive Features Of Health Care Management

It is important for nurses, and other health professionals, to articulate their values, goals and expectations both to each other and to their managers, especially in situations where general management has been carried down through unit structures to middle management levels. In such circumstances the general manager may have little experience or understanding of the distinctive perceptions of clinical professionals, and may try to impose managerial methods more suited to industrial settings or at least to environments where the analogy of the "garbage can" (Cohen, March and Olsen 1972) is less appropriate. (See Chapter 3.6.1 and Chapter 5.1) This is a particular danger where managers move from industry or business straight into middle management in clinical settings, which is not uncommon since the Griffiths' reforms were implemented. However, some voices are beginning to be heard warning against abandoning functional management completely. (Kinston 1987 : 59)

Writing under different cultural circumstances, an American nurse theorist said

> "The primary role of the nurse executive .... is to provide resources and suitable environment for professional nurses to provide quality care .... It makes sense for nurse managers to decrease dependence on industrial management techniques, and to increase reliance on theories and techniques developed by nurses to solve the ... complex problems in delivery of nursing services."
> Thibodeau (1983:142)

Another American, Stevens (1984:129) agrees with this view,

describing the health care setting, with all its uncertainties about the relationship of inputs to outputs, its multiple goals, its high levels of emotion and its urgency, in terms very similar to my description of the NHS and nursing at the end of Chapter Four (4.6.6). Loose coupling, rather than tight managerial control, may be one way of achieving effectiveness in such a situation, as suggested by Hasenfeld (1983:176). Self-management may be one aspect of loose coupling, because where each professional person accepts accountability for their own work, tight managerial control should not be necessary.

The responses of staff in Western Unit have shown that they do generally acknowledge their own accountability and expect to manage themselves, but many also recognise that they still need support in various ways, and need their managers' general management skills to facilitate them in their clinical work. I have already shown in the literature quoted in Chapter Three (3.7.3 and 3.8) that model-based nursing practice encourages personal accountability and self-management; it is important that professional management philosophies and systems are congruent with nursing models and facilitate and encourage their use. (See Stevens 1984, Thibodeau 1983, Wright 1986 and Farmer 1986). Pearson and Vaughan (1986:163) particularly emphasize that model-based practice demands facilitation from nurse managers rather than control, involving the provision of learning opportunities and the giving of moral support. I mentioned in Chapter Three (3.7.4) that nurses giving individualized care rather than

working on a task allocation system do need more personal support because of increased anxiety levels. (Salvage 1985:67 and Menzies (1960).

Wright (1986:127) says

> "It seems logical to assume that if nurses are to treat patients as human beings, then they in turn should be treated in the same way by those who manage and educate them."

He particularly emphasizes the need for managers to give opportunities to staff to share feelings, express their views and raise questions.

7.6 Managerial Roles

I have already explained that the conceptual categories listed in the figures showing staff's expectations of management (Figures 7.4.1, 7.4.3 and 7.4.4) were derived from the interview responses using the grounded theory method. These categories are the sharing of professional values and knowledge, innovation and inspiration, support for staff, meeting educational needs, and general management. Many writers and researchers on the subject of management have arrived at their own lists of the roles of managers. Stevens (1984:134) quotes a management model often taught to nurses, consisting of planning, organizing, staffing, directing, co-ordinating, reporting and budgeting. Blake and Towell (1982:314), following a period of action research with senior nurse managers in England, developed a very comprehensive list of nurse management functions. They are:

Setting objectives.
Deploying resources and ensuring safe staffing levels.
Using information to match patient needs with appropriate services.
Establishing policies, processes and systems to facilitate effectiveness.
Monitoring performance.
Maintaining accountability.
Leading, Supporting, Teaching.
Solving problems.
Co-ordinating differing disciplines.
Promoting innovation.
Long-term planning.
Staff development.

Most of these functions are included on at least one of the figures used in this chapter.

Perhaps the most interesting list of management roles, however, because of its relevance to the findings of this study, is that published by Mintzberg in 1973. Based on his research among American chief executives, Mintzberg (1973:56-57) divides his catalogue of roles into three sections. Interpersonal roles are those of figurehead, liaison worker and leader. Informational roles are monitor, disseminator and spokesman. Decisional roles are entrepreneur, disturbance handler, resource allocator and negotiator. Comparison of the three types of role with the expectations of the three groups of nurses shown in Figure 7.4.3 reveals that the staff who emphasize nursing as a professional response to need particularly value managerial roles labelled "decisional" and "interpersonal" by Mintzberg. These nurses respond predominantly to clinical needs of patients, using propositional knowledge and practical skills. The type of organizing process

associated with these roles is mainly political. Nurses who see their work as promoting health and preventing illness also value decisional roles, but particularly stress the importance of informational roles. This group of staff respond to the cognitive needs of clients, using propositional knowledge and communicative skills. The type of organizing process associated with these roles is cognitive and political. Nurses whose predominant image is of relationship building appear on the surface to relate to Mintzberg's interpersonal role, but looking at the constituent aspects of it there is not a clear identification. I did comment earlier, however, that this group of nurses had noticeably less to say about management than the other groups. Staff who stress relationship building respond to the emotional needs of patients, using personal understanding and creativity, and the associated organizing process is social.

The connections just demonstrated between nursing and managerial roles, organizing processes, aspects of knowledge and of patients' needs support my contention expressed originally in Chapter Five, (5.6.2) that the threads in the tapestry interweave in a variety of patterns. Sometimes many threads run close together, sometimes they separate more widely; ideas tha at first seemed unrelated now appear to be interlocked in unexpected ways.

7.7 Conclusion

This chapter has looked in some detail at two aspects of the pattern being woven into the tapestry - at professional philosophies of staff, particularly nurses, and at the implications of those philosophies for managing staff. I have suggested connections between staff perceptions of patients' needs, the kinds of knowledge needed, the organizing processes employed, and the philosophical emphases on the roles of nurses. These connections are only tentative, and need more research specifically focused on these aspects, but they do support the pleas of interpretive researchers in nursing for recognition to be given to the values and context of nursing. (See Chapter 2, 2.3.1, and Carper 1978, Sarvimaki 1988, Benner 1984).

I turn now from a close scrutiny of nurses' ideas, to considering more generalised patterns revealed in the tapestry of Western Unit.

CHAPTER EIGHT: THE PRINCIPLES OF THE GRIFFITHS REPORT AND THEIR MEANING AT UNIT LEVEL.

8.0 Introduction

This is the third and last chapter reviewing the empirical findings of the Case Study of Western Unit. In it I do not seek to answer a specific research question from the list in Chapter Five; instead I aim to examine participants' attitudes to the principles of the Griffiths Report (1983). This leads to consideration of questions of quality and consumerism within the Unit, and also some discussion of Unit goals. In the process of following these particular patterns through the tapestry depicting the Unit, concepts such as organisational culture and climate emerge; but as with other topics of great complexity in this thesis, such as profession and philosophy, I am only able to give them brief consideration. As I intimated in the introduction, breadth rather than depth characterises the thesis; it is a diet of crumbs from beneath the tables of a number of rich men.

8.1 Attitudes to Griffiths Principles

Since the creation of Western Unit and the restructuring of health service management in the rest of Stoneyshire District were direct results of the implementation of the Griffiths Report (1983) at local level, one would expect all participants in the case study to have strong views on the subject. However, this did not prove to be the case. Over forty per cent of district nurses and general practitioners, and fifty seven per cent of geriatric hospital nurses did not know enough about the contents of

the Griffiths Report or the changes that might result from it to make any meaningful comment. However, only about twenty per cent of each of the remaining groups interviewed felt unable to make any comment. Those who did respond very often had mixed reactions to the report itself, approving of some aspects and disapproving of others. Many of the perceptions about the manner of implementation locally were unfavourable.

(See Appendix 4 E and F for detailed responses).

Analysis of the responses among nurses revealed no obvious differences between the groups emphasising varying philosophies of nursing; therefore nurses' views are reported according to disciplinary entities. With the exception of the Nurse Manager for Midwifery, clinical nurse managers were more disposed to be favourable in their approach to Griffiths than were their field level staff. Here are some quotations from scripts to illustrate: again numbers in parentheses refer to numbering of scripts detailed in Appendix 2.

8.1.1 Health Visitors

> "The philosophy behind Griffiths is good, in that firmer management should bring quicker decisions. But the interpretation at local level is very important - it depends what sub-structure develops."
>
> Nurse Manager, Health Visiting (1)

> "There's an adjustment of management levels, so that money is spent either on general managers or on the field level. If more money is available for patient services, that should benefit

patients."

Health Visitor, Uppertown (23)

"I think it will mean streamlining everything - more fieldworkers, less managers. Also less money, or money diverted by people who don't have a true understanding of patient care."

Health Visitor, Uppertown (21)

"Health visitors will become more accountable for their work schedule. We will have to prove our cost effectiveness within the N.H.S."

Health Visitor, Lowtown (20)

"I think the whole thing is a cost-cutting exercise. Any service that doesn't show a good return on expenditure will be thought of as less value. You can't actually measure what health visitors do, so there is a risk of health visiting being cut back."

Health Visitor, Uppertown (24)

"I think Griffiths' main philosophy is to cut costs, and it is rather political in its influence. The introduction of outsiders to top management isn't necessarily a bad thing, so long as they are prepared to listen to the professionals."

Health Visitor, Middletown (30)

"The fact that U.G.M. posts are fixed term contracts, with a lot of competition, encourages risk-takers to apply, and minimises the chance of senior nurses applying - they've got too much to lose. That means the loss of a nursing voice at high level, and could lead to rationalisation of services without taking full account of patient needs."

Health Visitor, Lowtown (10)

"There may be a lack of caring - I feel the administrative viewpoint is coming to the fore, and nursing is losing influence."

Health Visitor, Lowtown (28)

"Nursing is being down-graded. Business managers may help to prevent waste of money, but they will need the advice and knowledge of experienced nurses."

Health Visitor, Lowtown (9)

8.1.2 District Nurses

> "The plan has much potential for good if the right people are appointed."
>
> Nurse Manager, District Nursing (2)

> "Griffiths' main change is the introduction of business-style managers. If we get what we need to treat the patients, that will be alright."
>
> District Nurse, Uppertown (40)

> "Bringing in business managers is an attempt to save money."
>
> District Nurse, Uppertown (7)

> "There will be an increased drive for efficiency, and cuts in manpower."
>
> District Nurse, Uppertown (19)

> "I'm afraid they may rationalise and not consider the individual."
>
> District Nurse, Middletown (13)

> "It is causing a loss of nursing influence in the management of the NHS, It encourages privatisation, and may be part of a process to prepare the NHS for going private .... The UGM will be paramount to the whole reorganisation - if he is good at his job, fine, but if not, bad news."
>
> District Nurse, Hilton (54)

> "It's another step towards privatisation .... we will be called to account, we shall have to justify and argue for our use of resources."
>
> District Nurse, Uppertown (26)

8.1.3 Midwives

> "They don't allow enough time to see if various management changes are effective .... Each change seems to me to bring more paperwork, and more "aggro". On the positive side, it means there will be a manager on the spot to relate to - and the application of business management principles should bring a fresh approach."
>
> Hospital Midwife, Uppertown (37)

> "I think it will mean cutting down the management hierarchy somewhat - and looking more to

clinicians. Because of the UGM's fixed term contracts, they'll have to show results.
Hospital Midwife, Uppertown (39)

"There is room in the health service for business management methods."
Community Midwife, Uppertown (38)

"The main change will be managers who are not nurses having authority over nurses - for us, the patient is very much number one - but do these new managers even know what a patient is? Nursing should still have a large influence, and the patients still need tender loving care."
Hospital Midwife, Uppertown (34)

"It's turning out to be a big reorganisation, even though it was not supposed to be. Cost-cutting and bringing in business methods seem to be the main theme, with patient care very much an after thought."
Midwifery Manager, Uppertown (16)

"The introduction of a business-style manager.... is a preparation for privatisation and will lead to the disintegration of the health service."
Community Midwife, Uppertown (45)

8.1.4 Cottage Hospital Nurses

"The service will become more pressurised, the relationship between demand and resources will be critical. There will be more attempts to meet the needs of the local community. I think the principle of general management is a good one - I hope we will have quicker decisions to resolve problems, which used to be lost in the bureaucracy. There will be stronger accountability, but roles will need identifying more clearly."
Nurse Manager (42)

"It means the introduction of more business oriented management methods, better ways of organising the financial side, saving money - its not necessarily a bad thing."
Sister (41)

"They are expecting a better performance in the NHS, greater cost control and a general sharpening

of management responsibilities."

Enrolled Nurse (64)

"The main emphasis will be on financial control, with less concern for nursing standards. The other aspect is that political control is reaching right down into districts."

Sister (49)

8.1.5 Geriatric Hospital Nurses

"I think Griffiths' implementation will lead to quicker decision making. The UGM should consult with professional staff, take advice, then make decisions."

Nurse Manager (22)

"My impression is that cost consciousness will be increasingly important - perhaps leading to ward budgeting."

Night Sister (61)

"I don't think we'll see a lot of changes, though I do think there'll be a greater emphasis on cost-cutting."

Sister (27)

8.1.6 Paramedicals and Clinical Medical Officers

"I think Griffiths' implementation will increase the general level of accountability, and bring professional managers into the NHS from outsde."

Clinical Medical Officer (66)

"I think decision making will become more localised."

Clinical Medical Officer (81)

"I think there will be greater accountability all round - the buck really will stop somewhere!"

Senior Chiropodist (35)

"The main change would seem to be managerial, and provided the DGM and UGM's take advice from the clinical care managers, on services for the patient, then the reorganisation should fit the needs of the patient."

Physiotherapist (72)

> "The main emphasis will be on running the health service like a business, but for the benefit of the patient."
>
> Speech Therapist (29)

8.1.7 Other Groups

Like the paramedicals, most other people interviewed were generally in favour of the Griffiths' principles. Unit Board members, service managers and two UGM's of the neighbouring health authority felt that the changes would lead to more participation in decision making through decentralisation, and consultation with patients and staff.

General practitioners and service managers felt that the District's response to implementation was in the spirit that Griffiths intended, and would give more local responsibility.

Several members of staff commented that the Griffiths Report had been a stimulus to them to take more interest in management development in the NHS, and to take a wider interest in the totality of the service altogether.

Individual comments made by members of the Unit Board are also worth recording.

The Unit Accountant (111) said

> "I think Griffiths' intention was to run the NHS on similar lines to industry - but I don't think that approach is appropriate ..... In the long run this will have turned out to be a very expensive exercise - not just in obvious ways but in the hidden costs of the effects of low morale. The whole restructuring process has dragged on for so long, and it is sad that the working of the old Unit Management Teams was not evaluated before changes were introduced."

The Unit Personnel Officer (112) said

> "Griffiths is about devolution of decision making, down to a level as near patient care as possible .... There is a real danger of being so cost conscious that patient care is lost sight of."

The Unit Nurse Manager (90) said

> "It is all about better management, setting objectives, using resources effectively, making sure quality of care is promoted and services are geared to meeting patients' needs."

The Unit General Manager, (106) himself a clinician, said

> "For me, the main message of Griffiths is the need to involve clinicians in management." He also said, in an open letter to all Unit Staff in March 1986 "Griffiths is mainly concerned with re-organisation at senior management level and I would hope for and anticipate little effect on the rest of the staff in terms of reorganisation."

8.1.8 Summary Of Respondents' Views.

As a way of summarising and looking critically at the perceptions of respondents about the principles of the Griffiths Report (1983) and their expected effects on the NHS, I list below (Figure 8.1.8) the main points made, arranged in order of enthusiasm. (i.e. most welcome features at the top, least welcome at the bottom.) In the right hand column I list either the place in the Griffiths Report corroborating the perception, or quote a remark in the Report which contradicts the perception. In the left hand column, underneath the perception, I have given the code number of the concept matching the perception in the analytic framework set out in Appendix 4.

Figure 8.1.8 Particpants' Perceptions Of The Griffiths' Report (1983)

Perception	Probable Source (or quote demonstrating perception incorrect)
Better, firmer management EA1	Griffiths Report p.20
Quicker decisions EA2	Griffiths Report p.5,9
More effective use of resources EB1	Griffiths Report p.6-7
Greater devolution leading to local needs being met EB3	Griffiths Report p.5,9,13,18
Stronger sense of account-ability EA1	Griffiths Report p.4,12,16
More attention to quality EB2	Griffiths Report p.9,10,21
More responsiveness to consumer opinion EB3	Griffiths Report p.9,10,14, 22,23
Better value for money and financial information, delegated budgets EA4	Griffiths Report p.6,7,13,19
More involvement of clinicians in management EB3	Griffiths Report p.6,18,19,23
Concentration on general management and delivery of care - less emphasis on middle management EB1	Griffiths calls for reduction of functional management structures Griffiths Report p.5,9,14,21
Business-style managers to be brought in from outside NHS EC8	Chairman and some members of NHS Management Board should be out-siders. Report p.4. Relevance of business management to NHS stressed. Report p.10. Regional & District Chairman to identify general managers from within or elswhere. Report p.17,19

Figure 8.1.8 continued

Perception	Probable Source (or denial)
Changes aimed at cost-cutting, cost control, efficiency. In future, decisions to be based more on financial considerations. Rationalisation will take place, at expense of caring service. EC1, EC6	Cost improvement programmes to be initiated Report p.5, 13 Management budgets to sharpen up questioning of overhead costs. Report p.7 "As a caring service, NHS has to balance the interest of patient, community, taxpayer and employees". Report p.11 Need for isolated, centrally directed efficiency drives should cease when proper management budgets functioning. Report p.16 Griffiths task was not to search for cost-cutting opportunities. Report p.24
Future health service to be run on industrial lines EC4	"NHS is about delivering services to people".Report p.10 Similarities between business and NHS are in concern over levels of service, quality, budgeting, productivity, motivation of staff, research, long-term viability. p.10 Probable source - press reports.
Greater political influence and control in NHS EC8	Supervisory Board, chaired by Secretary of State, to determine direction of NHS. Report p.3 Regional & District Chairmen (appointed by Secretary of State) to identify Regional, District & Unit general managers. Report. p.5-6.
Encouragement of privatisation EC8	Griffiths' task <u>not</u> a) to change financing of NHS b) to search for areas to be contracted out. Report p.23-4. (however, management have responsibiliity to look for cost reduction by contracting out. p.24). Probable source - press reports.

Figure 8.1.8 continued

Perception	Probable Source (or denial)
Loss of influence of Senior Nurses EC1, EC4	No designated place for CNO on NHS Supervisory or Management Boards. Report p.3-4. Reduce functional management - all functional managers report to general manager Report p.5. Personnel Director to determine optimum nurse manpower levels to enable Regional and District Chairs to reexamine unit nursing levels. Report p.8 Professional functions to be geared into objectives of general management proces - GM to set priorities & programmes for functional managers' work p.14.
Effect of Griffiths Report amounts to a reorganisation FA9.	Griffiths task not to change statutory structure or organisation of NHS. Report p.23. When changes are made, demands on staff will be part of orderly management process. p.2. Regional & District Chairs to be given greater freedom to organise management structure of authority in way best suited to local requirements. p.5 Reduce functional management p.5 GM to harness best of consensus aproach - but GM to be final decision taker. p.17

8.1.9 Discussion Of Attitudes To Griffiths' Principles

Despite a quite surprising degree of ignorance amongst some respondents about the contents and implications of the Griffiths Report (1983), the others seemed to be quite knowledgeable about it. Contrary to the initial reactions of the professions reported in Chapter Four, who concentrated their attention on who were to be general managers rather than on the process of general management itself, the participants were concerned with the expected effects of that process. Like the House of Commons Social Service Committee Report (1984), case study subjects seemed to recognise Griffiths' critique of the NHS as accurate, especially as it applied to slowness of decision making and a lack of accountability and willingness to evaluate services. The promise of more effective management and greater devolution in order to meet local needs received a general welcome. However, this welcome was tempered with suspicion because experience so far in Unit formation showed a tendency for decision making to be even slower, because the UGM was part-time.

The principal concerns of research participants centred round two aspects of the implementation of the Griffiths Report. The first was the loss of nursing influence at high levels in the NHS. This fear has been substantiated by recent research as documented in Chapter Four (4.5.1). Although there may have been an element of "tribalism" in nurses wanting to be managed by nurses, there was also justification for this desire. Nursing staff in Western

Unit felt reassured to some extent by the appointment of the Unit Nurse Manager to the Unit Board; they compared themselves favourably with the other Stoneyshire units who did not have such an appointment earmarked for a nurse. (If a nurse happened to be appointed to a care-group manager's post, then there could be a nurse on either of the other boards, but it was not a foregone conclusion.) The RCN's "Action Pack" (RCN 1985C), referred to in Chapter Four, specifically argued that nurse managers matter because they act as advocates for patients' interests, and protect standards in the face of competing "value for money" philosophies often associated with general managers.

The second major concern of respondents was the increasing importance of financial considerations at all levels in the NHS, which is of course linked to the first concern about nurses, as the RCN (1985c) argued. My argument in Chapter Four (4.4), that the Griffiths Report must be seen in the context of the "procession of management interventions" (mainly concerned with financial management and cost-saving) is obviously a view shared by many in Western Unit. In Chapter Six (6.4.5), I recorded that the Unit Board spent much of its time on financial matters, contrary to the hopes of the Consultant Member, and also that the low level of budget allocated to the Unit by the District was interpreted as a reflection of the lack of value accorded to the Unit. Meyer and Rowan (1977:350-1) write of the way accountants assign value to particular parts of organisations by using a "shadow pricing" system, so that monetary prices assume a ceremonial or metaphorical

influence. Morgan (1986:131-2) explains how accountants may shape the culture of an organisation, even a human service organisation; pupils in schools or patients in hospital become "profit centres", generating costs and revenues. He continues

> "where financial considerations become a major issue, the data generated by such systems often exert a decisive influence on the decisions that are made .... (accountants) can shape the reality of an organisation by persuading others that the interpretive lens provided by the dollar should be given priority in determining the way that organisation should be run. This, of course, is not to say that financial considerations are unimportant. The point is that thinking about organisation in financial terms is but one way of thinking about that organisation. There are always others, and these are usually forced into the background as financial considerations gain a major hold on the definition of organisational reality."
>
> (Morgan 1986:132)

The attitudes of research participants to Griffiths' principles demonstrate that they recognised the importance of financial considerations, but did not want them to become paramount. There was a risk, early in 1986, that Western Unit members would perceive Stoneyshire District's goals as verging on the illegitimate, in the sense described by Albrow (1973:409) as mentioned in Chapter Four, (4.6.2). Beyer (1981:171) writes

> "If organisations fail to incorporate the values and ideologies of occupational groups, they run the risk that members of these groups will make public denunciations based on their expertise and thus undermine the legitimacy of the organisation and its leadership."

We saw in Chapter Six (Figure 6.4(b)) that the Board

Members of Western Unit were committed to patient-centred approaches to health care. Their role in assuming custodianship of organisational values was therefore very important. Unit members were reassured that at least Unit philosophy was legitimate, even if they had doubts about the District's position.

This discussion has touched on the concept of organisational culture. I want to return to this theme later in the chapter because I believe it has not received much attention from nurses as a research topic. Before doing that, however, I shall report on the three remaining topics that were widely aired during the research interviews in Western Unit. Figure 8.1.8 has shown that attention to quality of care and consumer opinion were two aspects of the Griffiths Report to receive a general welcome by research participants. Their thoughts on these topics are now presented and discussed; additionally, some comments on Unit goals are given.

These topics, I believe, contribute to the building up of an organisational culture in Western Unit.

8.2 Perceptions About Quality Of Care In Western Unit

Because Griffiths placed much emphasis on quality of care as a management objective in his report, I asked everyone I interviewed how they felt about standards of care in the Unit. (See Appendix 4J). Were they good enough, and what needed to be done to improve them? About a fifth of respondents were unreservedly satisfied (including some nurses from each disciplinary group except health visitors, and several G.P.s). The remainder, whilst expressing some confidence in the standard, made suggestions for further improvement; the most popular of these being increasing opportunities for continuing education, which found favour with some nurses from every discipline, and with some paramedicals. Staff suggested that such education should also include in-service training for nursing auxiliaries, and that all these activities should be accessible to all staff, full or part-time, and working days or nights.

Another area singled out for its key role in determining quality of care was that of communications. Board Members and paramedicals felt that the slow pace of change resulting from Griffiths' implementation was a hindrance to communication, and some G.P.s and a clinical medical officer felt that poor communication between hospital paediatric departments, G.P.s and schools caused problems for some children. Consumers' representatives complained of a lack of co-ordination when a person, especially a handicapped child, was under the care of several different specialists and therapists, and stated the case for

training in communication for consultants especially. On the whole, consumers were realistic about limitations to service provision in rural areas - but they do desperately want people, especialy health service managers and planners, to listen, and to talk to them in ways they understand. One said

> "There seems to be a vast gap in communication between lower and higher levels of management. If only senior managers could talk to parents on a regular basis .... they might appreciate their concerns."
> Representative of Society for
> Mentally Handicapped (105)

Health visitors and school nurses were particularly conscious of the limitations to their work because of large case loads and numbers of clinic sessions or schools to visit. An increase in staff numbers would mean lower case loads and more time for group support work and health promotion.

One particular health visitor said

> "The most important thing to improve quality would be to set up a system of relief health visitors, so that if someone leaves or is off-sick for any length of time, their caseload is properly covered. You just cannot give a good quality of service if you're covering two full case-loads long term."
> Health Visitor, Hilton (55)

This group also pressed the need for better equipment and resources for health education, such as video players.

Piecing together perceptions about quality of care from all the different groups interviewed leads to the conclusion that quality begins with setting standards for the Unit

based on the values and philosophy determined by the Board after consultation with Unit members - in other words, knowing the kind of care the Unit wants to give, and the reasons why. Staff suggested that changes in attitudes and practice may be achieved by making use of existing research, sharing new ideas, using a good appraisal scheme, encouraging self-audit, and setting up patient service teams where the staff working in an area themselves devise and implement improvements. Some respondents felt that managers need to encourage staff to set their own personal priorities, such as for ward sisters and staff nurses to keep paperwork and routine in its proper place, not allowing it to overwhelm important personal and clinical contact with patients. Clinical staff also need encouraging to involve patients and their relatives in planning and giving their own care. Another suggestion was that managers should help office staff to understand their working environment and the implications to clinical staff of the quality of their supporting work.

8.2.1 Discussion Of Perceptions About Quality Of Care

The area of quality of care is one where I found concepts taken from the literature helped me to place the interview material within a framework of understanding, rather than relying solely on the workings of grounded theory methodology. (I used components of nursing models in a similar way to help classify nurses' philosophies in the previous chapter.) It may be that if I had prompted respondents to talk in general terms about quality, some of

the wider aspects of it may have occurred naturally; in the event my questioning led to concentration on standards and quality within the Unit. In Figure 8.2.1 , below, I compare aspects of quality related to health services suggested by just three of the many writers on this subject.

Figure 8.2.1. Aspects Of Quality In Health Services

Ham (1985:113)	Robinson and Strong (1987:11)	Best (1987:14)
Economic Efficiency	Efficiency	Efficiency and Economy
Effectiveness (medical outcome)	Effectiveness	Effectiveness (individually) Relevance to need (for the community)
Acceptability Communication Convenience Equity Environmental acceptability	Humanity sensitivity to need human dignity Equity of access geographically and by age, sex, class and ethnicity	Social acceptability Equity Accessibility

Looking back to respondents' views about the principles of the Griffiths Report, (see Figure 8.1.8) earlier in this Chapter, we see that efficiency was mentioned a number of times, usually in rather disparaging tones. Respondents gave the impression that general managers would seek efficiency at the expense of providing a caring service, although there was some grudging recognition that efficiency savings might allow more money to be spent on

clinical areas. Effectiveness was an implicit factor in quality according to some responses; several people stated that before trying to measure quality, the Unit must set out a philosophy for care. Achievement could then be measured against goals. The comments about communication and co-ordination of services relate to the concept of acceptability, and the need for more staff relates to provision of an equitable service. The concept of acceptability as an aspect of quality has links also with the notion of responsiveness to consumers which is one of the two remaining subjects to be reported in this chapter.

8.3 Perceptions About Consumer Participation in Western Unit

Griffiths, in his report, was as much concerned with knowing what the consumers of health care think about the service, as he was with quality of care from a managerial point of view. The idea of consumer participation in the health service covers a number of facets, including the individual patient's right to have a say in the determination of his own treatment, as well as ways for the community at large (potential patients) to be involved in planning health service provision. In my research interviews, a number of aspects of consumer participation were discussed. (see Appendix 4K).

Many hospital and community nurses, as well as paramedicals, support service managers and G.P.s, felt that consumer participation is already a reality in Western Unit. They said that patients today are more assertive,

especially in their own homes, and in small rural hospitals where individuality is preserved. Media pressure in recent years has resulted in more patient consultation over approaches to both childbirth, and general medical practice. Customer satisfaction is vital for medical practice survival wherever there is a choice presented.

Staff who see nursing predominantly as professional response to need particularly recognised the nursing process as a means of finding out the patient's wishes.

> "The introduction of "the nursing process" approach is beginning to make a difference here, in that patients' views and feelings are considered much more than previously. And as we have so many elderly patients, their relatives are very important too - they are encouraged to talk to staff."
>
> State Enrolled Nurse, Cottage Hospital (64)

> "Since more individualised care was introduced, patients are consulted here as far as possible - via their relatives if need be."
>
> Staff Nurse, Geriatric Hospital (59)

> "I think we do take notice of patients' views, now we use care plans, where the mothers can give their wishes for their care in labour."
>
> Midwife, Uppertown (39)

> "I'm all in favour of taking more notice of patients. I think the introduction of birth plans is a good idea .... They've introduced a "family room" at Millbridge Hospital where mothers and families can be together - ideas like that are positive."
>
> Community Midwife, Uppertown (45)

A health visitor who sees her role as responding to peoples' needs said

> "The service we give now is not by any means a "blanket" service. We "play it by ear" with each

> individual, sensing their needs; and these needs vary, not just by individual characteristics, but also by area or locality."
>
> Health Visitor, Hilton (55)

Staff who see nursing primarily as a process of building relationships are prepared to respect patients' wishes even if they go against the recommended treatment.

> "If a patient refuses to take his drugs, or a certain treatment, we don't force him in any way - we just record his refusal in the notes. (we have to cover ourselves, really, to show we haven't been negligent.)"
>
> Sister, Cottage Hospital (52)

> "Patients nowadays are much more assertive and less passive. They used to just open their mouths and swallow their pills without asking what they were for - but not now. They want to know what's going on."
>
> Sister, Cottage Hospital (49)

Staff who see nursing primarily as promoting health still try to do it in an individualised way, in accordance with their client's wishes.

> "Health visiting is already a very personal service .... not standardized - so taking notice of consumer views is part of the job. If we are promoting health, and increasing peoples' awareness of health, then we will be taking note of their views."
>
> Health Visitor, Uppertown (25)

> "There are no standard procedures in health visiting, not like hospital nursing - there are guidelines to follow, but the interpretation is an individual matter, according to the family circumstances."
>
> Health Visitor, Uppertown (23)

Many people interviewed felt that consumer participation needs to be developed far more strongly in the NHS, and suggested various ways for this to be done:- having

independent surveys carried out, using "suggestions boxes" in NHS premises, opening a health service shop in a prominent place (or a market stall) to canvass views, and taking more notice of existing research on consumer perceptions of the health service. Two Unit Board members particularly stressed the need for more to be done in this way.

> "We need research involvement in the developing of ways to test patients' opinions and views and develop services and systems sensitive to client needs - involving them in the decision making machinery wherever possible."
>
> Unit Nurse Manager (90)

> "Patients' views, through the expression of voluntary organisations, are being incorporated into the planning process.... The media are involved in expressing and influencing patients' views and expectations as well."
>
> Unit Personnel Officer (112)

One district nurse particularly highlighted the need for effective ways to report patients' comments.

> "Hospitals still intimidate patients, and they don't give enough information to people. District nurses actually get a lot of feedback from patients about what they think of hospital care, but there are no formal channels for passing the information on to where it might be used."
>
> District Nurse, Hilton (54)

A number of those interviewed, particularly consumers' representatives but also some nurses, G.P.s and paramedicals felt that the Community Health Council should be more active in Western Unit's area - stating that it appeared to be too Cobbletown oriented, despite its avowed policy to encourage development of facilities in Western

Unit, as well as maintaining cross-boundary access to Millbridge and Cityville.

> "I think we should involve the patient more, maybe by sending out a questionnaire after discharge. I think the C.H.C. could do more about that, especially local councillors who are on the C.H.C. We should open the doors here more, let the public see what is happening."
>
> Sister, Geriatric Hospital (27)

> "I think the C.H.C. could be more active in this area - at least making sure people have help in expressing dissatisfaction."
>
> Speech Therapist (29)

This comment from a voluntary society representative was typical.

> "I've not had any contact with the C.H.C. at all - but they are located in Cobbletown and possibly don't understand the problems of Western Unit and its rural areas."
>
> Voluntary Society Representative (99)

However, one group of G.P.s interviewed did state very clearly the value of the C.H.C.

> "We certainly need to keep our fingers on the pulse, to know how people feel about services. You need to be careful with consumer representation to the Western Unit Board - feedback needs to be generalised, perhaps through a body like the C.H.C., rather than from individual pressure groups. You only need to have one particularly vociferous representative and things can build into quite a hysterical reaction, which can do a lot of damage."
>
> G.P.s Lowtown (80)

A group who definitely would not want their feedback generalised, but intended it to be very specific, were the parents of the mentally handicapped. Their representative (105) said.

> "Not enough notice is taken of consumers' views. The different authorities concerned with the handicapped should consult with bodies representing parents, and should discuss the plans they are considering. The parents will know from experience what will work and what will not."

Despite the support for consumer participation shown in these responses, there were a number of problems also articulated. (See Appendix 4 KD) Firstly, for any particular service, there may be several groups of consumers whose needs differ and might be in conflict. For instance, in school health, consumers may equally be children, parents and teachers, all with differing expectations. Secondly, consumer preferences may be unknown or unclear (this seemed to be so particularly for health visitors.) Thirdly, the actual exercise of obtaining consumers' views may create a demand which cannot be met.

> "Parents may make demands beyond the scope of the professional, so it is up to the professional to set the limits to what can be offered."
> Paediatric Domiciliary Physiotherapist (51)

> "There is a possibility that if you provide a good service and promote it, demand increases which overloads the system"
> Clinical Dental Officer (103)

However, there is also a danger that services not geared to consumer demand may be wasted. Fourthly, in some services consumer preferences may be concealed. For instance, in geriatrics, patients may not be able to communicate their feelings, or they or their relatives may think that attitudes prevailing twenty years ago still pertain.

> "People are afraid to complain; they used to be told that if they weren't satisfied, their relative would be sent home - and they knew they couldn't cope with them. They often still feel guilty at having a relative here - they think they should be able to cope. It used to be forty year olds with their sixty year old relatives - now it's seventy year olds who can't cope with their ninety year old relatives - but they still feel guilty!"
>
> Sister, Geriatric Hospital (27)

Fifthly, in this list of problems of consumer participation, patients may abdicate from their right to express an opinion, by regression to child-like attitudes of dependence, and staff may encourage this. Sixthly, patient preferences may be encouraged officially, but discouraged unofficially.

> "Especially in hospitals, the NHS only pays lip service to patient and parent rights - in reality patients are expected to do as they are told. For example, over parents being with their children in hospital. Often parents who insist on staying with their children are branded as trouble makers."
>
> Health Visitor, Hilton (56)

The UGM (106) said

> "Doctors and nurses are often too autocratic.".

Then, seventh, patient preferences may be overruled for economic reasons, as in the case of the closure of the maternity home in Uppertown. As a group of G.P.'s (97) said

> "What patients want is not always practicable - so the public need educating as to what is practicable."

Problem number eight is that a patient's wishes may

contradict medical or nursing judgment - for instance, when a patient who needs turning regularly to prevent bedsores forming asks to be left undisturbed for hours because he is comfortable. Ninth, one patient's preference may cause disturbance to another patient - for instance in the geriatric hospital much more freedom had recently been given over bed-times and watching television - but one patient going to bed late may disturb others.

Lastly, a problem outlined by a domestic services manager points out the need for policies on consumer participation to be carefully thought out, because of unintended consequences.

> "New patterns of care in geriatrics can lead to a blurring of roles between nurses and domestic staff. If a patient asks a cleaner to help her wash her hair, the cleaner would enjoy doing that - but then the cleaning of the toilets might get skimped. Which is more important - doing what the patient wants, or keeping the place clean? It needs careful thought when these new patterns of care are discussed."
>
> Domestic Service Manager, Uppertown (100)

8.3.1 Summary Of Problems Of Consumer Participation

The last few paragraphs have dealt with the problems of consumer participation in the health service which need consideration by managers wanting to encourage this participation still further. I summarise the problems below, in Figure 8.3.1. The summary is another example of how grounded theory methodology can illuminate a subject and result in usable concepts capable of generalization.

Figure 8.3.1 Problems Encountered In Encouraging Consumer Participation In The NHS

Consumer preferences may .....

1. Conflict
   a) amongst individuals e.g. in a hospital ward
   b) amongst groups using a service e.g. school health

2. Be unclear, especially for services often meeting implicit rather than explicit need. (e.g. health visiting.)

3. Lead to service overload, if too low a level of a much demanded service is provided.

4. Lead to service underuse, if changes in preferences are not ascertained and acted upon.

5. Be hidden
   a) because the patient cannot communicate
   b) because the relative feels guilty so accepts anything offered uncritically
   c) because the relative fears reprisals if appearing to complain

6. Be abdicated when patient totally dependent or regressed

7. Be encouraged officially, but discouraged unofficially

8. Be overruled for economic reasons

9. Contradict professional judgment thus creating a dilemma - following personal preferences may harm a patient.

10. Cause unintended disturbance to other services or workers. ("knock-on" effects).

8.3.2 Discussion Of Consumer Participation In The NHS

Despite the existence of problems when consumer participation is taken seriously in the NHS, the idea has generally been welcomed. (Maxwell and Weaver 1984, Owen 1988, Scrivens 1988, Clay 1987). Danet (1981:401), an American organisation theorist, points out that there is great need for planned feedback from citizens about public

sector services, because such services lack the natural feedback device of the market. She also mentions (Danet 1981:382) that up to that time, organisation theorists (as opposed to sociologists) had hardly considered clients at all, in their research on organisations. The Royal Commission on the NHS (Merrison 1979) broke new ground in commissioning research on patient satisfaction.

There are, however, quite fundamental differences of opinion about how far the identification of patients with customers can be accepted. Even Len Peach, then Chief Executive of the NHS Management Board, said in 1987.

> "A great deal of the debate about increasing patient satisfaction in the NHS has been conducted in the language of the consumer movement. Patients are customers, consumers or clients. This is fair enough as an approach to increasing staff awareness and appreciation of patients' needs. It does, however, raise some problems. Patients can never be customers in the conventional sense. People do not choose to be ill. Approaching a GP's surgery, health centre or hospital, patients can be frightened, anxious and in pain."
>
> Peach 1987:212

Klein (1985:58) had already pointed out that a disappointed health care consumer often cannot react like a rational shopper, weighing up alternatives for price and quality. A faulty car can be repaired under guarantee, or exchanged - but an unsatisfactory heart operation cannot be traded-in for a better one. Continuing the shopping analogy, Scrivens (1988:184) argues that focusing on consumer services does not actually give the public any more power. Like ordinary customers of a shop, they do not have the right to be consulted about investment, or to determine

what should be on the shelves, especially at a time when increasing use is made of the services, and resources do not keep pace with demand.

Even before the current emphasis on consumerism in the NHS, Stacey (1976) had argued that the whole idea of patients as consumers was a misconception. She believes, following Hughes (1958), that the patient is part of the process of health care: he does not consume a product, but is part of the production of recovery or health.

Even though general managers make increasing use of consumer surveys, they may do so only as a substitute for real outcome measures which are difficult to achieve (Scrivens 1988:181) or as a mechanism to counter the freedom and authority of consultants (Scrivens 1988:182). Maxwell and Weaver (1984:10-11) set out a hierarchy of public participation in health, ranging from a minimum of consumer protection, through public consultation, openness of managerial decision making, full participation in management by public representatives to heightened individual and communal responsibility and power. Many observers would say that most areas of health care only allow the first two items on this list to take place.

However, as the case study of Western Unit was drawing to a close, there were signs that involving local voluntary groups in a Volunteer Council, as well as co-opting consumer representatives and local authority officers onto planning groups, would begin to make further progress

towards fuller consumer participation. Scrivens (1988:182) tells how health authorities are beginning to copy businesses in making the consumer the focus of organisational goals. I believe my study has already shown evidence of this in Western Unit, and I now discuss Unit goals in more detail.

8.4 Suggested Goals For The Unit

A good deal of the material presented in this chapter (and earlier chapters) already, implicitly if not explicitly suggests goals for the Unit, or parts of it. Nursing philosophies, whether of individual disciplines within the profession, or of broader groupings expressing predominating ideas, contain goals, as do statements of staff about the kind of manager they wish to have. Observations relating to ways of improving quality of care and service, such as continuing education, better communication, increases in staff and resources may all be expressed as goals, and perceptions about the creation of the new unit were often related to whether unit formation would or would not achieve the goals that person had in mind for the health service in the Western area. For instance, most people were agreed on the sense of isolation and deprivation in the Unit, but some disagreed that forming a separate Unit would be the best means of ending that isolation and deprivation.

However, as well as recognising implicit goals within ideas on other topics, I did specifically ask those I interviewed if they could suggest a goal for the Unit. (The most

popular answers are listed in Appendix 4I). A number of people produced such global statements as "to work towards a healthier community," but goals need to be more specific, and a suggestion by a participant that each discipline within the unit should formulate their own goals met with general approval. This would be a "bottom-up" process, and should lead to later attempts to weld the disciplinary goals into a more general framework.

Nevertheless, in addition to agreement with the idea of a "bottom-up" approach to goal setting, many respondents did attempt to sketch out an overall goal for the Unit, and these attempts are described here.

Some nurses, G.P.s, paramedicals and others felt the Unit should be aiming to overcome problems of distance and inaccessibility by responding to needs in a localised way, using the increased autonomy and scope of the Unit to co-operate with other agencies such as Social Services and voluntary bodies. Several respondents stressed the need for the Unit budget to be used effectively, balancing the needs for prevention, cure and care, and between hospital and community (remembering that the Unit caters for community health needs of all its population, whereas it provides hospital services for only a third of that population.) Whilst discussing needs of different sections of the community, some suggestions were made about means of determining those needs. The Nurse Manager for District Nursing (2) said

> "The goal should be shared by Social Services as well - we should use a problem solving approach as common ground, ... consulting people as to what their needs are and how they would like them to be met. This should be a total care concept, not just for health, but for social needs, housing etc. .... This would involve communication about future development plans for communities."

In this way population shifts or growth might be anticipated and so plans could be made to adjust services accordingly.

Another theme popular amongst nurses and paramedicals as a goal for the Unit was the idea of everyone working together for the good of the patients; this would involve different disciplines understanding each other's roles, and different geographical localities understanding each other's special needs and problems. In this way expertise, resources and vision would be shared between hospital and community staff, who would learn together as well as work together. Perhaps a corollary, or even a necessary condition for working together was this plea from a health centre secretary (32), echoed by a number of others

> "we desperately need some management stability - over the years the field staff have largely stayed the same, but there have been many changes in management."

Some nurses, service managers and consumer representatives wanted the Unit to aim to be more self-sufficient and independent, not relying as much on either Cobbletown or Millbridge - weather and geography being two factors supporting this plea. Allied to this aim were hopes expressed chiefly by paramedicals, consumers and G.P.s for

levels of service to be raised uniformly throughout the Unit, improving access and lowering waiting times for paramedical services, outpatient clinics and respite care.

The whole area of unit boundaries and relationships with other units within Stoneyshire H.A., and with the neighbouring District based at Millbridge, discussed in Chapter Six (6.3) provided further subject matter for articulation of goals. Nurses, particularly those working in the community, paramedicals, G.P.s and members of context organisations expressed the hope that relationships with both Millbridge and Cobbletown would be strengthened, and also that the Royal Hospital in Uppertown, belonging to Millbridge H.A., could be increasingly utilised as an asset within Western Unit, and might eventually become part of the Unit.

Many other goals suggested by nurses, Unit Board Members, consumers' representatives and G.P.s reflected the Operational Programme already listed in Chapter Six. Further goals, too numerous to mention here, were very specific to the interest groups proposing them. They were, however, reported to the Unit Board through the original Case Study Report in 1987, and are listed in Appendix 4 I.

8.4.1 Discussion On Goal Formation

Possibly the best known distinction between types of organisational goal is that of Perrow (1961:857), who divided goals into official, and operative.

> "Official goals are the general purposes of the organisation as put forth in the charter, annual

> reports, public statements by key executives and other authoritative pronouncements."

These would equate with the two highest levels of goal in a sequence of five levels explicated by Kinston (1986:12-13), banner goals and mission. These two categories express prime values, general purposes and organisational identity. In the examples quoted above, in Western Unit, such goals as "working towards a healthier community" or "working together for the good of patients" would be included in this level of banner goals or mission.

Perrow's operative, or unofficial goals (Perrow 1961:858) are more directly tied to group interest, and might support, be irrelevant to or even subvert official goals. In Western Unit, one goal proposed was for the Royal Hospital in Uppertown to belong to the Unit instead of Millbridge H.A. This is an example of the latter category. Kinston's three lower levels of goal (1986:12-13) would sometimes be seen as similar to Perrow's operative goals, but all are seen as supportive of the higher levels, rather than subverting them, as one might expect from the Brunel viewpoint which has a highly rational view of organisation theory. Kinston's lower levels of goal are political aims (politics or priorities), strategic objectives and operational objectives. Examples of these in Western Unit would be lowering waiting times in out patient clinics, or improving access to paramedical services such as physiotherapy.

8.5 A New Unit - Or The Proliferation Of A New Culture?

This brief coverage of participants' suggested goals for the Unit concludes the empirical evidence about the formation of the new Western Unit. Whether it is accurate to refer to it actually as "new" is questionable. The hospital and community services to the majority of the population had been in existence for many years. Some new services (especially community mental illness and mental handicap services) were being planned whilst the case study was going on, and were inaugurated soon after it ended. What was new was the identification of Western Unit as an entity, demanding its own policies and distinctive approach. One way to conceptualise this is by regarding it as the birth of a new culture, rather than seeing the need for a separate approach as an anomaly, a troublesome exception to general rules in Stoneyshire District.

8.5.1 The Concept Of Organisational Culture

I have referred several times, in this chapter and the two previous ones, to the concept of organisational culture, and many times throughout the thesis to the presence or absence of shared meanings or value systems. To many organisational theorists these are synonymous. Smircich (1983:345) refers to culture as "shared key values and beliefs", and Schein (1985:6) as

> "The deeper level of basic assumptions and beliefs that are shared by members of an organisation, that operate unconsciously, and that define in a basic "taken-for-granted" fashion an organisation's view of itself and its environment."

Schein (1985:6) lists a number of features which reflect the culture of an organisation, such as observable behaviour, language and social ritual, work-group norms, espoused dominant values, organisational philosophy, rules (both official and unofficial) and the climate or feeling of the organisation as expressed by the physical layout and manner of interaction between organisational staff and outsiders. Pettigrew (1979:572) describes a similar catalogue of components of culture, maintaining that these generate purpose, commitment and order amongst organisational members. Smircich (1983:355) asserts that the value of analysing organisational culture lies in the way it focuses attention on the expressive, non-rational qualities and subjective, interpretive aspects of organisational life. Harrison (1985:7) writes that belief systems are as real as organisation charts, but more elusive and difficult to describe.

In addition to the growing literature on organisational culture, there are also many references to organisational climate. Payne and Pugh's (1976:1126-8) definition,

> "Climate describes the characteristic behavioural processes in a social system at one particular point in time. These processes reflect the members' values, attitudes and beliefs which have thus become part of the construct."

has many similarities with the definitions of culture already mentioned. Payne and Pugh (1976:1168) conclude that research into organisational climate requires

> "deep involvement from the members of a complex system to gather meaningful data which accurately

reflect these peoples' experiences."

They continue by saying that the researcher must foster trusting and open relationships with respondents, and share interpretations of data with them. They describe this kind of research as idiosyncratic and time-consuming, making large-scale comparative work impossible. The features they describe are all ones which I have tried to include in my case-study, and the label "idiosyncratic" has certainly been applied to it by at least one critic.

Schneider (1975:454) warns that behavioural change will probably lag behind organisational change because people take time to form new climate perceptions which then serve as a frame of reference for adaptive behaviour. So any claim I might make to have uncovered part of the organisational culture of Western Unit would be open to challenge. The most I could hope for would be to have illuminated some of the areas contributing to the development of a new culture. These areas include the hope for an end to the feeling of isolation and resource deprivation described in Chapter Six, the shared professional and managerial values outlined in Chapter Seven, the interpretations of the Griffiths' Report demonstrated in this chapter, and the associated views on quality and consumer participation.

My conception of the development of the Unit being reflected in the metaphor of a tapestry is my way of trying to grasp the idea of organisational culture. Smircich (1983:347) differentiates between researchers who view

culture as a variable, either independent or internal and those who view it as a root metaphor - the difference between saying that culture is something an organisation has, rather than that it is something an organisation is. I believe the development of this case study has led me in the direction of culture being seen as a root metaphor, which is more congruent with my whole epistemological approach. As Smircich (1983:353) says

> "When culture is a root metaphor, the researcher's attention shifts from concerns about what do organisations accomplish and how may they accomplish it more efficiently, to how is organisation accomplished and what does it mean to be organised?"

Chapter Six showed to some extent how organisation was accomplished in Western Unit, and the previous chapter as well as this one have illuminated the aspects that health professionals feel to be important when they are being organised. That leads eventually to thoughts of what may be accomplished - in this case thinking that more will be achieved as a new Unit than was possible as a problematical appendage of one of the old units.

8.6 Conclusion

In this chapter I have considered the attitudes of various groups of research participants to the principles of the Griffiths Report (1983). Many people responded rather ambivalently, in that they approved of some aspects and disapproved of others. Perceptions of factors affecting quality of care and consumer participation have also been

discussed, in addition to the idea of choosing goals for the Unit.

All these varying strands of opinion and attitude contributed to the growth of shared values and beliefs in Western Unit, so that although it could not be said to be new in the strict sense of the word, nevertheless a new feeling of identity and purpose was evolving. People were beginning to see Western Unit as an entity, not a problematical appendage of something else. This sense of identify could be defined as the birth of a new organisational culture.

With these thoughts, I conclude this account of Western Unit; the final chapter reflects more generally on the whole research process.

CHAPTER NINE: CONCLUSION - REFLECTIONS ON THE FINDINGS, THE METHOD AND THE FUTURE

9.0 Introduction

In drawing this thesis to a close, I would like to do three things. First, I want to consider the conclusions I have reached in the preceding chapters, trying to put them into perspective. If Davies (1979:416) is right in asserting that there is an intimate relationship between the research methods used, and the kind of results arrived at, then this will lead naturally into reflecting on the process of naturalistic inquiry. Finally I shall suggest some future possibilities for research, both in the light of my own discoveries, and considering current events in the NHS.

9.1 Reflecting On Findings - Have I Achieved My Aims?

In Chapter Two (2.5.2) I defined three aims for the research study described in this thesis.

9.1.1 The First Aim

The first research aim was

> "to describe and consider the effects of new management philosophies, plans and practices on nurses, nursing care, nurse managers and members of other health care disciplines and supporting staff within one unit of management during a period of change."

The case study of Western Unit between December 1985 and September 1986 was my attempt to fulfil this aim. I have already concluded, towards the end of Chapter Six (6.5.1) that the time was too short to achieve much of it, because the middle management structures and boundary issues were

still under negotiation at the end of the research period. There was no possibility, given the methods I had chosen, of truly assessing the effects of new management on nursing care; I would have needed either to have spent time observing patient care before and after the changes in management, or to have received results form some acceptable system of auditing nursing care such as "Monitor" or "Qualpacs" (see Pearson 1987), had it been in operation in the Unit. However, I was able to ascertain answers to all the research questions listed near the beginning of Chapter Five (5.1.2); these answers are contained mainly in Chapters Six, Seven and Eight and are augmented by Appendix 4. The chapters cover such things as staff perceptions of management past and present and expectations for the future, their professional philosophies and the implications of those for management, and views about the creation of the Unit and the principles of the Griffiths Report (1983) from staff, consumers and members of context organisations.

Perhaps the best way to sum up how far the first research aim has been realised is to say that the effects of new management philosophies, plans and practices on staff and relevant consumers' opinions and attitudes have been described, but that neither the time scale nor the research methods adopted made consideration of behaviour change possible. This is not surprising in view of Scheider's (1975:454) expectation that behavioural change lags behind organisational change; because the former is related to the

growth of new perceptions of organisational climate, which serve as a frame of reference for behaviour, the whole process takes time. However, as an interpretive researcher I do believe that uncovering attitudes and opinions in the context of the formation of the new Unit has been of value. Using the tapestry metaphor as an aid to understanding, in Chapter Six I endeavoured to show how neglect of some organizing processes by Unit leaders allowed uncertainty and negative emotion to dissipate energy which might otherwise have contributed to greater momentum in developing a distinctive Unit identity. In Chapters Seven and Eight I showed how concepts relating to nursing knowledge, values and philosophies had implications for expectations of management, quality of care and consumer participation. I eventually concluded that all these attitudes and opinions contributed to the development of the unit as an embryonic culture; perhaps it would be more accurate to describe it as a sub-culture, because it is part of several wider cultures - Stoneyshire Health District, the National Health Service, and British society.

9.1.2 The Second Aim

The second research aim was

> "to study existing theories and models of nursing and of the organisation of health care, looking for any common features and relationships."

This I did in Chapters Three and Four, showing that in both nursing and health care organisation theorising has been a fairly recent phenomenon. Since, in Britain, most

professional nursing takes place within the context of the NHS, I dealt at some length with that institution, looking particularly at the way recent political imperatives have superimposed the values of the prevailing market economy onto its existing foundations of collectivism, comprehensiveness, universality, equality, professional autonomy and democratic representation. Many theorists find that human or public service organisations differ in many respects from businesses, showing the characteristics often associated with "organized anarchies", responding to loosely-coupled management systems and relying on professional staff's values rather than bureaucratic controls. Some theorists find that the idea of the presence of three separate "domains" or spheres of interest, pertaining to managers, professionals and democratic representatives in the NHS is a helpful one; such theorists see the introduction of the principle of general management as either a strengthening of the management domain to overshadow the others, or as the creation of a fourth domain to bring the others together. My overriding image of the NHS is of an edifice balancing on a number of see-saws representing conflicting principles and interests.

Such a turbulent environment inevitably affects nurses and nursing. Growth in academic achievement and political maturity has taken place in the face of management changes leading to at least a temporary loss of position and authority for many senior nurses. A degree of unity amongst different disciplines within nursing has emerged

from a decade of change, helped by discussion of distinctive models for nursing separate from the previously almost universally accepted medical model of care. Any model for nursing needs statements on at least six elements as a base; they are the role of the nurse, a view of the environment and the recipients of care, the goal of nursing, the process involved and the desired attributes of the nurse. Rather than describing in detail some of the well-known models for nursing, I suggested that models need to be context specific and compatible with the prevailing values and culture, following the example of Wright (1986).

Part of this second research aim was to look for common features between nursing and organisational theory. Obviously the turbulent environment of the world of health care in Britain points to the need for management models for both nursing, and health care more widely, to take this turbulence into account, to be context-specific and compatible with the values and culture of the professional care-givers yet sensitive to the needs of patients. Increased personal accountability and self-management for health - service workers, applying the image of the hologram to management practice in health care and nursing is one suggested way to progress. The use of metaphor in organizational analysis has been promoted particularly by Morgan (1986). His thesis is not that we should choose one particular metaphor to fit an organisation, but that organisations are complex and support many different comparisons at various times and in varying situations.

Perhaps if we were to think of nursing models as metaphors for nursing, rather than as formal theories, we would find it easier to accept different models in different situations, rather than searching for the one perfect model that has to fit every possible circumstance.

9.1.3 The Third Aim

My third research aim was to assess the relationship between experience as revealed in the case study, and theory, both of organisation and nursing. I then hoped to suggest areas where either might need to change, in order to bring theory and practice closer together. In Chapter Six I compared the organizing processes seen in Western Unit with interpretive organisation theory as expressed by Hoskin (1988), Pettigrew (1988) and Bouwen and Fry (1988). I studied the role of the Unit Management Board Members as leaders, using the concept of the management of meaning as expressed by Pettigrew (1979) and Smircich and Morgan (1982). I found, as mentioned earlier in this chapter, that the organizing processes were incomplete, and suggested that in future organisational changes of this nature, managers should give attention to all aspects, structural, cognitive, political and social.

In Chapter Seven I discovered that nurses in Western Unit had their own implicit models of nursing, although they were not used to articulating them. I found that their philosophies could be grouped according to discipline within nursing (see Figure 7.1.6) or according to the predominant philosophical emphasis (see Figure 7.2.4). It

was possible to synthesises the nurses' concepts into a basis for an overall model for the unit (see Figure 7.2.4.). This synthesis did not match any recognised nursing model but certainly was a foundation for a model for nursing, not derived from a medical viewpoint. Also in Chapter Seven I described staff's expectations of management in the same three ways - by professional discipline (Figure 7.4.1), by predominant philosophical emphasis (Figure 7.4.3) and in a synthesis (Figure 7.4.4). I found that many staff underlined their desire for self-management, whilst admitting that they did need facilitation by management as well as appreciating personal support. I compared the staff's perceptions of management with several known management models, particularly Mintzberg's (1973) and related this to other concepts prominent in this thesis such as organizing processes, professional philosophies, classifications of patients' needs and types of nursing knowledge. Comparing experience with existing theory leads me to propose that nurses in Western Unit work together locally, using the syntheses made in Figures 7.2.4.2 and 7.4.4, to build their own model of nursing and nurse management, using the methods suggested by Wright (1986). When the implications are fully worked through, nurses will themselves be able to set standards by which to measure the effectiveness of the care they give.

In Chapter Eight I discussed participants' views of the Griffiths' principles, especially related to health service

finance, goals, quality of care and consumer participation. I related these to the literature on the metaphorical significance of finance in organisations, (Morgan 1986, Meyer and Rowan 1977) on the legitimacy of organisational goals (Albrow 1973 and Beyer 1981) and the appropriateness of the use of the language of the market place in health care. (Peach 1987, Klein 1985, Scrivens 1988 and Stacey 1976). This discussion culminated in a consideration of the concepts of organisational culture and climate; using ideas from Smircich (1983), Schein (1985), Pettigrew (1979), Payne and Pugh (1976) and Schneider (1975). I believe I demonstrated that Western Unit, as an entity, did share many values and beliefs, essentially centred on caring for patients, and that although the financial imperative was acknowledged as important, it was not allowed to dominate.

9.1.4 Recommendations Overtaken By Further Change

I would have wanted to suggest that the Unit should continued to work together, growing into a more effective culture by making values explicit, as I suggested in my Case Study Report sent to the Unit Board and then to all participants in 1987. Sadly, however, the DGM of Stoneyshire District, backed by his Executive Board and the DHA, but in the face of opposition from Western Unit, has decided to change Unit structures yet again, the operative date being April 1989. Western Unit becomes a locality, under a locality manager, as a part of a district-wide Community and Continuing Care Unit, with Unit headquarters

once again in Cobbletown. So Unit culture, that intricate tapestry in the making, will be disrupted, disorganized and disturbed. Very great efforts will be required to preserve it and help it to adjust to the new managerial circumstances. Beyer (1981:195) wrote

> "Wildavsky (1972) pointed out that it may be difficult to persuade organizational members to live with constant change; members become cynical as "the wisdom of the day before yesterday gives way to new truth, which is in turn replaced by a still more radiant one" Leaders must not only sell the new policies, but also unsell the old ones to which they previously sought commitment."

Given that the new round of changes takes place in the context of discussion on the White Paper "Working for Patients" (Department of Health 1989) I would expect difficult times ahead for the staff of Western Unit. I do know that they will do their best to shield their patients from problems. I suspect that they will indeed become cynical about all formal organisation and "keep their heads down and wait for it to blow over" as was suggested to me during the case study in 1986, by some staff who were already cynical.

9.2 Reflecting On Method

At the beginning of this chapter I surmised that summing up research results would inevitably lead to reflecting on research method. because of the intimate link between methodology and the type of conclusion reached. The previous paragraph demonstrates the validity of this connection in that no self-respecting positivist would express such value-laden and obviously partisan views so

openly in a piece of academic work. The conventional scientist, according to Mitroff (1974:79) and Lincoln and Guba (1985:37) does not concern himself with the consequences of the knowledge he has revealed, claims to be totally independent and separate from his research subjects and to be value-free. (I would of course, in the light of Chapter Two (2.5.5) dispute that this is possible.) In contrast, the naturalistic researcher is concerned very much with the consequences of the knowledge gained (and inevitably with the fate of the research subjects), has developed relationships with participants and has values resonant with those of the research context. Such identification and bias is openly admitted in naturalistic inquiry, and I admit plainly my view that the Unit should have been allowed to continue as an entity, and not subjected to further disruption.

9.2.1 The Use Of Metaphor In The Thesis

I have, of course, already explored in some detail in Chapter Five the research process and the difficulties I experienced, and I do not wish to repeat myself unnecessarily. I have used a number of metaphors during the writing of this thesis and I would like briefly to consider these. In the introductory chapter I quoted Sir Geoffrey Vickers's (1968) Biblical analogy of gathering crumbs from knowledge-rich mens' tables. I think I have shown by my use of literature from so many fields that this has been an apt comparison. In several places I have acknowledged the shallowness of the conceptual development,

which was necessary to maintain the breadth. I have not found it easy to stay on the surface in many instances, but it has been inevitable because a thesis has to be of limited length. However, the blending of such a mixture of theories from such varied sources together may ensure that the crumbs constitute a balanced diet. Not only have I likened the development of Western Unit to a tapestry, but I think I have also been weaving a tapestry of my own as I write.

A further metaphor used has been the idea of the research process as a journey. Sometimes I have imagined a road, sometimes a maze and once even a voyage as the setting for the journey. I wrote about the voyage in my research diary, just after completing the case study data collection but before going very deeply into analysing the data. I felt as though I had cast myself adrift in a shifting sea of ideas, with no map, compass or guiding star. No doubt I was taking too dramatic a view of the situation, but a mass of qualitative material awaiting inductive analysis, with no pre-existing hypotheses to act as filters, can be very daunting.

Had I followed the true path of grounded theory methodology meticulously I probably would not have felt so near shipwreck. I mentioned in Chapter Five that I had rushed ahead with too many interviews too close together, not allowing myself enough time for analysis. This was partly due to another problem already mentioned, the tension between following a pre-set design to satisfy sponsors, and

the need in naturalistic inquiry for an emergent process. I was trying to steer a middle course between the two extremes which was not an easy thing to do. Had I progressed into the constant comparative analysis right from the start of data collection, I would have had far more compass bearings to help me on my way. In addition, had I forced myself to write memos, as Glaser and Strauss (1967) suggest, right from the start of data collection, that too would have guided me on the voyage, as well as making the writing easier at the end. I think I was trying to write the thesis straight from the "barebones analytic framework" as Charmaz (1983:120) puts it.

9.2.2 Learning The Process Of Naturalistic Inquiry

I suppose that a research process as complex as naturalistic inquiry, utilizing grounded theory methodology, takes time to learn; I would really like to be able to undertake another similar project, despite all the difficulties involved, to profit from the lessons I have learned. I did discover, however, a valuable aid to academic writing, through adapting grounded theory methodology in compiling the chapters on the NHS and nursing. I treated all the separate points I wished to make, and all the references to literature, as grounded theory concepts, writing them on small cards in abbreviated form. I was then able to sort them and re-sort them according to various themes, thus avoiding a purely chronological pattern, and then use them as a guide as I wrote. One other helpful device that proved invaluable to

me in both analysing and presenting data was the use of "arrays" using words rather than figures, as suggested by Miles and Huberman (1984), for instance in figures 7.1.6 and 7.2.4.

Space forbids further comment on my own perceptions of my use of research method except for one point. Writing this thesis has been a truly emergent process - I really did not know what I thought, or what my conclusions would be, until I wrote them down. That abiding sense of suspense has certainly ensured that I have never been bored with either the case study material, the literature or the writing process.

9.3 Reflections On Future Possibilities For Research

So many of the areas covered in this thesis are under-researched that I could compose a very long list of possibilities. However, I feel that it would be preferable to recommend just a limited number relating to issues which, like this thesis, involve many perspectives and several different academic disciplines. It would be good to think that in the future, it might not be just a few dogs scavenging under tables that try to get a balanced diet, but that researchers in nursing, medicine and other clinical disciplines might regularly sit for a time at other tables - maybe historical, political, economic, sociological or organisational behaviour tables. Perhaps too, occupants of those tables might more often eat with health service managers as well as clinical staff.

I would like to see more research in nursing take notice of contextual issues - not just organisational matters, but also politics, history, culture and economics. I would particularly like to see case studies in nursing attain more recognition for their value, rather than being thought of as something to fall back on when no other research method is possible. Teams of researchers could design a range of case studies using similar methodology and criteria, adopting some of the ideas of Yin(1984) and Miles and Huberman.(1984). This would be particularly useful in tracing developments in NHS management structures and practices now that there is so little standardisation. More work certainly needs to be done in relating organisation theory to the National Health Service - one particular area would be comparing business take-overs (with all their implications for staff personally as well as for organisational effectiveness and survival) with health service unit and district mergers which seem to happen with increasing frequency.

This kind of research would be in line with the recommendations of Pettigrew et al (1988:314) when they plead for more research that is processual, (emphasising action as well as structure), comparative (looking at different local health care agencies), pluralist (examining competing versions of reality seen by actors in change processes) and historical (taking account of the evolution of ideas about change as well as constraints decision-makers have to deal with.)

The latest White Paper (D of H 1989) makes it increasingly urgent for research to be undertaken which explores the underlying value systems implicit in using the language of the market-place in the National Health Service. The research described in this thesis illuminated the value-systems underlying one unit - this kind of research needs to be done on a much larger scale, to alert NHS workers more generally to the way that paradigmatic shifts may occur almost imperceptibly, aided by the introduction of new vocabularies. Comparative research studying other public service organisations along the same lines would also help in this respect.

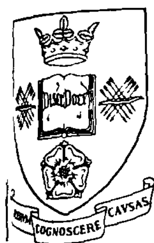
I believe such research was perhaps what McLachlan might have had in mind when he criticized the too narrow application of the customer/contractor principle currently in use within the Department of Health. He said

> "Research should of course be "relevant" and cost-beneficial but a healthy research capability requires also the funding of more general inquiries. ..... The study of health service goals, and of the social and institutional relationships which develop in pursuit of these goals, is considerably more complex (than much applied research) and requires much exhaustive long-term research in the Social Sciences."
>
> McLachlan 1985:14-15

9.4 Conclusion

I have tried, in a limited way, to study a small part of the NHS, looking at goals and institutional relationships, and have certainly found it to be a very complex undertaking. I care passionately that the NHS should continue to provide a comprehensive, equitable, accessible,

humane and effective service, free at the point of use, for everyone in the United Kingdom. If this thesis has helped to illuminate some of the problems the NHS faces, and some of the lesser known aspects of its functioning, thus alerting people to possible dangers ahead, then I shall be satisfied.



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APPENDIX 1

TO: MEMBERS OF STAFF, WESTERN UNIT. December 1985

Dear Members of Staff of Western Unit

May I introduce myself to you? Some of you will remember me as a health visitor at Middletown and then at Bridgefield but I am now a research nurse studying for a Master of Philosophy degree at Sheffield University under the supervision of Professor Lowe and Mr. Hespe, as a result of being awarded a DHSS Nursing Research Studentship. I am based in the new Consumer and Operation Research Department of Stoneyshire Health Authority, under the leadership of Dr. Robin Fields. My study is concerned with the formation and development of the new Western Unit of management, and I am seeking your co-operation in this research.

The study will seek to describe and consider the effects of new management ideas, plans and practices on nurses, nursing care, members of other health care disciplines and supporting staff during the early months of the Western Unit's formation. Interviews will cover such topics as peoples' expectations of management, and their view of their own roles in relation to other health care staff.

Most of you will know that the recent and forthcoming changes in management patterns and unit structures are a result of the influence of the "Griffiths" enquiry. It is very important for these changes to be recorded, not only from the point of view of top management in Cobbletown, but also from the point of view of each and every one of you, of your patients and clients, and of the other services with whom you co-operate. (eg local authority services etc.)

In order to record the differing points of view, and to document the formation and development of the Western Unit, I would like to talk individually with as many of you as possible, to spend time with you wherever you work, and attend some staff meetings and other gatherings. I expect this stage of the research to take about six months.

Research reports will be of two kinds - the major one will be in the form of a thesis, in which the names of people and places will be disguised. Copies of the thesis will eventually be placed in Sheffield University Library, and the office of the Chief Scientist at the DHSS in London, and probably the RCN Library's thesis collection. I will also write a much shorter, more practical report for local use, and I promise to allow each participant to see the

account of my contact with them and add comments before the report is compiled. This report will focus on issues, not personalities; individuals will not be identified but the force of the concerns expressed will be retained. It will be available to be read by everyone who takes part.

This research plan has the agreement of the UGM, Mr. F. Smith, but it is not carried out on his behalf, nor on behalf of the DHA. Any information collected will be treated confidentially, and will only be disclosed to my university supervisors where necessary for academic verification purposes.

I do hope you will all view this project as an opportunity to present a realistic view of the impact of changing management on the day to day experience of health care staff.

I will be available for informal talks at the times and places listed below, and invite you to meet me at one of these venues to discuss these matters further. If you cannot meet me at any of these times, but wish to contact me separately, you may ring me on Cobbletown xxxxx ext. xxx between 8.30 am and 5.00 pm on weekdays (Consumer and Operation Research Department, Cobbletown Hospital) or at home (xxxxx) in the evenings or weekends.

Looking forward to meeting you.

Yours sincerely,

Mrs. Susan Read
Research Nurse

APPENDIX 2

List Of Scripts (interview records and accounts of meetings) used in analysis.

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
1	Health Visitor Nurse Manager	Uppertown	A	19.12.85
2	District Nurse Nurse Manager	Churchtown	A	3.1.86
3	District Nurse	Lowtown	B	6.1.86
4	Health Visitor	Middletown	A	14.1.86
5	Health Visitor	Uppertown	A	14.1.86
6	District Nurse	Middletown	B	21.1.86
7	District Nurse	Uppertown	B	21.1.86
8	District Nurse	Uppertown	A	21.1.86
9	Health Visitor	Lowtown	C	22.1.86
10	Health Visitor	Lowtown	C	22.1.86
11	District Nurse	Middletown	A	22.1.86
12	District Nurse	Middletown	C	22.1.86
13	District Nurse	Middletown	B	22.1.86
14	District Nurse	Hilton	A	24.1.86
15	District Nurse	Middletown	B	24.1.86
16	Midwifery Nurse Manager	Uppertown	A	28.1.86
17	District Nurse	Uppertown	B	29.1.86
18	District Nurse	Uppertown	B	29.1.86
19	District Nurse	Uppertown	B	29.1.86
20	Health Visitor	Lowtown	A	29.1.86
21	Health Visitor	Uppertown	C	4.2.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
22	Nurse Manager Geriatric Hospital	Uppertown	A	4.2.86
23	Health Visitor	Uppertown	C	5.2.86
24	Health Visitor	Uppertown	B	5.2.86
25	Health Visitor	Uppertown	C	7.2.86
26	District Nurse	Uppertown	B	7.2.86
27	Sister, Geriatric Hospital	Uppertown	A	11.2.86
28	Health Visitor	Lowtown	B	12.2.86
29	Speech Therapist	Uppertown and Hilton		18.2.86
30	Health Visitor	Middletown	C	19.2.86
31	Health Visitor	Middletown	C	19.2.86
32	Health Centre Secretary	Middletown		19.2.86
33	School Nurse	Middletown	C	19.2.86
34	Midwife, Maternity Home	Uppertown	A	20.2.86
35	Chiropodist	Uppertown		21.2.86
36	Enrolled Nurse Geriatric Hospital	Uppertown	A	25.2.86
37	Midwife, Maternity Home	Uppertown	A	25.2.86
38	Midwife, Community	Uppertown	A	26.2.86
39	Midwife, Maternity Home	Uppertown	A	26.2.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
40	District Nurse	Uppertown	B	26.2.86
41	Sister, Cottage Hospital	Uppertown	B	26.2.86
42	Nurse Manager Cottage Hospital	Uppertown	B	27.2.86
43	Enrolled Nurse Geriatric Hospital	Uppertown	B	27.2.86
44	Sister, Cottage Hospital	Uppertown	B	27.2.86
45	Midwife, Community	Uppertown	A	28.2.86
46	Midwife, Community	Lowtown	B	28.2.86
47	District Nurse	Lowtown	B	28.2.86
48	Senior Clinical Medical Officer (School/ Community) and Board Member	Uppertown		4.3.86
49	Sister, Cottage Hospital	Uppertown	B	11.3.86
51	Community Paediatric Physiotherapists - x 3	Covering All Of Western Unit		14.3.86
52	Sister, Cottage Hospital	Uppertown	B	17.3.86
53	School Nurse	Hilton	C	19.3.86
54	District Nurse	Hilton	C	21.3.86
55	Health Visitor	Hilton	A	21.3.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
56	Health Visitor	Hilton	C	21.3.86
57	Night Sister. Geriatric Hospital	Uppertown	A	30.3.86
58	Cancelled-	Script Not Returned		
59	Night Nurse Geriatric Hospital	Uppertown	A	1.4.86
60	Night Midwife Maternity Home	Uppertown	A	4.4.86
61	Night Sister Geriatric Hospital	Uppertown	A	4.4.86
62	Night Midwife Maternity Home	Uppertown	A	11.4.86
63	Meeting- UGM/Staff	Uppertown Health Centre		9.4.86
64	Enrolled Nurse Cottage Hospital	Uppertown	A	15.4.86
65	Midwife, Maternity Home	Uppertown	A	15.4.86
66	Clinical Medical Officer (schools/ community)	Hilton Clinic		16.4.86
67	Family Planning Clinic Secretary	Hilton Clinic		16.4.86
68	Meeting UGM/Staff	Hilton Clinic		16.4.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
69	Meeting UGM/Staff	Uppertown Geriatric Hospital		21.4.86
70	G.P.	Middletown Surgery		21.4.86
71	Midwife - Community	Middletown	B	25.4.86
72	Physiotherapist - hospitals	Uppertown		25.4.86
73	G.P.	Uppertown Surgery		28.4.86
74	G.P.	Uppertown Surgery		28.4.86
75	Education Officer, Local Authority	County HQ		29.4.86
76	G.P.	Uppertown Health Centre		29.4.86
77	Catering Manager	Churchtown		1.5.86
78	Meeting UGM/Staff	Uppertown Cottage Hospital		1.5.86
79	Meeting UGM/Staff	Lowtown Health Clinic		7.5.86
80	GPs x 5	Lowtown Surgery		7.5.86
81	Clinical Medical Officer (Schools/ Community)	Lowtown Clinic		8.5.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
82	UGM Millbridge HA	Uppertown Royal Hospital		8.5.86
83	Social Services Officer, Local Authority	County Northern Offices		9.5.86
84	GPs x 3	Middletown Health Centre		9.5.86
85	UGM Millbridge HA	Millbridge Hospital		9.5.86
86	Secretary, Community Health Council	Cobbletown		13.5.86
87	Deputy UGM	Uppertown Unit HQ		14.5.86
88	Medical Social Worker Uppertown Hospitals	Uppertown		14.4.86
89	Education Officer Local Authority	Uppertown Education HQ		14.5.86
90	Unit Nurse Manager	Uppertown Unit HQ		15.5.86
91	Voluntary Society Representative	Uppertown		15.5.86
92	GP	Uppertown Surgery		16.5.86
93	GP	Uppertown Surgery		16.5.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
94	GP	Uppertown Surgery		16.5.86
95	Meeting UGM/Staff	Middletown Health Centre		19.5.86
96	GP	Hillside		20.5.86
97	GPs x 2	Brookside		21.5.86
98	GP	Uppertown Surgery		21.5.86
99	Voluntary Society Representative	Uppertown		22.5.86
100	Domestic Services Manager	Uppertown Hospitals		22.5.86
101	Engineering Service Manager	Uppertown Hospitals		22.5.86
102	CHC Member	Lowtown		28.5.86
103	Clinical Dental Officer	Uppertown Health Centre		3.6.86
104	Unit Board Meeting	Uppertown-Unit HQ		3.6.86
105	Voluntary Society Representative	Hilton		6.6.86
106	U.G.M.	Uppertown Unit HQ		6.6.86
107	Senior Radiographer	Uppertown Cottage Hospital		10.6.86

Reference No. Of Script	Designation	Working Base	Philosophical Group (nurses only)	Date of interview etc.
108	Voluntary Society Representatives	Uppertown		16.6.86
109	Voluntary Society Representatives	Uppertown		17.6.86
110	Physiotherapist - Hospitals	Uppertown		25.4.86
111	Unit Accountant	Uppertown Unit HQ		25.7.86
112	Unit Personnel Officer	Uppertown Unit HQ		25.7.86
113	Unit Board Meeting	Uppertown Unit HQ		29.7.86
114	Consultant Representative - Unit Board	Uppertown Cottage Hospital /Millbridge Hospital		5.9.86
115	GP Representative -Unit Board	Uppertown Surgery		5.9.86
116	Cancelled			
117	Stoneyshire HA Member	Resident in Middletown		5.9.86

APPENDIX 3

List Of Documents Used

Date	Reference No.	Title	Who Issued?	Purpose
2.1.85	D1	Units of Management	Stoneyshire DGM	Information re: proposed restructuring of units
11.1.85	D2	General Management	Stoneyshire DGM	Information re: proposed Management Board at District Level
25.7.85	D3	Implementation of management arrangements	Stoneyshire DGM	Information re: proposed timetable for Unit changes
27.11.85	D4	Introducing general management	Notes taken by researcher at meeting	3 UGMs informed staff of implications of introduction of general management
Nov. 85	D5	Organisation structure Western Unit	UGM Western Unit	Outline of structure and function of Unit Management Board
8.1.86	D6	Revised management arrangements	UGM Western Unit	Lists sites Western Unit responsible for
25.3.86	D7	Western Unit Newsletter	UGM and Deputy UGM Western Unit	Announces to staff first Unit Board appointments, open meetings and commencement of Unit
Summer 86	D8	Annual Report of Stoneyshire DHA 1985/6	Stoneyshire DHA Chairman	Reports on Western Unit and sets out operational objectives

Date	Reference No.	Title	Who Issued?	Purpose
4.4.86	D9	Minutes, First meeting of Western Unit Management Board	UGM	Record of 1st meeting. Sets terms of reference, operational objectives, budget
6.5.86	D10	Minutes, 2nd meeting of Western Unit Management Board	UGM	Record of 2nd meeting. Discussed extraordinary expenditure, training, setting up, of Mental Illness and Mental Handicap teams
3.6.86	D11	Minutes, 3rd meeting Western Unit Management Board	UGM	Record of 3rd meeting. Does not record conflicts between UGM and Board. see also script 104
3.6.86	D12	Review of costs accounts	District Treasurer	Reveals high cost of Western Unit facilities (said to be inaccurate .. compiled at HQ not locally).
1.7.86	D13	Minutes, 4th meeting of Western Unit Management Board	UGM	Record of 4th meeting. Most items ongoing from D9,10,11.
29.7.86	D14	Minutes, 5th meeting of Western Unit Management Board	UGM	Record of 5th meeting. Does not record conflicts between UGM & Board. Preparing for Unit Review. See also script 113

Date	Reference No.	Title	Who Issued?	Purpose
22.5.86	D15	Minutes of meeting between Units 1 and Western over overlap problems	UGM	To record discussion on problems, identifying who is responsible for action
7.7.86	D16	Minutes, Western Unit Joint Planning Group	UGM	Sets out strategy for Joint Planning between local authority & Unit
9.7.86	D17	Minutes - Western Unit Medical Advisory Committee	UGM	Records discussions of strategic plans, planning cycle, priorities for development
21.4.86	D18	Minutes - Western Unit Psychiatric Team Planning	UGM	Discuss progress on team formation
29.5.86	D19	Minutes - Western Unit Psychiatric Team Planning	UGM	Discuss progress on team formation
10.7.86	D20	Minutes - Western Unit Psychiatric Team Planning	UGM	Discuss progress on team formation
24.4.86	D21	Minutes - Western Unit planning mental handicap team	UGM	Discussion of care for mentally handicapped in community

Date	Reference No.	Title	Who Issued?	Purpose
17.7.86	D22	Minutes - Western Unit planning mental handicap team	UGM	Discussion of care for mentally handicapped in community
15.5.86	D23	Western Unit Planning team on health promotion	UGM	Discussion health promotion strategy
18.7.86	D24	Minutes - informal meeting re. care of elderly	UGM	To encourage joint initiatives between Unit, private and voluntary sectors, and local authority
24.6.86	D25	Minutes - CHC meeting at Hilton	CHC Secretary	Discussed difficulty of transport from Hilton to Cobbletown
22.7.86	D26	Minutes - CHC meeting at Middletown	CHC Secretary	Very little relevant to Western Unit

APPENDIX 4

Analytic Framework

This section expands on Sections 5.4.2, 5.4.3, and 5.6.2. As stated there, any concept mentioned by twenty per cent or more of a group of research participants is recognised as important. Many of the concepts are quoted in Chapters Six, Seven and Eight, but a comprehensive list of all concepts reaching twenty per cent acceptance by any group is given here. There were originally twelve categories of concept, which I labelled with letters A to L inclusive. Category B is omitted here, because none of the concepts in the category reached twenty per cent acceptance. Category D is also omitted because that has been dealt with in detail in Chapter 6. section 6.3.2. Categories A and C apply only to nurses, whereas E to L inclusive apply to all research participants.

Here is a key to abbreviations in the right hand column of the figures.

HV = health visitors and school nurses

DN = district nurses

MW = midwives

CH = cottage hospital nurses

GH = geriatric hospital nurses

gpA = nurses who see nursing primarily as professional response to need

gpB = nurses who see nursing primarily as relationship building

gpC = nurses who see nursing primarily as promoting health and preventing illness

gpA, B and C are explained fully in Chapter Seven, Section 2

PM = paramedicals (therapists etc.) and clinical medical officers

SMS = service managers (e.g. catering etc.) and secretaries

MB = management board members

GP = general practitioners

CX = unit context representatives (e.g. local authority officers, neighbouring HA UGMs)

CR = consumer/voluntary organisation representatives

<u>The 12 main categories were</u>

A Professional philosophies

B Teamwork

C Expectations of management

D Experience and expectation of management support

E Perceptions of the message of Griffiths (1983)

F Perceptions of effects of Griffiths' implementation

G Expectations of the difference the creation of Western Unit will make

H Issues related to the identity of the new Unit

I Goals for the Unit

J Factors involved in improving quality of care

K Consumer participation in health care

L Management issues

I now list the concepts meeting the twenty per cent acceptance rule for each of the categories except B and D as explained above.

Concepts		Percentage of Percentage of different groups holding concept
A. Professional Philosophies of Nurses		
	AA nursing as activity	
AA2	Basic nursing care is the heart of nursing	28%GH
AA3	Nurses aim to give best possible care, and at least do no harm	57%GH
	AB nursing as relationship	
AB1	Nurse is almost one of the family	45%MW 27%gpB
AB2	Care and competence help to build relationship of trust over time	35%DN 32%gpB
AB5	Aim of nursing - to think how patient thinks and feels	28%CH
AB7	Nursing is giving individualized care to whole person and family	59%DN, 86%CH, 43%GH 24%gpA, 50%gpB
AB11	Service should be patient-centred	27%MW
	AC Nursing as health promotion	
AC2	Encourage people to use own judgement about when to ask for help	24%HV, 33%gpC
AC4	Nurses teach patients to care for themselves, and families to care for patient	59%Dn, 32%gpB
AC5	Aim for healthier society by helping people to improve quality of life	24%HV, 28%CH, 25%gpC
AC6	Aim to enable people to cope by giving tailor-made advice when asked (not forcing advice)	41%HV, 43%CH, 50% gpC
AC7	Aim to change peoples' attitudes by health education	29% HV, 24%DN, 58%gpC

Concepts	Percentage of different groups holding concept
AC Nursing as health promotion	
AC9 Health visiting and school nursing - preventive arm of NHS	29%HV, 33% gpC
AC10 Use screening techniques to search for health needs	24%HV, 33%gpC
AD Nursing as professional response to need	
AD1 Using steps of nursing process gives flexibility in interpreting patients' needs	36%MW, 71%GH, 44%gpA
AD2 Feel prepared to meet broad spectrum of indivdual and group needs	24%HV
AD4 Feel responsible for local community not just individuals and families	24%HV
AD6 Use professional skill, knowledge and experience to care for people	24%DN, 43%GH 28%gpA
AD7 Midwives are "practitioners in their own right".	45%MW, 24%gpA
AE Nursing helping to maintain normality	
AE2 Hospital is unnatural environment, try to nurse people at home	24%DN
AE3 Midwives try to ensure a safe delivery as naturally as possible	45%MW
AE5 Goal of rehabilitation permeates nursing practice, night and day	28%GH

NOTE ON USE OF CONCEPTS TO DISCERN PREDOMINANT PROFESSIONAL PHILOSOPHIES

(see Chapter Seven, 7.2)

Nurses whose responses on professional philosophy mainly

contributed to section AB above were classified as Group B. Those who mainly contributed to section AC were classified as Group C. Originally it seemed as though there should also be groups A, D, and E - but I found that membership of these three groups seemed to overlap, and that most of those who would have fallen in groups A and E also held views consistent with Group D. So groups A, D and E were collected together to form one larger group, Group A.

C. Expectations of Management

Nurses want a manager who:-

	CA Shares values	Percentage of different groups holding concept
CA1	Is trained in own discipline	65%HV, 65%DN, 20%gpA, 55%gpB, 67%gpC
CA2	Shares caring values, understands what goes on at patient level	29%DN, 36%MW, 57%CH, 28%GH, 24%gpA, 36%gpB,
CA5	Gives staff scope to care for individuals, putting care before money saving	27%MW
CA6	Recognises professionalism of staff and gives them space to exercise it	24%HV, 29%DN, 73%MW, 44%gpA, 22%gpB
CA7	Will facilitate them to be flexible, enabling them to do their job in their own way	53%HV, 35%DN, 27%MW, 28%GH, 36%gpA, 22%gpB, 50%gpC
CA9	Values sisters' roles in taking responsibility for staff and maintaining good relationship with them	28%CH, 28%GH
	CB Has Vision For Service	
CB2	Has vision for service, is prepared to innovate and take risks	41%HV, 28%GH, 24%gpA, 33%gpC

	Concepts	Percentage of different groups holding concept
	Nurses want a manager who	
	CB Has Vision For Service	
CB3	Will be strong voice at top level management, advocating value of staff's work	35%HV
CB7	Will not get bogged down in administration, but will motivate and demonstrate philosophy in practice	24%HV
	CC gives support	
CC1	Will solve problems and give definite answers, deal with staffing problems	24%HV, 35%DN, 27%MW, 28%GH, 28%gpA, 32%gpB, 25%gpC
CC2	Is on the spot and clinically involved - gives security and consistency	57%CH
CC3	Is accessible, approachable, available	24%HV, 35%DN, 27%MW, 27%gpB, 42%gpC
CC6	Takes interest in them as people	41%HV, 28%GH, 20gpA, 22%gpB, 33%gpC
CC7	Supports staff, especially in problems with primary care team	24%HV, 25%gpC
CC9	Supports staff in situations with legal implications	53%HV, 50%gpC
CC10	Gives guidance and information in difficult cases (clinical advice)	65%HV, 35%DN, 28%CH, 24%gpA, 32%gpB, 58%gpC
CC11	Is good listener & sounding board, then gives counsel	41%HV, 24%DN, 28%CH, 57%GH, 3%gpA, 32%gpB, 33%gpC
	CD educates and monitors	
CD1	Arranges continuing education	24%HV, 29%DN, 71%CH, 43%GH, 28%gpA, 32%gpB, 42%gpC
CD2	Keeps up to date, then up-dates staff	29%HV, 35%DN, 28%GH, 24%gpA, 22%gpB, 42%gpC

	Concepts	Percentage of different groups holding concept
	Nurses want a manager who	
	CD educates and monitors	
CD3	Monitors, appraises, develops staff, also checks case-load levels	29%HV, 24%DN, 42%gpC
CD4	Is also supervisor of midwives - monitors standards and assesses training needs	82%MW, 32%pgA
CD5	Guides new staff, re-orients after service break and gives career counselling	24%DN
	CE exercises general management	
CE1	Takes a wider view, sees significance of social trends, recognises interdependence with rest of organisation and environment	24%HV, 28%CH, 33%gpC
CE2	Sees to smooth-running of service including supplies, equipment etc.	35%DN, 28%CH, 28%GH, 32%gpA, 22%gpB
CE4	Negotiates and liaises over referral and cross-boundary problems, and acts as public relations officer	24%HV, 24%DN, 27%MW, 20%gpA, 25%gpC
CE6	Has worked way up through nursing hierarchy, but has good theoretical training	28%GH

E. Perceptions of Griffiths' Message (1983)

	EA Griffiths means better management	
EA1	Griffiths' reforms mean tighter accountability, greater cost effectiveness and value for money but with risk of putting efficiency before patient care, and increasing paper work	29%HV, 35%DN, 71%CH, 28%GH. 24%gpA, 41%gpB, 33%gpC, 20%PM
EA2	Firmer management should lead to quicker decisions (so far the opposite seems to be happening.)	28%CH, 20%gpA

	Concept	Percentage of different groups holding concept
	EA Griffiths means better management	
EA4	Griffiths' implementation will lead to new management ideas more oriented towards business, and better financial information for managers	27%MW, 30%PM
	EB Griffiths should benefit patients and staff	
EB1	Griffiths' implementation should mean more money available for patient care, rather than being spent on management	27%MW
EB2	Griffiths' changes should bring tangible benefits to patients and relatives	29%PM
EB3	Griffiths' changes should lead to more participation in decision makng through decentralisation and consultation of patients and staff	20%SMS, 29%MB, 33%CX
EB5	District H.A.'s response to Griffiths follows spirit of report, gives more local responsibility	20%SMS, 25%GP
	EC Griffiths may cause damage	
EC1	Lack of senior nursing influence after Griffiths could lead to rationalisation of services detrimental to patients' interests	24%HV
EC4	Griffiths' reforms lead to down grading of nursing influence, with increased emphasis on adminstrative view	29%HV, 36%MW, 42%gpC
EC6	Griffiths' reforms may make short-term cost savings but cause long-term damage to NHS	41%HV, 29%DN, 20%gpA, 22%gpB, 33%gpC
EC8	Griffiths' reforms increase political influence in NHS and move it closer to privatisation	33%gpC

	Concept	Percentage of different groups holding concept
	ED Response uncertain	
ED1	Do not know enough about Griffiths to give an opinion	41%DN, 57%GH, 32%gpA, 32%gpB, 20%SMS, 42%GP
F. Experience of Griffiths' implementation		
	FA Stressful effects	
FA1	Do not notice much effect yet at field level, except that managers are anxious	47%HV, 71%DN, 71%CH, 57%GH, 44%gpA, 68%gpB, 42%gpC
FA2	Implementation of Griffiths has led to lowering of morale, especially for nurse managers, because of uncertainty and rumours	53%HV, 29%DN, 55%MW, 40%gpA 58%gpC
FA8	Griffiths has led to increased stress because concurrent with other change e.g. Cumberlege Report for HV's, staff grading for MW, building of psycho-geriatric unit for GH, competitive tendering for SMS	24%HV, 91%MW, 28%GH, 52%gpA, 40%SMS
FA9	Implementation of Griffiths has led to disruption of normal management - feel as though in a vacuum, or in the dark	24%DN, 64%MW, 32%gpA, 25%gpC, 30%PM, 29%MB
	FC Awakening of interest	
FC1	Implementation of Griffiths has stimulated interest in management process and wider aspects of NHS	20%PM
	FD Effect not noticed	
FD1	Implementation of Griffiths does not seem to have made any changes so far	28%CH, 43%GH, 20%gpA, 30%PM, 20%SMS
FD2	Sceptical that change will be noticeable because previous reorganisations have not	25%gpC

Concept	Percentage of different groups holding concept
FD Effect not noticed	
affected field workers very much - saying "we'll just keep our heads down".	

G. Expectations of difference to be made by creation of new Western Unit

	Concept	Percentage of different groups holding concept
	GA Positive approach to Unit creation	
GA1	Creation of Western Unit is good, sensible, logical idea - should have happened years ago	29%MB, 75%GP, 67%CX, 63%CM
GA2	New Unit has potential to be effective - local goodwill, plenty of voluntary organisations, GP hospital, no large institutions	33%CX
GA4	New Unit with localised management should give quicker decisions, better communication, more accessible management and more personal service	45%MW, 43%CH, 43%GH, 32%gpA, 30%PM, 40%SMS, 33%GP
GA5	New Unit should meet more of area's needs because local people understand influence of geography and are aware of local problems	20%PM, 57%MB
GA7	New Unit will mean local staff are more involved in taking decisions	20%SMS, 29%MB
GA11	New Unit should improve partnership and integration, bringing hospital and community nurses closer together	35%HV, 24%DN, 45%MW, 32%gpA, 42%gpB
	GB Difficulties caused by Unit creation	
GB1	Number of problems faced by Unit are disproportionate to small size of budget - especially in view of consumer demand	24%HV, 20%PM, 57%MB, 38%CR

Concept		Percentage of different groups holding concept
	GB Difficulties caused by Unit creation	
GB2	Unit will have to fight for money to develop non-existent services - other units just have to maintain existing services	29%MB, 25%CR
	GC Problems for Hilton	
GC2	Hilton should not be included in new Unit - it is "on the wrong side of the hill, geographically, socially, emotionally."	25%gpC, 20%PM
GC3	Problems for Hilton being in new Unit - public transport from there only links with City ville	20%PM
GC4	Workers at Hilton will have to serve 2 units - will have cross-boundary and paperwork problems	20%PM
	GD Uncertain if any difference	
GD1	Do not expect creation of new Unit to make much difference	35%DN, 28%GH, 28%gpA, 27%gpB 20%SMS, 33%GP
GD2	Do not know whether new Unit will make any difference	28%CH, 28%GH, 22%gpB, 25%GP
H. Issues related to identity of new Unit		
	HA Identity related to isolation	
HA1	Stress on isolation of services in Unit	64%MW, 57%CH, 43%GH, 40%gpA, 27%gpB, 40%SMS, 38%CR
HA6	Danger of new Unit increasing insularity, stagnation and polarisation	29%HV, 20%gpA, 29%MB

	Concept	Percentage of different groups holding concept
	HA Identity related to isolation	
HA7	Unit creation recognises separate identity. Unit needs own policies - can draw attention to poverty of services because has voice at District level	28%CH, 25%gpC, 30%PM, 25%GP
	HB Relations with Cobbletown and Stoneyshire HA	
HB3	Difficult to relate to Cobbletown - they don't understand problems of Western area	27%MW, 20%PM, 33%GP
HB4	Past experience of contact with Stoneyshire HA gave impression that Cobbletown feels Uppertown to be insignificant	25%GP, 33%CX
HB7	Relationship of Western Unit to Stoneyshire District very important, especially over boundaries, and levels of service in agency agreements	43%MB
HB8	Relationships at District level likely to be difficult because Western Unit has geographical basis, as opposed to other units' functional basis. Also complication of some services coming from Millbridge and some from Cobbletown	43%MB
	HC Relations with Millbridge	
HC1	Western Unit's natural ties are with Millbridge, not Cobbletown	24%HV, 25%gpC
HC2	Millbridge provides many services for Western Unit - consultants, diagnostic, therapeutic and support services	33%CX
HC3	Relationship of Western Unit and Millbridge units very important at all levels	29%MB, 50%CX

	Concept	Percentage of different groups holding concept
	IH Implement operational programme	
IH6	Get major developments on operational programme up and running	57%MB
IH9	Improve service for mentally handicapped - respite care and long-term accomodation	25%CR
IH10	Increase facilities and resources for primary care teams to cope with increased mental illness and age problems in community	25%GP
IH13	Increase number of psycho-geriatric beds	33%GP
IH14	Cut waiting lists by increasing consultants' clinics in Unit	42%GP
	II Specific service improvements	
II2	Improve health education resources	47%HV, 50%gpC
II5	Increase staff numbers so case loads could be reduced and more health promotion done	53%HV, 42%gpC
II7	Use staff more flexibly	28%CH
II11	Improve laboratory facilities in Uppertown, and transport for specimens to Uppertown & Millbridge	25%GP
II13	Improve and enhance school health service	20%PM, 33%CX
II24	Instal ultra-sound scanner at Uppertown	36%MW
II31	Shorten waiting lists and improve treatment for ear, nose and throat and audiology	25%CX

	Concepts	Percentage of different groups holding concept
I. Suggestions of goals for Western Unit		
	IA meeting local needs	
IA1	To overcome problems of distance and inaccessibility by localisation of services and provision of more domiciliary services	20%PM, 20%SMS, 25%GP, 33%CX
IA2	To use budget effectively, balancing needs of curative and preventive services	20%PM
IA3	To use Unit's increased scope for initiative and decision making to benefit locality and meet needs	29%MB
IA10	Best for different parts of Unit to work out own goals for locality, because needs differ	71%CH, 71%GH, 36%gpA, 27%gpB 25%gpC, 40%PM
	IB Working together	
IB1	All members of Unit should work together, understanding each others' roles, keeping patients at centre, for good of patients	45%MW, 22%gpB 30%PM
IB3	To bring hospital and community staff together for continuing education	28%CH, 28%GH
	ID Improve morale	
ID5	Aim for stability	40%SMS
	IE Recompense previous neglect	
IE1	Unit to be as self-sufficient and independent as possible (because of geography and weather) - not relying so much on Cobbletown or Millbridge	60%SMS
IE2	To raise level of paramedical services in Unit uniformly, improve access and waiting times	40%PM, 25%GP

	Concept	Percentage of different groups holding concept
	IE Recompense previous neglect	
IE3	Reverse cost-cutting trends, make up for past neglect by bringing Unit service levels up to match rest of District	25%GP
IE5	Increase levels of service in Unit, especially to mentally handicapped - but not repeating past mistakes of other areas	25%CR
	IF Improve relations across boundaries	
IF2	To maintain nurse education link with Cobbletown (including continuing education)	28%CH
IF3	Develop inter-unit liaison within District, and cross-boundary liaison with Millbridge	29%DN, 33%gpC
IF5	Unit to develop improved communications with Millbridge, demonstrating problem-solving approach	33%CX
IF7	Share more services of Royal Hospital in Uppertown, eventually making it part of W. Unit instead of Millbridge HA	20%PM
	IH Implement operational programme	
IH2	To widen use of Uppertown CH, making it more like small District General Hospital	27%MW, 43%CH, 20%SMS, 29%MB
IH4	Raise activity levels at Uppertown CH (theatres, throughput, bed-occupancy etc.) and community premises	57%MB
IH5	Decrease waiting - for initial out-patient appointment, in out-patient clinics, and for surgical treatment	38%CR

	Concepts	Percentage of different groups holding concept
	II Specific service improvements	
II32	Increase physiotherapy service, allowing direct access for GPs, and continuation for out-patients	20%PM, 42%GP
II34	More individualized, rehabilitative and homelike care for geriatric hospital residents	43%GH
J. Factors involved in improving quality of care		
	JA Quality thought to be good	
JA1	Belief that quality of service in Unit is good, that patients are well cared for	35%DN, 55%MW, 43%CH, 57%GH, 40%gpA, 41%gpB, 25%GP
	JB Quality improvement linked to education	
JB1	To improve quality, more continuing education, more in-service training needed	41%DN, 27%MW, 71%CH, 86%GH, 48%gpA, 50%gpB 20%PM
JB2	To improve quality, localised in-service training is needed	24%DN
JB3	Hospital and community nurses should spend more time learning from specialist nurses (e.g. stoma-care, diabetic care)	25%GP
JB6	All staff, including office staff, should understand implications of their work, and effect on other workers	28%GH
	JC Improvement linked to attitude changes	
JC11	Hospital sisters should ensure paperwork does not crowd out patient contact	28%CH

	Concept	Percentage of different groups holding concept
	JD Improvement linked to better communication	
JD2	Better co-ordination needed when patients under several consultants and therapists	25%CR
JD8	Quality hampered by poor communications, and slowness in approving mangement sub-structures	20%PM, 43%MB
JD11	Doctors (especially consultants) and nurses need training to communicate better with deaf	25%CR
JD15	Need better communication between GPs and hospitals	25%GP
	JE Improvement linked to greater resources	
JE1	Need more staff (as II5)	41%HV, 42%gpC
JE3	Need better health promotion resources (as II2)	35%HV, 50%gpC
K. Consumer participation in health care		
	KA Consumers already participating	
KA1	People are more assertive now, therefore patients do express views	27%MW, 43%CH
KA2	Patients are more forthright in rural areas, so nurses do get consumer feedback	35%DN
KA4	Use of individualised care plans ensures patient's views known	36%MW, 285CH, 71%GH, 36%gpA
KA5	Because DNs are guest in patients' homes, they do take joint decisions with patients	29%DN
KA6	If patients at home do not like nurse, or care she gives, they can refuse access	29%DN

	Concept	Percentage of different groups holding concept
	KA Consumers already participating	
KA7	Consumer views are considered in Unit's hospitals because of their small size	36%MW, 43%CH, 28%GH, 22%gpA
KA8	No standard procedures in health visiting, so consumer views always considered	295HV, 25%gpC
	KB Ways to improve participation	
KB3	To really involve consumers, need to involve them in planning and decision making	29%MB
KB7	Need to invite public into hospitals more, to demonstrate understanding of consumers' wishes	28%GH
KB17	Consumer views just beginning to be considered - now consulted in Joint Care Planning	25%CR
KB18	Consumer views recently sought by Education Service in survey for "special needs" children	25%CR
KB20	Should be recognised channels for community nurses to pass on patients' views of hospital care, especially if there are complaints	25%gpC
	KC Role of CHC	
KC8	Most voluntary groups in Western unit have had no contact with CHC - feel they are too Cobbletown oriented, do not understand	75%CR
	KD Problems with consumer participation	
KD2	More notice is taken of consumer views than previously, but consumer choice restricted by financial constraints in NHS	43%MB 38%CR

	Concept	Percentage of different groups holding concept
	KD Problems with consumer participation	
KD4	Relatives may be afraid to complain, or get too involved in patient care, in case patient is sent home	28%GH
KD5	HVs feel they do not know what consumers want from them - but would like to find out	24%HV
KD8	Doing what a patient wants is not always good for him, or may clash with another patient's wishes	43%GH, 40%PM, 40%SMS
KD9	Consulting consumers may lead to ipossible demands on service - causing overload	20%PM
L. Management issues, especially relating to Unit Board		
	LA UGM's role	
LA1	Unit philosophy - utilise resources with maximum efficiency for benefit of patients	43%MB
LA3	Vital for UGM to recruit right people to jobs, then delegate to them	29%MB
LA5	In practice, UGM seems reluctant to take decisions	43%MB
LA9	UGM seen as chairman rather than manager	43%MB
LA11	UGM relies heavily on team to implement policies - has conflicting interests because he is part-time (is also clinician)	57%MB
LA22	Local authority officers and Millbridge UGMs received personal visit from Western UGM on his appointment	50%CX

Concept		Percentage of different groups holding concept
	LB Deputy UGM's role	
LB3	Deputy UGM is key figure because "on the spot" yet lacks authority so in difficult position	29%MB
	LD Board Members working together	
LD3	UNM and UPO work closely together on forward planning, especially for manpower for new developments	29%MB
LD5	Importance of individual board members integrating into team	29%MB
	LF Medical Membership of Board important	
LF1	Communication between GPs, hospitals and Board helped greatly by GP and Consultant members	57%MB
LF3	GP representation on Board very important, because most of Unit services are community-oriented	92%GP
	LH Management Board issues	
LH1	Board's performance to be judged at Unit Review	43%MB
LH5	Board not yet functioning fully as decision-making body - needs clearer ground-rules, and role development	29%MB
LH7	Too much business done at formal meetings - Board needs more informal time	29%MB
LH10	Relationship of Unit and Board with District-managed para-medicals needs clarification	40%PM
LH11	Relationships with other units helped by good contacts at middle-manager level	20%SMS, 43%MB
LH12	Volunteer council to be set up for Board to relate to voluntary bodies	29%MB

	Concept	Percentage of different groups holding concept
	LH Management Board issues	
LH13	GPs invited to contribute to planning mechanisms through GP member on Board	29%MB
LH15	Millbridge relations with Unit rather one-sided - Millbridge provides services at Unit's request	33%CX
	LI Planning issues	
LI1	Core of Unit Planning team are UGM, Depty UGM, UA, UPO, UNM and UMO as necessary	57%MB
LI2	Staff encouraged to contribute to planning - implementation then more effective	29%MB
LI3	Crucial issue on Joint Planning - for Board to be clear who is responsible for implementation	33%CX
LI6	Millbridge believe there is scope for rationalisation between Royal and Cottage Hospital	33%CX
LI7	Joint care planning in Western Unit should lead to better implementation, because of localised input being realistic	50%CX
LI8	Past experience of joint planning problematical - planners not involved in implementation	33%CX
LI12	Local education service is consumer of Unit services - school MO's, nurses, etc.	33%CX
LI13	DHA did not inform Local Authority departments (Social Services and Education) for Millbridge HA in writing when decision to form new Unit taken	50%CX

	Concept	Percentage of different groups holding concept
	LJ Miscellaneous issues	
LJ1	Unit organisation must not get bogged-down in committees - Unit needs high degree of autonomy	25%GP
LJ3	District nurses believe they could help save money, particularly on supplies, if asked	24%DN
LJ6	Board should monitor effect of regulation of bus-services on NHS consumers	25%CR
LJ7	Board should consider problems of people having to travel long distances to see specialists	38%CR
LJ8	Board need to monitor ambulance situation - controlled from long distance	25%CR

APPENDIX 5

RESPONSE OF WESTERN UNIT MANAGEMENT BOARD TO THE RESEARCH REPORT OF SUSAN READ 30 JULY 1987

The Unit Management Board wishes to place on record its gratitude to Mrs. Susan Read for the thorough research on which her project is based, for the sensitivity with which she carried out the staff interviews and for the insight she has used in interpreting the information she received. The Board appreciates the emphasis placed on the values and philosophies of care of the Unit's staff and her report has shown the importance of giving due weight to the contributions of each member of staff.

Through the report the board has been made aware that it has been challenged to respond in a very positive way. It is hoped that the progress seen during the past year has gone some way to raising staff morale as management structures have been clarified. We take the point that in any future changes of management arrangements staff members should be consulted and kept informed as much as possible.

Two-way communication is stressed in the report and this is an area of concern to the Board. Some work has been done in setting up regular meetings of line managers with staff, particularly in nursing and in the community teams. More effort needs to be put into developing meetings at the place of work where staff's ideas could be considered. It is likely that a forum such as this would be fruitful in developing locality planning and quality assurance for that particular place of work and that a sense of identity would be thus fostered.

The Board is convinced that the opportunities for liaison with Millbridge Health Authority have been realised with benefit to Western Unit services, and that this improved relationship will continue to develop.

In the near future there is likely to be much more stress on the joint planning process between Local Authority and Health Services and it is apparent that little stress was placed upon this in the interviews contributing to this report. Therefore it behoves the Board members to work hard in communicating with staff the philosophy underlying the joint planning process, so that the idea is received positively across the Unit.

This report has shown clearly to the Board that one of its most valuable resources is the enthusiasm and commitment of its staff. The Board hopes to maximise this potential, and believes that this resource is one which will increase as it is tapped. We thank Mrs. Read for impressing on us the urgency and importance of identifying and building on the values and philosophy of our staff.

(signed......) on behalf of the Unit Management Board.

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