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Continuity and tension in the definition, perception and enactment of the first-line management role in healthcare

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Contents

Glossary of terms/abbreviations

A&E	Accident and Emergency
CAQDAS	Computer Assisted Qualitative Analysis
CD	Clinical Director
CIP	Cost Improvement Programme
CQC	Care Quality Commission
DH	Department of Health
FLM	First-line manager
GDP	Gross Domestic Product
GM	General Manager
HR	Human Resource
HRM	Human Resource Management
MHDU	Medical High Dependency Unit
NHS	National Health Service
NIHR	National Institute for Health Research
PALS	Patient Advice and Liaison Service
RCN	Royal College of Nursing
RMI	Resource Management Initiative
SBU	Specialty Business Units
SDO	Service Delivery and Organisation
SM	Service Manager
SNP	Site Nurse Practitioner
TPOT	The Productive Operating Theatre
WS	Ward Sister

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Contributions of authors

Professor Colin Hales (Principal Investigator) was responsible for the overall design and management of the project, was involved with some data collection and analysis, wrote several sections of the report and edited the final report.

Dr Carole Doherty (Corresponding Author) was responsible for day-to-day management of the project, performedsome data collection and analysis and wrote some sections of the report.

Dr Mark Gatenby (Research Fellow) was responsible for day-to-day administration of the research, conducted the bulk of the data collection and analysis and wrote some sections of the report.

Executive Summary

Background

The study reported here sheds light on the first-line management (hereafter 'FLM') role in healthcarewhich is regarded as central to implementing and monitoring health policy, delivering front-line services and determining the quality of patient care.

There is some debate about whether the FLM role has changed from its traditional focus on direct supervision and operational implementation of policy through routine planning, scheduling and monitoring of work and dealing with unforeseen operational problems. On the one hand, it is claimed that, with the 'empowerment' of work teams and decentralisation of decision-making, the FLM role has become either a residual one of 'team coordinator', facilitating the work of teams that manage themselves, or an enhanced one of 'business unit manager', with responsibility for the performance of an organisational unit. On the other hand, recent workplace studies show that, despite the rhetoric and aspiration, the traditional role has not altered significantly (1, 2, 3).

Broader trends in management in the NHS have ramified intoconcomitant developments at the level of first-line management. However, there remains limited evidence on how these management roles are defined, experienced and enacted. This was recognised in Theme (iii) of the 2008 SDO call for further research to build the evidence base on the roles, behaviour and lived work experience of junior managers in healthcare organisations.

Aims

The study sought to answer the following questions:

1. How is the FLM role in healthcare defined, both formally and in terms of others' expectations?
2. Within that role, what is the balance between professional work and managerial work and between routine supervision, performance management, team leadership and wider resource responsibilities and what are the tensions between these?

3. How do managers with first-line responsibility interpret, experience and enact their role?
4. What are the areas of overlap and conflict among others' expectations of the role and between others' expectations and FLMs' own interpretations and sense-making of their role?
5. How do FLMs resolve these conflicts enacting their role in practice?

Methods

A comparative diagnostic case study was undertaken, focusing on two distinct FLM roles - a 'line' role (Service Managers) and a professional role with de facto FLM responsibilities (Ward Sisters) – in two acute care trusts (*Alpha* and *Beta*), with the primary focus on the Ward Sister role where tensions in first-line management in healthcare are a priori likely to be more acute and the more unambiguously Service Manager role used as a comparator.

The study employed a multi-paradigm and mixed methods approach, blending critical realist analysis of how FLM positions are shaped by wider institutional structures with sense-making analysis of FLM practices and experience. Institutional context was investigated through a combination of secondary sources and internal documents.

The two FLM roles were investigated through 37 semi-structured interviews with role set members and 30 semi-structured role perception and sense-making interviews with FLMs themselves.

How FLMs enacted their role was investigated further through work shadowing 7 FLMs and observation of four Ward Sister 'Study Days' at *Beta.*

Results

The growth of the management cadre as a mechanism of coordination and control in healthcare has spawned an assortment of *first-line management* positions. Two in particular are evident. Firstly, de facto FLM positions, such as that of 'Service Manager', have been created, largely as adjuncts to General Managers with ad hoc responsibility for assisting with planning, monitoring and measuring operational performance against targets and budgets. Secondly, front-line senior clinicians, notably Ward Sisters, who always had a leadership role at ward level, have acquired additional formal managerial responsibilities.

The interpretation and enactment of these two roles show similarities and differences. For Ward Sisters, the division of responsibilities specified in organisational structures and transmitted through others' expectations defines their role as a 'practitioner-manager' - a complex blend of hands-on nursing, professional ward leadership and, increasingly, organisational management. The combination of clinical and organisational demands so created gives rise to tensions and ambiguities in the role, expressed in the divergent, often conflicting, expectations of nurses, doctors and managers. The inherent role-conflict in being, simultaneously, a clinician, directly engaged in patient care; a clinical leader, overseeing, mentoring and developing junior nurses and ensuring clinically-defined high quality patient care; and a manager, responsible for monitoring and reporting work performance against business criteria, is coupled with role-ambiguity over the distinction between the Ward Sister and Matron roles and the dissonance between greater managerial accountability without a commensurate increase in managerial authority.

Despite pressure to become, think, speak and act like managers, Ward Sisters continue to value, embrace and prioritise their nursing and clinical leadership roles. They perceive themselves as both part of the clinical team on the ward, with hands-on responsibility for 'their' patients, requiring the credibility and professional authority that comes from maintaining their clinical expertise, and as leaders on the ward, with 24-hour responsibility for ensuring continuity of care. They see both roles as threatened by growing managerial responsibility for HR management, clinical auditing, performance management and budgets and for following the formal procedures which these entail.

Ward Sisters have to reconcile their professional priorities with a growing range of role expectations. They do so by: re-affirming their identity as uniquely competent senior *nurses,* delivering patient care and developing junior nurses; delegating management tasks perceived as routine and tangential to patient care; and juggling those that remain by giving priority and attending to immediate clinical matters, whilst formally complying with unavoidable targets and procedures.

In contrast, the Service Manager role in the two trusts is more conventionally that of *first-line management*, in that it is formally defined as responsible for a discrete clinical specialty or service and subsumes day-to-day operational coordination of work, supervision of administrative and clerical staff, monitoring performance against targets and solving ad hoc work-flow problems. In practice, however, the role is weakly defined. Clinical Directors and General Managers, acting in concert, are principally accountable for operational and financial performance. The Service Manager role is more of a constructed, operational-level adjunct to the General Manager than a distinct role in its own right. As such, it is an attenuated version of first-line management, comprising an assortment of ad

hoc monitoring, supervisory and information collecting tasks - routine work which General Managers wish, or need, to off-load.

The inherent structural ambiguity and uncertainty which this creates comes through, in Service Managers' experience, in the dissonance between organisational targets and operational constraints. Service Managers see their credibility and position as managers as dependent on meeting senior managers' expectations that they 'make a difference' to organisational performance by meeting targets, whilst working with financial constraints, limited capacity and limitless demand, with few staff whom they can manage directly and with little authority over the senior clinicians and other staff with and through whom they work. In the absence of this authority, they develop a subordinate 'working relationship' with consultants, going out of their way to avoid conflict and provide support, if necessary by undertaking routine administrative tasks.

To cope with this, Service Managers construct an identity as 'hardworking employees', thriving on ad hoc, reactive problem-solving in demanding circumstances and enact a role as 'conformist administrators', doing what they have to do without questioning senior managers or alienating consultants.

Conclusions

The emerging Ward Sister role is an unenviable one, given its multiple and often competing elements. It is constituted in such a way as to require its incumbents to reconcile clinical, leadership, and organisational demands. This is especially challenging given that Ward Sisters have trained as *nurses*, with a professional mind-set, orientations and values.

That Ward Sisters cope with this role is testimony to their resilience and creativity but, from an organisational point of view is problematic if Ward Sisters are acting in ways that are organisationally sub-optimal. If by prioritising clinical work, Ward Sisters relegate management control to formal compliance and 'box-ticking', they may be failing to bring sought-for management disciplines to nursing activity on the ward. The practical implication of this is that either Ward Sisters be left to get on with patient care– with management of wards the responsibility of another, more explicitly managerial position – or they receive training and development which cultivates the skills required to finesse the competing demands and priorities. If the former, the Matron role is the obvious candidate to undertake a more explicitly managerial function, given that the division of responsibility between Ward Sisters and Matrons is currently unclear.

The Service Manager role is not an explicit, well-defined FLM role with clear responsibility for front-line supervision and performance management, but a rag-bag of ad hoc activities which assist General Managers. That Service Managers themselves make themselves useful by providing information and owning others' problems and are busy doing so are weak grounds for retaining the role. Equally, there are no obvious training and development solutions since the problem lies less with how the role is undertaken, more with the role itself. Rather, the role should either be removed, with General Managers taking greater responsibility for front-line management, or replaced by a more clearly-defined FLM role.

Effective first-line management in the NHS requires more coherent, focused and credible FLM *roles.*

1 Background, aims and methods

1.1 Background

The first-line management (hereafter 'FLM') role is one of direct responsibility and accountability for front-line non-managerial employees and the functions and tasks which flow from that responsibility and is seen as pivotal in implementing and monitoring organisational policy, strategy and procedures and in the delivery of front-line services.

The traditional FLM role has been one of supervision in its broadest sense: translating policy into operations through routine planning, scheduling and monitoring of work and dealing with unforeseen operational problems. Those engaged in FLM have stood at the intersection between broad strategic intent and specific operational implementation, between the abstractions of the 'system' and the complex technicalities of operations, and between the divergent interests and expectations of senior managers and the work group.

There is some debate about whether this role has changed. Some claim that, with empowerment of work teams, delayering of middle management, decentralisation of decision-making and 'empowerment' of work teams, the FLM role has become either a residual one of 'team coordinator', facilitating the work of teams that supervise themselves, or an enhanced one of 'business unit manager', with responsibility for the performance as well as day-to-day operations of an organisational unit. However, recent workplace studies and studies of industrial supervisors suggest that, despite changes in rhetoric and aspiration, this traditional role has not altered substantially.

An earlier study conducted by one of the authors (1, 2, 3) investigated the FLM role in the UK in the context of this debate and showed continuity at the core and change at the margins of the FLM role. Common responsibility for routine supervision and translation of strategy into operations had been extended to include 'softer' elements of team leadership, more sharply framed by a focus on performance management and, to varying degrees, supplemented by responsibility for stewardship, operational management and, more exceptionally, resource management. Traditional conflicts within the supervisory role revolving around the disparity between accountability for operations and performance but limited authority and involvement in decisions had been supplemented by new conflicts between supervisory control and facilitative leadership, supervision of processes and management of performance and between direct supervisory immersion in operational routines and more detached business management. A key finding of the study of relevance for healthcare was that the role of FLM was not confined to line managers per se; in many organisations the role was

being carried out by senior professionals and this gave rise to particular tensions in the role.

The study also showed how these structural tensions in the FLM role were expressed in conflicting expectations and how FLMs interpreted and managed these tensions by the way that they managed employees and work performance. Although the FLM role was increasingly the de facto 'point of delivery' for management of operations, employees, customers and performance, delivery was problematic and contested. There were differences between 'line manager' FLMs and the 'senior professional' FLMs in how this problem was manifested and handled.

In health care, those designated as FLMs, including ward sisters who take de facto FLM responsibility for front-line staff, work alongside clinicians and other healthcare professionals. Described as 'the backbone of the NHS and the hub of the wider clinical team' (4) ward sisters/charge nurses are positioned at the interface between management and employees. Their job includes both clinical and managerial responsibilities and is central in determining both the quality of patient care and the use of resources.

Over time, there has been both continuity in and change to the role. The growth of management in general in the NHS has ramified at the level of first-line management in two ways. On the one hand, a number of de facto FLM positions have been created, largely as adjuncts and supports to general managers, with rather diffuse and ad hoc responsibility for assisting with the overall process of planning, monitoring and measuring performance against targets and budgets. On the other hand, clinical leaders, notably Ward Sisters, have acquired greater managerial responsibilities relating to staffing/HRM and performance management in addition to their clinical responsibilities.

However, there remains limited evidence on how the FLM role in healthcare is defined, interpreted and enacted in the healthcare sector and the variations and tensions within it. This was recognised in Theme (iii) of the 2008 SDO call for further research to build the evidence base on the role, behaviour and lived work experience of, inter alia, junior managers within the specific context of healthcare organisations. This call placed emphasis on research which is both firmly located in and framed by current theory and research on management processes and managerial practice and which is relevant to the practice of managers in the health sector and, by extension, to the framing of policy for the effective delivery of healthcare services.

Holistic understanding of the FLM role in healthcare needs to attend to structural context, individual agency and the dynamic relationship between the two and, therefore, adopt a methodological approach which takes these into account. One way to do so is through a mixed paradigm approach. We have argued elsewhere (5) that critical realism and sense-making can be so

combined to address both the structural conditions which constrain and enable the FLM role and how FLMs themselves interpret and enact it. Both perspectives are sensitive to the dialectic between structure and agency in the shaping of actions within organisations and how these intersect in 'positions-practices' (6). What differentiates them is the relative emphasis that they give to positions or practices. Critical realism attends more to positions and how these are located in and shaped by wider organisational and socio-economic structures which operate as generative mechanisms and thus focuses more on how positions pre-date and shape practices. Sense-making, on the other hand, attends more to practices and how these are enacted by social actors as they attempt to make sense of their situation, or position and therefore, focuses more on how agent actions/ practices 'enact' positions .

On a number of theoretical, practical and methodological counts, therefore, a strong case existed for research to develop a more detailed understanding of how the FLM role in health care is defined, interpreted and enacted which locates this within a wider institutional context and which is sensitive to the sense-making and experience of FLMs.

1.2 Aims and objectives

The aim of the study reported here was, therefore, to develop a situated account of how the FLM role in healthcare is defined, interpreted, experienced and enacted, which traces the linkages between the 'lifeworld' of FLM's experience and practices and the 'system' of institutions, resources and positions in which they are located and shaped.

This account sought to answer the following questions:

1. How is the FLM role in healthcare defined, both formally and in terms of others' expectations?
2. Within that role, what is the balance between routine supervision, performance management, team leadership and wider resource management responsibilities and what are the tensions between these?
3. How do those with FLM responsibility interpret, experience and enact their role?

To that end, the specific objectives were to:

1. Identify how the tasks and responsibilities of the FLM role, relative to those of middle management roles and those of front-line clinicians, are defined organisationally and how these are expressed through role expectations

2. Identify how the FLM role in practice is negotiated between others' expectations and FLMs interpretations.

In particular, to identify:

1. Areas of overlap and conflict among others' expectations of the FLM role and how these arise
2. Areas of overlap and conflict between others' expectations of the FLM role and FLMs' own sense-making, in terms of their perceptions of these expectations and their own interpretation of their role
3. How FLMs construe and attempt to resolve these conflicts
4. How the interplay between how the FLM role is defined and FLMs' sense-making shape the way that the FLM role is enacted in practice.

1.3 Research design and methodology

Within a mixed paradigm approach, combining critical realist and sense-making perspectives, a diagnostic comparative case study research design was adopted, examining two types of FLM role, a 'practitioner-manager' (Ward Sister) and 'line manager' ('Service Manager') in two hospital trusts ('*Alpha*' and '*Beta*'). Mixed methods of data collection were employed, combining face-to-face interviews, ethnographic observation and document analysis to investigate the two FLM roles in the two sites.

The section is organised as follows. Firstly, we elaborate and offer a rationale for our chosen conceptual framework, which combined critical realism and sense-making. Secondly, we discuss the use of a comparative case study design as the most appropriate to investigate the research questions and explain the choice of cases for investigation. Finally, we describe and explain the methods which we used to collect and analyse our data.

1.4 Research paradigm and conceptual framework

In framing the study, a central starting assumption was that developing an holistic understanding of the FLM role in healthcare needed to attend to structural constraints and resources, individual agency and the dynamic relationship between the two. It needed, therefore, to adopt a methodological approach which took these into account. One way to do so is through a 'mixed paradigm' approach (7, 8). We have argued elsewhere (5) that critical realism and sense-making can be so combined to address both the structural conditions which constrain and enable the FLM role and the interpretations and choices of FLMs themselves which shape how they enact it.

Critical realism (9, 10) attempts to penetrate beneath the surface observations of phenomena to reveal the underling mechanisms or tendencies that shape reality. It posits a stratified ontology of separate domains which are non-reducible to each other but contingently related: the *real* domain of structures or generative mechanisms with causal powers, the *actual* domain of events to which these structures give rise and the *empirical* domain of experience. Real structures with causal powers and liabilities give rise, under specific conditions, to particular events which shape and condition experience. These events and experience, in turn, instantiate, reproduce and transform those structures. From a critical realist perspective, therefore, we see the structures that impact on the FLM role as more than aggregates of human actions, whilst the actions of FLMs as agents are more than manifestations of structure. Further, we assume that whilst these structures pre-date and shape FLMs' actions, FLMs actions reproduce and/or modify those structures. We assume that these structures comprise resources, positions, institutions, ideas which are activity-dependent, in that they are manifested in actions, or practices, and conceptually-mediated, in that they are mediated by meanings but, at the same time, are more than the sum total of the actions of agents. Because agents have a capacity for reflexivity, interpretation and intention, their actions are more than mere instantiations of structures.

A pivotal concept in critical realism, linking structure and agency is that of 'positions-practices' (6): the point where pre-existing and enduring structures with emergent properties and causal powers intersect with transient, reflective, purposive agents giving interpretation to their experience and intention to their actions. Therefore, we assume that FLMs, as occupants of pre-existing, structurally-located positions engage in specific practices associated with those positions which are partly conditioned, partly chosen and which, in turn, partly reproduce and partly transform those positions.

Thus, consistent with a critical realist approach, we sought to penetrate beyond the surface events and experience of FLMs' work to uncover the structures which shape them by both constraining and enabling what is possible. To do this, we employed the key analytic methods of critical realism: abduction, the conceptual reframing of observable events and experiences, and retroduction, construing the conditions which must be necessary and sufficient for the observable event and experience to occur. In short, we sought to ask: why are FLMs' roles and experience as they are?

However, while critical realism is attentive to structures or 'positions' at the meso- or macroscopic levels, it is less clear about how to answer questions at the micro levels of individuals or groups. We assumed, however, that a sense-making perspective would complement critical realism through its focus on inter-subjective meanings which are framed within the wider, established, generic subjective meanings, embodied in the rules and procedures of healthcare organisations and the practices of the healthcare professions (3).

Sense-making is the ongoing accomplishment through which agents 'create their situations and actions and attempt to make them rational and accountable to themselves and to others' (11: 171). Thus, in investigating the sense-making of FLMs in healthcare, we focussed on the events, experiences and interactions associated with their work, and *how* these are made intelligible and rationally accountable - how FLMs' dissonant experience arising from the ambiguous events associated with their work is rendered both 'sensible and sensable'. We sought to investigate, therefore, how FLMs drew upon linguistic resources to place their experience into an interpretive framework of categories and labels, thus 'converting the world of experience into an intelligible world' (12: 9).

Consistent with this perspective, we sought to examine how information overload, increased complexity of experience, or 'problems' in the form of disparities between intentions and reality create 'shocks' to the flow of FLMs' experience and create ambiguity (an excess of competing interpretations) or uncertainty (insufficient interpretation). We sought to investigate how FLMs engage in a sense-making process of attempting to place their inchoate experience into a framework of known categories and labels by bracketing experiential cues, linking them to existing vocabularies - in short, putting experience into words and categories that make sense. We assumed that this process of labelling and temporarily 'fixing' the nature of experience would occur continuously, retrospectively, selectively, and discursively, resulting in a temporary, contingent, plausible account or representation of this experience – or, in Weick's words, developing 'plausible images that rationalize what people are doing' (12:460)

We assumed, therefore, that we would need to attend to four inter-related elements of this process. First, that FLMs would not passively experience their environment but actively 'enact' it, i.e. create an environment that is sensible and can be responded to in known ways – 'accomplishing reality rather than discovering it' (12: 460). Second, that problems are not so much identified as 'set', and that FLMs would seek to crystallise diffusely problematic situations into specific 'problems' by attending to particular aspects of the situation and placing them into a known conceptual framework. Thirdly, that FLMs' responses to these problems would be rationalised - retrospectively justified through the construction of a plausible story that accounts for outcomes. Finally, that FLMs; sense-making would involve the attempt to construct or maintain a positive, consistent, competent identity or sense of self.

Further, like Weick, we assume that organisations are the *locus classicus* for sense-making because of their inherent ambiguity and uncertainty as open systems and their susceptibility to continuous negotiation among a multiplicity of actors, and that healthcare organisations are no exception to this. In particular, healthcare organisations are the location for continuous interplay between 'generic subjective' meanings crystallised in rules, procedures and customary practices, and 'inter-subjective' meanings negotiated through interaction. The

former prevail in situations of continuity, routine and control; the latter in situations of change, innovation and autonomy.

On the surface, critical realism and sense-making appear to offer somewhat different ways of framing and investigating social phenomena, with different concepts, vocabularies and programmes. Our position, however, was that, these differences notwithstanding, both could be deployed in conjunction to generate cumulative, complementary interpretations and permit the development of 'adaptive theory' (13), tracing the linkages between the 'lifeworld' of FLMs' experience and practices and the 'system' or 'network' of healthcare institutions, resources and positions. A critical realist lens enabled us to focus on the structural conditions which constrain and enable FLMs' actions and interactions; a sense-making lens enabled us to focus on the detailed processes of FLMs' actions and interactions, whilst; combining the two enabled us to examine the dynamic inter-relation between constraining and enabling healthcare structures and meaningful, enacted FLM practices. Employing both perspectives in tandem also enabled us to avoid crude structural determinism – seeing FLMs' actions as purely an echo of NHS rules and procedures – and reductionism – seeing the FLM role as purely the product of FLMs' individual choices.

1.5 Research design

This research adopted a case study approach as the most appropriate design for answering the central research questions. In effect, it is a case study at three, embedded levels – positional, two types of FLM role; organisational, two hospital trusts and institutional, the NHS at a particular point in time.

Yin (14) distinguishes among three types of case studies: descriptive, which aim to present a complete description of a phenomenon; exploratory, which attempt to define a question or examine the feasibility of an in-depth study; and explanatory, which attempt to offer a cause-and-effect relationship. The reported study was a combination of all three - descriptive, in that it sought to offer an account of the lived reality of the FLM role; exploratory in that it investigated a hitherto under-researched management role in health care; and explanatory, in that it sought to develop an account for the way in which the role has been both shaped and experienced.

Stake (15) differentiates between an 'intrinsic' case study, where the researcher is interested in the case per se, and an 'instrumental' case study where the aim is to learn about a broader phenomenon which individual cases can help inform. Here we followed an instrumental approach, considering each case as 'as instance drawn from a class' (16: 3) which could be used to explore, systematically, phenomena that occur more broadly within that class. Thus we treated the two hospital trusts in the study as instances of NHS trusts generally

and the two focal managerial roles in the study as instances of the FLM role in healthcare.

Multiple cases enable target phenomena to be compared and contrasted in different settings and hence yield more generic findings. Adopting a comparative, multiple case approach, focusing upon two types of FLM role in two hospital trusts, permitted comparison across both different roles and different settings.

Following the choice of a combined research paradigm, the study also adopted an 'embedded' case study design, exploring multiple levels of analysis (14). This permitted intra-case comparisons across organisational sub-units such as wards, offices, clinical specialties and directorates, as well as inter-case comparisons between the two roles and two organisations. This approach also made it possible to analyse the two roles and the organisations in which they were located within the wider institutional context of the NHS and the politico-economic context of government health and economic policy. Yin (17) argues that this approach is particularly suited to the complex nature of health services, characterised by continual and rapid change, both in terms of internal dynamics driven by the needs of patients, and wider institutional and political structures characteristic of public sector organisations.

Thus, overall, the comparative, explanatory and instrumental case study design was consistent with the interpretive and inductive objectives of the study, the data requirements which flow from those, and the theoretical imperative to situate the case studies within the broader context.

1.5.1 Case study selection

Research funding was granted for the investigation of two types of FLM role - one where a senior professional was the FLM and another where the FLM was purely a line management role - at two sites – *Alpha*, an acute Foundation Trust in the south east of England and *Beta*, also an acute Foundation Trust in the south east of England.

Sampling of both the managerial roles and organisations followed, theoretically and practically, from the research aims.

1.5.2 The focal managers

Two focal FLM roles - one 'practitioner-manager' and one 'line manager' – were selected for investigation. FLMs generally are central to front-line service delivery of health care and policy implementation but have been comparatively under-researched as a management layer. The two FLM roles on which the investigation was focused were chosen on the grounds that a role which is exclusively designated as line management would exhibit somewhat different expectations,

tensions and practices from one which blends managerial and professional elements. This contrast would then, enable the identification and diagnosis of both commonalities and differences between the two roles and, in particular, point up the tensions in a role in which professional/clinical elements are combined with managerial elements..

In order to identify the precise FLM roles on which to focus the study, the new NHS pay scale following A*genda for Change* (18) was used to review how management roles within acute trusts are described and graded. The vacancy database NHS Jobs (http://www.jobs.nhs.uk/) was also used to search for job titles, along with role banding details and job descriptions.

The NHS jobs database, along with preliminary interviews, revealed that a key practitioner-manager role within the hospitals, where tensions between professional/clinical elements and managerial elements are likely to be particularly acute, is the 'senior ward sister' or 'charge nurse' (male equivalent) which is generally positioned at band 7. This is the most commonly occurring clinical-managerial role within secondary care, found within every clinical unit or ward, and, therefore, the role of **Ward Sister** was chosen as the focal 'practitioner-manager' role.

The database aalso revealed that hospitals regularly employ line managers with common job descriptions at band 7 or 8a, who are given titles such as 'business unit manager', 'service managers', or 'specialty manager'. This role represents the largest population of managers within secondary care, where every business unit or clinical specialty will usually have at least one business manager accountable for the service. This role was chosen as the focal 'line management' role, providing a more unambiguously managerial role to act as a comparator for the tensions in the Ward Sister role, and will be referred to henceforward in the report as **Service Managers**.

After some preliminary corroboration with the HR departments and senior managers in each trust, these two roles became the focus of the respondent sampling strategy and data collection process.

1.5.3 The case organisations

Many features, or variables, of healthcare organisations could potentially be used to categorise a prospective case site. Following a review of the literature features considered relevant to case selection were:

- services provided
- organisational status (e.g. Foundation Trust)
- organisational structure
- workforce size

- performance data comparisons for English district general hospitals
- staff survey results
- patient survey results
- number of beds

It is sometimes argued that comparative case studies should be selected on the basis of diversity (19) and that a choice of polar types makes the phenomenon of interest 'transparently observable' and 'generalisable' to the wider population. Whilst we accept the value of this kind of theoretical sampling, we opted to choose case organisations on the basis of their similarity rather than difference. Aside from theoretical reservations about how far polar types of case organisation can, in fact, reveal, even by implication, characteristics of the intervening population of less extreme organisations or merely reveal their own divergent idiosyncracies, or whether, by pointing up inter-case variation, they obscure intra-case variation, our choice of similar organisational cases was driven by more practical considerations. The primary focus of the study was not hospital trusts per se but the FLM role. Thus the important comparative focus was between different FLM roles, rather than different hospital trusts.

Therefore, the selection of organisational cases in this study was based on 'typicality'. Cases were selected on the basis of statistical and categorical similarity to the majority of acute trusts in each of the characteristics listed above. Crucially, holding organisational context broadly constant meant that the comparison between the two FLM roles – the principal focus of the study – would be thrown into sharper relief.

There are 179 NHS Trusts in England providing acute care services. The majority of these provide an emergency and general service to meet the health needs of a local population. The majority of trusts (60%) have between 2,000 and 5,000 employees. The selected cases for this study sit with the majority of Trusts for workforce size. Hence they are of a similar size to many secondary care services. Both trusts share a staff group composition close to the NHS average, with around fifty per cent working in clinical areas.

Overall, the two case organisations are broadly typical of NHS services based on a number of criteria, including the performance data published by the Care Quality Commission and The Dr Foster Hospital Guide 2009, with one trust performing slightly, but not significantly, better than the other.

Once the two hospital cases were selected for their appropriateness to the study, the principal investigator made contact with the respective R&D departments and established an interest in participating in the research. Full ethical and organisational research governance permissions were obtained, following the promise of anonymity and confidentiality to participating individuals and organisations.

1.6 Data collection

Perforce, different data sources and methods of collection were used to collect data on the different elements of the investigation – the institutional and organisational context, how the two FLM roles were defined and how the two FLM roles were interpreted and enacted. The first of these data-sets sought to inform the development of a critical realist account of the underlying structures, facilitating and limiting conditions and surface events that shape the role of FLM in healthcare. The second sought to form the bridge between these structures and conditions, as articulated by the proximal expectations of members of the FLMs' role-set, and the experience of FLMs themselves as the targets and recipients of these expectations. The third data-set sought to inform the development of an account of the process of sense-making undertaken by FLMs in order to interpret and enact their role.

1.6.1 Data on the institutional and organisational context of FLM roles in healthcare

Data on the **institutional context** of the NHS were collected through a combination of published books and articles; NHS reports and policy documents; and reports by the NHS Confederation, NHS Institute for Innovation and Improvement and NIHR/SDO. These data are brought together in Section 2, tracing the development of management in the NHS and how this has impacted at the level of first-line management. This represents, therefore, the first level of our critical realist account in which we seek to identify the underlying politico-economic structures, their inter-connections and their articulation in the empirical trends and events which have shaped the role of FLM in healthcare .

Data on the specific **organisational context** of the two trusts were collected through a combination of internal organisational documents and researcher observation.

These included:

- Department of Health reports and policies
- Reports by NHS Confederation
- Reports from NHS Institute for Innovation and Improvement
- Performance data from CQC, Audit Commission and Dr Foster Intelligence
- Demographic and workforce statistics from NHS information Centre
- Reports and data from Strategic Health Authorities
- Local socio-economic and demographic data for hospital locations

Internal documents included:

- Organisation and department strategy documents
- Policies (e.g. communication policy)
- Organisational charts
- Job descriptions
- Internal audit data
- Historical documents (e.g. annual reports)
- Board meeting minutes
- Internal presentations
- Newsletters
- Training documents

These data then represent the second level of our critical realist account in which we seek to show how broader politico-economic structures and conditions ramify in the policies, structures and forms of organisation in the Health Service in general and specific healthcare organisations particular.

In both cases, data were sought that would identify the *actual* domain of events relating to management in general and first-line management in particular within the Health Service and the *empirical* domain of the reported experience of FLMs that would provide the starting point for the identification of the *real* domain of structures or generative mechanisms with causal powers and mediating conditions that would have shaped these events and experiences and which, in turn, had instantiated, reproduced and transformed those structures.

Thus data were sought on the events and reported experience that would point to the resources, positions, institutions and ideas together constituting the underlying structures by virtue of those structures being activity-dependent, instantiated in actions, or practices, and conceptually-mediated, mediated by meanings.

Data were sought, therefore on the 'positions-practices' (27) of FLMs in healthcare, where pre-existing and enduring structures with emergent properties and causal powers intersect with FLMS as transient, reflective, purposive agents giving interpretation to their experience and intention to their actions. This entailed collecting data on how the occupants of pre-existing, structurally-located FLM positions engaged in specific practices associated with those positions which are partly conditioned, partly chosen and which, in turn, partly reproduce and partly transform those positions.

1.6.2 Data on the nature of and tensions in the FLM role

The study used two main methods of primary data collection to investigate the nature of and tensions in the FLM role: in-depth interviews and ethnographic observations. The central overall aim was to obtain data that would illuminate FLM positions-practices from two complementary perspectives: firstly, how FLM *positions* are shaped by the proximal expectations of the FLMs' roles-set and how these intersect in both complementary and competing ways; and secondly, how FLM *practices* are shaped by the dynamic relationship between FLM perceptions and interpretations of these expectations and the process of active sense-making in which they engage in order to realize and enact their role.Data collection proceeded on the basis of theoretical sampling, where data are collected via an iterative, inductive process rather than a deductive or probabilistic strategy (20). The FLMs who formed the focus of the interview stage of the study were initially identified from staff records and organisation charts in the participating organisations, with the assistance of the Human Resource department. Members of the FLMs' role sets were identified through an examination of organisational documents and preliminary interviews with key informants.

All participants in the study were recruited in such a way as to preclude their being pressured or coerced to participate or not to participate. Prospective participants were recruited initially by invitation email along with a Participant Information Sheet giving details of the project and their invited involvement in it. They were invited to indicate their willingness to participate and their availability for an interview. Subsequently, they were contacted directly by one of the researchers on the project, to arrange an interview, at which point their informed consent was requested.

Qualitative, semi-structured interviews with FLMs and members of their role set were the cornerstone of the data collection on the project. As with other qualitative research interviews, these were purposeful discussions between interviewer and interviewee conducted in order to collect a wide range of information types (21), but primarily detailed descriptive and diagnostic data on role-set members' expectations of the FLM role and FLMs' perceptions of and attitudes towards their role. They were informal in nature and took the form of 'conversations with a purpose' (22: 102). A semi-structured format, however, allowed the researchers to formulate themes and questions to be covered while retaining methodological flexibility (23). Conducted in this way, the interviews facilitated production of dialogical data that possessed a richness of detail (24, 25). They offered 'the opportunity for the researcher to probe deeply to uncover new clues, open up new dimensions of a problem and to secure vivid, inclusive accounts that are based on personal experience.' (26:34) and to collect these accounts in respondents' 'own unvarnished language' (Mayhew, 27: 3). Qualitative interviews were appropriate, therefore, given that our aim was to garner descriptions of and reflections about role-set members and FLMs' behaviour, opinions and attitudes (28).

The informality of the interviews also carried potential advantages for generating data, in that researcher and respondent could engage in face-to-face dialogue and flexible flow of information. This meant that questions could be developed and adapted for individual respondents and interviewers could reflect back in order to 'confirm their interpretations and seek elaborations upon the person's account' (29: 54).

The potential problem that respondents might provide 'socially desirable' responses to satisfy the interviewer or omit relevant information (30, 26) or that they would not provide sufficient information in themselves to judge the trustworthiness (including reliability and validity) of accounts (31) were overcome by using multiple data sources to cross-check and corroborate responses. These additional sources included other participants, notes from observations and secondary data such as job descriptions.

Semi-structured interviews are also criticised for offering poor reliability, generalisability or replicability. However, since this study was primarily concerned with developing a conceptual understanding of the context-specific nature of the function, characteristics and tensions in FLM roles in healthcare, the primary concern was with theoretical, rather than statistical generalisability (14). We sought not to statistically measure the characteristics of a role that had hitherto been under-researched, but to develop, inductively, a better theoretical understanding of how the FLM role in healthcare is shaped, defined and interpreted.

1.6.3 Interview design: investigating expectations and perceptions of the FLM roles

Data on how the FLM roles are constituted by the intersection between others' expectations and FLMs' own role perceptions and interpretations were collected in four stages: firstly, identifying the FLMs' role sets; secondly, eliciting role set members' expectations of the FLM role; thirdly, eliciting FLMs' perceptions of their own role; and, fourthly, investigating FLMs' sense-making of others' expectations. This interview process had been developed by one of the authors in a number of earlier studies (32, 33, 34, 35).

1. Identifying the FLMs' Role Sets

Here we were concerned to identify those who contributed to the external definition of the position-practices of the FLM role through their expectations about the nature of the role and the practices associated with it – the FLMs' role-set. The role set is the 'complement of role-relationships in which persons are involved by virtue of occupying a particular social status' (36: 113). Hence, members of the role set surrounding a role are all those who interact with the

role incumbent and/or have expectations of the role incumbent's behaviour and attitudes.

To develop a comprehensive picture of the FLMs' role set, the researchers examined organisation charts, with the independent assistance of the HR department, posing the question: 'Who would have expectations or requirements of first-line managers?' A snowballing approach was then used through interviews with FLM role incumbents and role set members until no further additions to the role set could be made without including individuals or groups whose relationship with the FLM was too distant or fleeting to be of consequence in defining the role. The result was a series of role-set diagrams (see Appendix 1 for an example). This was useful both as a preliminary stage in the investigation, to identify the sample of respondents and as an interesting form of data in its own right - for example, as a way of comparing the role networks of different first-line manager roles.

2. Eliciting Role Set Members' Expectations of the FLMs

Here we were concerned to uncover the specific ways in which role-set members sought to shape the position-practices of the FLM role through the nature and strength of their articulated expectations. This involved semi-structured interviews with role-set members identified at Stage 1, using the 'managerial wheel' interview instrument (Appendix 2) developed for earlier studies of managerial roles, to elicit their expectations and requirements of the FLM role (32, 33, 34, 35). This process involved asking participants to imagine the focal manager as being at the hub of a wheel and to express each separate expectation that they had of the focal manager as one 'spoke' of the wheel. Respondents could express as many or as few role expectations and therefore, to label as many spokes of the wheel, as they wished. Respondents were encouraged to express expectations in as specific and concrete form as possible. Respondents were then asked to elaborate on each of their expressed expectations, in turn.

Once respondents had exhausted all the role expectations that they had of the FLM role, they were asked to indicate, for each expectation in turn, the strength of that expectation and to depict that by overdrawing the relevant spoke of the wheel. The strength of expectation was represented on three levels indicated by three rings on the diagram. A line to the centre of the wheel denoted a 'must do' expectation; a spoke overdrawn to the inner ring indicated an expectation that took the form of a less strong requirement: what they believe the first-line manager 'should' do; a spoke overdrawn to the outer ring indicated an expectation that took the form of a weak requirement: what they believed the first-line manager 'could' do. It was emphasised to participants, however, that the inner and outer rings served only as broad guides and respondents are encouraged to use the whole length of the spoke to indicate finer gradations of

strength of role expectations. Again, respondents were asked to explain in more detail the reasons for the strength of their expressed expectations.

Despite its simplicity, the 'managerial wheel' instrument has proved in previous research to be both an effective data collection tool and an illuminating representational device that can be used as a basis for managerial self-reflection. It combines an open-ended, respondent-driven exploratory method of collecting qualitative data, allowing managers to express their expectations in their own words, with a structured, systematic method of recording the data in a form that has strong visual impact and permits comparative analysis. Thus it is possible to demonstrate, for example, the range and content of the role expectations attaching to a particular managerial role, the sources of those expectations and the weight of those expectations. The wheel surfaces, clarifies and makes explicit role expectations that are otherwise hidden, hazy or implicit. It is especially instructive in identifying and surfacing conflicts and tensions in the content, perceived importance and sources of role expectations and disconnects among different role set members' expectations and between these and managers' interpretations of these expectations and their own perceptions of their role.

We conducted a total of 37 role set interviews, 20 at *Alpha* and 17 at *Beta*, with a wide range of staff including senior and middle managers, consultants, matrons, sisters, staff nurses, HR officers and support services. Most sections of the FLMs' role-set were well-represented. However, doctors and consultants were generally unwilling to engage with and participate in the study and so are somewhat under-represented. The interviews were of around one hour duration and were digitally recorded following consent from the participant.

3. Eliciting FLMs' own interpretations and perceptions of their role

Here we sought to identify the starting point for FLMs' sense-making of their position and practices - their awareness, perception and interpretation of others expectations; in short, to identify what it was that FLMs' were attempting to make sense of. This stage employed the same wheel instrument as above. The FLMs themselves were asked to follow the same process by indicating what they perceived as the expectations surrounding their role, elaborating on each of these, in turn, and indicating their perception of the strength of the expectations.

We conducted 23 interviews with incumbents of the two focus roles, 12 in *Alpha* and 11 in *Beta*.

4. Investigating FLMs' Sense-making

Here we sought data that would enable us to uncover the sense-making processes undertaken by FLMs as they attempted to enact their role as a position with a specific identity and practices that contributed to that identity. In particular, we sought data that would relate to sense-making as the ongoing

accomplishment through which FLMs created their situations and actions and attempted to make them rational and accountable to themselves and to others. Thus, the focus of the data collection was upon the events that impinged upon FLMs and upon aspects of FLMs' experience and interactions that created the ambiguities and dissonant experience that had to be rendered both 'sensible and sensable' and upon the linguistic resources deployed by FLMs to place that experience into an interpretive framework of categories and labels.

Data collection focused on identifying instances of information overload, increased complexity, instability of experience and 'problems' in the form of disparities between intentions and reality and the cognitive and linguistic drawn upon by FLMs as they attempted to place inchoate experience into a framework of known categories and labels. Thus we sought to collect data on the experiential cues, vocabularies and interpretations devised and developed by FLMs as they sought to label and so temporarily 'fix' the nature of their experience. As a key part of this we sought to collect data that would identify the two types of meaning upon which FLMs might draw in doing so: the 'generic subjective' meanings that are crystallised in rules, procedures and customary practices, and the 'inter-subjective' meanings that are negotiated through interaction.

Thesedata on FLMs' sense-making were collected through follow-up depth interviews. The focus of the follow-up interviews was the findings from the expectations interviews with members of the role-set and FLMs themselves; these constituted, as it were the experience out of which FLMs were obliged to make sense of their role

FLMs were presented with a summary wheel of the expectations surrounding their respective roles (see Appendix 3 for an example). This summary wheel was developed through a lengthy discussion and analysis by the research team of the collected wheels from the role set members relevant to each role. FLMs were asked to comment on these expectations and any perceived tensions within them, how they interpreted them and how they shaped their experience of their role.

7 follow-up interviews were conducted, 4 in *Alpha* and 3 in *Beta.*

1.6.4 Ethnographic observations: investigating FLMs' sense-making and enactment of their role

Throughout the data collection process, the researchers had the opportunity to observe and make notes about organisational context opportunistically. In addition to this informal process, the interview evidence was strengthened by arranged periods of ethnographic observation. These served to furnish more data that would shed light on the way in which wider politico-economic structures were ramifying in the policies, structures, programs and role-set expectations

within the two trusts and the way in which FLMs were seeking to interpret and make sense of these and to enact their role in the light of this.

Observation is 'the act of noting a phenomenon, often with instruments, and recording it for scientific or other purposes' (37: 906). Gold (39) distinguishes four different roles for the observer: complete participant, participant as observer, observer as participant, and complete observer. The most popular form is to have some kind of involvement (usually observer as participant), where the researcher shares and contributes in the routine activities of the research context. For this study, however, the nature of work in healthcare and ethical considerations precluded this and the researchers generally assumed the role of 'complete observer'.

The most notable advantage of these observations was the naturalistic context in which they occurred. The researchers were exposed to the local language and behaviours of the FLMs and the different groups with whom they interacted (38) which had been more difficult to elicit through interview. A key advantage of this naturalistic observation was that hidden, deviant or forgotten activities could be discovered, in particular what Smith (40: 221) calls 'the tacit skills, the decision rules, the complexities, the discretion and the control in jobs that have been labelled routine'. Observation also shed light on the implicit activities, taken for granted by FLMs themselves (14).

To be sure, observation techniques are labour intensive, in that they are demanding of both observer and observed, and potentially intrusive. There is also a risk that events are staged for the observer's benefit (41) or that employees believe the researcher is an agent acting in the interest of management (42). Thus, acceptance and trust can be difficult to develop. With long periods of observation there is also the danger of the researcher 'going native' (38) which means they become enfolded into the worldview of the people being studied and lose necessary detachment and objectivity.

Observation was used in this study as a way of collecting supplementary evidence to support, strengthen and corroborate, or otherwise, the interview data. The potential problem of intrusiveness was obviated by ensuring that those being observed were fully aware and accepting of what it entailed and that no-one whose consent had not been obtained (e.g. patients) were observed. The demands of the method were reduced by limiting the periods of observation. The problem of 'staging' was much reduced by the way in which much of the FLMs' work was driven by others and external events. Nevertheless, the researchers needed to retain a critical detachment.

Observation in the study took two forms. Firstly, 7 FLMs, 3 in *Alpha* and 4 in *Beta*, were work shadowed over the course of one or more working days. 10 days of work shadowing were conducted in total. One of the researchers accompanied the FLM wherever it was possible or ethically acceptable to do so and observed and noted the nature, purpose and location of the activities in which the FLM was engaged, with whom they interacted and how (face-to–face,

by telephone or electronically) and with what equipment they worked. Informal discussion with the FLM in real time or after the event was used to establish the FLMs' perceptions and interpretations of the activities in which they were engaged.

Secondly, and unanticipated at the outset of the research, the research team were invited to sit in on and observe a series of training days for Senior Ward Sisters/Charge Nurses at *Beta*. These took the form of presentations by senior managers on topics and issues considered to be of relevance to the Ward Sister/Charge Nurse role, followed by small-group and subsequent plenary discussion of these topics. Further insights into how the Ward Sister/Charge Nurse role was defined and perceived were afforded by: firstly, the content of the training which suggested, by implication, those areas of responsibility which were perceived by the Trust as being, or soon to become, part of the role; secondly, the contextual messages conveyed during the day, which indicated the Trust's perceived priorities and constraints how these were thought to ramify in the Ward Sister role; and, thirdly, Ward Sister/Charge Nurse reactions to the training content and attendant messages, which indicated participants' interpretation and opinion of these implied responsibilities and priorities.

Observations were secured through requests with participating FLMs following the initial expectation interview. The researchers described how the research could be strengthened through 'work shadowing' which would provide an opportunity for the researchers to see first-hand the range of issues discussed in the interviews.

1.7 Data analysis

The combined critical realist and sense-making perspective adopted by the study informed both the strategic purpose and the mechanics of data analysis.

Critical realist analysis of the structures and mediating conditions that had impinged upon and shaped the position-practices of FLMs in health care sought, crucially, to penetrate beneath surface events and FLM experience to uncover the structures which, as generative mechanisms, had given rise to them by both constraining and enabling what constituted first-line management. Thus the analysis sought to develop a generative, rather than sequential; substantive, rather than correlational, and conditional and contingent, rather than deterministic, explanation of these events and experiences in terms of the contingent tendencies produced by multiple generative mechanisms mediated by context and meanings. This meant employing the 'transcendental methods' that are central to critical realism - abduction, the conceptual reframing of observable events and experiences, and retroduction, construing the conditions which must be necessary and sufficient for the observable event and experience to occur - that is, positing the question: 'What underlying structures and mediating conditions would, if they existed, account for these events and experiences?

The analysis of data on FLM sense-making was concerned to identify and illuminate four central aspects of the sense-making process. This process has four inter-related characteristics: firstly, how FLMs actively enacted their environments in ways that would render it, to them, 'sensible' and 'sensable' and amenable to response in known ways; secondly, to identify how diffusely problematic situations were congealed into specific 'problems' by virtue of the aspects of the situation to which FLMs attended and the conceptual framework which they employed to place it; thirdly, to identify how these problems were rationalised and responses to them justified through the plausible stories that FLMs constructed to account for outcomes; and, finally, to identify how FLMs attempted to construct or maintain a positive, consistent, competent identity or sense of self in the face of the situations that they faced. Central to this was the identification of the two types of meaning upon which FLMs were drawing in doing so: the 'generic subjective' meanings crystallised in rules, procedures and customary practices, and the 'inter-subjective' meanings negotiated through interaction.

Because of the way in which the critical realist and sense-making perspective adopted for the study shaped the strategic purpose of the data analysis – that is, the intended product of the analysis - it followed that a key part of the mechanics of data analysis was the *interrogation* of the surface data that had been collected in order to identify underlying structures and processes, rather than simply to collate and organized surface data. This meant interrogating the data on the surface events and reported experiences in the historical development of management and organization in the Health Service to ask what kinds of structures, operating through what kinds of enabling and constraining mediating conditions, would have given rise to these; and to interrogate the data on FLMs experience, perceptions and actions to ask what processes – in terms of both form and content - of sense-making had given rise to these.

Thus the secondary data, in the form of texts, on wider politico-economic trends and developments, institutional developments and specific organizational structures and policies that had impinged upon management in the Health Service were subject to thematic, template analysis in which the aim was to identify trends, patterns and interconnections through hierarchical coding.

The interview and observational data were analysed through an iterative process of data compression involving reading, re-reading and coding transcripts, field notes and documents; identifying salient themes; cross-checking themes through further reading and discussions; grouping together themes and linking themes to theory and literature. This process was complex, and time-consuming because the data collected were voluminous, and unstructured (43, 44). Following Burgess (22) we followed no rigid procedures in recording, coding, indexing, and analysing the data, but, rather, proceeded through 'organisation, reflection, commitment, thought and flexibility' (p. 183). The analysis, therefore, occurred concurrently with data collection (45).

Analysis of the data rested on the central process of data coding 'whereby the data are inspected for categories and instances' (46). The aim was to disaggregate the text of the interview transcripts and observational notes into a series of fragments, which were then regrouped under a series of thematic headings' (p. 455). We followed Miles and Huberman (47) in: affixing codes to a set of transcripts and field notes; noting reflections or other remarks in the margins; sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, and common sequences; and gradually elaborating a small set of generalisations that cover the consistencies discerned in the database.

Central to the analytic strategy in this study was the synthesis of contextual, role expectations, role perceptions, sense making and work activities data to build up a detailed, holistic picture of how the two types of FLM role were constituted, interpreted and practised. Thus the analytical process carried out can be summarised in five stages:

1. The secondary data were analysed to identify the wider structures, conditions and trends that had appeared to shape the nature and form of management in healthcare generally and of first-line management in particular.

2.The semi-structured interviews were analysed to determine which tasks/responsibilities, areas of authority and accountability and involvement in decision-making we seen by others and by FLMs themselves as central to the FLM role, which are peripheral, which are shared with others and which are located on other work roles

3. Detailed verbatim statements from each respondent were coded by content, source and strength of expectation

4. These statements were aggregated into more general, comparable types of expectation/ perception and classified into generic areas

5. Each FLM role was analysed in terms of the content, source(s) and 'weight' of the role expectations surrounding them and the managers' own role perceptions. Comparisons and patterns were identified both within and between cases.

This process was undertaken 'by hand' rather than through the use of computer assisted qualitative analysis (CAQDAS) software such as NVIVO. This was for two reasons. Firstly, analysis through personal immersion in the data and iterative coding and re-coding allowed the researchers to gain a stronger holistic appreciation of the nature of those data, which a more mechanical form of analysis would preclude. Secondly, the size of the data set was such that this more desirable approach was possible in practice.

Thus, whilst the research team had been prepared to use innovative methodological tools to make the analysis more efficient had the data-set been larger, CAQDAS did not offer anything that could not be achieved by other methods

1.8 Limitations of the Research

As the foregoing discussion suggests, the reported research was subject to a number of limitations, primarily related to data sources and permissible methods of data collection.

Firstly, the unwillingness of doctors and consultants to participate in the study, despite repeated efforts to secure their co-operation, means that data from a key segment of the FLMs' role-set are derived from a limited number of sources and, consequently, that the reported doctor and consultant perceptions and expectations of the FLM role are somewhat narrow. Strict and proper assurances that potential respondents would be entirely free to decline, or withdraw from, participation in the study, as required by good research practice as well as for ethical approval, meant that nothing could be done to rectify this.

Secondly, and similarly, the pressures of work on FLMs meant that they were unwilling to participate in data collection of their work activities through activity sampling, as had originally been envisaged in the research design. FLMs felt that having to record their work activities in a way that would be sufficiently detailed to be meaningful would be an additional burden on an already heavily-loaded working day. However, this was off-set by a willingness on their part to be observed on a more continuous basis over the course of their work by members of the research team. FLMs were amenable to this because it did not impose an additional burden on them and because they were satisfied by the assurances from the research team that there was no ulterior motive to the exercise beyond neutral, research-driven observation and that the results would be presented in an aggregated and anonymised way, with no reported behaviour traceable or attributable to any individual. How far this is deemed a critical limitation of the research depends on the value given to self-reported structured observation. A criticism of research on managerial work based on this form of structured observation and one which the research team came increasingly to appreciate, has been that it has tended to reductionism: breaking down the holistic, blended nature of that work, where tasks and activities inter-weave, inter-relate and take place simultaneously to a disaggregated list of discreet activities that are then subject to an artificial counting exercise, implying that time spent or frequency are somehow proxies for importance or relevance. In short, the research team used the preclusion of activity sampling as an opportunity to undertake observation of a more holistic nature.

Thirdly, because of the difficulties that attempting to collect data from patients would have posed for gaining ethical approval, patients were not included as members of the FLMs' role-sets. This was less of a limitation for examining expectations of the role of Service Manager since it is unlikely patients would have any knowledge or expectations of these managers per se: at most they would only have expectations of some of the services for which the managers had responsibility. However, it is possible that some patients and relatives of patients would have expectations of the role of Ward Sister as being 'in charge'

of and responsible for the ward environment, as well as expectations of the ward environment generally and, therefore, it would have been interesting and potentially instructive to collect data on these expectations.

Fourthly, fieldwork was conducted at *Beta* at a time of some organisational upheaval and uncertainty, most relevantly over the future status and extent of the Service Manager role. It meant that some Service Managers at *Beta* were reluctant to grant interviews – although a surprising number did – and those that did were either guarded in their responses or inclined to use the interviews as outlets for their job anxieties. Although the research team took pains to probe the responses of the former group and focus those of the latter, the responses of Service Managers in *Beta* need to be interpreted in the light of this.

1.9 Summary

This study deployed a combined critical realist and sense-making conceptual framework, a comparative, explanatory, instrumental case study design and a combination of interview and observational methods of data collection and qualitative analysis.

The results are presented in the following chapters. Firstly, we offer a critical realist account of how the FLM role in healthcare, particularly that of ward sister, has been shaped, structurally and historically, by institutional developments in management more generally in the NHS. We then present, in turn, critical realist accounts of how the 'practitioner-FLM' role of Ward Sister and the FLM role of Service Manager are shaped by the organisational structure of the hospital trust and by the expectations of the role-set, followed, in turn, by sense-making accounts of how Ward Sisters and Service Managers themselves perceive, interpret and enact their role.

2 Management and first-line management in the NHS

2.1 Introduction

This section examines how first-line management in healthcare has been shaped by the wider structural context of management in the NHS more generally as it has evolved over three distinct phases: first, following the Griffiths Report (48); second, following the 1989 structural reorganisation involving the implantation of an internal or pseudo-market; and third, following the 1997 NHS 'modernisation' by the New Labour government. Two features of NHS reform are highlighted: managerialisation, which aims to organise the service using 'the principles, powers and practices of managerial co-ordination' (49) and marketisation, 'the gradual and relentless disciplining of the NHS according to the market model' (50). It then examines how changes in the conception and purpose of management generally within the NHS have resonated within the specific role of first-line management, a role which is deemed to be pivotal in implementing and monitoring organisational policy, strategy and procedures and in the delivery of front-line services (51, 52, 53, 54).

We examine the characteristics, tensions and limitations of successive models of management within the NHS and show how increased central government control in the form of greater internal and external regulation and inspection coupled with the emergence of structures imitative of private sector business and the language of enterprise, has impacted on managers' tasks, responsibilities, practices and experiences and seek to re-construct managers from 'supervisors' to 'leaders' of a flexible, high-skilled and educated workforce (55). We show how managers have been subject to the combined forces of centralisation and decentralisation, embodied in, on the one hand, performance management based on centrally-prescribed targets, characterised as 'a regime of targets and terror' (56), where managers are held accountable for achieving targets and at risk of dismissal for failing to meet them; and, on the other, 'the culture of the customer' (57, 58) where clinicians and managers alike are exhorted to be enterprising, risk taking and less rule-bound (59).

The section is structured in two parts. Firstly, we examine the role of management as it has evolved in the NHS and consider the nature and characteristics of successive organisational (re)structures and how these have impacted on the distribution of power and control over decision

making within the tripartite relationship between managers, doctors and nurses. The second part traces the implications for first-line management in general in the NHS and for the hybrid practitioner-manager, the Ward Sister (hereafter 'WS'), in particular. We consider the contradictions and tensions which result from the way in which this role encompasses professional and managerial objectives and requires both managerial and technical skills.

2.2 Management in the NHS

Tension between meeting the demand for health care as social provision and resource efficient provision in order to minimise the cost to the State has been a feature of the NHS since its inception (60). State provision of health care services sits uncomfortably in a market economy governed by a capitalist logic, where the taxation required to finance state provision is a drain on the surplus generated by private capital but where state provision is necessary for the reproduction of labour power, maintenance of social order and supply of social goods which cannot attract private capital but which enable private capital to function (58). The construction of the British Welfare State reflected this tension. In health care as elsewhere, attempts to alleviate these tensions entailed a peculiar combination of professional and bureaucratic organisation which served both to uphold a conception of institutions like the NHS as guarantors of the public good and to ensure that the public good did not come at any price (61).

What ended this arrangement were a combination of problems and changes occurring in the social, political-economic and organisational fields in the mid-1970s as contradictions in the post-war settlement became increasingly evident. A growing belief that welfare spending was an unproductive cost converged with governments' inability to manage male unemployment and with women's and ethnic minority groups' growing reaction to the second class status accorded to them in the structure of the Welfare State (62). The professions came to be seen less as upholders of the public good, more as special interest groups complicit in maintaining structural inequalities in British society to their own particular advantage (63). Professionals, previously considered to be altruistic, impartial and trust worthy (64, 63, 65) were increasingly re-presented as self-interested and wasteful of resources (66, 67). At the operational level, pressure to control public spending exacerbated the tension between professional autonomy and administrative control, precipitating a 'crisis of the organisational regime' in which the 'old welfare institutions emerged as the major battleground for the new welfare order (61:13).

The NHS received particular criticism for being an outdated, inefficient and costly institution dominated by provider monopoly, and lacking responsiveness to patients' needs (68, 53). Consequently, health care has been at the centre of government 'reform' strategies (69) seeking to reduce public expenditure, challenge producer monopoly, and expand individual consumer choice and

freedom (66) on the assumption that this will stimulate competition and value for money while improving quality (70, 71). The key instruments of reform in the NHS have been managers and markets.

Prior to the 1984 management reform, the NHS operated as a form of 'negotiated order' (72) where the organisational response to external factors was driven by discussion and compromise. In this context 'street level bureaucrats' could subvert policy implementation by arbitrary self-interested decision making (73). Nurses were key negotiators within a structure that supported doctors' clinical freedom and did not challenge their authority (74, 75), although resentment towards this order from nurses also gave rise to the 'internecine rivalries' commonly found within the hospital system (76, 77). The organisation was governed by a system of consensus management led by teams of senior medical consultants, nursing and administrative officers, combining the rule-based impartiality of bureaucracy with the technical and ethical dictates of professionalism, where all patients could expect to be treated equally according to professionally defined need rather than social status. Professionals were deemed to be integral to ensuring that state action which was the public interest and were trusted and given the discretion to act as they saw fit (61). Clinicians exercised a form of 'craft management' through networks of co-operation and negotiation which had little regard for formal organisational hierarchy (74, 78, 79). Consensus decision-making was the pragmatic solution to organising work where the tasks involved complex problems and when competing interests and sub-groups were organised around functional and professional hierarchies (80). This represented, in effect, a 'management of the stable state' (81) in which managers were often recruited from the professions and had similar attitudes and beliefs about the service. At the same time, this consensus management was criticised as 'reactionary', with an over-emphasis on 'crisis management' and 'putting out fires' (79).

In 1983, the NHS Management Inquiry team was set up by the first Thatcher government. Led by Roy Griffiths, the Managing Director of Sainsbury's, its purpose was to advise on a managerial structure that would provide greater efficiency and value for money(78). The subsequent Griffiths Report criticised the structure of the NHS as weak and lacking clear managerial authority, accountability and control. However, further restructuring was deemed unnecessary on the grounds that more could be achieved by making the existing organisation work better in practice (48). In short, the problem was seen as less one of organisational structure, more one of organisational dynamics (82). Explicit management 'roles' and individual managerial accountability were seen as key to this (83) This new 'managerialism' was presented as the neutral scientific solution to creating services in the public interest and it was seen as self-evident that better organisation would control public expenditure while increasing productivity (84, 82, 85). Hence the NHS was to be controlled by managers who would be responsible for taking decisive action: contention would replace the cosy consensus (83).

Under this new dispensation, planning and decision-making were firmly located within a *management* structure where resources were uniformly directed towards outcomes determined by unit general managers (74). The general managers' role was concerned with 'levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long-term viability of the undertaking' (48). At the same time, decentralisation of operational decision-making was proposed with all day-to-day decisions taken within the hospital. Hospitals were to be 'liberated' to manage the service as they saw fit. However, this freedom was constrained by an overarching hierarchical structure where an NHS Management Board, part of the Department of Health and Social Security, was responsible for taking key strategic and policy decisions (48) and a clear system of accountability to government via a managerial hierarchy was instated (74, 83, 86). Thus, a system where there had been little planning and even less control (82) was supplanted by a rational bureaucratic form of management where central government, as the single purchaser provider, had sole responsibility for strategic direction and remained the body to whom hospitals' managers were accountable.

Planning, implementation and control of performance was vested in the new general manager position. Below them 'functional managers', by which, in effect, the Griffiths team meant first-line managers, would report directly to the general manager and together 'they would be responsible for developing management plans, securing their implementation, monitoring and measuring outputs against clearly stated management objectives and within a tight budgetary system (48). From the outset, therefore, first-line management was constituted more as an adjunct to general management than as a distinct tier of responsibility in its own right.

Prior to this re-organisation the emphasis had always been on control over the *inputs* to the system, in particular by having the right amount of suitably qualified staff (83). Now control was focused on *outputs* - hospitals' performance measured against 'performance indicators'. These would be determined by the regional health authorities reflecting central government priorities, rather than local professional decisions of 'need' (87). Linked to this was the introduction of management budgets, later re-styled as the Resource Management Initiative (RMI). These were used as way of making doctors accountable and thus alert to the financial implications of their clinical decisions (78). Cost consciousness was encouraged by adoption of a cost improvement programme (CIP) which required hospitals to identify annual savings of a centrally-determined percentage of their budget (74). Managers were to be motivated by the introduction of annual individual performance appraisal with rewards for good performance and there was to be career development and management training courses for clinicians (48).

2.3 The balance of power between clinicians and managers

Essentially the NHS had been founded on paternalism in which the doctor knew best, rather than consumerism in which patients could exercise choice; clinical need prevailed over market demand (88). Now the message from governments was that business principles were to be favoured over administration and that professional knowledge and power should be subordinate to management objectives (56, 49, 61, 85). Following the Griffiths Report (48) a new cadre of general managers was created, expected to be change agents in this 'cultural revolution' and to challenge the dominance of the medical profession (89). A rational bureaucratic form of management, based on distrust of the professions (74, 78, 79) was imposed on an organisation where previously doctors, not managers, had controlled resources (90). Unfettered professional control was supplanted by 'commercialised professionalism' (67). Clinicians working within the organisation were expected to be team players and employ both managerial and entrepreneurial skills (91), to make the organisation 'lean and mean' (84).

However there were obvious tensions between the Griffiths model and the structures existing at operational level in the NHS at that time. Firstly, there was no guarantee that doctors were on either the NHS supervisory board or the management board, implying at least a formal reduction of power for the medical profession at strategic level. On the other hand, doctors were deemed to be the 'natural managers' whose involvement was 'critical to effective management at local level' and who needed to participate fully in decisions about priorities in the use of resources and accept that with clinical freedom went managerial responsibility. Doctors and other clinicians were made more financially accountable for their actions (92), whilst reform was focused on efficiency over other aspects of health care quality (85). However, contrary to the ethos of the management reforms, where an hierarchical managerial structure meant that managers were, effectively, agents of government (66, 86), doctors saw the role of managers as providing an infrastructure that would enabled them to exercise clinical freedom and maintain their control over the clinical division of labour and the organisation of service delivery (74, 84).

Secondly, while Griffiths envisaged a single individual accountable for organisational performance and to whom all others would be accountable, the professionals, doctors in particular, remained legally and professionally accountable to their regulating bodies for their clinical practice. Indeed, it was not until the election of the Labour Government in 1997 that hospital chief executives became accountable for the *quality* of *clinical care* provided by their respective organisations (93). Rather, clinicians worked with individual patients whilst managers were concerned with managing resources across the whole system (90). Hence the conflict between managers and clinicians reflected a conflict between occupational and organisational goals and between the needs of individual patients and the needs of the population as a whole (94, 95). This

created tensions for managers who had accountability for a budget but no control over spending related to decisions about individual patient care. At the same time, the medical profession's responsibility for health care rationing, as part of its wider relationship with the state, suited both parties in that it provided a sheltered market for the occupation, kept rationing decisions covert and enabled politicians to stay out of an area that could be politically problematic (96).

Thirdly, the desire to ensure that the professional functions are effectively geared into the overall objectives and responsibilities of the 'general management process' (48) indicated that organisational priorities, primarily for efficiency, were to take precedence over occupational concerns for clinical effectiveness. High reliability and adaptability, a characteristic of public administrative values (84) embodied in *Primum non nocere* (First, 'do no harm'), required an organisational structure that facilitated integration between the interdependent parts of the system, information sharing, honesty with regard to error and minimal hierarchy (84, 97). A system of accountability based on measurable outputs was likely to be inappropriate for a service composed of professional work that is non-measurable and non-visible in situations of ambiguity or uncertainty (84). Nonetheless, a system of hierarchical management roles and responsibilities, roughly modelled on private sector management; explicit performance indicators linked to outputs; and emphasis on resource efficiency (84), gave managers a clear role in a complex, professionally-dominated service (56).

It soon became apparent, however, that the new general managers were failing to make headway against medical dominance. They were on short term contracts with individual performance reviews linked to performance related pay and, consequently, were focussed on reacting to short term political objectives rather than challenging the status quo (92, 98, 79). In response to critical media reports about underfunding and surgical cancellations, another NHS review was announced in 1988 (87).

2.4 The internal market in healthcare

The result of this review, 'Working for Patients' (99), signalled a radical restructuring of the NHS with the introduction of an internal market designed to subject the NHS to market principles of competition which, it was argued, would improve efficiency and '…make the NHS more consumer conscious.' (49). Central to this was a purchaser-provider split where hospitals acted as providers and fundholding General Practitioners and District Health Authorities would act as purchasers on behalf of patients, with the 'money following the patient'. As providers, hospitals were expected to compete with other providers for contracts, receiving payment for a basic level of activity but higher rates of payment for additional activity (66). This system flowed from the political assumption that competition between providers would increase efficiency, stimulate greater productivity and lower costs (66, 92). The role of managers in all this was to

coordinate the market by agreeing contracts and costs for patients' treatment and maximise the use of public resources. Contractual relationships replaced professional discretion and trust (100). A system of contracts, business plans and performance monitoring elevated the operational significance of managers, but not necessarily their power, since they still had to gain the cooperation of clinicians to fulfill contract specifications (74, 101, 66). To encourage this cooperation, consultants were given more detailed job descriptions and alterations to their distinction awards to include evidence of commitment to managerial objectives (79).

Hence the motivational system was a combination of autonomy from central control and financial rewards: efficient hospitals could choose to become 'self-governing' NHS trusts, remaining within the NHS but independent of the DHA, with their own board of directors and more control over their affairs. Consultants' contracts held by the regional health authorities were transferred to self-governing trust hospitals, making consultants directly accountable to hospital managers with the freedom to employ staff on local pay and conditions (99), shifting power from national collective bargaining to local managers (66). The new trust hospitals were free to expand their services and generate income, for example by providing specialist services for patients living outside the hospital's catchment area. Financial surpluses could be retained by the hospital and used to improve services and facilities for staff (49, 66). Although in theory market competition would result in closure of inefficient hospitals, in practice, government intervention ensured this did not happen; hospitals were not free to fail (102).

Hospitals began to develop new organisational structures, the most prevalent of which was the clinical directorate structure (103). Previously, for administrative purposes, hospitals were unitary entities; the new structure created intra-hospital business units based on medical specialties. Each clinical directorate had a tripartite structure comprising a doctor, nurse and manager, in theory, working together to develop and manage the service. However, clinical directors were invariably doctors. While this increased some doctors' involvement in, and responsibility for, corporate interests, the structure also served to maintain the dominance of the medical profession. Clinical directors with both clinical and managerial expertise could develop a power base (104) since this boundary-spanning role was unavailable to managers unfamiliar with clinical work (98). This created a new jurisdiction of 'medical-management' exclusive to those with a medical degree (98, 105).

The purchaser-provider split set the context for fragmentation of the NHS and the creation of a competitive environment which undermined cooperation between professionals (58). As self-governing NHS trusts, hospitals were at liberty to develop their own distinctive corporate identities. Staff were expected to participate in management development courses and encouraged to think of their role as employees of a particular trust rather than NHS employees within a unitary organisation (106). It was assumed that inculcating employees in certain

key beliefs would condition them to act in accordance with the interests of the organisation (87, 107) – an attempted exercise of the 'third dimension of power' (109) or 'manipulated consensus' (108:49) whereby dissent is neutralised because employees are unable to envisage a different order (106, 108). Evidence, however, indicated that clinicians were cynical about managerial claims, attempted to resist such normative controland aligned themselves more to their profession and the NHS rather than to specific organisations (108, 110).

Rather than the market replacing the managerial hierarchy introduced by the Griffiths reforms, market elements were introduced alongside the management hierarchy as a form of 'hands-off control' (58). Self-governing hospitals composed of semi-autonomous specialty business units were incorporated in an already decentralised professional organisation. At board level, a new hybrid culture emerged, incorporating aspects of both private sector management and public administration. However, it was unclear what the effect this internal market structure had on managers, sandwiched between doctors' expertise and clinical authority and government strategic control (111) except that they were accountable for ends but powerless over the means to achieve them. General Managers came to be seen as government agents imposing resource constraints (66, 86) and not to be trusted because they did not understand clinical issues and were not concerned about the quality of care (98). An organisation imbued with this kind of conflict, tribalism and low trust on the front line was scarcely likely to produce the cultural revolution that the government desired.

2.5 Post-1997 'modernisation' under New Labour

In opposition, New Labour claimed that it would end the internal market but on coming to office, the new government, expressing its faith in the medical profession, disavowed any need for more structural re-organisation and it became apparent that the market structure would be kept, with only the language changing: strategic health authorities would 'commission' rather than 'purchase' health care (112). Indeed, New Labour's initial years in office were relatively uneventful until the extent of pressure on accident and emergency (A&E) departments came to the media's attention and increasingly vocal criticisms were made about standards of care (113). The 'NHS winter crisis' (114), described as 'now a near annual event' (115) acted as a catalyst for the development and implementation of the NHS Plan (53), a ten year programme for the process of 'modernisation' linked to a Prime Ministerial pledged to raise NHS spending to the EU average over six years (116). However, in return for investment, the government expected 'reform' and 'modernisation' (53), involving a combination of partnership and competition.

The approach entailed a shift in the balance of power, moving from a system of hierarchic control to one where there was 'greater authority and decision-making power to patients and frontline staff'. Budgetary responsibility and decision-

making was to be delegated to frontline clinical teams, including those who were, in effect, becoming first-line managers. WSs were given delegated responsibilities for ward staffing budgets and expected to 'walk the job with a strong focus on clinical quality' (117:4). Delivery of targets was to be achieved as a by-product of wider improvements in service quality (117) and the government would reward those NHS trusts that met the performance standards through a system of 'earned autonomy' where they would be granted more freedom to run their own affairs (53). Later policy enabled well-performing trusts to apply to become NHS Foundation Trusts (118). No longer directly accountable to the Secretary of State for Health, they would be accountable to their local community and to an independent regulator known as Monitor and would have greater autonomy to decide local priorities and manage their finances (118).

Autonomy came at the price of an obligation to perform. Only those hospitals that met the growing number of centrally dictated performance framework standards and targets were permitted more control (119) and the Department of Health would 'intervene more rapidly' in respect of underperforming trusts (53:11). Indeed, rather than giving managers greater freedom to manage, more central direction was created within the structure with additions to national performance standards and by the formation of a range of regulatory bodies, such as the Commission for Health Improvement, to whom NHS organisations were accountable (93). National standards for clinical care, National Service Frameworks, were introduced and all organisations were expected to carry out annual patient satisfaction surveys using the same predetermined questions. Further, a range of human resource management policies, such as Improving Working Lives (53) and Agenda for Change (18), were produced by the Department of Health and organisations were expected to comply with these in a specified time period. Compliance against national performance measures was assessed by an 'annual health check' which required NHS trusts to report performance against a number of core and developmental standards over a range of domains including safety, clinical and cost effectiveness and governance (120). Hospitals were then 'star rated' on their performance, ranging from three stars for those with the highest level of performance to no stars for trusts with the poorest levels of performance (121).

Senior managers, whose working lives had been described as 'chronically insecure' even before this period (122), were now threatened with forced removal from their posts if their organisations were judged to be 'poor performers' on the government's performance assessment framework (123). Thus simultaneously with espousing managerial freedom and autonomy to respond to local needs, the government maintained tight de facto central control.

As NHS reform appeared to be progressing rather slowly, the government increasingly took recourse to market forms of control (123): financial flows were altered to a system known as 'payment by results' (124) where hospitals were paid for the work done on an individual patient basis rather than the previous

block contract agreement (125). This would give NHS organisations 'greater freedom' (124:7) but in addition there would be expansion of the role of the private sector within the NHS with the introduction of Independent Sector Treatment Centres to provide day surgery and carry out diagnostic procedures (126). A greater plurality and diversity of providers, combined with 'patient choice' enabling patients to choose to have their treatment anywhere in the country, rather than at their local hospital, would stimulate competition between trusts. Since this would have adverse financial consequences for those trusts perceived to be poor performers it was assumed that this would stimulate more efficiency and responsiveness (127).

While the performance management framework may have given managers a clear raison d'etre – to 'manage performance' - it also put considerable pressure on them (123) with politicians' priorities dictating the concerns of managers (128). Instead of 'freeing' managers to be more risk-taking and entrepreneurial, the reward system of 'best to best budgetary allocations' for performance against targets and the naming and shaming of poorly performing organisations engendered risk aversion and 'gaming' because of fear of failure (35, 56). Gaming included inattention to services that were not part of the targets, manipulation of waiting list and waiting times and prioritisation of targets over patients' clinical needs (129). Thus, the unintended consequences of the system were that what was not measured ceased to matter, unacceptable workloads were placed on staff and patients' safety became compromised (97, 56, 130).

At the front line, this gradual replacement of professional values with managerial ones generated tensions between managers and clinicians (131, 132). This, in turn, led to disrespect of, and lack of credibility for, managers among clinicians (77), to the extent that they were described as 'hostile to patient care' (133) and derided as 'office boys' who were intellectually inferior to clinicians (98). Further, whilst managers now had greater ability to control front-line staff (131), an increasing proportion of their time was spent on the collation of data required to show compliance with targets, thus diverting their attention from human resource and change management (128). The outcome was more time and resources devoted to management decision-making, greater delegation of routine management tasks to first-line managers and more managerial work for hybrid practitioner-managers (131). Indeed, the effectiveness of managerialisation may have been inversely proportional to the resources spent on it (131). Rather than being the solution to the problem of entrenched occupational monopoly and self-interest, managers were increasingly constructed as part of the problem (123, 134) and engaged in their own professional project (135). The idea that the NHS was, consequently 'over-managed' took hold and has only recently been questioned (136).

2.6 The role of the first-line manager

As the foregoing account has suggested, the growth of management in general in the NHS has ramified into the creation of more formalised systems of *first-line* management. The roles forming part of this system have received variable attention from researchers. Whilst hybrid practitioner-managers, such as WSs, have been the subject of a number of research studies, generalist first-line managers in the NHS have not. Nevertheless, it is reasonable to assume that first-line managers in the NHS have not been immune to developments in first-line management taking place elsewhere.

Traditionally, the role of the first-line manager – defined as those positions, regardless of specific job title, representing the first level of management to whom non-managerial employees report – centred on the immediate and proximal supervision of a bounded organisational operational sub-unit/work group and entailed responsibility for the key functions of 'keeping production going' (137) and 'translating paper plans into operational reality' (138), functions usually undertaken in circumstances of considerable ambiguity. This role, in turn, subsumed a number of specific tasks relating to the day-to-day supervision, monitoring and reporting of operational activities (139).

Recently, many have argued that, in the less hierarchical, more decentralised and flexible networked organisations that have evolved in response to the environmental 'turbulence' created by greater competition and more demands from a wider diversity of stakeholders, the traditional 'supervisory' role of the FLM has been superseded by two new forms. Firstly, with the spread of self-managing teams, and a transfer of responsibility for day-to-day planning and monitoring of work operations from managers to team members, FLMs have either disappeared or lost their supervisory function, acquiring in its place the residual function of building, facilitating, co-ordinating, communicating with, mentoring, coaching and leading teams that otherwise supervise themselves. Secondly, it is maintained that instead of, or as well as, *losing* routine supervisory functions *downwards* to work teams, FLMs are *acquiring* broader managerial functions *from above.* As the result of devolution of managerial responsibility as part of market-driven decentralisation to smaller business units, FLMs have acquired erstwhile middle management functions and become 'mini-general managers' of an area of work designated as a cost- or profit-centre. The role of the FLM becomes one of detached administration of a unit, focused on deploying resources prospectively to facilitate, and controls retrospectively to monitor, performance, with commensurate authority over budgeting and staffing decisions and accountability for business performance. The tasks of the FLM consequently focus on aligning operations with wider business objectives; managing budgets and controlling costs; recruiting, appraising and training staff; and monitoring quality standards (For a review of these accounts, see 2).

Set against this, however, has been a series of empirical studies (140, 141, 142, 143, 144, 145, 146, 147, 148, 149) which have painted a picture of resilience

and continuity in the supervisory character of the FLM role and confirmed Delbridge and Lowe's conclusion that 'the death of the supervisor has been greatly exaggerated' (144: 423). Specifically, they show that whilst there may have been aspirations or limited attempts to shift the FLM role into something more discernibly 'managerial', such attempts have been so piecemeal and compromised that, in practice, the role retains the responsibilities and problematic authority usually associated with the supervisor (For a fuller review, see 2).

A study which sought to shed some empirical light on this debate (1, 2), based on an in-depth survey of 135 UK organisations on how the role of FLM was defined and how it had changed, showed that the role exhibited both stability and change. A common supervisory core, framed by responsibility for monitoring and improving performance, was surrounded by a penumbra of additional managerial responsibilities relating to stewardship, translating strategy into operations, unit management and, exceptionally, business management. The FLM role remained part of an hierarchical system of individual managerial responsibility and vertical accountability, with narrow spans of control, contacts which were primarily vertical and internal and a level of authority, participation in decisions and accountability confined largely to operating routines. Changes to the FLM role had been as much towards a strengthening of the supervisory core as a broadening into business management responsibilities. The persistence and prevalence of the supervisory core stemmed from the continued location of FLMs within systems of external, hierarchical supervision and, far from being weakened, the supervisory core of the FLM role had often been strengthened by the adoption of more stringent controls over work practice in order to handle a growth in operational activity or comply with more external regulation. In some cases, however, a re-division of managerial labour had led to formerly middle management responsibilities being shifted 'down the line' (34) and added to the supervisory core to produce an expanded FLM role. In many service organisations in the study, including those in the health sector, this downward shift of managerial responsibilities had been to professionals who, by virtue of their seniority within a professional work group, had acquired, often reluctantly and without appropriate training, supervisory, HR and budgetary management responsibilities on top of their professional work. These hybrid 'practitioner-managers' found the obligation to reconcile their professional work and values with their newly acquired managerial tasks challenging, a challenge which prompted elaborate strategies of sense-making and identity-construction (5). One such practitioner-manager is the WS.

2.7 The Ward Sister as practitioner-manager

Ward Sistersare professionally accountable for standards, co-ordination and delivery of care (150) and have a pivotal role in decisions affecting the

implementation of governmental and organisational policy. The direct relationship they have with patients means that WSs, unlike more senior managers, witness the consequences, and are required to manage the realities of competing policy objectives and may be blamed when things go wrong (151). In this section we take an historical perspective on management in nursing and the role of the WS, examine how this role has been defined and redefined in line with organisational changes in the NHS and point up the resulting tensions to which WSs have become subject. In short, we examine the structural conditions which have shaped the WS role as it is today.

2.8 What do Ward Sisters do?

Management has always been an integral part of nursing with the best nurse considered to be the natural manager (152). Historically, WSs were responsible for discrete clinical areas and a matron had overall responsibility for nurses and nursing. Thus WSs had a central role in creating and maintaining the culture of the ward by setting the tone for interpersonal communications between the nursing team, patients and other staff (153, 154, 155, 156, 157). The ward was a microcosm of the entire hospital; not only was the WS considered to be wholly responsible for what occurred within its walls (158) but was also the link between a discrete ward area and the wider organisation (159, 160). The WS was assumed to have an administrative, educational and clinical coordinator role, responsible for allocating tasks to staff nurses and others, prescribing the nursing care to be given to individual patients and monitoring and supervising the work done by nurses and other ward staff including doctors and domestics (159). As clinical expert (161, 162) the WS determined the work to be done and how nurses were organized to provide a particular standard of practice (154, 157). They were also supposed to have a key role in providing supervision and practical education for students and junior nurses (153, 154, 156) but an early job analysis (163) found that the WS's day was equally divided between administrative work and nursing tasks but with little time spent on teaching junior nurses.

As early as the 1950s it became clear that demand for the NHS would run in excess of allocated resources and improved managerial control of staff was considered to be a method of generating efficiency (164). The Salmon Committee set up in 1963 sought 'to advise on the senior nursing staff structure in the hospital service (Ward Sister and above), the administrative functions of the respective grades and the methods of preparing staff to occupy them' (165). The Committee's report was extremely critical of nursing's management capacity while emphasising the importance of the managerial over the clinical component of nursing work (152). The report stated that WSs were unable to make managerial decisions owing to lack of preparation or suitability for administration work. A new nursing hierarchy was proposed which gave nurses responsibility for

nursing matters only. An unintended consequence of this was that it gave nurses the opportunity to construct a nursing hierarchy that ensured nurses were not managed by a non-nurse (96). However, this structure only survived until the Griffiths (48) reforms were implemented. When the new cadre of general managers was introduced, fewer than ten percent of these posts went to nurses, entailing a significant loss of professional power for the occupation since general managers had authority to reform organisational structures. Organisational restructuring also brought removal of the middle management nursing officer grade, a flattening of the nursing hierarchy and, as a consequence, nurses lost the right to be managed solely by other nurses (96, 166). This signalled a process of ongoing change to the role of the WS as factors both internal and external to the profession converged to make the role more uncertain and ambiguous while increasing the demands placed upon it.

2.9 Organisational change and the 'new' ward manager

As part of the substantive and linguistic managerialisation taking place within the NHS, WSs were reconstructed as 'ward managers' (167). Commensurate with this, responsibility for ward budgets; human resource management, including staff recruitment, performance appraisals and sickness and absence management; management of complaints; and monitoring and audit of care quality standards were all devolved to ward managers (166, 168, 169, 170), who were expected to spend more of their time managing and developing their staff than providing direct patient care (167).

Now formally responsible for their ward twenty-four hours a day, ward managers were expected to remain on the ward or alter their own rota if there were staffing shortages and until the situation was resolved (162). This expectation had historical precedent with Nightingale's heavy emphasis on 'duty' and the expectation that the WS was on call for patients day and night. Staff shortages and government policies aimed at improving working lives (53) resulted in nurses being offered working time flexibility. This has increased the pressure on WSs with some compromising their own work life balance to ensure adequate staffing of difficult-to-fill shifts (171).

At the same time as the managerially-imposed removal of the nursing officer grade and flattening of the nursing hierarchy was increasing the WSs' managerial role, changes imposed by the occupation were affecting the WSs' clinical function and hierarchical authority. 'New' nursing (172) or 'primary' nursing (161), a mixed bag of ideas introduced by leaders within the occupation and given government support by the concept termed 'Named Nursing' in the Patient's Charter (173), was designed to increase the status of nursing (172, 174). At the front line it involved re-organisation of work to support one-to-one relationships between staff nurses and patients with a named nurse being responsible for each individual patient's care. The WSs' 'new' clinical role became one of coach,

professional adviser and facilitator of autonomous nursing teams (170, 175). This decentralisation of clinical control to 'named nurses' left some WSs feeling insecure, devalued and redundant (175).

In effect, WSs became first-line, or hybrid practitioner-managers (84) with the managerial element of the role expanded beyond hands-on management of clinical tasks to include formerly middle management functions (176, 166, 169). Yet, WSs were still counted in the clinical staffing resource for their respective wards, creating the potential for conflict between the reactive needs of a clinical environment and the more strategic demands of their managerial functions (157, 177). This created tensions in that increasing managerial responsibilities reduced WSs' time for clinical work and WSs were expected to be clinical experts although they did not practise regularly. Further, WSs had always been motivated to manage their wards more by a passion for nursing than an aspiration or desire to be 'a manager' (178) and this stems from their commitment to an*occupational*, rather than an organisational, identity (110, 178). One way of resolving this tension was to select and manipulate the administrative aspects of their role so that they align more closely with their professional interests; in short, subordinating administration to clinical concerns (110, 98). While the clinical aspects of their role were compromised the managerial functions were unclear (179). As 'ward managers', they had little real autonomy over their budgets nor were they involved in any negotiations about how they were set (180).

All these tensions were consequential in that the effectiveness of practitioner-managers is predicated on their ability to be credible in both their professional and managerial roles (69). The change to their role meant that WSs/ward managers lost their clinical credibility without gaining status as managers (157). Ward managers had reached their managerial position by virtue of their clinical competence not their managerial knowledge and skills (181, 182). Yet, in common with many professionals who find themselves in managerial roles, WSs had not all had the appropriate education and training to perform their managerial role competently and confidently (2, 183). All this meant that the WS role was beset by status ambiguities and conflict (2, 178). They had become supervisors without the power or authority to manage resources (178, 179) and having been recruited from within the ranks of the workforce rather than directly as managers and without managerial qualifications (159, 168, 178).

Following the election of New Labour, the National Nursing Strategy (4) reverted back to the traditional WS/Charge Nurse title. WSs, previously undervalued and lacking the recognition they deserved (4) were to have a pivotal role in delivering efficient, high quality health care. The leadership provided by WSs was seen as crucial for the provision of efficient and effective care and '…to prevent lapses in….fundamental and essential aspects of care' (4, 150). If WSs were to be professionally accountable for standards of nursing care and co-ordination of care delivery, it was essential that they were supported by organisational structures and arrangements that gave them the authority to do this effectively (150).

Despite this rhetoric, broader workforce developments in the form of the creation of new roles and strengthening of existing ones combined to further reduce WSs authority to manage their wards, adding to role conflict and uncertainty. A new Modern Matron role with clear authority at ward level (150), was introduced, which overlapped with WSs' responsibilities. With increasing financial pressures, Modern Matrons not only took over authority for *management* decisions made about staffing levels but often did so without consulting the relevant WS (184). Thus the taller nursing hierarchy had the unintended consequence of weakening the WSs' position (178). In addition, urgency to meet access targets in some trusts resulted in bed managers acquiring the authority to override the WSs' *clinical* priorities in order to meet performance targets (184). There has also been an expansion of specialist nurse posts (185), creating an alternative clinical career pathway for nurses and serving to break down aspects of the *clinical* hierarchy of task allocation, in particular between doctors and nurses. Whilst this may have led to greater satisfaction for the specialist workforce and enhanced the status of nursing as an occupation (186, 187, 188), it may also have undermined further the 'expert practitioner' component of the WSs' job. WSs had been regarded by other clinicians as clinical experts (189). However, certainly in acute care, this became more an aspiration than a reality, since expert supervision of clinical practice was increasingly undertaken outside the line management structure (190, 191).

In all this, the WSs' historic professional identity of 'nurturing mother' (192), with an emphasis on caring and concern for patients and colleagues, was being challenged by a competing management logic of rational efficiency, yet at the same time, it also limited their capacity to meet the expectation to act as leaders of self-directed teams charged with acting in more 'enterprising' ways (192). Embracing their role as 'manager' undermined WSs' professional identity. All this served to de-stabilise WSs' interpretations of their professional and personal identity (177) and a number of studies indicate that the tensions and contradictions in balancing clinical and managerial demands have resulted in WSs experiencing stress and job dissatisfaction (184, 182) to the extent that some feel that their job has become 'almost impossible' (178:5).

2.10 Conclusions

As demand for health care threatened to consume an increasing proportion of GDP, greater management control combined with private sector type marketisation was seen by successive governments as the solution to the intractable problems of balancing health care supply and demand and challenging the medical profession's hegemony, self-interest and intransigence that were seen as blocking modernisation. In short, NHS management reforms have been designed with the aim of controlling public expenditure, challenging producer monopoly and expanding individual consumer choice (66) on the assumption that

these would stimulate competition and value for money while improving quality (70, 71) and in this, managers and markets have been central.

The role of management has been, variously, to plan and control resource allocation, monitor and manage performance against centrally-determined targets and standards, co-ordinate and monitor systems of internal contracts and thus set the business framework in which clinical decisions and practices are undertaken. Managers and managerial values have been set as counter-weights to clinicians and clinical professional values. However, in practice, NHS managers have had neither the freedom nor authority to deliver on these responsibilities.

The impact of burgeoning but problematic managerialism on first-line management roles in the NHS has been two-fold. On the one hand, a rag-bag of de facto first-line manager positions has been created, largely as adjuncts to general managers, with diffuse and ad hoc responsibility for assisting with the overall process of planning, monitoring and measuring performance against, targets and budgets. On the other hand, clinical leaders, notably Ward Sisters, have acquired greater managerial responsibilities relating to staffing/HRM and performance management in addition to their clinical responsibilities.

In the remainder of this report, we examine in detail the way in which these two first-line management roles set up in this way are defined, perceived and enacted in practice in two hospital trusts.

3 How the Ward Sister role is defined, interpreted and enacted

3.1 How the Ward Sister role is defined

Here, we consider how the Ward Sister role is shaped by a combination of first, its structural location within the immediate context of the two hospital trusts and the wider context of the NHS and, second, the specific expectations of those with whom WSs work and interact, their role set. The findings derive from a number of data sources: firstly, formal documents such as job descriptions and organisation charts; secondly, depth interviews with members of the WSs role-set in the two hospital trusts; thirdly, work shadowing of WSs in the two trusts; and, fourthly, observation of a series of Training Days ('Study Days') for WSs at *Beta*.

Three broad components of the role are identified: those relating to nursing and clinical work per se ('The pure professional role'); those relating to clinical leadership and ward management ('Management within the clinical role') and those relating to organisational management ('Management beyond the clinical role'), each subsuming specific tasks and responsibilities. The tensions both between the expectations of different members of the WSs' role-set and between the different tasks and responsibilities which WSs are expected to undertake are highlighted, showing how the WS role is a contested terrain over which the conflict between a clinical/nursing perspective and a managerial one is being played out.

3.2 Dimensions of the Ward Sister role

3.2.1 The 'pure' professional – nursing and clinical work

In section 2, we showed how the role of WS has been increasingly constituted, by successive management initiatives within the NHS, as a first-line management role, with organisationally-driven managerial tasks and responsibilities focused on efficiency, added to the WS's traditional role as senior nurse concerned primarily with direct involvement in patient care and leadership of more junior nurses. In this process, however, the nursing component of the WS role has been supplemented, not supplanted: nursing care remains central to the WS role as it is constituted. These 'pure' professional duties of nursing work are hands-on, personal and performed in real-time in the ward environment; are informed by professional training and experience; are performed in accordance with

professional norms; and are driven by the immediate needs of patients. Although the WS has become more of a practitioner-*manager*, they are still seen primarily as a nurse, required to be registered with the MNC and having accumulated some years of post-registration experience

Expectations of the WS qua nurse subsume a number of different but interlinked elements, considered, in turn, below. However, the role is recognised as being more than simply the sum of its parts:

> there's thousands of things really which she should be doing ... you know what they move forward, it all forms a circle (Matron1, *Beta*)

> [the WS must] be all things to a lot of people (Associate Director, *Alpha*)

3.2.1.1 Doing their 'fair share' of everyday nursing work

WSs are expected to take their 'fair share' of the nursing workload as a 'member of the nursing team'. For nurses, actively 'caring' remains at the core of the WS role, with other activities deemed less important. Indeed, some staff nurses feel that 'non-nursing' managerial tasks could be used by WSs to avoid hands-on nursing responsibility:

> Some sisters disappear and the nurses can't understand it. This leaves them feeling resentful that the WS is not doing anything. (Staff Nurse 1, *Alpha*)

Deputy Sisters are more understanding of the range of non-clinical activities for which WSs are responsible but emphasise the importance of prioritising clinical work:

> ...so you don't actually just see them doing their managerial role which is important but they also do ward work as well, the practical day to day things as well when they have the time to do so (Deputy Sister, *Alpha*)

3.2.1.2 Having clinical credibility

Nursing work is driven by the number and healthcare needs of patients on the ward. Most wards or units are organised around a specialism (e.g. paediatrics) or healthcare pathway (e.g. A&E) and WSs are expected to have clinical credibility within that area, not only in terms of general nursing expertise and experience but also through specialist training:

> My primary expectation would be that they [are] an expert in the clinical field that they're working in, so they'd be able to offer advice and guide junior staff in safe and appropriate care (Deputy Chief Nurse, *Beta*)

However, there is disagreement over how *expert* the WS should be. Some Deputy Sisters, for example, feel that there are few differences between the clinical skills of the WS and other nurses:

> She's got no further responsibilities clinically than myself or my colleagues. Clinically, I can't see any difference whatsoever (Deputy Sister, *Alpha*).

Others consider that, because of their additional management responsibilities, WSs are *less* able than other nurses to keep up with clinical competencies and developments and are in many ways just another member of the team:

> She's like a colleague [rather than my manager] because as sisters we very rarely work together because we work on different shifts to cover (Deputy Sister, *Alpha*)

> I don't see her as a clinical expert, more of a manager. I would go to other people for advice. (Staff Nurse 1, *Alpha*)

Some suggest that if WSs are left behind clinically because of their managerial duties, this contrasts unfavourably with specialist nurses who can develop their skills further and become recognised clinical specialists:

> I think that people are very keen to be specialist nurses, because they see that as being able to develop their own specialism - still have some clinical input, still have some management of patients input - but maybe not have the bits that are quite onerous for the WS (Deputy Head of Nursing, *Alpha*)

However, there is agreement that the best WSs are sufficiently strong clinically to be able to take control of difficult clinical situations:

> .....part of being a good WS is actually having that increased knowledge, the skills to enable you to care for the sicker patient that happens to be out there now, so you can't just sit back and think, "Ah I've done my registration, I don't need to do any more", I think you do both clinically and managerially. (University Tutor 2, *Alpha*)

3.2.1.3 Part of nursing establishment or supernumerary?

Potential conflict between the WS's clinical responsibilities and managerial duties surfaces in the way that they are expected to maximize their clinical time as much as possible, despite the tensions that this creates:

> whatever they're doing in terms of the managerial side, then they would have to go and do some clinical time. ... if they're having to then do extra clinical sessions, well they're not going to be able to devote their time to

> training their staff and do the appraisals and all the usual things. (Head of Ambulance, *Beta*)
>
> I don't want them to sit away in the office, nobody can ever see them, the WS needs to be like the Matron: highly visible. (Matron 1, *Beta*)

Nurses acknowledge the demands on the WS from being both clinician and manager but have a strong expectation that whatever the WS is doing they should always be clinically available:

> ...she's down in the office, but she's a resource ... as she's walked past I can say, "can you check some drugs?" she's always still clinical even if she's in her managerial role. (DeputySister, *Alpha*)

This tension is expressed in divergent views about whether the WS should be considered supernumerary or part of the nursing establishment. The employment agreement for most WSs in *Beta* and *Alpha* is that they have one (or sometimes two) 'management shifts' a week when they can focus on non-clinical tasks while the rest of the time they are part of the nursing establishment with assigned patients. However, the two trusts are investigating the option of WSs becoming supernumerary at all times. At *Alpha* they have conducted a research study into the feasibility of this and a trial across several wards:

> I think one management [shift] is enough when you work properly because ... there's her junior staff like the band sixes, the Deputy Sisters, so really and truly as a good WS you should just delegate ... she shouldn't do twenty appraisals, maybe she should do four of them and delegate the rest down, otherwise you get overworked. (Matron2, *Beta*)

Some senior nurses think that becoming supernumerary allows the WS to have a better overview of clinical needs and planning but others feel that as long as WSs are included in the nursing establishment, they will marginalise the managerial side of their work because immediate clinical demands always take priority:

> [if things are too busy] you may not do equipment, staff interviews, financial costs, so how much we've overspent, how much we've overspend on pharmacy in one of those things that would pile up ... because it's not an emergency need (Deputy Sister, *Alpha*)

3.2.1.4 Providing care advice on the ward

WSs are expected to help and advice other health care professionals, including junior doctors, allied health professionals and health care assistants. The clinical routines and procedures of nursing care are seen as instructive and educational for the work of other health care professionals, particularly junior doctors. By reassuring them that they are doing the right thing or by demonstrating

particular procedures, such as taking blood, the WS is an integral part of their clinical development:

> If they've just come straight out of medical school they need to learn from somebody and you know, the doctors, the senior doctors themselves don't always see them so they would learn from us (Deputy Sister, *Alpha*)

> working with doctors, very important because the doctors you have on the ward tend to [be] quite junior so they need support...and the Ward Manager tends to be the fount of all knowledge (Associate Director, *Alpha*)

3.2.2 Management and leadership within the clinical role

Some managerial responsibilities have always arisen, organically, from the nature of nursing work itself and the working 'environment' of nursing care. The ward is seen as a place where WSs must 'construct' the conditions for the work of others, by a combination of role performance, supervising and ensuring standards, leadership behaviour, mentoring and teaching. Here the WS emerges from being another member of the nursing team to being the nurse 'in charge'.

Nurses see the 'ward environment', as shaped by WS, as a key determinant of how they experience their work:

> I am more relaxed when the WS is on the ward [because] they have experience. The nearer you are to qualifying the more you feel that. (Staff Nurse 1, *Alpha*)

> it's their domain if you like, so they'll usually have a lot of knowledge about what's going on with the patient [and] they know the nurses (Associate Director, *Alpha*)

The boundaries of the ward also delimit the jurisdiction of WS authority, which non-clinical groups must, firstly, acknowledge, and secondly, tread carefully within. This is particularly the case for non-clinical managers and support staff:

> you have to be really careful that you go [onto the ward] and you don't say, "Right, OK, do this, do that and do the other" and "that's not how I do it"... but there are times when I will make suggestions and there will be times when I push (PALS Manager, *Beta*)

However, the boundaries of the ward environment also create uncertainties in expectations of the WS role. The ward is seen as a discrete, special and complex domain about which others feel relatively ignorant; what the WS does within their ward remains opaque to them:

> inpatient care, you know, here ... isn't something that I get hugely, hugely involved with, of course I know how wards work because I've been in the NHS a long time, but to be honest I'm far removed from the trappings of

> how things run on a day to day you know …. … [I have not] thought about the Ward Manager role for a very long time (Associate Director, *Alpha*)

3.2.3 Supervising nursing work

A core expectation is that WSs directly supervise nursing work on the ward by overseeing junior staff and giving particularly close attention to the work of student nurses, health care assistants and bank nurses. This supervisory role is sometimes cast as 'coaching':

> encouraging people to make sure that they have done observations or done checks as they should have done...make sure that other people are picking up (Deputy Chief Nurse, *Beta*)

> I think there's coaching so I would say as a Sister that's probably their main role in supporting healthcare assistants and their ... nurses to do their job well [as] a guide and support, ensure that the clinical side is done well. (Head of Ambulance, *Beta*)

However, being the nurse 'in charge', and therefore having constantly to supervise all activity on the ward, is seen by nurses as an unattractive part of the role:

> some people don't want the hassle, because you are the end person who has to say, "why didn't that order get done?" ... people who've been here longer than me but haven't gone for [the Senior Sister role] ... I think they see it as a hassle (Deputy Sister, *Alpha*)

3.2.3.1 Being a leader and role model

WSs are often described as 'role models' for other nurses in that their own 'role performance' constitutes one of the main elements of clinical leadership. They are expected to have acquired this over time from the training and on-the-job support received from earlier role models:

> the majority [of Sisters] cope very well because they have been in that unit for a period of time, and they've – they have role models – they've known, they've looked and seen, "Ah that's a good role model, that one isn't" and so they will have picked up themselves which way they want to go. (University Tutor 1, *Alpha*)

However, WSs are also expected to develop their own 'style' of leadership to suit the demands of their ward, on the grounds that no one style is the most effective. The personalised nature of clinical leadership through leading-by-example is emphasised:

> A lot of all of this depends on what type of person the Ward Manager is and what their leadership style is and how they choose to approach it, you know, some people are very good at delegating and saying, "I'm not doing that and I'm going to sit here and let everybody lead" other people are quite controlling in how they approach it and they want to do it themselves, so it depends where on the leadership sort-of-spectrum you are really (Associate Director, *Alpha*)

3.2.3.2 Gatekeeper to the nursing profession

WSs are expected, especially by those in nurse education, to be gatekeepers to the nursing profession, since they are in a position to judge the practical competence of student nurses on a day-to-day basis:

> She is responsible for those people that are entering into the nursing profession ... that's not my responsibility, that would be very much her responsibility. (University Tutor 2, *Alpha*)

They are expected, therefore, to work in 'partnership' with outside stakeholders such as a university:

> Working in partnership would include things like recruiting of students... it may well also be that they're doing involved with some teaching either in clinical skills within clinical practice or coming here and teaching ... (University Tutor 2, *Alpha*)

3.2.3.3 Supporting student progress

The gatekeeper role links into teaching and mentoring student nurses within the ward environment as they undertake their training. WSs are responsible both for progression of student nurses and safety of the wards during the training period. Since they cannot closely monitor all students, nurse mentors are assigned to assist in this but WSs are expected to monitor this arrangement to 'ensure' professional standards:

> I suppose there's a teaching role in that for students whether that be student nurses, people doing post-graduate studies, so people doing primary care courses, orthopaedic courses (Deputy Head of Nursing, *Alpha*)

> In addition to mentoring, WSs are also expected to engage directly in the training of all nursing staff. This is particularly the case with mandatory training (Matron 2,*Beta*)

WSs are also expected to extend their educational role beyond the immediate ward environment and into the university. For example, one of the Study Days at

*Beta*emphasised how WSs are increasingly expected to scrutinise the quality of teaching provided by university and external providers to make sure students are learning appropriately and sharing new knowledge:

> ....we use the University for nurse courses more than any other trust in the region – what are we getting back from that? We need to link it to performance on wards..... we are their customers, we need a good level of service (Deputy Chief Nurse, *Beta*)

3.2.3.4 Developing future Ward Sisters

Because WSs define the ward environment and shape others' behaviour through role modelling, the development of nurses from the current nursing complement to the position of specialist nurse or WS is seen as part of the WS role. Part of this is delegating managerial tasks to Deputy Sisters and, sometimes, more senior staff nurses:

> [On intensive care, a deputy sister] will take on maybe an auditing role or an educational role or looking at various policies, it would be divided by the Intensive Care Sister. ... the WS on the general ward may have to do much more of that herself (University Tutor 1, *Alpha*)

3.2.3.5 Workforce planning and resolving staffing issues

WSs are expected to plan to ensure that there is the requisite number and skill-mix of staff on the ward, even though it is also recognised that they do not have the authority to determine staffing levels:

> .....ensure their workforce was deployed appropriately and efficiently to manage the workload they have and be able to gauge that workload, obviously not just for that day or that week but for the month or so in advance so ongoing planning role really about how they're going to manage their workload over time (Deputy Head of Nursing, *Alpha*)

> They're responsible for rotas and things like that but when it actually maybe comes to the ultimate staffing levels, I think maybe they don't have full responsibility for that or full authority for it but they are in a position to maybe say, 'This is no longer safe, we need more staff on this ward' (Occupational Therapist, *Alpha*)

WSs are also expected to handle staffing issues on the ward, including managing staff expectations and resolving conflicts, preferably through informal means. Much of the HR session on one of the Study Days at *Beta* was used to voice the expectation that WSs resolve staffing issues or conflicts without recourse to formal disciplinary procedures and manage staff expectations, since nurses look

to the WS to facilitate a positive work experience for them and solve their problems. This creates a tension between planning for efficient operations which meet senior management expectations and planning in order to create a congenial working environment which meets nurse expectations.

> ....staff expect the ward to run smoothly and the senior sister to ensure that they go home on time and get their breaks. (Staff Nurse 1, *Alpha*)

WSs are also expected to deal with sickness absence and recruitment. Again, there is a tension here in that, although these have become more formalised and procedural, the expectation is that WSs attempt informal, interpersonal resolution of the problem before resorting to formal procedures.

3.2.3.6 Managing patient and family experience

WSs are expected to take a lead on listening to the questions or concerns of patients and relatives and providing relevant information, advice and support. As lead nurse on the ward, they are expected to take particular responsibility for more complicated or serious issues, especially since families often ask to see the 'nurse in charge' when complications arise:

> She's [on] the front line to deal with relatives but others may be more familiar with the patient so it may not be the Senior Ward Sister, but if it's a particularly difficulty family, generally it's the Senior Sister who would interact with them. Likewise she would be asked to provide a statement from a patient or relative made a complaint because again, she's responsible for the quality of the care provided in her ward (Service Manager, *Alpha*)

Thus, the WS, as the public face and senior representative of hospital care who is ever-present on the ward, is expected to undertake emotional labour and give well-calibrated counselling and advice:

> ...whether that be a sort of counselling role or an information giving role or a empathetic supportive role I suppose in minimising the stress of being admitted to hospital (Deputy Chief Nurse, *Beta*)

Similarly, WSs are expected to manage the expectations of patients and their families, actively shaping their perceptions of their needs so that these are congruent with the kind and level of care that they will, in practice, receive:

> People have such a high expectation nowadays of what they're going to get in hospital but the WS's role is really key in managing to defuse some of those situations and also to be able to explain the constraints, people think that because of the element of choice which everyone's told about, you know, they are really going to be able to say, "I want to have my

lunch now" and go to x-ray later... working on those expectations. (Deputy Head of Nursing, *Alpha*)

3.2.3.7 Monitoring the physical environment

WSs are expected to monitor the physical environment within which care takes place, both as a matter of basic safety and to counter the ever-present risk of patient infections:

> from an infection control point of view and managing their environment of the ward, that is now more and more important, WSs directly manage the housekeeping staff for their area. (Deputy Head of nursing, *Alpha*)

This extends into more formal auditing:

> quality indicators, yes we have quality indicators whereby, for instance cleaning […] quality indicators for the Trust are cleanliness, infection control, environmental audits... (Matron 1,*Beta*)

3.2.3.8 Liaising with other departments

Activities on any ward are interdependent with those of many other departments. WSs are expected to have boundary-spanning knowledge of the work of other departments so they can coordinate the care pathways of their patients:

> I mean in terms of the Ward Managers' role, you are liaising right across the organisation with pretty much every staff group you know, liaising with the site nurse practitioners who manage the sort of site and around who might need to come onto the ward (Associate Director, *Alpha*)

One key element of this is whether and when patients are discharged. This requires the WS to coordinate with other practitioners, such as doctors and pharmacists, before the patient leaves the ward:

> on the ward actually we can't control the TTOs, the drugs to take home, we can't control when the wound is going to be completely ready for the patient to go home so in that respect a lot of the co-ordination and communication has to come I think from the WS or one of the senior nurses on the ward. (Occupational Therapist, *Alpha*)

3.2.4 Management responsibilities beyond the clinical role

The third major component of the WS role as defined extends beyond 'pure' nursing work and clinical leadership within the ward to 'managerial'

responsibilities framed more by wider organisational goals and criteria. The distinctiveness of these is shown by the expectation that WSs undertake them on designated 'management days'. The expectation is that WSs will share some of these duties with Deputy Sisters, but ultimate responsibility remains with them:

> We all participate in audits but she [WS]'s got ultimate responsibility if I didn't do them. She's got the business head on it so she understands our finances [and] how we apply for new staff. (Deputy Sister, *Alpha*)

Because the management element of the WS role extends *beyond* the ward environment to the wider organisational structure, many of these managerial tasks are located within a wider political and social context and set in relation to the work of other professionals, managers and support staff. It is recognised that this side of the role has increased considerably in recent years, both in quantity of tasks and their importance:

> I think probably there's been more management responsibility put into that role ... there's a lot more people work demands now, there's a lot more box-ticking and making sure that you've done what you've said you've done and all of that (Associate Director, *Alpha*)

Whereas much of the WS's 'pure' professional and clinical leadership work relies on tacit knowledge and experience, their managerial activities are framed by formal, explicit knowledge embodied in procedures. Managers therefore expect WSs to undergo 'managerial acclimatisation' where they become accustomed to a new set of non-clinical demands and learn how to allocate time and effort to these:

> everyone who is starting to do management, you- you do lose that balance of clinical and managerial .. it does become very heavily weighted towards the managerial side but for a lot of the nurses I think they've really missed that clinical input and deliberately take themselves almost out of the WS role in order to be able to do some of that clinical work (Occupational Therapist, *Alpha*)

3.2.4.1 Having management training

Human Resource and general managers expect WSs to have formal managerial training and support in order to become 'professional managers'. Obversely, on-the-job training and role modeling are regarded as inadequate for becoming an effective manager:

> Management is a profession and you know, it's something that we need to be trained to do ...and you know, just because they've been a wonderful nurse they're there, they don't know any management theory, they don't know any HR stuff, they don't know employment law (Associate Director, *Alpha*)

One of the Study Days at *Beta* explicitly focused on management training. This entailed management consultants delivering a 'values-led' training course, with particular focus on imparting the rhetoric of customer service, such as 'going the extra mile' for patients as 'customers'.

3.2.4.2 Recording work performance

WSs are expected to participate in recording the quality of healthcare performance and care across departments and hospitals by monitoring the activity on their wards through formalised procedures and according to organisationally-determined criteria expressed in formal performance indicators. In addition to recording patient details and care needs assessments, WSs are expected to record other aspects of ward activity, such as health and safety, hygiene, nutrition adverse incidents, pressure sores, patient falls, and complaints:

> Her hands are tied by Government objectives which we have got to meet for the trust's ratings (Staff Nurse 1, *Alpha*)

> ...they all go onto a certain [computer] system and report is produced from that and then we have to have a look to see if there's any trends in our area, anything we can do differently, anything we're doing wrong (Matron 2,*Beta*)

Whilst some recognise that WSs will delegate some of this auditing work to their teams, they insist that the responsibility remains the WSs':

> The WS next door, she likes to go round and do the audits herself... whereas [the WS] on here will give it to some of her deputies to do so they get the experience of what she needs to do for her responsibilities but the buck does stop with the Sister. (Matron 2,*Beta*)

3.2.4.3 Dealing with complaints

An increasingly demanding part of the WS role as it is defined, and perhaps symptomatic of a wider customer-oriented and litigious health care culture, is managing complaints made by patient and relatives. WSs are expected to take full responsibility for any adverse experiences within their wards and write formal responses to complaints. They are expected to work closely with the Patient Advice and Liaison Service (PALS) and defuse negative patient experiences before they turn into formal complaints:

> In terms of my role and the way that I interact with them I think I would be thinking about them listening very carefully to what I'm saying and actually that, if you like, it's taking, I guess, ownership and identifying what it is that they can do (PALS Manager, *Beta*)

In addition, WSs are expected to draw on the knowledge so gained to propose service improvements:

> ...on the back of they will make recommendations as to how they might be able to improve the patient experience. (Head of Ambulance, *Beta*)

> It's not just about an immediate solution, it's about how that's going to be used for the future to improve standards (PALS Manager, *Beta*)

However, there is ambiguity about whether dealing with complaints is the province of the Matron or the WS:

> .... I think initially when I first came along I would always go to Matron and then she would sort of, we were sort of going with the Sisters and so on then, but you know now we go to the Sisters... and if necessary I will get Matrons involved you know, it depends on the issue. (PALS Manager, *Beta*)

3.2.4.4 Patient throughput and discharge

As WS responsibility and accountability extend beyond the ward environment to the wider context of the directorate and the Trust level, so different criteria and forms of measurement of care, relating to 'efficiency' - such as patient throughput - apply. It is in multi-disciplinary meetings, such as the discharge meeting, that WSs are exposed to these efficiency-driven criteria:

> …the Sister has to come every week to the Delay Discharge meeting and explain her delayed discharges and we have Social Services there and you know, that's supposed to speed things up but actually it's still quite a daunting process for the WS … because obviously Social Services are defending themselves and Discharge Team are defending themselves and the WS's the one that sometimes gets it in the neck! (Deputy Head of Nursing, *Beta*)

It is here, too, that the language of nursing work shifts from individual patient care to 'efficiency' and 'throughput' and where nursing care is framed within the wider constraints of scarce resources:

> The WS has to run the ward as efficiently as possible, and ensure that there's a smooth throughput of patients, so for example if a patient's coming up to be discharged home, it's very important...they shouldn't have patients stacking up on the ward ready to go home and no-one doing anything about it. (Service Manager, *Alpha*)

3.2.4.5 Financial management: budgeting and ordering

One ramification of the growing business perspective on nursing work is the expectation that WSs engage in some financial management and, by absorbing the language of 'budgets' and 'resource codes', view nursing as an economic activity where everything has a cost:

> Because nowadays nurses are also managers it all entwines, you know, a ward has a certain amount of money that it can use for different areas of the ward, i.e. your staffing, supplies, medicines, so you know, she needs to be aware of the monetary aspect but she's the one that's got her finger on the purse (Deputy Sister, *Alpha*)

However, financial management is an area over which there are different views as to the precise role of WSs. Most expect some level of budgetary 'awareness' but there is disagreement over how far the WS should be involved in financial allocation and decision-making:

> [they have] got to manage their budget, got to manage within their budget, ...there's just no question of that and you know, consistently we make more and more savings and become more and more efficient and they need to understand that and how that works (GM medicine , *Alpha*)

> For starters I think they should have a whole over understanding of the budget because.... if you don't understand the budget then you can't manage it. (Matron 1,*Beta*)

One of the Study Days at *Beta* was concerned with imparting the language of budgets and instilling some financial awareness in WSs, particularly as it relates to 'staffing' which represents around seventy per cent of total ward costs.

> What I would want Sisters to be doing from a financial point of view [is] at least once a month look at the financial statements ... in essence I'd want someone to look at how the month has done whether over or under spending on the month, how they're doing year to date. ... I would say would be a good nursing Sister is...managing that resource in an optimal kind of way (Divisional Accountant, *Beta*)

The key element here is keeping staff costs, particularly those relating to the relatively expensive temporary staff obtained through nursing bank and agency staff, within budget allocations.

Material ordering is also key:

> Ordering I think, they don't need to do that, I think they need to be aware of the resources but you know, and they need to think through what it is they're actually doing and- and get some good support (Associate Director, *Alpha*)

Some nurses, however, feel that financial management requires a set of skills that do not come naturally to them and have misgivings about making resource calculations:

> Suddenly you're looking at numbers and statistics ... when you're looking at costing and whatever, things like that ... having to work out numbers I just think it's bad enough having your own bank statement...(Deputy Sister, *Alpha*)

3.2.4.6 Human Resource Management

Beyond day-to-day management of staff within the ward, WSs are also expected to be involved in the more procedural aspects of human resource management and, in doing so, adopt the language of HR. For HR managers, this means WSs taking greater ownership of, and responsibility for, HR issues:

> ... the WSs get involved in the recruitment and they interview and they do the short listing and they do quite a lot of the general recruitment activity if you like. However, when it comes to say, speaking to a new employee or picking up the phone or trying to arrange a new start date with an employee or any kind of HR related that a new employee might have, they get shoved straight through to us …. I think we've got some education to do around assisting our WSs to enable them, if you like, to be able to answer those questions (HR manager,*Alpha*)

HR activities in which WSs are specifically expected to be involved include recruitment and selection, HR planning, performance appraisal and performance management. However, the HR department can be critical of how WS manage HR matters:

> Now I appreciate that there's sickness rates and there's unplanned leave that goes on and sometimes we have to get short term cover for that, but what strikes me is that the WSs ... they're not necessarily horizon scanning around where they might utilise their additional people (HR manager, *Alpha*)

The study days at *Beta* included training in areas of HRM capability given by members of the hospital HR team. Sessions covered performance appraisals, performance management, employee feedback, discipline and recruitment. WSs were expected to have an awareness and understanding of new policies and be able to access the new HRM tools through the hospital intranet and deliver each new practice – in short, to become competent HR technicians

Another session emphasised the importance of planning, rationing and focusing training so that it was targeted on those who would stay in the organisation or benefit most from it. Much was made of how training should meet specific organisational needs, rather than satisfy staff feelings of entitlement or be used

as a panacea for poor performance. In other words, WSs were enjoined to adopt a stronger 'business case' approach to training based on cost-effectiveness, an approach which may be at odds with professionally-driven coaching.

3.2.4.7 Meetings and communication

WSs are expected to liaise across functional areas beyond the ward so that they can translate and communicate activities of other departments to the nursing workforce. One vehicle for this is the ward meeting - an opportunity to provide and share information, but often perceived by nurses as bureaucratic and of limited value:

> [organising ward meetings] are difficult because you can- I'm sure you're aware of this but you can come up with a date and say, "yes we're going to do it this particular time on this particular day" and then something just happens and everything just goes awry and you just can't manage it so because we try to have them every month but it's not always easy to do (Deputy Sister, *Alpha*)

3.2.4.8 Implementing change

WSs are expected to interpret and implement wider policies from the Department of Health or other external bodies, such as over single-sex bays:

> I think we now have single sex bays in every area apart from the ones we're allowed not to have, so A&E, ITU, Coronary Care and our High Dependency Units, but it isn't just that …. I think people still think that they're going to go into a single sex ward, they don't understand so it's managing expectation around that as well (Deputy Head of Nursing, *Alpha*)

This extends to developing and implementing top-down service improvements, ranging from small-scale adjustments to a care procedure or shift routines, to large-scale ward refurbishment or major initiatives such as the 'Productive Ward' programme. This programme supported by the NHS Institute for Innovation, it is designed to help nurses to improve ward processes to enable them to spend more time on patient care:

> I think they absolutely should be undertaking service improvement but I think sometimes when the ward's so busy and you know, they've got lots of run-of-the-mill, day-time stuff to do, that is very difficult to achieve so yes - they should do it but it's just not as important as patient care in some respect. (Matron 2,*Beta*)

3.3 Tensions in how the Ward Sister role is defined

The tensions in the way that the WS role is defined resolve into two kinds: firstly, those between different members of the WSs' role-set and, secondly, those between different substantive areas which are considered to be part of the role.

3.4 Tensions among different role-set members

Tensions exist both among the expectations of different nursing staff and between nursing staff generally and other members of the WS role-set. **Nursing staff** expectations of the WS role vary by ward, specialty and, notably, level. Students and junior staff nurses expect WSs to be clinical figureheads and mentors; more experienced staff nurses and deputy sisters expect clinical leadership and operational coordination; Matrons expect WSs to appreciate the wider service demands of running a ward and maintain performance standards; and senior nurse managers expect WSs to take on an ever-growing role as practitioner-managers, pursuing clinical and business orientated ends simultaneously.

We have limited direct evidence on how the expectations of **doctors** conflict with those of other members of the role-set, given their unwillingness to participate in the study. However, others perceive this conflict. Nurses feel there are overlapping leadership responsibilities with doctors, particularly junior doctors working on the ward, and that consultants attempt to off-load less desirable work, such as audits, onto WSs without communicating clearly with them.

One instance of this emerged at the second study day at *Beta*. Participants noted that the planned changes proposed in 'Liberating the NHS' white paper could mean nurses being responsible for doctors completing drug cards and taking the blame for what doctors fail to do, despite being unable to compel doctors to do this.

The consistent expectation of **managers** is that WSs understand and adopt a business perspective on running an NHS hospital, managing their wards according to criteria of 'efficiency', 'throughput' and 'budgeting', even if there is disagreement over whether WSs are 'budget holders'. This means WSs seeing patients and their relatives as 'customers' with expectations to be managed, having 'awareness' of budgets and being more actively involved in planning and monitoring ward expenditure and keeping costs, especially staff costs, down. This conflicts with nurses' expectations of WSs as clinical leaders, guided by nursing criteria of care and staffing the ward to providing 'proper' nursing care.

3.4.1 Substantive tensions

The key substantive areas of tension in the WS role are: how the WS role differs from that of Matron; whether the WS is a nurse or a manager; whether staff

management on the ward should be driven by cost-control or the congeniality of the work environment; what constitutes the quality of patient care and how it should be measured; and growing WS accountability without a commensurate increase in their authority.

3.4.1.1 Differentiating the Matron and Ward Sister roles

Tensions arise from the difficulty in differentiating the responsibilities of the Matron and those of the WS. This is particularly evident at *Beta* where these roles are being re-defined and restructured:

> Maybe it is from the fact that they don't have the same authority, maybe the fact that we bought Matrons in again, maybe that's taken some of their authority away, or maybe it's just that they are pushed from demands, everybody's expectations, the patients, the relatives and their junior staff have all increased.....We needed to change...Matrons were doing your jobs, managing your wards. You need to be in control of your own wards. (Deputy Chief Nurse, *Beta*)

This confusion is echoed both inside the ward amongst the junior nurses and also beyond it amongst business managers and senior nurses. For some, the matron has a more 'strategic' role, in comparison to the WS's 'operational' focus, leading to different responsibilities over management and business performance:

> If I look at that WS role, she's always going to be slightly overshadowed by the Matron because ....the Ward Manager is responsible for the ward, the Matron is responsible for the whole service, you know, and that's a very different thing. (University Tutor 3, *Alpha*)

> The Matron's role is more strategic, they're running the budget, their trying to meet Trust objectives and they're also responsible for bed management (Service Manager, *Alpha*)

On the other hand, Matrons themselves feel that they get dragged into more operational, clinical issues, whilst WSs needed to act strategically:

> we always get pulled into beds and capacity, like yesterday afternoon there weren't enough discharges, you know, "What can we do, who can we move through a little bit quicker, have all the social services been to see all the patients, have the doctors seen all the patients?" So we will regularly get pulled to do that (Matron 2,*Beta*)

This issue arose on several occasions during the study days at *Beta*. With a planned restructure to the nursing hierarchy and removal or redeployment of many Matron posts, there was considerable confusion about the relative managerial responsibilities of the two roles:

> WS: Can I just ask, what is the matron role now? I'm confused

> Deputy Chief Nurse: It is evolving like all these things ... Patient experience and care quality ... supporting you as a facilitator ... not involved with beds.
>
> WS: They still will!

3.4.1.2 Manager or Nurse?

The question of whether the WS is a 'manager', 'nurse' or both applies not only to the job title and grade – whether the WS *is* a ward *manager* - but extends to the role itself, and especially how much time is spent performing different kinds of activities, which processes and outcomes are prioritised and the appropriate criteria for measuring successful role performance. *Alpha* and *Beta* distinguish between 'clinical' and 'managerial' 'days' or 'shifts'. On the measure of time, WSs are still very much nurses, working four or five 'clinical shifts' and only one or two 'managerial shifts' over the course of a week. However, in practice, the two spheres of activity cannot be de-coupled: in effect, WSs are expected *always* to be managers and *always* nurses and the result is constant time pressure:

> I think if you were to talk to any of the Sisters, they would say they don't have enough management time to do the things they need to do (Matron A&E,*Beta*)

One sphere of activity where this tension is particularly acute, is financial management. While all role-set members accept, to varying degrees, the need for WSs to link activities to costs, the value attached to particular activities is contentious. While some appeal to business criteria, others appeal to clinical criteria to guide priorities:

> [The business manager has] ... done an MBA and you can see where his head is, and that's important and we need people who are business [minded],' (Deputy Sister, *Alpha*)
>
> when you say to [our matron] "we cannot do this because of patients care, we cannot do this" and you think being a nurse she'd understand but it's like you're hitting your head because she's only thinking on a business, business, business, side. (Deputy Sister, *Alpha*)

The question of whether a sister is a 'manager' or a 'nurse' also colours expectations about their training, skills and competencies. General Managers who are *ex*-nurses are seen as having good knowledge of both the nursing and business side of the hospital, with their experience of clinical work giving them greater managerial leverage:

> When there was a new General Manager in who was an ex-nurse and I was talking to her … budget control's a bit iffy here, within about six months that was all brought into check because there was a nurse over

> her and you know, the General Manager was a nurse who said, "Oh yes we can manage on x ... why have we got all these people?" (Divisional Accountant, *Beta*)

There is less certainty, however, that this is the case with WSs. Despite recognition that 'there's going to be quite a lot of training in finance' (Matron), there is a common view that sisters have limited knowledge of financial matters:

> So I think the limitation's more likely to be a Ward Sister, quite a busy schedule, sits down to do the thing and someone knocks on the door and says, "Oh we've got the patient, you know, the relative of so-and-so's come in, they're very worried because you want to discharge their dad, their mum or whatever" and then find she's sort of drawn into operational stuff and I think that's going to be the limitation. (Divisional Accountant, *Beta*)

The issue of whether the WS role is one of nursing or management was a recurrent area of debate during study days at *Beta*. WSs were involved in re-writing their job description. As part of this process, the Deputy Chief Nurse asked:

> Have you talked about job title. Will you be ward managers?

In response to the ensuing silence, some attempt at clarification was offered by a Head of Nursing:

> you won't be supernumerary for the whole time; it was only a suggestion for early shifts

This scarcely served to clarify, however, since WSs had earlier been told that their role would become completely 'supervisory'. The Head of Nursing then tried a different tack:

> [the new nursing services manager] wants everyone to be called ward managers and have spotted blue dresses but we can't have different titles in different parts of the trust, we can't have silos. We need consistent language across the trust..... management days are being stopped altogether. It has never been supernumerary, always supervisory… we will attempt to resolve the supervisory issue again.

3.4.1.3 Managing Staff

There are tensions over how WSs should manage their nursing teams, especially whether this should be driven by efficient staff deployment to achieve cost savings or by the needs of staff for a stable, supportive work environment. There are clear tensions in WSs being expected to be, variously, teachers, mentors, figureheads, supervisors, and performance managers.

One example is the conflict between the informal, supportive local roles of mentoring and supervising and the formal organisational, efficiency-driven procedures of rostering and appraisal. Another is how work is distributed on the ward and the extent to which it is delegated to different staff groups:

> The Band Six [deputy sister] is supposed to take on more ... you need to develop them. Care assistants here do nothing compared to HCAs in other trusts – we need to spread the work more. (Deputy Chief Nurse, *Beta*)

Nurses on the ward expect the WS to allocate work fairly and in a way that enables them to give the kind and level of patient care which they see as clinically appropriate:

> Management work is invisible until people want something (Staff Nurse 2, *Alpha*)

This sets up a clear tension between organisational demands and staff preferences, which WSs are then expected to resolve:

> You need to tell them there will be consequences. They will huff and puff and not talk to you but they need to get to a point where you agree what will happen – give them a chance to agree. ... Performance management and disciplinary action need to be taken if your staff are not responding positively. (Chief Nurse, *Beta*)

3.4.1.4 Measuring and delivering care quality

An area of growing tension is over whether WSs' main concern is with delivering care or merely reporting 'care quality' and over how that 'care quality' is measured and reported. For senior managers, performance measurement is all part of the 'evidence-based healthcare' agenda in the NHS and the growing customer service ethos:

> The good old days will never be the same again. We are measured and accountable for everything we do. (Deputy Chief Nurse, *Beta*)

> The role of the Ward Manager is to police staff documentation (Deputy Chief Nurse, *Beta*)

However, this creates tensions both in terms of workload and also in how WSs define and prioritise activities, given that nurses are sceptical of the validity and reliability of audits. This tension is exemplified in a discussion of an auditing tool called 'Nurse Rounding' at one of the study days at *Beta*. This requires all nurses in charge to visit every patient in each shift and ask them a set of questions, such as "How are you feeling?" The Chief Nurse emphasised how this is part of a customer service ethos:

> I would really like all of you to give it a go. How can you say you are accountable if you haven't been around to see every patient?.... I think it should be a priority

However, nurses believe that there are too many audits and performance measurement procedures and that WSs are spending their time duplicating the same indicators on different databases or for different audiences:

> This is almost exactly the same as the audits you already have to measure. (Directorate Head of Nursing, *Beta field notes*)

Technology is looked to as a way of alleviating this tension:

the IT department [will] sort this out.....It's all about making it easier and quicker for you. (Chief Nurse, *Beta field notes*)

However, this creeping technicisation of nursing work creates as many tensions as it resolves, particularly over how much time WSs spend performing actual nursing care and how much time and effort they spend measuring it. WSs are expected to become analysts and data-driven managers, responsible for technical surveillance and control in a domain as complex and subjective as nursing care – and senior nurses know it:

> I know it's a bloody nightmare inputting all this data ... this organisation is awash with data but how much of it do we really understand? (Chief Nurse, *Beta field notes*)

At the same time, managers insist on the performative value of data measurement, performance comparison and competition:

> I think we need a more competitive nature here.... I want to publish league tables for all data measures. I know it's not nice being bottom of a table but it leads to improvement. ... I will visit the department if it is scoring badly to find out what is going on. (Chief Nurse, *Beta*)

The WS role, then, exhibits tension between formal reporting of activities for the purpose of accountability in an increasingly cost-driven environment and engaging in the activities which have to be reported, between accounting for nominal 'care quality' and delivering substantive quality care on the ward.

One specific issue where this tension surfaces is over when, and by what criteria, patients are discharged from the ward. This is highly contested terrain in both *Alpha* and *Beta*. Expectations clash most strongly between the management conception of patients as service users, or case statistics, and nurses' view of patients as people in need of care. Nurses' belief that patients remain on the ward for as long as they require care is being challenged by a growing patient caseload and management targets to reduce length of patient stay.

The Chief Nurse at *Beta* acknowledged the concern of WSs on this issue but warned that the interests of nurses and their experience of work on the wards

should not be pushed too hard; in the end, what was important was what worked:

> If the quality of care is good then it doesn't matter where the patients are being treated ... they could be in a zoo. (Chief Nurse, *Beta field notes*)

The issue is given a further twist by the wider context of hospital financial incentives. Acute trusts incur a financial penalty for re-admitting patients within thirty days of discharge. Whilst this creates tension in the WS role between the efficiency of services and the effectiveness of patient outcomes, it also offers an opportunity for WSs to resist the rate of patient throughput on grounds of preventing re-admissions.

3.4.1.5 Greater accountability without increased authority

The responsibility and accountability of the WS has increased but without the commensurate power and authority to be able to perform an enlarged role. WSs are obliged to juggle a staff complement, the size of which they have little or no say in determining, and are obliged to meet care and performance targets which they are able neither to define nor determine. There is a clear tension in expecting WSs to have responsibility for activities beyond the ward environment whilst they continue to have little say, or involvement, in wider management decision-making. In short, WSs are expected to be nurses who act and talk like managers.

3.4.1.6 Conclusion

The division of labour and responsibilities specified in hospital organisational structures and others' expectations combine to define the WS role as a blend of hands-on nursing, professional ward leadership and organisational management, with increasing emphasis upon the last of these and hence one that is subject to both clinical and organisational demands. This has created both tensions and ambiguities in the role, articulated in the differing, and often competing, expectations of other nurses, clinicians and managers. It has exacerbated tensions between being a clinician, directly engaged in patient care; a clinical leader, mentoring and developing junior nurses and ensuring good patient care according to clinical criteria; and a manager, involved in directing, monitoring and reporting work performance against business criteria of cost-efficiency and throughput and has created ambiguities in the distinction between the WS and Matron roles. In the next section, we turn to how WSs themselves perceive, interpret and make sense of their role and the tensions within it.

3.5 Ward Sisters' perceptions, interpretations and enactment of their role

Here we examine how WSs perceive, interpret and enact their role, focusing on the sense-making process which they deploy to handle the tensions and contradictions arising from both divergences and conflicts in others' expectations and divergences between others' expectations and WSs' own interpretations of their role. The findings derive from a number of data sources: initial and follow-up depth interviews with WSs in the two hospital trusts; secondly, work shadowing of WSs over a number of days; and, thirdly, observation of a series of Training Days ('Study Days') for WSs at *Beta*. The analysis considers the three major aspects of their role and their component elements identified in the previous section– professional nursing work, clinical leadership and organisational management.

3.5.1 The 'pure' professional – nursing and clinical work

Whilst WSs recognise their role as multi-faceted and diverse, encompassing practitioner, managerial, and administrative dimensions, they still see it - and who they are - primarily as that of a 'professional nurse' whose first priority is clinical care:

> when I'm clinical I'm very clinical, I don't touch any of the [managerial] stuff, which is lovely (WS 3, *Alpha*)

This is seen as distinct from and potentially compromised by, 'non-clinical' or managerial aspects of the role.

3.5.1.1 Doing their fair share of nursing work

For WSs, 'hands-on' nursing work is the central , most rewarding and most enjoyable part of their role. For example, as part of the Productive Ward improvement initiative, WSs had to itemise the activities of a typical working day. Most emerged as 'majority clinical' and saw this as a good thing:

> clinical work is still really important to me….. hands-on with a patient is [important]- I really like doing that, I wouldn't want to lose that at the moment. ... Obviously my priority is the patients (WS 2, *Alpha*)

For WSs, 'fair share' of nursing work is defined primarily by how much they are able to do within the constraints of their total role demands whilst avoiding the danger that desk-based work can be used to shirk the 'real' work of ward-based care. For this reason, they separate clinical and managerial work, as much as possible, to different days and even wear different work clothes to symbolise the distinction. Some do not wear their uniform on 'management days':

> each week I've got ... two days which is this [management] stuff and I think that has worked better now because [the nurses] not looking at me thinking, 'She's sitting down!' you know, 'they're running around like headless chickens and she's sitting down' so they don't see that anymore and I think that helps them (WS 3, *Alpha*)

However even on 'management' days, sisters get drawn into clinical matters and, visa versa. Consequently some wish they could compartmentalise each sphere of activity in particular shifts:

> we were trying to actively recruit a Band 5 staff nurse and I knew that we kept missing her during the morning, then a child needed a nebuliser so I assist[ed] the child, put the on, then the nurse rang up and so I went into the office and discussed briefly, I told her [that]obviously I was busy-discussed how the ward was and what the role was about and when the closing date was and how to apply and she wanted to come on an informal visit. [I] then clicked straight back into taking the nebuliser off and doing the observation on the child again which I found quite weird at first, when I was doing it I was thinking 'Oh I've got to do-' so it's difficult to do your clinical and your management and not switch off either because you've still got your fingers in everything and you're still thinking about both aspects of it (WS 2, *Alpha*)

3.5.1.2 Having clinical credibility

WSs believe that their role requires them to be clinical experts, capable of taking control of more complex or unusual clinical procedures and, indeed, taking on aspects of doctors' clinical work, such as taking blood:

> it's the doctor's role really, to take all the bloods but we make their job easier by taking all the bloods off the patients before the round and hopefully the results will be back for the round. (WS 6, *Beta*)

> you get called for the complex things because of course people, you know, a nurse will have a look at a wound, won't understand what's happening to the wound, will call you to have a look, so you do get involved obviously because it is more complicated. (WS 13, *Beta*)

As one of the most experienced nurses on the ward, WSs see themselves as having the confidence, familiarity with routines and tacit knowledge that more junior nurses often lack and which enables them to support other nurses:

> ...there is a degree of gut-feeling in nursing as well so whilst your patient might look OK on paper, if you've got that feeling that something isn't right and quite often you're- quite often you are right … well and it's just teaching them how to, you know, work with that gut-feeling and what

other thing could you do that the doctors have maybe not thought of (WS 12, *Beta*)

On the other hand, WS do not see themselves as beyond criticism and expect junior nurses to challenge them with alternative assessments:

> A lot of my staff will answer back constantly and my staff will criticise me and that's how I want it, you know, I'm not perfect and I never expect to be and I expect them to say, 'you did that wrong' .. but in a constructive manner, you know'(WS6, *Beta*)

Indeed, WSs admit it is difficult to keep abreast of clinical developments and maintain or develop their clinical skills. Although they may be up-to-date with their clinical knowledge, they cannot find time to conduct research themselves and so rely on other members of their nursing team to do so:

> we do something with a drug called double-pumping and I was under the impression we were going to stop doing it but one of the other girls researched it and said, 'No, no we continue double-pumping' and this is the current practice and this is the protocol (WS 6, *Beta*)

Similarly, WSs recognize that their managerial responsibilities for the whole ward may oblige them to take on less demanding patients:

> If I'm in charge you give yourself the less dependent patients … and sort of the less sickest because you can actually oversee a nurse having a sick patient, it's safer to have someone actually overseeing ... some people always say you need to actually take the sick children if you're the senior nurse, but it's all very well but then you don't know what's going on in the rest of the ward (WS 2, *Alpha*)

3.5.1.3 Part of clinical establishment or supernumerary

The issue of whether WSs are supernumerary to a shift or part of the nursing establishment is one which exercises WSs. They find it difficult to separate fully their management and clinical responsibilities, since although they are always the 'nurse in charge', they may not be the 'lead nurse' for a particular shift:

> A lot of it is clinical management ... [but] what do you define as clinical management and what do you define as clinical? I think it's a very close thing actually, you know, because if I'm in the office I'm managing the whole clinical area you know (WS 10, *Beta*)

> You are hands-on ... and I would never give those two [clinical] days up because I think you can't be a manager without knowing what's going on in the ward, and having your clinical and people need to see that you're competent (WS 2, *Alpha*)

Because WSs do not want to lose hands-on clinical work, there is equivocation about becoming supernumerary:

> I think that [supernumerary] side of it is good because if its busy you're an extra pair of hands but then I still think it's nice to do actually have your own patients ... because you don't get that rapport with the patient if you just dip in here, dip in there….[a sister I knew at a previous trust] didn't have any patient contact ... they weren't counted in the numbers which was good in a way because they got a lot of stuff done and if we were short they would come in but I still, yes, I still do like having patients (WS 2, *Alpha*)

3.5.1.4 Supporting other healthcare professions

WSs see their clinical role as extending beyond nursing work to supporting the work of other clinical practitioners on the ward, in particular junior doctors:

> Educate the doctors, especially the juniors when they've just come out of med school, gosh, you don't want to, as they say, you really don't want to be in hospital in August when they all come out! ...it's quite scary actually, their lack of knowledge to start with (WS 12, *Beta*)

More experienced WSs even feel that they can contribute ideas and challenge the assessment of registrars and consultants:

> Going around with the doctors and maybe saying to them, 'No I don't actually agree with what you're saying, why don't we try this?' (WS 13, *Beta*)

In sum, WSs embrace nursing as central to their role but see it as threatened by increasing managerial responsibilities.

3.5.2 Management and leadership within the clinical role

WSs concur with the view that their role goes beyond hands-on nursing to include elements of leadership. They see themselves as experienced overseers of nursing work, able to take over and intervene when necessary or act as a comforting maternal figure:

> I see my role as well is to sort of [to] keep everybody calm in the environment (WS 11, *Beta*).

3.5.2.1 Supervising nursing work

'Supervising' or 'overseeing' are seen by WSs as the main leadership task within the clinical environment and they draw on different forms of authority to enact it.

Some deploy personal authority or presence, whilst others rely on formal procedure, policy and documentation:

> I've got no manager in my title but then I you know, sort of I manage the staff, like I said and basically supervising, I'm supervising everybody and supervising what's going on and things like that and making sure everything's alright and smooth and all this sort of thing... I don't physically see myself as a supervisor but I am … because I'm overseeing what's going on. I'm overseeing everything, I'm supervising everything (WS 10, *Beta*)

Consequently, WSs will intervene in nurses' work if necessary:

> if you see somebody doing poor hand practice, you know, then you're going to pull them up about it because at the end of the day they're going to go to the next patient…I think I perceive myself as changing practice for the better (WS 10, *Beta*)

3.5.2.2 Clinical leadership

WSs feel that, as nurse 'in charge', they are obliged to develop a style of leadership. Some opt for a 'commanding' or 'authoritarian' style while others prefer a more 'facilitating' and 'coaching' style:

> I think everybody has got their own leadership style and I think it varies, I mean I say I'm a despot, actually it varies, only if the occasion needs it, I'm very, very strict on things like sickness and that sort of thing….the essential things (WS 13, *Beta*)

> my predecessor was much more autocratic than I ever am...[I am] very keen on you know, disseminating as much power and responsibility to the group as possible (WS7, *Beta*)

> you can't- you know, you can't walk in and go 'that's wrong, this is wrong, that's wrong' because people will get their back up (WS 2, *Alpha*)

With this, they seek to balance safeguarding the immediate care needs of patients with developing junior nurses, using Deputy Sister as safety net:

> My deputy Sisters are the same, they say they know that probably things are done differently when the senior people are actually around and probably people are more conscious, 'Oh Sister's in with us today, we'll have to be careful' or something like this (WS 10, *Beta*)

> I'm a true believer of if I'm on a shift, I let the junior nurses take charge, I step back and have my own patients and oversee them because I think the only way they're going to learn to be in charge if someone's around so

> they can actually make decisions but they can bounce it off of us as well (WS 2,*Alpha*)

Being 'the boss', means intervening, making hard decisions and disciplining individuals. Consequently, they cannot be popular with their team all of the time:

> as far as I'm concerned I'm here for the patients and if somebody is going to compromise that patient, I will say, 'No you're not going to do that (WS 10, *Beta*)

> These people are not your friends, you know, you've got to do whatever it takes to run the ward properly, sometimes that's being nice and sometimes that's not, you can't be buddies (WS 3, *Alpha*)

One particular occasion for the exercise of clinical leadership is handover between shifts, which the WS directs, getting the nursing team together to run through the health status of each patient and allocating nurses to these patients:

> you get a full handover from the night staff and then you'll say to them exactly what's going their role [is] and then you will add, 'Well actually we also need to do this or whatever'. (WS 13, *Beta*)

3.5.2.3 Staffing and nursing establishment

WSs acknowledge that a key part of their role is ensuring that there is sufficient ward staff on each shift to maintain a safe and high quality care environment, by being an advocate for both the nursing workforce and patients. Here, considerations driven by clinical leadership clash with those driven by organisational management:

> working out your staffing and that's really up in the air thing at the moment because they're just bringing out new establishments and the numbers don't add up! …it's just- providing I've got enough people I can cover the shifts and sickness and things like that ... (WS 5, *Alpha*)

> I think they're so much around saving money and things - yes, I think they look at any possible way of doing it but what they come up against is us saying 'patient safety'…. so that's how we go, we just keep doing the patient safety – patient safety aspect (WS 12, *Beta*)

3.5.2.4 Rotas, staffing levels and skill mix

For WSs, managing the complement of ward staff for every shift and ensuring sufficient qualified nurses within budget is a key role. Some baulk at the idea of

using bank or agency nursing staff to cover shifts because of the financial costs and the quality of staff available:

> I don't use any bank or agency and it's not because I've got too many staff, it's because my staff are very flexible …..if we employ any bank or agency, the quality of the care of the patients will deteriorate and the knock-on effect is the patients could then complain and then we have to then write responses to complaint letters so it makes our work even harder I said to [the chief nurse] 'Many of the bank or agency nurses that are being employed, I wouldn't let them look after my rabbit, let alone a patient!' So why would I want them in my department looking after my patients?' (WS 11, *Beta*)

WSs feel a responsibility to be flexible in their own working patterns in order to meet staffing shortfalls due to sickness of annual leave, even if this is difficult for them, relying on Deputy Sisters if necessary:

> I can't be off the same time as any of my deputy Sisters really and I shouldn't really be on leave the same time as Matron, so I am a bit sort of stuck where I actually take my leave, you know, (WS 10, *Beta*)

> the phone can ring … 7 o'clock in the evening on a day off and they'll say, 'We haven't got anyone for the nightshift' and unless I've had a glass of wine, you know, the buck does stop with me (WS6, *Beta*)

One perceived challenge is the work expectations of students and junior nurses and their assumption that they can change their working times or swap shifts at short notice:

> they expect you to be here, you've got to be there for them, you've got to you know, drop everything, you've got to- if they phone up and say, 'My Mum's in ITU' you've got to say, 'OK, I'll cover your shifts for the next two days (WS 3, *Alpha*)

Consequently, WSs feel they have to get to know their staff – both in terms of their skills and abilities but also in terms of their personal and professional interests:

> I would hate to have a nurse and I didn't know her skills or her strengths or weaknesses because that is- it's just so important so that you can, as you say, get the right balance, get the right skill mix, have the right people doing the job. (WS 2, *Alpha*)

3.5.2.5 Bed management and patient discharge

A crucial issue for WSs is bed management and patient discharge. The primary driver of this is the supply of patients either from outside the hospital or from other units or wards (e.g. A&E or ITU). WSs see their role as actively liaising with

'site co-ordinators', 'bed managers', Matron and other WSs to determine bed availability and flow of patients. Flow of patients measured by indicators such as patient length of stay is a key performance criteria for the ward. However, actual patient flow and discharge is largely determined by the position of the ward or unit in the health care pathway and the service demand created by patient numbers or acuity. Thus WSs' performance is assessed on something over which they have little control:

> we have a huge turnover of patients and spend a lot of time every day managing beds…. and we're the piggy-in-the-middle person as well because we need people coming in but we can't get people in unless we can move people out and we can't move people out until that person's gone home on the ward so we spend a lot of time liaising with different wards trying to say, 'Has your patient moved, has your patient moved, has your patient moved?' (WS 12, *Beta*)

WSs' over-riding concern is for the capacity of the ward to house patients and for each patient to receive a good standard of care for the right length of time. However, they are under pressure to discharge patients even when they are not in a position to be moved in order to meet flow targets. This leads to patients being moved at inappropriate times, leading, in turn, to poor patient experience and complaints. The Study Day at *Beta* revealed these concerns:

> moving patients at night because they are in the wrong place, and in breach of targets, is very destabilising and gets them confused. (WS, *Beta field notes*)

Managing patient throughput also depends on working closely with other healthcare professionals, particularly consultants:

> it's about trying to pin down the consultants to do it [discharge assessment]. Dr. X does the ward round at 4pm at the moment. It's ok because at least we know he is coming. (WS, *Beta field notes*)

3.5.2.6 Mentoring students and university liaison

While accepting their role as student mentors, WSs can be critical of student expectations and their relationship with the university:

> They are a different sort of type of nursing student than what we were when we trained, they're far more confident; they're quite gobby to be quite honest (WS 12,*Beta*)

> A lot of the time students are quite near the end of finishing so we expect quite a lot of them at that stage and if it suddenly turns out that they haven't done all that then that can be a real problem (WS7, *Beta*)

Mentoring students is therefore an unpredictable process, highly dependent on the individual mentor and requiring the WSs to pay close attention to student performance:

> if there's expected trouble or expected development plans and stuff like that then I'll be the mentor but what will happen also is that I will involve a junior sister with me to work through it so that you can't because otherwise it's just me saying no she's not developing (WS 3, *Alpha*)

3.5.2.7 Teaching

Whilst accepting teaching as part of their remit as a senior nurse, WSs rarely find time for it on the ward. Apart from formal mandatory training, other aspects of professional development and teaching have to take place informally and ad hoc. WSs rely heavily on the Practice Development Nurse to identify training needs:

> you don't have the senior nurses as we used to so you know, instead you just have to do it when you can, … we don't have time for teaching sessions and stuff, it would be nice to do that at some point, maybe, you know… Um, I'm ever hopeful (WS 1, *Alpha*)

> I have to say there's too much else going on in my life to worry about the student, I do go to the meetings with the students, I do teach the students, you know [but] … if something has to give, then actually students is one of those ones that does… because I know that they'll get a good student experience whether I'm here or not (WS 9, *Beta*)

3.5.2.8 Developing deputy sisters

Because the support of Deputy Sisters is crucial for sharing management responsibilities, WSs are at pains to make sure that they get experience in the full range of management activities so they can take charge in their absence:

> what I was saying when we first started this leadership programme ... is that it should be open to the Band Six's as well, I do think the Band six's should be included on it because when I'm away my Band Six is expected to run the unit (WS 12, *Beta*)

> my junior sisters that I've got on the ward ... they need to know all aspects of my job because if I'm not here they need to be able to do my job for managing the ward because you always want the ward to be able to run without you (WS 3, *Alpha*)

3.5.2.9 Physical environment

WSs see monitoring the physical environment as a standard and routine part of their role, achieved in coordination with the cleaning staff:

> making sure that the unit's clean and things like that so that's the first thing people complain about is dirty beds, dirty floors and things like that so that's a daily thing and we've got good cleaners and we get on quite well with them (WS 13, *Beta*).

3.5.2.10 Patient and family experience

WSs see being a point of reference and advocate for patients and families as an important facet of clinical leadership responsibilities:

> We have had a couple that I sort of interacted with the parents and they- we sort of calmed the situation down before it actually got to a level where they would make a complaint, dealt with it ….. and the parents went away happy and content, it was all sorted and I thought that was quite good actually, sorting it before parents actually left and rolled it all up made into a huge snowball (WS 1, *Alpha*)

3.5.2.11 Liaising with other wards

WSs get involved clinically with the activity on adjacent or related wards, especially if the corresponding sister is away or not on duty:

> I do get involved in the other areas, the other clinical areas, you know, if there's problems on other wards, if the Sisters aren't there…if they need anything then they come to me (WS 13, *Beta*)

3.5.2.12 24hr accountability

WSs accept that, as senior nurse on the ward, they are fully responsible for the safety and quality of care when they are on duty. They are more equivocal, however, about being responsible for care outside working hours:

> I've always made it quite clear as far like blood transfusion, if there's a problem, you phone me at home…. the job description says twenty-four hour responsibility which, you know, I took the job, I knew what it was about (WS 3, *Alpha*)

> There was a WS at another Trust who was disciplined because a patient wasn't fed on their ward. Now she was, well whilst this whole thing kicked

> off she was actually on annual leave, she wasn't even in the hospital yet she was held completely accountable for that and that worries me …that's why I feel that we might be a scapegoat for some things (WS 12, *Beta*)

In sum, WSs embrace and enact a leadership role beyond their immediate clinical work, primarily by ensuring the availability of nursing staff and monitoring and shaping their competence and performance, mentoring students, monitoring and shaping patient experience and by being the senior ward representative with whom other professionals and patients interact. Much of this means reconciling their own clinical orientations and priorities with the work expectations of nurses and care expectations of patients and with the growing constraints of budgets and managerially-imposed targets.

3.5.3 Management responsibilities beyond the clinical role

WSs accept, sometimes reluctantly, that they have management responsibilities beyond those of clinical leadership and that this side of the role is growing.

3.5.3.1 Managing staff and human resource management

For WSs, managing staff is a time-consuming and demanding aspect of their role, involving continuous juggling of staff numbers, negotiating shifts and resolving staff problems in real-time:

> I feel like I spend the majority of my time doing staff management ... personal problems and you end up hearing things that you really don't want to hear but you kind of have to so that's…the area that I lack my most confidence in. (WS 13, *Beta*)

> When you become a Band Seven you're totally thrown into managing sickness, managing appraisals, all that kind of stuff which is more, I think, confidence-building around it rather than sort of an issue of actually doing it (WS 12, *Beta*)

Some aspects of managing staff, such as performance appraisal, have been formalised by HR but these, in turn pose different challenges in terms of time and skill.

3.5.3.2 Attending meetings

Consistent with their general disparagement of organisationally-driven management activities, WSs see meetings, such as daily bed meetings, as, at best, of secondary importance to patient care and, at worst, as irrelevant and time-consuming:

> I don't always think you need meetings to communicate. I meet with my staff once a month and that's only a recent thing, um, but it's working really well…[Now] we've been told by the Trust we have to attend at least six a year out of twelve, and ... the Trust wants it built in to people's performance reviews. I think that's a bit harsh personally (WS 10, *Beta*)
>
> obviously my priority is the patients not meetings (WS 2, *Alpha*)
>
> it doesn't help me to go and sit there [meetings] and hear that A&E have got sixty people waiting for beds because I can't change my situation so I don't participate (WS 13, *Beta*)

3.5.3.3 Clinical auditing

Managing the auditing of ward activities against organisationally-defined critieria is recognized and enacted as a key non-clinical activity for WSs:

> There are too many audits. We self-audit so I don't necessarily believe that everyone is perfect. There is pressure to tick a box and make everything look better than it really is. (WS 9, *Beta*)
>
> They want staff satisfaction audits, they want patient satisfaction, they want length of stay reduced. The whole hand hygiene audits as well that's massive in the Trust (WS 3, *Alpha*)

Some conduct audits by themselves, others involve Deputy Sisters and more junior nursing staff:

> My Band Six does most of the audits every month. So then she just reports back to me what we're not doing quite so well on and what needs to be nagged at and then I'm the chief nagger! … [I'm] pleased to be quite honest that my Band Six does them because they are time-consuming (WS 2, *Beta*)

However, clinical auditing is something over which WSs feel they have little control or much say in shaping, since most are cascaded down from senior management with little consultation. They accept audits as a useful tool - a 'necessary evil' - for monitoring performance against key indicators and in working towards improvements but also feel that there are too many audits of doubtful origin and originality:

> So clinical audit ongoing always, I hate it, I really hate it but I think it's necessary but I hope that the Trust in the future gives us more support with it…. as I keep pointing out to them, we lie about some of our audit data because if we didn't lie, then we'd be told off so sometimes it's easier to lie about it rather than do it properly (WS6, *Beta*)

> As much as I complain about the audits, I do like having them there because I think it keeps your standards of care up. (WS 12, *Beta*)

A common concern for WSs is that they are being asked to complete audits that others, mainly doctors, should be doing but offload on them as undesirable 'administration':

> We've just had to do a consent audit, we have to go through and make sure that the doctors have consented their patients properly. Why we have to do it I'm not sure, because we're not even involved in the consent process and then we have to audit the medical notes to make sure everything's dated, timed, signed. Is it legible? Is there crossings out? That kind of stuff and then most of it gets fed back via that and that's what they hold us- that's what they're holding us accountable to. (WS 12, *Beta*)

> it's meant to be a joint responsibility but many of these joint responsibilities end up by being nursing responsibilities. (WS6, *Beta*)

The burden and limited perceived relevance of the auditing process threatens the accuracy and validity of audit records. For example, traffic-light based audit 'scorecards' are produced by the audit department and circulated to each department, ostensibly so that WSs can monitor their ward's performance. However, the scorecards are also used for comparative performance assessments across wards and departments and, hence, as a disciplinary tool:

> clinical governance meeting ….the Matron was sick that day so they made me go and sit there, it was horrendous, I don't ever want to go through anything like it again. There was myself, the clinical governance person and two of the surgical consultants with the whole Board and it was horrendous[ly] scary, it was awful and they just fired questions at you, you know, 'Why is it that the nursing staff aren't doing their appraisals?' and it was horrible so no I don't ever want to be in front of the Board… I can still feel the palpitations from sitting there! It was horrible, it was really intimidating (WS 12, *Beta*)

There is, therefore, a temptation to 'game' the system and falsify audit scores:

> so they've lied and I know other departments have lied and I have lied myself, sometimes because I think I can't bear the fallout of completing something incorrectly …. So everybody's going to lie because the consequences of not so you'd go into a room and there would be all these managers and you'd have to justify why it wasn't achieved and so people started lying about it and you wonder why! (WS6, *Beta*)

During a conversation about a new care audit at a Study Day at *Beta*, several WSs declared: 'I don't believe the audits are right…we all lie … we have to'.

WSs defend this on the grounds that 'measuring' something as complex as nursing work is extremely difficult and that audits are subjective, inaccurate and misleading:

> you ask the patient how thing were and they say it was great, all very good, "then you ask them to rate it from 1-10 and they say 5! ... what? (WS, *Beta field notes*) [laughs]
>
> we have a strange man who likes to lay on the floor in the unit, the audit says we should have a breach each time for that. (WS, *Beta field notes*)
>
> I don't include doctors on my hand-washing audit now because they will bring our scores down (WS, *Beta field notes*)

3.5.3.4 Budgets and finance

Budgeting and financial management are acknowledged by WSs as a growing part of their role, one made problematic by the perceived dissonance between the managerial priorities implicit in budgets and the priorities of clinical practice.

The aspect of financial management that they most readily accept relates to equipment stocks, seen as important in ensuring that clinical practice and safety are not hindered by a lack of appropriate materials, whilst at the same time there is not unnecessary build-up in store rooms:

> we've started looking, you know, I've got it all printed off from stores about what stock we get and looking at other cheaper options, do we actually needs this, are we supplying surgery in the middle of the night, you know…..so I think somebody on a clinical level needs to look at that (WS 3, *Alpha*)
>
> my role I suppose make sure that we're not over-supplied on stuff so we're not getting loads and loads of say syringes when we've already got loads left (WS 2, *Alpha*)
>
> it's one of my pet things … can't bear working in an environment like I do and running out of stuff (WS6, *Beta*)

However, WSs are much less sure about the other financial aspects of their role. For some, finance and budgets remain the province of the Matron:

> as a Ward Sister [I do] nothing financial whereas, again, because I did a Matron's role, I was quite lucky, I understand about it, I know about the budget, I know what our budget is and Ward Sisters have none of that (WS, 13*Beta*)
>
> I think for the main sort of budget … I think will be the Matron[']s role] (WS 2, *Alpha*)

> I'm not established right but you know, so I don't really know how this budget and finance is going to go because I get the impression that they're going to say, 'Right, you've got your budget, now don't be overspent' without really telling us how we manage it so that is going to be interesting! Very interesting when the people above you don't really know how it works (WS 12, *Beta*)

WSs are, therefore, somewhat confused about handling more budgeting in the future and partly reluctant to take it on but at the same time see having more financial control as 'quite exciting', offering potential for staff development and improvement on the ward:

> I am a bit cynical, I have to say, I think we'll be told what our budget is, 'This is your staffing' but whether we'll have the flexibility I don't know. I'm a little bit cynical. It's a very good skill and I think it's a very necessary one but I don't like the fact that it takes you away from the patients (WS 13, *Beta*)

> If we were to be given totally the budget and say, 'Right, this is what your budget is, you use it as you see fit' kind of thing, what I would like to do is skill up my staff…and I think they'd quite like it ….but also it would become almost healthy competition, 'Well I've managed to save this, what have you saved?' you know (WS 13, *Beta*)

3.5.3.5 Implementing change and improvement

Making changes to work routines and procedures to improve the ward environment and performance is something which WSs embrace as part of their role. There is a tension, however, between wishing to introduce new ideas and initiatives based on their own observations or the suggestions of the nursing team and being obliged to implement initiatives originating either from senior management within the trust or centrally within the NHS:

> [I'd like to] implement nurse-led discharges and increase the ambulatory service, that kind of thing... and utilise the children's unit more outpatients clinics rather than having them on the ward, that kind of thing and sort of get the link between children….I want to actually bring it all together (WS 5, *Alpha*)

Thus, overall, whilst WSs grudgingly accept the growing managerial element of their role as inevitable, they are both reluctant and skeptical managers, primarily because they see managing budgets, audits and improvement programs framed and imposed by senior managers as conflicting with time spent on patient care and with what they regard as clinical priorities.

3.5.4 Ward sister sense-making

WSs are obliged to 'make sense' of the ambiguities, tensions and conflicts in their role by interpreting their experience analogically within a framework of known categories and thus constructing for themselves and others a coherent picture of their role which renders it accountable to others and maintains a sense of personal identity. Out of the ambiguities and tensions in their role, they attempt to construct a plausible answer to the question: What does being a Ward Sister mean?

The WSs' interpretation and enactment of their role presented above represent the product of this sense-making process – in effect, the contingent 'sense' that they have made of their role. A number of sense-making processes contribute to this.

Firstly, WSs pick up on the cues supplied by others that the WS role remains central to healthcare delivery. WSs' perception of their 'role set' and their expectations produces a *spatial* understanding of the role as the 'hub' of operations and a mechanistic analogy of 'lynchpin', where the WS is essential for structural stability. They then deploy this structural/spatial construct to find political leverage within the organisation. For example, at the Study Day at *Beta*, WSs gratefully seized on the assurance by managers and trainers that they were highly valued by senior management.

Whilst appreciating that this means they will have greater responsibilities in the future, WSs also recognize that their imputed importance can be leveraged to resist further management-imposed activities in favour of clinical priorities. One example of this is citing the system of financial penalties for re-admission to resist pressure to discharge patients.

WSs handle the perceived conflicts in the demands of their role through a mixture of juggling, delegation and resignation – juggling in the sense of thinking on their feet and resolving problems in real-time, usually by attending to immediate clinical issues at the expense of management tasks; delegating in the sense of farming out more routine tasks to Deputy Sisters and junior nurses; and resignation in the sense of seeing the tensions to which they are subjected as being not of their own making but as something created by others. In so doing, they deploy a blend of analogic frames relating to: personal dexterity in dealing with problematic situations (juggling); depersonalizing those tasks that are insufficiently worthwhile or important to warrant dexterity work (delegating); and acquiescence over things that cannot be 'juggled' or delegated (resignation):

> when you've got the telephone ringing first thing in the morning and three people are phoning in sick and you think, 'Oh no!' and you think 'What am I going to do?' you know, first thing is to go into a normal human panic mode… quite often, I get pulled away from doing something…. I have it all planned in my mind so I come in at half past seven, telephone's ringing, somebody's off sick and then somebody else is off sick and then I think to

> myself, 'Right, that's those business cases gone today, another day to do those' ...help! What can I do? Knit nurses, that's what I say (WS 10, *Beta*)

WSs make sense of the conflicting demands and expectations which they face by re-affirming their identity as senior *nurses* and the centrality of patient care in their role, an identity and role which others are willing to confirm; by defining certain management tasks as secondary, routine and clerical and hence capable of being done by more junior staff; and by defining the system in which they are obliged to work as inherently chaotic:

> I'm somebody who can multi-task quite well so it makes- that makes life quite easy so it's quite easy to juggle things around but as I say sometimes you just want to change your name when there's everyone going from one side to the other but I try and build the staff up so that they- in terms of training and that so that they can cope with some of the minor stuff (WS 12, *Beta*)

By virtue of their structural position at the hub of operations, WSs also describe their role as 'buffering' and 'filtering' activities and information from outside the ward environment. The clinical shift handover offers the opportunity for them to interpret, relay and construct the organizing logic and knowledge relevant to the ward environment and maintain a strong identity as clinical leader:

> For me part of the communication happens at handover, um, any changes that happen during the morning I will hand over at lunchtime and- and as soon as I do a doctor's round, I'll go to each individual, each nurse and say to the nurse in that bay, 'This is what we're doing with your patient so that you know to hand it over' (WS 13, *Beta*)

However, the role of filter also has the unintended effect of attracting blame for activities and problems that occur within the ward:

> It's just so very, very tiring not just physically but you have everybody's emotional life to deal with …so you have to deal with all this stuff and be there I mean it says be visible but you know 24 hour responsibility...we're in each others' lives almost because it's so busy and it's so overwhelming for the new staff so they have to have somebody who will listen to them (WS 3 *Alpha*)

There are, however, occasions when the incongruities of the role cannot be easily made sensible by juggling, delegation and resignation, such as when decisions are made within the hospital, or beyond, that the WS is unable to influence but that are deemed too significant to dismiss as 'not being their fault'. On these occasions WSs distance themselves from their role altogether by referring to it as 'only a job':

> they are my employer and I will just go along with whatever the majority decision is but I- I'm not sure quite how we'd get that to work here … they

> change it all so often that I just- after a while you just think I'll just carry on and do my job (WS7, *Beta*)

WSs make sense of the confusion over their role and that of Matron by emphasising the contrast between the Matron's greater responsibility for management, particularly financial management, and their own continued emphasis on patient care. Part of this is to draw on the spatial analogy of 'management' as 'up there' and question both the clinical competence and awareness of ward realities of Matrons: if, because of their management responsibilities, Matrons no longer have clinical relevance or credibility, then it falls to the WS to maintain clinical leadership. This, in turn, becomes a justification for resisting excessive additional management responsibilities:

> I've got a really brilliant Matron, who's really helpful, supportive, um, and I- it- it will be a great loss when I don't have her. But the problem is because the way they've developed her role, she would struggle to work back on a ward again because they've made her clinically incompetent. The environment has made her ..incompetent. (WS 10, *Beta*)

> I acted up as Matron from time to time and I hated it. It was meetings, it was lots of people standing in rooms […] over things that you think, 'Get real!' just come out and see the reality of it rather than all stand in a room shouting (WS6, *Beta*)

At the same time, defining the Matron as manager re-assures WSs that their predominantly clinical role is being protected. Without the 'protection' of the Matron, that role is under threat:

> we're not going to be reporting to the Matron any more, we're going to be reporting directly to the Head of Nursing. Now the Head of Nursing will have so many different wards because it's not just surgery that she'll be covering and not having that immediate contact I think is quite- leaves us feeling a- quite vulnerable (WS 13, *Beta*)

WSs make sense of the ubiquity and pace of organisational change, much of it incomprehensible, by holding to the central importance and unchanging nature of patient care. When much else seems not to make a great deal of sense, the fundamentals of caring for patients are fixed and known. This then gives their role a stable core and themselves a stable identity. Whatever else they might be expected to be, they remain nurses and whatever other orientations they may be enjoined to adopt, clinical criteria remain paramount:

> I've never known an environment to change so often, you know, one minute we're doing one thing, another minute we're doing another thing I just come in every day and think, 'What's new today?' (WS 11, *Beta*)

> the clinical work is still really important to me…. actually hands-on with a patient is [important]- I really like doing that, I wouldn't want to lose that at the moment. ... Obviously my priority is the patients (WS 2, *Alpha*)

WSs' self-perceived identity as competent actors in the face of ambiguity and uncertainty is also strengthened by emphasising their role – and indeed, duty – to exercise clinical *leadership* on the ward. They see themselves not simply as nurses, but as *leaders* of nurses, with 'leadership' defined in clinical, rather than managerial, terms – to inspire and support junior nurses to meet clinical goals relating to patient safety and care, rather than managerial goals of efficiency and throughput. Thus, whilst the question of whether and how far they are managers and what, as managers, they are required to do, remains highly ambiguous and uncertain, being a role model, mentor and teacher for junior nurses and defending the integrity and standards of the profession remain clear and unchallenged parts of their role.

The tension between, on the one hand, management activities in the form of conducting formal audits and meeting formal managerially-imposed targets and budgets and, on the other, clinical activities to maintain substantive clinical standards is finessed by re-defining what 'compliance' with targets and budgets entails. Since WSs cannot ignore these, they undertake them by formally complying, to the letter - supplying requested data, ticking the appropriate boxes and doing so on time - without over-concern for what the data represent or what the ticked boxes denote. This creates space to get on with the real-time needs of patients and, therefore, care in a substantive sense, defined by professional standards. Thus, WSs wrest some control over the important parts of their role, allowing them to consciously 'give up' control over the less important components:

> we had a patient with us for- in hospital for a month, she got a really nasty sepsis, came to us, went home and over the weekend she found that she had a lump developing on her rib cage…there was no beds on the ward, her mum and dad are quite pushy so we brought her up here, put her in the day room, got her admitted by the back door. Bed managers were going berserk about it [but] sometimes you have to intercept these things, the fallout would be the family would have put a formal complaint in and then I would have spent hours filling out complaints forms. Sometimes you just have to- just … think one step ahead (WS11, *Beta*)

There are, however, forms of management performance measurement that WSs find difficult to resist from a clinical perspective. For example, clinical audits are seen as a 'necessary evil' by most WSs, but rather than giving in to the discourse and control of management, they re-define performance criteria and improvement as a professional interest and a professionally-driven process. Rather than seeing auditing as a task they are performing for management, they conduct it as 'healthy professional competition' with fellow clinicians, to promote the interests of their patients and professional development:

> I don't have a problem with [competition] at all. If I'm not doing as well as other wards that's fine then, you know, tell me where and then I will

> say to the staff, 'Oh look we're- you know- we need to pick up-' no I don't think it's- a little bit of healthy competition's good (WS 13, *Beta*)

This sense-making process is also evident in the way that WSs handle complaints from patients or relatives. Initially, they seek to head off any complaint by dealing with the problem informally. Once the matter becomes a formal complaint, however, it becomes a *procedural* matter in which compliance is key. Thus, WSs distinguish between dealing with the substance of patient issues professionally and complying with formal 'complaints procedures':

> for example I had a staff nurse last week had a incident and she'd already filled out the incident form and so I sat down with her and said, 'OK what would you do now?'….' and she realised actually at their level now, they are thinking about not just the incident it's how am I going to deal with it (WS 2, *Alpha*)

In handling staffing issues, the dissonance between formal policy and procedures and the realities of the ward is resolved by dealing initially with staff issues informally and extemporaneously as they arise and only resorting to complex and time-consuming formal procedures in the last instance:

> sickness policy is a bit grey, it's not black or white so there's always maybe this, maybe that, when I guess I thought that when you sent people to Occy' Health they would give you a clear answer of, you know, 'You need to do this' and they don't….you read the policy and it could be so misinterpreted and it's just- it just feels sometimes, even HR don't give you definite answers….. this is the thing that takes me the longest and most stressful part of my job .. it's going to have to go down a formal route (WS 3, *Alpha*)

WSs also cope with the tensions and conflicts in their role by defining them in terms of a 'training need' – having to acquire the skills and competencies that permit a 'technical' solution to be found. Again, there is 'identity work' here; their inability to deal with tensions and changes becomes simply a contingent, temporary gap in their skills – what they do not know how to do *yet* – which is remedied through training, not some fundamental deficiency on their part. Having 'more IT skills' is a key part of this technical fix:

> we're going to have to learn a lot more IT skills which many of us haven't got because of our generation.. many of us haven't got IT skills to do a lot of these other roles (WS, *Beta field notes*)

Similarly, tensions created by the perception that WSs will, increasingly, have to manage budgets are salved by the belief that these will diminish, if not disappear, by having more training in financial skills:

> WSs: It feels like we should already know all this stuff.

> Deputy Chief Nurse: No - it will take time. You have never done it before ... it's about learning the tricks of the trade of management. ..It's a journey.

In this way, the 'management' that WSs feel under increasing pressure to do becomes less a political matter of confronting competing priorities, more a technical matter of applying the 'tricks of the trade'.

3.5.5 Conclusion

Despite growing pressure to become, think and speak like managers, WSs continue to embrace and prioritise both the nursing and clinical leadership components of their role. For them, they are both part of the clinical team on the ward, with hands-on responsibility for patient care requiring the credibility that comes from maintenance of clinical skills and expertise, and leaders on the ward, with 24-hour responsibility for ensuring the availability, competence and performance of the nurses and students in their charge, the physical fabric of the ward, the patient experience and co-ordination with other professionals. They see both of these as threatened by their growing managerial responsibilities for HR management, clinical auditing, meeting budgets and implementing change initiatives. This means reconciling their own clinical orientations and priorities with the work expectations of nurses and care expectations of patients and with the growing constraints of budgets and managerially-imposed targets. They do so by: re-affirming their identity as uniquely competent senior *nurses,* central to delivery of patient care and development of present and future nurses in a system which is inherently chaotic and beyond their control; delegating management tasks perceived as routine, clerical and secondary to patient care to more junior staff; and juggling their other responsibilities by prioritising and attending to immediate clinical matters whilst formally complying with those targets and procedures which they cannot avoid and treating 'management' as technique.

4 Service Manager role expectations, tensions and sensemaking

Here we firstly consider how the role of the Service Manager (hereafter 'SM') is shaped by a combination of its structural location within the immediate context of the two hospital trusts and the wider context of the NHS and, second, the specific expectations of those with whom SMs work and interact, their role set. Following this we explore SMs' own interpretations of their role, how they make sense of their position and how that sensemaking shapes how the role is enacted in practice. The findings presented in this chapter derive from a number of data sources: firstly, formal documents in the form of organisation charts, job descriptions and policy documents; secondly, depth interviews with members of the SMs' role-set and the SMs themselves and finally, observation of SMs' in the course of their work.

We show how SMs are positioned between the *organisational* priorities as defined by senior managers and the *clinical* priorities of medical consultants and everyday needs of other non-clinical staff. We consider the specific tasks and responsibilities expected of SMs and the tensions which arise in attempting to meet the diverse expectations of the different role-set members. We then consider how SMs make sense of these conflicting expectations, ambiguities and tensions by constructing an identity as reliable hardworking managers thriving on complexity and enacting a role which entails coping with and fulfilling senior managers' expectations through reactive problem solving, juggling and building facilitative interpersonal relationships.

4.1.1 The Structural location of the Service Manager role

Within the overall hospital management structure managerial divisions or clinical directorates are further subdivided into specialty or strategic business units (herafter 'Specialty Business Units' (SBU)). These are led by a Clinical Director, normally a medically qualified consultant, have a nominated first-line manager often known as a specialty or SM and a more senior Associate Director or General Manager.

An important matter for clarification is discriminating between what *is* and what *is not* a first-line SM within the context of acute care. Unlike the Ward Sister, which represents a consistent position across the clearly defined context of the ward or clinical unit, and has clear line management responsibility for a team of nurses, non-clinical managers are given various titles across hospitals and may manage an assortment of employees – some clinical, some administrative –

depending on the departmental structure and workplace setting. Where the ward sister clearly operates at the front-line interface between the service users and service producers, non-clinical (or 'back office') managers generally do not operate in a clearly defined front-line setting.

To disentangle the SM role, a more consistent starting position is the middle manager role, labelled the 'General Manager' or 'Associate Director' (hereafter, 'General Manager' (GM)). It is in the non-clinical managerial positions subordinate to the GM that we can identify the various manifestations of SM, variously labelled 'Specialty Manager', 'Business SM', 'Business Support Manager', 'Operations Manager' 'Clinical Business Manager'. One GM neatly demonstrated this lack of clarity:

> [There are] lots and lots and they're in various guises, they're very different in different departments... they've got slightly different titles because, I mean in our department we're fairly compact so we've only got one SM at a Band 6 but say something like medicine, which is an absolutely enormous directorate, they have, I think two 8A business managers as well to help with daily [operations]. (GM Paediatrics, *Beta*)

As details of the management structure of the case study sites emerged throughout the participant recruitment and interview process, it became apparent that the 'SM' is a role variously and flexibly deployed to fit individual specialties and directorates, which are, in turn, shaped by the wider organisational structure and healthcare setting. This means the line management structure is more visible in some departments than others:

> A [service] manager role in medicine, surgery or any other specialty will be different and they need the same core skills around having the business head but their actual day to day life might be rather different … however the way that specialty behaves is what will make your day, or not as the case may be! (GM Medicine, *Beta*)

Here we focus on the commonalities and tensions which different actors use to define the SM role. SMs' job descriptions show that there are common responsibilities and relationships that, at least formally, help to define the role:

> working closely with the General Manager, this post will play a key role in ensuring that the Specialist Medicine Directorate meets the requirements of the performance agenda.

The job description reinforces this relationship by outlining the relative responsibilities of the role:

> work with the general manager … to ensure junior doctor rosters are compliant and provide the required support for the service
>
> supported by their manager, the role will be responsible for prioritising the use of available resources

supported by their manager, the role will be responsible for policy implementation, and service development in their area.

The strength of the role relationship between the SM and the GM is unambiguous from the job description and is the only relationship described more than once in the job specification. The GM is, therefore, a key member of the SM role-set and the dyadic relationship between them is central to how the role is defined.

4.1.2 Support to General Manager

The GM, as line manager, provides the clearest account of what is expected of the SM role and, in this, GMs recognise their responsibility in job design and creating realistic expectations:

> I think there is something about me insuring they have space to do that. (GM Diagnostic services, *Beta*)

Many expectations point up the shared responsibility between the GM and SM. While the GM is responsible for a wide range of departmental business-related issues, the SM is expected to manage some of these issues in a more speciality-focussed way:

> I get it for the whole global thing and I pick out and I know which [SM's] dealing with that and I say, "Look at that for your specialty, I think there's something you'll need to do here" and then they pick up more the specialty related detail round that. (GM Medicine, *Beta*)

> I think they are [the GM and SM] quite different … the [GM] and myself we are basically in charge of sort of SBU direction strategy and those kind of issues … now where [the SM] comes into that for me is to be able to help us to make sure that we've got the proper information to make the appropriate decisions … I wouldn't necessarily expect her to say, come up with the strategy. (Clinical Director, *Alpha*)

Because boundaries between the SBUs and the wider directorate are not always clearly defined, this creates space for some negotiated order of task expectations between the two management roles. Indeed, 'fuzzy' boundaries between the roles mean that defining the specific role expectations of the SM is not even a straightforward task for GMs themselves. They often express role expectations in terms of '*we* will' – suggesting that there is a certain amount of management work that gets shared between the GM – SM dyad. To some extent, the SM role is constituted as a management instrument *through* which the *GM manages* in response to the specific management-related pressures of the department.

Rather than having clearly defined roles and responsibilities of its own, the SM role appears to be fed down as a residual of that of the GM. The rapidly evolving nature of individual specialties and wider healthcare setting obliges GMs

constantly to make sense of their respective service areas and design the SM role around those interpretations.

> I think she is relatively new in post and that aspect of the role has not been defined. *(*GM Diagnostic services*, Beta)*

How SM role responsibilities are defined relative to those of the GM recurs in the themes pervading the weekly manager meetings. These meetings were attended by the GM, SM, Clinical Director (CD) and other functions such as HR, accountants and clinicians where necessary. The four recurrent themes are 'operations', 'finance and performance', 'service development' and 'clinical governance' and SMs are expected to liaise with the IT department to collate performance data into a specified format that could be used by CDs, GMs or sometimes the SMs themselves in performance management meetings.

4.1.3 Role set expectations

One clear expectation on the SMs is that they oversee the operational flow of activities within their department through a combination of passive monitoring of specific clinical or administrative work and, where necessary, reacting to various 'problems' relating to this work. 'Problems' here can mean, variously, the functioning of equipment, the general flow of patients, complaints or serious incidents, government waiting time targets or other issues determined by senior managers or clinicians:

> The SM should ensure that the process is running smoothly and there is mostly care flow and if there's a breakdown in flow due to restrictions of bed numbers, due to a large number of ambulances arriving, due to the department getting full, that they would respond to those sort of criteria ...What I'm describing now is a responsive rather than a proactive role so it's responding, it's a fall down in their process, they are responding to correct it. (GM Diagnostic services, *Beta*)

For GMs, this side of the SM role mirrors their own as a 'sort of caretaker role' that exists to 'make sure that all of that stuff is being done' and 'making sure the loop's closed'. This part of the SM role is seen as primarily reactive and very time-consuming and demanding, leaving little freedom for more planned managerial activities:

> … there will be very much day to day things that they have to deal with; if a call comes in the morning, a doctor's off sick, the [SM] will immediately be thinking, "Was he running a clinic today, is he on call, what's he doing?" …she's going to have to go down to the clinic, talk to a set of patients and say, "I'm really sorry, your doctor's not here, we'll fit you to this clinic, meanwhile she will have had to have negotiated with another doctor to do some more patient. (GM Medicine, *Beta*)

However, GMs also worry that there is a temptation for managers to over-monitor things by, for example, 'board watching':

> Managers stand by whiteboards, you see this in lots of Trusts…you'll get a number of people who stand there looking at the board and it doesn't actually change until someone rubs something out and then writes something in ... occasionally, you know one time out of ten, I'll look at the board there will be something that I can intervene and make a difference to... I suppose you know there's not a lot I can do ... it's very easy to get trapped into that thing and looking up there and saying what can I do there. (GM Medicine, *Beta*)

Capacity or target management frames the manner in which management is performed in both *Alpha*and*Beta*. Hence much of the day-to-day operational management expected of SMs revolves around achieving targets. This is problematic because of the perceived gap between demand and capacity and creates conflict between clinical and organisational priorities, or the 'clinical vision versus the business constraints'. Senior managers, however, expect SMs to be focused on the *organisation's* priorities.

> They have to have a very clear targeted attitude towards waiting lists and waiting times, they're a bit more target-orientated than someone who's clinical, …sometimes clinical priorities versus target priorities sometimes have a bit of a conflict and so they're the people that are looking at someone waiting near to eighteen weeks, not because of their clinical need but because of a waiting need and a target needs so they have a slightly different slant. (GM Medicine, *Beta*)

SMs are expected to monitor performance against targets using information provided by the IT department and, in particular, monitor breaches, that is failure to meet a government target on a patient-by-patient basis, and the reasons for these. From the GMs perspective this involves taking action to *resolve* performance issues by reporting any problems and by giving 'me their account of what happened and what they are doing about it'. However, it is also recognised that this can mean 'taking the blame for events that are outside of their control'.

From the CD's perspective, the SM is not expected to *resolve* problems which involve consultant medical staff. Rather, the SM is expected to identify issues and gather information which enable the CD and GM to take appropriate action:

> …having identified bottlenecks in a process she might say, "OK well we need an extra clinic for this particular clinic (sic) because otherwise we're going to have breaches" and then that has to be negotiated between myself [Clinical Director], [general manager] and the consultant involved … she shouldn't go up to people and go, "You've got to do an extra clinic" because that's not her role …her role is to identify this is where we're

> going to have problems hitting our targets and highlight it to those that can do something about it. (Clinical Director, *Alpha*)

Capacity management is particularly acute in medical specialties, where there is an accident and emergency department (A&E), where there is close monitoring of performance by the Department of Health and where levels of demand are unpredictable. SMs are expected to deal with these issues when they are the on-call manager of the day. When acting as on-call managers, a role they share with other more senior managers, they are expected to respond to issues that arise across the whole trust outside normal working hours and for coordinating activity to meet accident and emergency targets on an hourly basis.

> [if] there's no beds in the hospital then I would [expect the on call SM] to go and see what we could sort out from a Trust-wide perspective. (GM Surgery, *Beta*)

Meeting targets involves negotiating with and cajoling others, including doctors who may be resistant to managers interfering in an activity which in their view they do not understand:

> I've had plenty of instances where bed managers in desperation to clear beds, have been ordering the moving around and worse still,… discharging a patient who turned out…to have two lumbar vertebrae fractured and a seventy-five percent occlusion of the spinal canal …but was caught at the front door by one of the junior members of the team, …'Where the hell are you going Mr X?'… these folk have been pressurising clinical staff …pressurising ward staff … to act inappropriately. (Consultant, *Alpha*)

4.1.3.1 Human resource management

SMs are expected to undertake both the general line management and specific human resource management of 'front-line' staff within their department. These include mainly medical secretaries, whom SMs manage on behalf of the consultants, clinic coordinators and receptionists. The SMs are responsible for annual performance appraisals, recruitment, disciplinary issues and ensuring and monitoring attendance of the administrative and secretarial employees at mandatory training sessions:

> HR reports monthly on you know, the training uptake, appraisal rates, staff sickness levels, all of that kind of stuff and again, we would manage that through our management group, talk about it, change things that need changing. (GMDiagnostic services, *Beta*)

SMs are expected to hold regular meetings, both informal and formal, with these employees. In practice, planned meetings are frequently postponed or cancelled due to work pressures on the administrative staff. They are also expected to

complete health and safety inspections for their areas, although this is a task that they might delegate to a secretary.

In addition to line management responsibility for largely non-clinical staff, SMs are also expected to get involved in coordinating junior medical staff rotas. This generally involves contacting locum agencies or negotiating with junior doctors from within the Trust to cover extra shifts at short notice usually due to sickness:

> That's particularly relevant to staffing on a day to day basis, so if there's people phone in sick or there's been a replacement or we have to get bank staff in or those sort of scenarios definitely is within their remit. (GM Surgery,*Beta*)

> I do the rota but what I expect her to do is to manage getting the locums so interacting with the locum agency and feeding back to me to let me know if something has been achieved or not…if there wasn't availability [of junior doctors] then I might say to her, "would you mind speaking to X, Y and Z" and seeing if they're happy to stay on and do extra hours after their shift has finished and we'll pay them a locum rate. (Clinical Director, *Alpha*)

4.1.3.2 Financial resource management

In addition to day-to-day operational and line management, SMs are expected to be involved in the business management of the specialty and wider department. However, as noted earlier, this is carried out on behalf of, and under the supervision of, the CD and GM, with whom 'budget holder' accountability resides. CDs and accountants expect the GM to have chief responsibility for budgetary and wider financial issues alongside the CD. In general, the expectation that SMs get involved with budgetary monitoring and decision-making is not particularly strong although there is some disagreement about this across individuals and specialties. Some GMs consider that there could be scope for more SM involvement:

> It's not going to be the specialty manager who's going to be making a decision about whether we're going to have less nurses or less of a service, that's going to be my decision. (Clinical Director, *Alpha*)

> If you look at Orthopaedics, which I think the turnover is probably about 35 million …the General Manager is running what is essentially quite a big business … and if it all goes pear-shaped, they're the ones that are going to get you know, beaten up over it. (Divisional Accountant, *Beta*)

That said, SMs *are* expected to have some fluency in the *language* of finance and accounting and to get involved as much as they can.

> ...there's another task for me so speaking to customers and delegating more budget responsibility. If you asked me a couple of months ago I would have said oh yes they have budget responsibility but actually I don't think that's necessarily the case' …that's something that needs clarifying. (GM Diagnostic services, *Beta*)

4.1.3.3 Strategy and service development

Generally, there are only tentative expectations that SMs be involved in strategy and service improvement. They are not expected to be strategic decision-makers, but largely information gatherers. One CD for a surgical directorate was enthusiastic about 'business' opportunities, colourfully described as 'to drill for oil elsewhere', but expectations of responsibility in this area focus mainly on the GMs and accountants. The role of the SM in business development is seen more as one of picking up issues when they have been decided by the senior managers or clinicians, gathering performance and cost data and liaising with clinical groups. This, again, means working closely with and in support of the GM rather than independently.

Consultants see the SM role as forming part of the 'underpinning structure' necessary to facilitate clinical work. SMs are expected to provide the 'nuts and bolts' to enable the implementation of consultants' ideas for service development. When SMs do attempt service developments, this is considered extraneous to the core purpose of the NHS and even described as 'childish' by doctors. The productive operating theatre (TPOT), which is part of the NHS Institute for Innovation and Improvement's 'Productive Series', is an example of a management initiative that doctors consider to be a managerial contrivance. It involves the Toyota production system's lean management (Spear, 2005) methodology for the purpose of encouraging 'NHS employees to redesign and streamline the way they manage and work to achieve significant and lasting improvements in the quality of care delivered to patients whilst reducing costs' (NHS, 2011):

> …management likes to go in for play …this…TPOT… irritates grown-up people to be honest and there is an awful lot of that so a [SM] has to be, I think, careful not to put the backs up people that have to work and deliver. (Consultant, *Alpha*)

From the doctors' perspective, there is a lot of 'management for management's sake' and some aspects of the SMs' role are seen to reflect this. While it is accepted that this has in part been driven by central government, the hierarchical management structure is also seen as 'a career plot' to further managers' self-interest. Similarly some Ward Sisters take the view that there are 'too many managers':

> Business managers have lots of meetings, not sure what about, they don't decide much or make things happen. (Ward Sister12, *Beta*).

4.1.3.4 Interdisciplinary working and meetings

The working relationship between the GM and SM, as part of the general management function in the acute care, is a close one. However, there is a wide range of staff with whom the SMs interact in the course of their work. While many different groups interact with SMs, each interaction is largely over recurrent specific issues. For example, Ward Sisters send SMs details of staffing numbers or audits by email periodically; some CDs request a regular performance report from the SM every week or month. Often these tasks will involve translating the 'business' issues of performance data or financial accounts into a language that clinicians can understand:

> [my specialty manager is] good at sort of talking the right language to certain groups of people so that they can understand what we're talking about and I think that a really handy- that's a really handy thing to be able to have. (Clinical Director, *Alpha*)

> What I say to my SMs is they spend as much time as possible going out and speaking to people and making those relationships, connections and engaging opinions as much as possible. (GM Diagnostic services, *Beta*)

The ability to navigate between the terminology and jargon of different groups is seen as an important task for SMs and a prerequisite for the more diplomatic negotiations between competing clinical and managerial priorities and in facilitating meetings between different clinical interest groups, such as doctors and nurses. Several managers and Ward Sisters feel that a clinical background can help SMs in this respect because they then better understand the clinical perspective:

> From my own experience it is really useful to have a [service] manager who has some sort of clinical background, it's very powerful, my best conversations and my leverage often as a manager are that I can get on to the clinical conversation wavelength if I need to and it works really well and you can never get that thing, "Well you're only a manager, what do you know?" –, you fight for your credibility as a manager because you haven't got the- the clinical thing to … and of course, everything's the managers' fault! (GM Medicine, *Beta*)

4.1.4 Service Managers' interpretation and enactment of their role

The economic logic of efficiency and the political nature of the public sector dominate the context within which the SMs experience and practice their role.

This is translated and transmitted within both organisations as performance targets and budgets, which are largely dictated by the Treasury, the Department of Health and external bodies such as the Care Quality Commission, the regulatory body tasked with ensuring NHS organisations are meeting national standard of quality and safety. SMs believe that they are personally responsible and accountable for the performance of 'their' SBUs.

> Everything becomes your problem, so if it's in your Specialty 'Oh you're the Specialty Manager, you sort it out' no matter what it is, you know, if it's piece of bloody rubbish on the floor. (SM5,*Alpha*)

> They [finance] want to know what I'm going to be spending, is the activity we're doing making us money, how much money, how much activity we're going to put through, how much am I paying my doctors. (SM 1,*Alpha*)

The language used by SMs implies that they have control of staff and other resources related to the respective SBUs. However, in reality, they have few staff who are directly accountable to them for their performance: the SMs directly manage around twenty or so medical secretaries and other administration staff, often on behalf of the consultants.

SMs believe that administrative staff expect them to provide the equipment and support they need to work effectively and expect them to be available, respond to their needs in a timely manner and provide them with information about issues relating to the SBU and wider trust.

More importantly, the SMs interpret their role as one of meeting the often competing and conflicting demands of different executive directors to achieve the organisations' respective targets by identifying reasons for under-performance and by intervening actively on a day-to-day basis to find ways of improving systems and processes:

> when I first started [it was] said that ninety percent of my role was managing the waiting lists, it was very much a target driven role …I can remember talking to the Director of HR a few years ago who said,… 'you know the role of a Specialty Manager, ninety per cent of it is people management and HR!' … and your financial management accountant will say, 'Well you know, you've got to achieve your finance targets, you know, this job is all about finances! (SM 3,*Alpha*)

> Associate Director, I mean she just wants me to deliver everything, she want no complaints, she wants the target to hit, she wants the budgets met, she wants breaches notified, she wants services developed, you name it. (SM 1,*Alpha*)

SMs see this as being shaped by senior managers' expectations, translated into SBU performance targets and embodied in data management systems such as Balanced Scorecard. SMs directly experience senior managers' expectations in

regular performance management meetings where SMs, the CD and GM are, together, expected to account for performance failures:

> We have a monthly review with the Chief Exec, now that's a three-line whip, where the whole progress and our delivery of our services is monitored, that is absolutely essential. Every Thursday morning at 8.30 we have a performance meeting where the graphs go up and it shows you how many people you've got on your waiting list and all that kind of thing, that's also essential. (SM 3,*Alpha*)

> Then there's these capacity meetings twice a week, twice a day, … they tend to go through the breaches they found the day before every day with the person that analyses those ... seeing why they're breached and making sure that they really were breaches, seeing if we can learn anything. (SM 8, *Beta*)

What SMs perceive as a problematic structural relationship with consultant medical staff further complicates the picture. While consultants are nominally managerially accountable to the CD they are de facto autonomous professionals. Ultimately it is the consultants who are the arbiters of the cost-efficiency and effectiveness of the SBUs' work performance and they make this clear to the SMs:

> I've been told ... 'I will make sure that the operations are done but …if you haven't got enough capacity that's down to you rather than down to me.' …they're there to treat the patients, you're there to be the bureaucrat and see the number. (SM 4,*Alpha*)

> There are a few really nasty bullies that are consultants but that's just because they think they're God. (SM 6, *Alpha*)

Hence it is this group with whom the SMs feel they have to interact directly in order to meet their performance targets. Thus, they see themselves as 'managed' by and have, in turn, to attempt to manage, their consultants. This involves skilful negotiation and careful management of interpersonal relationships.

> It's essential that you have good working relationships with the consultants… I take away a lot of the hassle for these guys to enable them to do what they do. (SM 9,*Beta*)

> …it's personable skills, it's trying to get people on board that they will do additional work. (SM 3, *Alpha*)

> …she [Consultant] will fall out; usually she's cross that I've done something you know, managerial, and she'll scream and swear at me and shout at me 'Never darken my outpatient clinic again!' and physically shove me out the clinic but she's made to apologise and … eventually we'll make it up again. She'll …say, 'Oh I like your shoes'. I have to make up with …the consultants because I work with them on a day to day basis, I

> can't afford to fall out with them so that's how I manage my consultants. (SM 5,*Alpha*)

Some of this conflict between SMs and consultants is seen by SMs as relating to consultants protecting their private practice:

> The conflict that you have with the consultants is down to the private practice territory. (SM 5, *Alpha*)

However, more substantial conflict is seen as arising between the SMs' organisational remit to meet government targets and consultants' wishes to pursue their clinical practice as they see fit.

> The managers now have so many targets to achieve that we are challenging clinicians because of targets and they're not able to deliver the service they want to deliver, the care they want to deliver, they actually think we're the ones that are damaging that and we do. (SM 6,*Alpha*)

This tension between organisational and clinical priorities can often be at its most acute when SMs are the on-call manager. This aspect of their role involves taking responsibility for the running of the hospital; carrying a bleep and being contactable day and night on either a 24-hour or weekly rotation for the purpose of dealing with any untoward incidents as varied as a fire or a missing patient. However, they are mostly expected to ensure that the hospital meets the national waiting time targets especially those relating to patients being seen, treated and discharged from A&E. Despite not having a clinical qualification and having only worked in a hospital for nine months one of the SMs believed that when she was SM of the day, the Site Nurse Practitioners (SNPs), whose role it is to coordinate bed capacity on a day to day basis, expected her to make admission and discharge decisions about patients.

> What they [SNPs] want from me is they want me to manage the beds for them, they want me to give them guidance on who they can admit and not admit, they want me to make decisions quickly so that they don't have to chase me around all the time and wait for me to make a decision about who I'm going to admit, whether I'm going to cancel people....I had to walk a gentleman to the bus at half past seven in the evening and put him back on the bus and send him home because I couldn't get a bed for him you know, an elderly gentleman and his suitcase, it's horrible! (SM 1, *Alpha*)

SMs are acutely aware of performance targets and regard performance management meetings as an opportunity for senior managers to create a situation where SBUs 'are pitted against each other'. These meetings are important and threatening not only because they allow SMs to demonstrate their competence as managers who are coping and complying with the demands of the service but also because the SMs perceive that they are on the receiving end of public rebuke for perceived failure to meet performance targets:

> I didn't realise what a big [issue the] target is. I mean I knew about it but I didn't know that actually how hard people come down on you if you don't hit it. (SM 8, *Beta*)
>
> Cardiology score card last month, most of it was red, Executive director X came to the meeting and started insulting everybody, calling them a bunch of idiots and things like this. (SM 6, *Alpha*)
>
> We'd get flak from the executive team on a monthly basis so we can't be in the red. (SM 3, *Alpha*)
>
> …I will be crucified for missing this target! (SM 5,*Alpha*)

SMs crystallise the diffuse conflicts and contradictions in their role into the specific 'problem' of pressure: meeting performance targets over which they have little control since the admission, discharge and treatment of patients is decided by medical and nursing staff and performance targets are set by senior managers but imposed largely by government. They are meeting infinite demand with limited resources; and doing so with little real managerial authority. They attempt to resolve this by defining themselves as 'conformist administrators rather than as interventionist managers' (Hales, 2007). They do what they haveto do, without challenging senior managers, whom they believe expect them to make a difference to organisational processes, and without antagonising consultants, whom they believe expect them to support and facilitate a work environment conductive to their clinical practice.

> I'll just do it because I've been told that I will do it. (SM4,*Alpha*)
>
> … they talk about these strategic business units we've got, it's a [lot] of **** we might as well not have them because if you're going to have a business unit, you need to be able to run it like your own company and reinvest your profit- you can't do that and profit is just sucked out of it to support another SBU that's failing and that's like *McDonald's* supporting *Burger King*, it just wouldn't happen. (SM *6, Alpha*)
>
> so I went to see Consultant X, who was not going to listen to me- who am I? I'm thinking. (SM5,*Alpha*)
>
> We're not allowed to disagree with the [senior managers] because if you disagree you don't get developed, you don't get promoted. (SM 6,*Alpha*)

Thus, SMs handle the competing and often inconsistent demands made upon them by coping and complying. They enact their environment as one that requires them constantly to monitor waiting lists and waiting times and have a visible presence with secretarial staff, in clinical areas and at meetings even when they may have little or nothing to contribute. Consequently, they are quick to respond to the demands of others both above and below them in the organisational hierarchy:

> I manage about twenty secretaries and they want support, annual leave, they just want things to be done quickly… some will want a new fax machine and this, that and the other. (SM 1,*Alpha*)

To meet the perceived pressures SMs manipulate the scheduling and allocation of out-patient clinics and in-patient beds as far as they can on a day-to-day basis. They 'juggle patients around to try and get them in' and negotiate with doctors to work extra hours or to add patients on to the end of their operating lists:

> Sometimes we can put on an extra list …other times we've had to cancel or move a routine patient in order to get a cancer patient seen quicker…I think that's probably what takes up most of my time…sending emails out to consultants asking if anyone can do any extra lists this week,… they might agree to see one extra patient at the end of that morning list. (SM 10, *Beta*)

> I work a lot with admissions looking at consultants' waiting lists if they've got problems with their waiting list I might have to arrange extra operating lists on a Saturday or something. (SM 5, *Alpha*)

Certainly, SMs *aspire* to managing the SBUs in ways that would meet or exceed performance targets and to construct an identity as managers who can 'make a difference'. In reality, having limited managerial authority means that they need to build collaborative relationships and, even so, can be lured into reactive problem-solving:

> [I] just spend a lot of time every day just talking to people … because I'm trying to have relationships with people, build relationships …and get to know everyone's name because I don't want the first time I go to them to be when I am asking them to do something. (SM 8,*Beta*)

> I'll get a call from the theatre saying, 'Consultant Such and such is kicking off … and I will get back to my desk four hours later having spoken to patients, relatives, the consultant, the anaesthetist, calming people down, taking people aside and I'll get back four hours later going, 'Now where was I? (SM1,*Alpha*)

> if a patient came and they were… not very pleasant to a member of staff and they didn't want to deal with it, then I would go down and try and resolve the situation, make it a little bit calmer and try and sort it out. (SM4,*Alpha*)

As junior managers, some without managerial qualifications, in a professionally-dominated organisation, SMs can feel undervalued, a feeling reinforced when they are asked to undertake clerical tasks such as taking minutes in meetings:

> I think it's completely underestimated and undervalued the role of specialist manager is I don't think people have the concept of how pivotal it is in the organisation. (SM 3,*Alpha*)

All this creates a sense of frustration, with SMs believing that if only they could stop reacting to events and take the time to review processes, they would find more effective and efficient ways to organise their services. Indeed, some have *been* involved in process redesign work using the principles of 'lean management':

> the most challenging is project management; that's the one that gives you the most nightmares because you're dealing with an extremely difficult group of staff… you need such unbelievable skills and knowledge of what cultures are like, it's no good going in to a load of medical doctors with a posh suit on and a cheesy, you know what I mean, because they just don't like that at all… so it's different styles… if you get it wrong early on, you're stuffed because unfortunately NHS staff are unforgiving! (SM 7, *Alpha*)

> doing the project work and doing yellow belt and green belt I've found very valuable …I won't be fire-fighting as much, I'll be stepping back a bit and saying, 'Well let's get to the bottom of this, let's get to the root cause' rather than just you know, put on extra clinics all the time, and putting on waiting list initiatives. (SM 5,*Alpha*)

In meeting the competing demands of others, SMs pay comparatively little attention to their own needs and have no particular expectations that the organisation would or should help them to achieve a balanced work and home life or to develop personally. They talk of working on average fifty hours per week, missing meal breaks and not having time for a cup of tea. In short, they feel that they cannot be seen to be not coping, especially given that they are constantly told that it is simply about prioritising their workload:

> I am so new to this, other people who are just used to this culture, everyone's ..like, 'You should prioritise' … it's so funny because the thing is everything's a priority, financial picture is a priority, achieving Foundation Trust status is a priority for us .. having a good patient survey, …keeping the department safe and having high quality- that's an absolute priority! And our staff survey and our staff well-being which hasn't been always great, that a priority. So there's actually like nothing that can't be a priority. (SM 8,*Beta*)

This need to be seen to be coping is reinforced by their lack of clinical knowledge and their desire to be seen as credible in the eyes of the consultants. It partly determines how SMs enact their role; in particular, the long hours worked by SMs in surgical specialities is often driven by a desire for acceptance by consultant surgeons who structure their day so that they can fulfil their NHS contract whilst maintaining a distinct private practice:

> …7.30 this morning we had our surgical consultants' meeting so I was in at 7 o'clock… I take the minutes and the reason I do that is they don't actually want a secretary there listening to what can be quite private conversations - I am trusted to sit in on these conversations… (SM 8,*Beta*)

> …a lot of them [consultants] will check their emails 8 or 9 o'clock at night so we'll communicate then. (SM 1,*Alpha*)

Therefore, SMs handle the conflicts which they face by constructing an identity as dedicated, responsible individuals holding things together at the centre of *their* respective SBUs, cajoling, fixing and juggling both people and processes to maintain the unit's functional integrity on a daily basis:

> The minute I'm off on holiday, everything kind of falls apart, and I come back to over a thousand emails. (SM 9,*Beta*)

At the same time, in common with many managers, they take pleasure in 'busy-ness', and enjoy working under pressure, 'working with people' and 'putting things right' in an often dramatic and highly emotive context:

> I do love that, predictable, boring stuff no … I absolutely thrive under pressure. (SM 8, *Beta*)

> I love my job, I absolutely love being a specialty manager. (SM 5,*Alpha*)

> You get one person that complains there's a tea stain on the floor and then another person complains that you killed their father, it really is that extreme, and actually it really upsets me,… there's some that are heartbreaking, … I've read them with tears rolling down my face thinking, God that could be my Dad. (SM 6,*Alpha*)

Given their ambiguous position in the organisational hierarchy and the complex and often conflicting role set expectations SMs enact their role in a manner that reinforces the demands and expectations placed on them . In this way, SMs collude in the creation of the very conditions that they then have to manage. This can come at a cost to their health and emotional wellbeing:

> I don't sleep very well , I dream about it all the time- I think about- it's absolutely completely taken over my entire life, my personal life, everything, I don't think about anything else… I wake up thinking about it. (SM8,*Beta*)

> I'm starting to feel it now, I've been unwell for about two weeks with colds and things … and I've been working like that since December and the minute you're off sick you're bullied. (SM 6,*Alpha*)

4.1.5 Conclusion

Prima facie, the SM role is a conventional first-line management one. Formally defined by responsibility for a discrete clinical specialty or service area, it subsumes day-to-day operational coordination of work processes and supervision of administration and clerical staff, framed by responsibility for performance management relating to critical waiting time targets. SMs are expected to solve

workflow problems by monitoring information, identifying gaps or problems in the system and generating solutions. However, often the solution requires manoeuvring clinicians and other staff, over whom the SM has little to no authority, into working more or different hours. Medium to long-term solutions are not considered to be within the remit of the SM.

However, in practice, the role is weakly defined. It is the CD and GM acting in concert who are the specialty figureheads and accountable to the trusts' senior managers for their respective specialties' performance and financial management. The SM role is more of a recently constructed, operational level adjunct to the GM role than a role in its own right with distinct and well defined responsibilities and tasks. There are few clear-cut tasks and responsibilities which are peculiar to it and distinct from that of the next level up.

The SM role is constituted as a residual one, comprising various direct monitoring, supervisory and information collecting task - the 'dangerously routine work' (193) - which GMs wish to off load. It represents is an extension of the management hierarchy to the point where 'management' meets, and has direct contact with, the operational level. Consequently, as a downward partial addition to the GM role, it is an attenuated version of the traditional FLM role. As the GM's subordinate, the SM is expected to undertake *aspects* of what would be regarded as a conventional FLM role, pieced together out of those tasks and responsibilities which the GM does not wish or does not have the time to perform. As a kind of an 'echo' or 'ghost' role, it is characterised by inherent structural ambiguity and uncertainty.

This structural ambiguity and conflict is instantiated in SMs' experience of specific dissonances between organisational targets and constraints and in the divergent expectations of senior managers, consultant medical staff and other employees. SMs perceive that their credibility as managers depends on their meeting senior managers' expectations that they make a difference to organisational performance by meeting organisational targets, whilst working within financial constraints, limited capacity and infinite demand and with little authority, given their structural location at the lowest point on the managerial hierarchy, with few staff to manage directly.

Since it is doctors and consultants who control financial resources by their treatment decisions and ability to attract 'business' in the context of a competitive pseudo-market driven by patient (or general practitioner) choice, having a convivial relationship with consultants is the only way SMs believe they can do their job. They perceive their ability to manage as dependent on their skilful maintenance of relationships with consultant medical staff and, therefore, attempt to enact their role in a way that avoids conflict with consultants and supports their needs. To this end, they are prepared to perform routine administrative tasks such as taking minutes, co-ordination of the junior doctors' rota and by managing the medical secretaries.

Because SMs see themselves as dependent on consultants and other clinical and non-clinical employees over whom they have little or no control, they enact their role as one of 'reactive problem-solver', constantly monitoring waiting lists and waiting times, juggling and negotiating. They 'walk the job', so as to have a visible presence and aim to be constantly available, rarely saying no to staff requests for them to resolve issues. Although they can see more effective ways of doing things and would like to get to the root cause of problems, they find it difficult to extract themselves from operational fire-fighting. Consequently, they maintain the ill-defined boundaries of their role to which they feel obliged to react.

Thus, they construct their identity as 'hardworking employees' who thrive on problem-solving in demanding and complex circumstances and define themselves as 'conformist administrators', doing what they have to do without questioning senior managers or alienating consultants. They work long hours and thereby generate further pressure to perform. Consequently, their self-imposed identity as frantic, reactive problem-solvers becomes a self-fulfilling prophecy with potentially harmful effects on their health and wellbeing.

5 Conclusions and implications

5.1 Concluding discussion

The growth, over a number of phases, of management as a mechanism of coordination and control and a multiplicity of general managerial positions charged with undertaking it, coupled with various, tentative forms of marketisation and motivated by the goal of ensuring public provision of adequate healthcare without an excessive drain on public expenditure and providing a counterweight to the professional power and perspective of clinicians, has ramified into the growth of assorted de facto *first-line* management positions in the NHS.

As expenditure on healthcare threatened to consume an increasing proportion of GDP, successive governments have seen greater management control, combined with forms of quasi- marketisation, as the solution to the inter-related problems of balancing health care supply and demand and challenging the perceived threat to modernization from the medical profession's hegemony and self-interest. In successive NHS management reforms aimed of controlling public expenditure, challenging producer monopoly, expanding consumer choice, stimulating competition, ensuring value for money and improving quality, more managers and internal markets have been central.

In this, the role of managers in general has been, variously, to plan and control resource allocation, monitor and manage performance against centrally-determined targets and standards, co-ordinate and monitor systems of internal contracts and set the business framework within which clinical decisions and practices are undertaken. Managers and managerial values have been set as counter-weights to clinicians and professional values. However, without either the freedom or authority to manage, mangers have struggled to deliver on these responsibilities.

The growth of management in general in the NHS has ramified at the level of *first-line* management roles in two ways. On the one hand, an assortment of de facto first-line manager positions, such as that of Service Manager, has been created, largely as adjuncts to General Managers, with diffuse, ad hoc responsibility for assisting with planning, monitoring and measuring performance against targets and budgets. On the other hand, front-line senior clinicians, notably Ward Sisters, who always had a leadership role at ward level, have seen greater managerial responsibilities relating to staffing/HRM and performance management added to their clinical responsibilities. The way that these two roles have been constituted structurally, shaped by others' expectations and

interpreted and enacted by managers themselves displays both similarities and differences.

For Ward Sisters, the division of work and responsibilities, specified in hospital organisation structures and echoed in others' expectations, defines their role as a complex blend of hands-on nursing, professional ward leadership and organisational management, with increasing emphasis upon the last of these - in short, a practitioner-manager role, subject to both clinical and organisational demands. This has given rise to both tensions and ambiguities in the role, expressed in the divergent, and often competing, expectations of other nurses, clinicians and managers. The inherent role-conflict in being, at the same time, a clinician, directly engaged in patient care; a clinical leader, mentoring and developing junior nurses and ensuring high quality patient care according to clinical criteria; and a manager, involved in directing, monitoring and reporting work performance against business criteria of cost-efficiency, throughput and 'quality standards' is coupled with role-ambiguity over the distinction between the Ward Sister and Matron roles and a dissonance between increased managerial accountability without a commensurate increase in managerial authority.

Despite pressure to become, think, speak and act like managers, Ward Sisters continue to value, embrace and prioritise their direct nursing and clinical leadership role. They perceive themselves as both part of the clinical team on the ward, with hands-on responsibility for patient care that requires the credibility and professional authority that comes from maintenance of their clinical skills and expertise, and leaders on the ward, with 24-hour responsibility for ensuring the availability and competence of the nurses and student-nurses in their charge, the condition of the physical fabric of the ward, the quality of patient experience and co-ordination with other professionals. They see both as threatened by their growing managerial responsibilities for HR management, clinical auditing, performance management, budgets, implementing change initiatives and for complying with the formal procedures associated with these. They have to reconcile their own clinical orientations and priorities with the work expectations of nurses and care expectations of patients and with the growing constraints of budgets and managerially-imposed targets. They do so by re-affirming their identity as uniquely competent senior *nurses,* central to delivery of patient care and development of present and future nurses in a system which they perceive as inherently chaotic and beyond their control; by delegating management tasks perceived as routine, clerical and tangential to patient care to more junior staff; and juggling their remaining responsibilities by prioritising and attending to immediate clinical matters, whilst formally complying with those targets and procedures which they cannot avoid. In short, when not resigned to chaos, they prioritise, juggle and delegate.

In contrast, the Service Manager role is, prima facie, more conventionally a first-line management one. Formally defined by responsibility for a discrete clinical specialty or service area, it subsumes day-to-day operational coordination of

work processes and supervision of administration and clerical staff, framed by responsibility for managing performance against targets. The role is a largely tactical one, with Service Managers expected to monitor and collect information and identify and solve ad hoc work-flow problems. This requires working with and through clinicians and other staff over whom they have little or no authority, to develop solutions. But, in practice, the role is weakly defined. The Clinical Director and General Manager, acting in concert, are the head of a specialty and are accountable to senior managers for that specialty's operational and financial performance. The SM role is more of a constructed, operational-level adjunct to the General Manager than a role in its own right with distinct and well-defined responsibilities.

The Service Manager role as formally constituted is a residual one, composed of various direct monitoring, supervisory and information collecting tasks – the 'dangerously routine work' (193) - which General Managers wish to off-load. It is, in effect, an extension of the management hierarchy to the point where 'management' directly encounters the operational level. As a downward partial extension to the General Manager role, it is an attenuated version of what is conventionally seen as first-line management, concerned with undertaking *aspects* of that role, pieced together from those tasks and responsibilities which the General Manager has neither the time nor the inclination to perform. As a kind of 'ghost' role, it is characterised by inherent structural ambiguities and uncertainties.

This general ambiguity and uncertainty comes through, in Service Managers' experience, in specific dissonances between organisational targets and constraints and in the divergent expectations of senior managers, consultant medical staff and other employees. They perceive that their credibility and position as managers depends on their meeting senior manager expectations that they 'make a difference' to organisational performance by meeting organisational targets, whilst working within a 'wicked environment' of financial constraints, limited capacity and infinite demand, and without the benefit of clear authority, given their location at the bottom of the managerial hierarchy, or staff whom they can manage directly. Rather, since doctors and consultants control financial resources by their treatment decisions and ability to attract 'business', Service Managers are obliged to develop a subordinate 'working relationship' with consultants in order to their job. Because they perceive their ability to manage as critically dependent on skilful maintenance of relationships with consultants, they attempt to enact their role in a way that avoids conflict with, and gives support to, consultants, if necessary by undertaking routine administrative tasks. Thus, they are adjuncts of the General Manager obliged to act as assistants to consultants.

To manage this situation, Service Managers construct an identity as 'hardworking employees', thriving on ad hoc, responsive problem-solving in demanding and complex circumstances and enact a role as 'conformist administrators', doing what they have to do without questioning senior managers or alienating

consultants and working long hours. This, in turn, generates further pressure for themselves. Paradoxically, their chosen identity as busy, reactive problem-solvers becomes a self-fulfilling prophecy with potentially harmful effects on their health and wellbeing.

In short, Ward Sisters are nurses labouring under an increasing obligation to manage, whereas Service Managers are managers in search of some management to do.

5.2 Policy implications

The key policy implications arising from the way in which these two first-line management roles are defined, interpreted and enacted relate to the nature, status and integrity of the roles themselves and to their future function in the delivery of healthcare.

The implications for the nature of the two are somewhat different. The practitioner-manager Ward Sister role would be a challenging one for *any* incumbent, given its different, often competing elements. It is structurally constituted in such a way as to require of Ward Sisters a capacity to reconcile the clinical demands of being a hands-on nurse, the leadership demands of being a senior nurse and the organisational demands of being a de facto first-line manager. This, in turn, requires the capacity to develop and direct and monitor the work of junior nurses, within the constraints of budgets and operational targets and the need to comply with formal control procedures, whilst at the same time maintaining their clinical expertise and professional credibility. The role is especially challenging given that Ward Sisters are trained as *nurses*, with a professional mind-set, orientationsand values.

That Ward Sisters cope with this role is testimony to their resilience and creativity but, from an organisational point of view, is problematic. No organisation should expect employees merely to cope, especially if by doing so, they act in ways that are sub-optimal from an organisational point of view. If by adhering to and prioritising clinical work and nurturing leadership, Ward Sisters relegate management activity to formal compliance and 'box-ticking', they may be failing to bring necessary management disciplines to nursing activity on the ward. The practical implication of this is that either Ward Sisters are left to get on with patient care, either directly or through developing, coaching and overseeing junior nurses - with management of wards the responsibility of another, more explicitly managerial role - or they are given extensive training and development to instill in them the deep skills (and not simply given a smattering of superficial 'tricks of the trade) required to appreciate and reconcile competing demands and priorities. If the former, the Matron role is the obvious candidate for a more explicitly managerial function, especially given that the division of responsibilities between Ward Sisters and Matrons is currently

unclear. If the latter, Ward Sister training and development has to be oriented to cultivating 'reflective practitioners', able to think through the complexity with which they are confronted.

By contrast the Service Manager role is in a structurally ambiguous position and as a relatively recent addition to the organisation's division of labour it lacks the historical continuity accorded the ward sister role.. It is not an explicit, well-defined first-line management role with clear responsibility for front-line supervision and performance management of a bounded team of employees, but a rag-bag of ad hoc 'gofer' activities which assist General Managers and both 'service' and cajole consultants. That Service Managers themselves manage to make themselves indispensable by providing information and taking ownership of others' problems and are frantically busy doing so are not sufficient grounds for retaining the role. Equally, there are no obvious training and development implications since the problem lies less with how the role is undertaken, more with the role itself. Rather, the role should either be removed, with General Managers taking greater responsibility for front-line management and other employees taking greater responsibility for their own administrative tasks and problem solving, or replaced by a more clearly defined first-line management role, with responsibility for day-to-day supervision, performance management and stewardship of a bounded operational area and group of employees.

First-line management is a crucial for delivering and monitoring of healthcare services; without effective implementation at the front-line, the intentions embodied in policy count for little. The extent to which the Ward Sister and Service Manager roles as currently constituted and enacted can fulfill that function, and, in particular, how far they can deliver any reforms designed to hold down costs whilst preserving or enhancing care quality, is questionable. Ward Sisters have the clinical expertise, status and credibility to leverage nursing staff into undertaking changes to practice that will deliver cost-savings and meet performance targets, but may be loath and reluctant to do so since these changes clash with their professional orientations and values. On the other hand, whilst Service Managers are more comfortable with managerial values and priorities, and, hence, more sympathetic to a cost-saving, performance management project, they will struggle to deliver on this because they lack a clear role, credibility and authority and, therefore, leverage over the clinicians upon whom they must rely to implement change.

It follows, therefore, that effective first-line *management* in healthcare requires first thinking through and developing coherent, focused and credible *first-line manager roles*.

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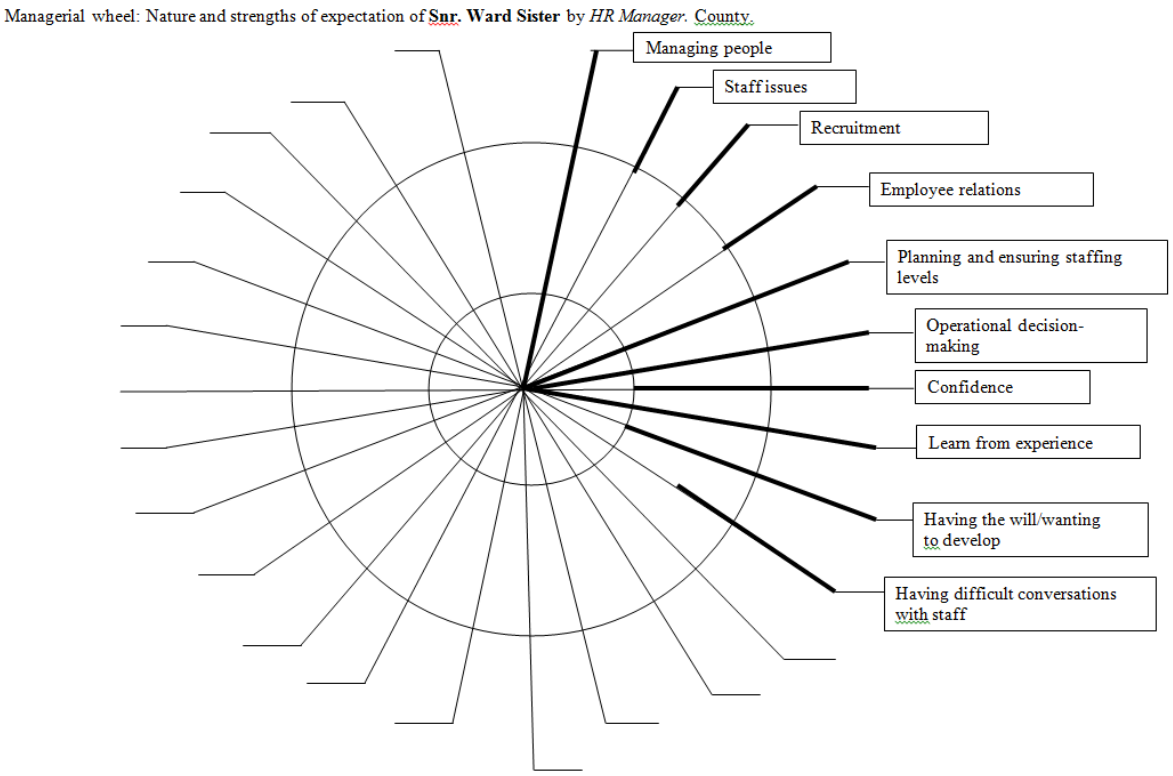
Appendix 1

An example of a manager's role set

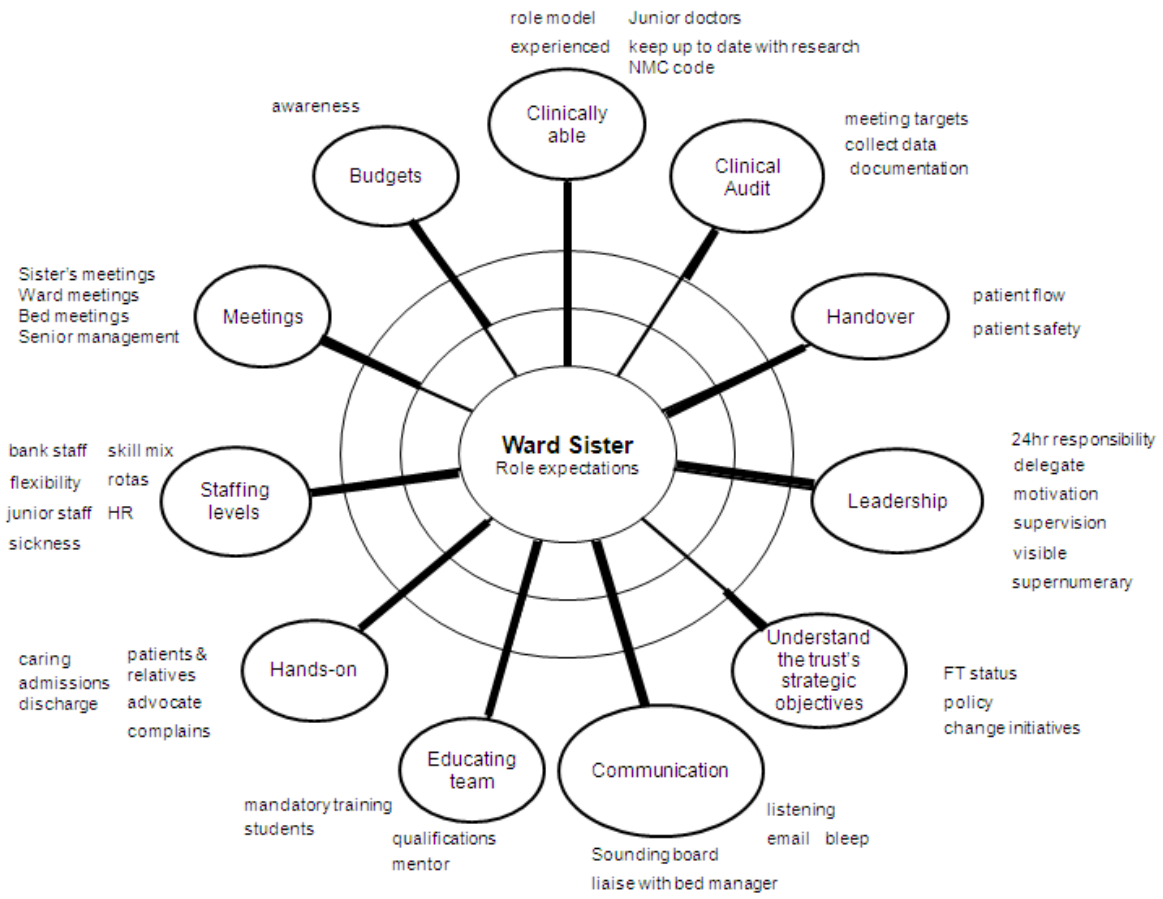
Appendix 2

An example of a completed managerial wheel showing nature and strength of a HR manager's expectations of a Ward Sister



Appendix 3

Follow-up interview role-expectation diagram for Ward sister



Appendix 4

Details of Ward Sister Interview Participants

Ward sister 1- Surgery, Alpha

Ward sister 2 – Medicine, Alpha

Ward sister 3 – Medicine, Alpha

Ward sister 4 – Medicine, Alpha

Ward sister 5 – Paediatrics, Alpha

Ward sister 6-Intensive Care, Beta

Ward sister 7-Paediatrics,Beta

Ward sister 8 -Medical Admissions Unit, Beta

Ward sister 9 - Surgery, Beta

Ward sister 10 -Surgery, Beta

Ward sister 11 - Medicine, Beta

Ward sister 12 - High Dependency Unit,Beta

Ward sister 13 - Medicine, Beta

Appendix 5

Details of Service Manager Interview Participants

Specialty Manager 1 – Surgery, Alpha

Specialty Manager 2- Oncology, Alpha

Specialty Manager 3- Medicine, Alpha

Specialty Manager 4 –Paediatrics, Alpha

Specialty Manager 5 – Surgical specialties, Alpha

Specialty Manager 6 – Medical specialties, Alpha

Specialty Manager 7 – Clinical Governance, Alpha

Specialty Manager 8 – Surgery, Beta

Specialty Manager 9 –Medicine, Beta

Specialty Manager 10 – Clinical Investigations, Beta

Appendix 6

Details of Ward Sister Role Set Interview Participants

Assistant Director of Nursing, Alpha

Associate Director, Alpha

Deputy Head of Nursing, Alpha

Deputy Sister, Alpha

Human Resources Manager, Alpha

Matron Surgery, Alpha

Occupational Therapist, Alpha

Specialty Manager, Alpha

Staff nurse 1, Alpha

Staff Nurse 2, Alpha

University Tutor 1, Alpha

University Tutor 2, Alpha

University Tutor 3, Alpha

University Tutor 4, Alpha

Deputy Chief Nurse, Beta

Head of Ambulance, Beta

General Manager medicine, Beta

General Manager paediatrics, Beta

Matron 1, Beta

Matron 2, Beta

Matron A&E, Beta

PALS manager, Beta

Physiotherapist, Beta

Superintendent Physiotherapist, Beta

Theatre manager, Beta

Appendix 7

Details of Service Manager Role Set Interview Participants

Associate Director, Alpha
Clinical Director, Alpha
Consultant, Alpha
Deputy Director of Nursing, Alpha
Occupational Therapist,Alpha
Physiotherapist, Alpha
Divisional accountant,Beta
General managerDiagnostic services, Beta
General managerPaediatrics, Beta
General managerMedicine, Beta
Head of Occupational Therapy, Beta
PALS Manager, Beta