THE PERCEPTIONS OF NHS MANAGERS TOWARDS THE RECENT NHS REFORMS AND THEIR EFFECTS ON THE NHS MANAGERIAL CULTURE

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CONTENTS

LIST OF FIGURES

LIST OF TABLES & DIAGRAMS

SUMMARY

The last few years have seen the introduction of a raft of new NHS reforms and, as in the past, NHS managers as change agents have been given the responsibility for their implementation. The views, beliefs and attitudes of managers to such changes can therefore be considered to be paramount to the effective and successful implementation of the proposed NHS reforms. Twenty-eight managers from two Acute Care and one Community Care NHS Trusts in London were interviewed, after completing questionnaires, with a view to understanding the factors that influence and affect the "social construction of reality" of the actors involved. It emerged that managers from Acute Care NHS Trusts particularly identified Clinical Governance as being the most welcome reform and this appeared to be partially linked to the belief that it would enhance their own power by making clinicians more accountable to management through a legitimate framework. Furthermore they saw Clinical Governance as a mechanism which would allow managers to be replaced by clinicians as convenient media scapegoats. The Community Care Trust managers were more concerned with the formation of Primary Care Groups and Primary Care Trusts as this had an immediate relevance to their day to day work because of the nature of their Trust. Although generally in favour of the recent reforms these managers were rather circumspect about increased workloads. By and large the managers believed that the NHS had a pan-organisational "altruistic" culture which had been unchanged by the past and recent reforms, and although they believed that the public did not see them as being part of this culture, the managers believed that this public view was misguided and unfair. The fit between the managers' perceptions of the recent reforms and their view of their own value system should generally have positive implications for the successful implementation of the recent reforms. If managers are to continue to support the NHS reforms it may be important that they receive acknowledgement of their contributions as well as wholehearted support from their own senior ranks, the public and from their political masters.

Keywords/phrases:

NHS managers, NHS reforms, Culture.

SECTION 1: INTRODUCTION

This research aims to investigate the perceptions of NHS managers towards the recent NHS reforms and their effects on the managerial culture within the NHS. In the course of this dissertation a case will be made to show how these perceptions will in turn have implications for the successful implementation of the recent NHS reforms. The investigation and analysis of this issue will be discussed against a backdrop of theories related to organisational culture and change and the potential value and contribution of this research will be highlighted.

The NHS is consistently subjected to considerable public scrutiny and has always been regarded as a politically "hot potato". As the largest employer in Europe employing approximately one million people [Corby, 1997] its size, complexity of operation and performance makes the NHS of great interest not only to practitioners within the field but also to policy formulators, academics and the public at large. Over the recent years, the NHS has undergone a series of fundamental politically led changes and the manner in which the NHS has responded and adapted (or failed to adapt) to these has sparked considerable interest. General Managers who were given responsibility and decision making power were introduced into the NHS by the last Conservative government with the objectives of achieving efficiency and effectiveness [Pollitt, 1990]. Prior to this process of Managerialism the NHS was deemed by the then government to run in an inefficient, bureaucratic manner with little regard for cost cutting measures or efficiency. Through the introduction of tight managerial control at various levels throughout the NHS, Managerialism aimed to replace this inefficient approach with one based on a more economistic and rationalist model in order to achieve the desired objectives of efficiency and effectiveness [Thompson & McHugh, 1995].

The introduction of this management layer also served to facilitate the implementation of various other major reforms and therefore the views, beliefs and attitudes of managers, as the major change agents, should be considered to be paramount to the effective and successful implementation of proposed NHS reforms. However as will be demonstrated in the Literature Review section there has been a relative poverty of

research examining in any great depth what the reforms have actually meant on a day to day basis to the people (including managers) who work in the NHS [Ham, 1995]. Furthermore the relatively limited amount of research undertaken in this area has usually adopted a positivist approach to the analysis and understanding of the issues and therefore neglects the recognition of the multiple factors that influence and affect the social construction of reality of the actors involved in the implementation of the reforms.

This research seeks to redress this relative lacuna by exploring and analysing how the changes in the NHS have so far affected the perceptions and attitudes of NHS managers. This may help to understand and predict the extent of and support for, the successful implementation of, the new wave of reforms introduced under the current Labour government. This study has purposely restricted itself to investigating the views of NHS managers rather than those of the healthworkers in general. The choice of NHS managers was not arbitrary; managers were identified by the government to be the change agents and hence their commitment to the change process should be an important factor in the implementation process.

In the course of this research one of the questions to be addressed is: **What are the managers' perceptions of the recent NHS reforms?** This will be useful in establishing whether managers personally perceived the NHS reforms as being potentially positive or negative, this study will then try to establish if their subsequent reaction and response to the reforms was an enactment of this perception [Weick, 1969]. The issue of perception is linked to that of organisational culture; while there is the view that beliefs and perceptions of individuals fashion an organisation's culture [Williams et al, 1989], the unstated assumption that workers inherently share common beliefs has attracted criticism [Hatch, 1997]. This research was therefore designed to include managers from different spectrums of NHS activity; the views of managers working in busy and large teaching hospitals engaged in high profile Acute services such as Accident and Emergency departments can be compared and contrasted with those of managers working in Community Care Trusts which provide more Cinderella services such as community Geriatrics and Mental health. An analysis of the different views should help to also address the question as to **whether the NHS managerial culture shares common beliefs and values over a range of issues, or alternatively**

if views are more fragmented and based upon coalitions determined by agreement or disagreement over salient issues as they emerge (as is the view held by Meyerson & Martin, 1987). If there is a definable managerial sub-culture it would also be of value to investigate **whether there has been a change in the managerial sub-culture within the NHS following the recent reforms.** This should provide an insight into the degree to which the managers' shared beliefs, attitudes and values are supportive of the recent NHS reforms. Furthermore this study will also address the question: **What are the managers' perceptions of society's expectations of their role?** This is useful as, in keeping with the views of Meyer and Rowan [1991], this may influence the managers' own personal perceptions and in turn the way they function in order to conform to society's expectations.

The data for this research was based upon a series of interviews with twenty-eight managers from Guy's and St Thomas' NHS Trust, Hammersmith Hospitals NHS Trust and Barnet Healthcare NHS Trust held between August 1999 and May 2000. The former two Trusts are high profile Acute NHS Trusts with large teaching hospitals while the latter is a smaller Community health Trust. The significance and relevance of the distinction between Acute Care Trusts and Community Care Trusts in this study is discussed in the Methodology section. The managers interviewed worked in diverse spheres of NHS activity at various levels of seniority. While the majority of managers had a managerial/administrative background, others had a nursing or a clinically related background. After due consideration a combination of questionnaires and semi structured and semi directed interviews were used which aimed at exploring managers' perceptions of NHS reforms as well as their values and beliefs and their views of various issues related to the NHS and its reforms. Whilst the data has been analysed mainly from a qualitative approach, there is also a degree of quantitative analysis. A fuller rationale of the choice of methodology used in this study is discussed in section 3 (Methodology).

This research places individual workers as the focus of attention and explores their personal reactions to a series of major transformational changes and it is hoped that this approach will prove to be meaningful in understanding the way the current reforms are viewed and implemented and may predict the extent of successful implementation of the proposed reforms.

SECTION 2: LITERATURE REVIEW

The NHS came into being under the stewardship of Aneurin Bevan (the then Labour Health Minister) in 1948 in order to provide free health care for all [Webster, 1992]. Today the NHS is the largest employer in Europe employing approximately one million people [Corby, 1997], with a complexity of operation and performance that makes it of great interest to government policy formulators and academics and not to forget the public at large who are interested stakeholders in its funding and performance. Over the recent years, the NHS has undergone a succession of politically motivated changes which will be outlined later in this section. Up until the late 1980s the government's approach to controlling the public sector was to focus on controlling public expenditure, costs and inputs, however this emphasis changed in the 1990s towards seeking instrumental objectives of economy, efficiency and effectiveness [Farnham & Horton, 1993]. Furthermore the NHS no longer enjoyed its cushioned protection from market forces as politicians and policy makers sought (and continue to seek) to achieve cost cutting and efficiency from the NHS by exposing it to quasi market forces [Best et al, 1994] by producing a split between the Purchaser (Health Authorities and Fundholding GPs) and Provider (NHS Trusts) of health care to determine resource allocation and efficiency within the NHS. The manner in which such a large organisation has implemented and responded to changes of various magnitudes has provided organisations, both in the public and private sectors, with a template for understanding issues related to the management of successful organisational change.

The importance of such an understanding is discussed by Rosenfeld and Wilson [1999] who highlight the significance of organisations surviving in the dynamic and changing environment of today's world; they emphasise that organisations today can only survive if they respond and adapt to the great number of challenging pressures facing them, these pressures include those related to rapid advances in technology, uncertain political environments and internationalisation. Rollinson et al [1998] point out further triggers of change which include financial losses and profit reductions, increased competition and catering for a diversified workforce. Furthermore, European state owned organisations like the NHS which in the past have enjoyed a degree of protection from market forces are now having to contend with the same

forces as their private sector counterparts as governments favour more individualistic and market oriented philosophies [Rosenfeld & Wilson, 1999]. Those organisations which for one reason or another are unable to respond to such pressures "are likely to become dinosaurs in the evolution of modern society" [ibid: pg 284]. Burnes [1996] also echoes this view point and emphasises the notion that the history of the human race is one of constant massive change and dislocation and he eloquently describes how the management of effective change is essential for organisations if they are to survive in today's uncertain environment. Furthermore Nicholson [1993] succinctly points out that those organisations which do not confront pressures to change from their internal and external environments are destined to fail. The NHS is not immune to such pressures and is facing a number of challenges which include rapid advances in technology and research; soaring drug prices, a longer living population and increased public awareness and expectations.

The significance and importance of the recent changes introduced within the NHS can be better understood in the context of an understanding of the historical roots of the NHS and its evolution over the years. The following summary of health care in the United Kingdom from a historical viewpoint is therefore of some value.

The basis of health care in pre NHS Britain was market driven with medical practitioners and hospitals operating in competition with each other with market forces and financial factors superceding any charitable national desire to provide health care as a right of every citizen. In the early part of this century and in the period between the two world wars health care in the UK was provided by private general practitioners and "self funding" voluntary hospitals which worked in a "medical market", raised their own funds, and worked in competition with each other. These voluntary hospitals dominated acute care in Britain [Webster, 1995]. By the 1930s the voluntary hospitals (especially those which ran prestigious medical schools) were facing serious difficulties in remaining economically viable, and therefore Local Authorities began to invest in setting up Local Authority hospitals which did not work in a competitive market. In December 1938 The Times in an editorial wrote of "a position so grave that the breakdown of the whole voluntary system looms on our horizon" [Webster, 1995]. Hospital services were unevenly distributed, inadequately funded and lacked co-ordination [Godber, 1988] and it was clear by the end of the

second world war that the health care structure had to change. The Beveridge report, published in December 1942, was the single most important document associated with this change [Webster 1992].

On the 5th of July 1948 under the stewardship of Aneurin Bevan, the then Labour Health Minister, the NHS came into being with the intention of providing "free health care for all from cradle to grave". In the first phase 2,751 hospitals came under the control of the new Regional Health Boards (RHBs) [Mercer, 1988]. For the next two decades the NHS did not undergo any major organisational change.

With the election of a Conservative government in the late 1970s Margaret Thatcher became prime minister and applied her brand of Thatcherism with a "wide brush". The NHS was not immune, in fact it was specifically targeted to receive a special dose of Thatcherism. In 1979 a consultative paper on the structure and management of the NHS entitled "Patients First" advocated a major shift away from the Keynesian public service model of an expanding centrally funded service provision to a decentralised one. This was proposed to be achieved through simplification of structure and the encouragement of local decision making. In 1983 the government commissioned Roy Griffiths, a senior Sainsbury executive, to look at management in the NHS and his report [Dept of Health & Social Security, 1983] which was subsequently implemented, introduced General Managers at Regional, District and Unit levels. This "line management" supplanted the existing "consensus management" by multi-disciplinary teams of officers from many professional groups [Black, 1995]. As Townsend et al [1988] put it "the Griffiths team was struck by what it saw as an apparent lack of clearly identified leaders and lines of management authority. In a frequently quoted passage they wrote "if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge". The prescription in the 1980s was to avoid time consuming statutory change, to create new types of posts (General Managers) and to reinforce their authority with a battery of reviews and performance indicators and eventually to introduce the competitive incentives of an internal market [Pollitt, 1990].

In 1989 a major White Paper entitled "Working for Patients" was published [Dept of Health & Social Security, 1989] with the intent to create a market in which the

hospitals (providers of heath care) competed with one another to win contracts from District Health Authorities (DHAs). The contracts would enable the DHAs to increase their control over the amount and quality of health care, while the competition would cause hospitals to provide a low cost service but of sufficient quality [Morgan & Potter, 1995]. This particular white paper contained revolutionary proposals which included allowing hospitals to apply for self governing status as separate legal entities among the NHS. They were to be called "NHS Hospital Trusts". The White Paper obliged hospitals to compete for patients by separating the "Provider" role of the hospital from the "Purchaser" role of the health authority, managers were key in this new process and managerialism was the favoured agenda. The White Paper encouraged general practitioners to hold their own budgets and to purchase care for their patients. It extended medical and value-for-money audits while encouraging a commitment to management among hospital consultants [Trevelyan, 1994]. Specific to London, plans for the restructuring of London hospitals were set out in the Tomlinson report [Tomlinson, 1992] and have since been implemented.

It was clear that from the late 1980s the Conservative government had embarked on its own programme of reconstruction which proclaimed a new philosophy that was fundamentally at odds with the original conceptions of the NHS [Webster, 1992]. Further reforms and proposals followed with the Patients Charter [Dept of Health, 1995] and the Private Finance Initiative which allowed private enterprises to collaborate and invest in the NHS [Marks, 1996; Suzman, 1996]. The merger of the Family Health Service Authorities and District Health Authorities in April 1996 promised to be the biggest catalyst of change in the delivery of primary care for the last 30 years [Warden, 1996].

Even as this increasing complex web of reforms was being spun the entire political picture changed with the electoral defeat of the Conservatives and the election of the New Labour government in 1997. The new government immediately set out its plans to abolish GP fundholding and establish a system in which GPs and Health Authorities cooperate together as "commissioning groups" to determine which services to purchase. The 1997 White Paper [Dept of Health, 1997] abolished the internal market and reorganised Health Authority functions into Primary Care Groups (PCGs) and Trusts (PCTs). The National Institute of Clinical Excellence (NICE) and

the Commission of Health Improvement (CHIMP) were set up to give high priority to Clinical Governance which is defined as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" [Health Service Circular, 1998]. Quality in the NHS has been given priority through the setting up of the National Quality of Services and by the setting up of NICE which will promote clinical and cost effectiveness through guidance and audit while health and health services will be attempted to be improved by CHIMP which will assess local arrangements and check on frameworks set by NICE.

Whilst the driving force behind the NHS reforms could be argued to be politically motivated [Thompson & McHugh, 1995] it is important to note that most of the reforms have been primarily aimed at achieving the fundamental objectives of efficiency and effectiveness in the NHS through structural changes [Dept of Health & Social Security, 1983]. However the importance of supplementing structural change with cultural change has only been recognised more recently by politicians, policy analysts and managers [Hughes, 1996].

It has been noted by practitioners in the field that there has been a relatively limited evaluation of the effects of the NHS reforms and this was considered by Robinson [1996] to be a consequence of government hostility to scrutiny, and subsequent evaluations of various changes in the NHS have been hampered by various confounding factors in the form of simultaneous change elsewhere (in the NHS). These incomplete evaluations have mainly focused on analysing and evaluating the changes from the point of view of issues such as the "performance of Trusts", "monitoring changes in health services", and "evaluating the equity implications of the NHS reforms" [Le Grand, 1994]. Through these yardsticks, evidence of promised benefits such as greater efficiency, better quality and choice have been examined with the conclusion that inspite of there being "little actual change of any kind", there were "at least in some areas, potential for real gains arising from the reforms" [ibid]. However these forms of evaluations have neglected to analyse and examine in any great depth what the reforms have actually meant to the people who work within the NHS on a day to day basis and the impact, if any, of the NHS reforms on the beliefs,

values and assumptions of the health workers has hardly been addressed. The closest Le Grand [1994] gets to this issue is when attempting to examine the perceptions of NHS managers to the reforms, he concludes that a "favourable outcome" in perception depended upon the management adopting a proactive approach to the implementation of the reforms through clarification, prioritisation, communication, simplification, corporate commitment and learning by doing.

The criticism that there is a lack of any meaningful provision of broader information on the NHS workers' views and attitudes to the reforms is also shared by Ham [1995] and similar omissions recur in an analysis and evaluation of the effect of some of the main components of the NHS reforms (e.g. market competition, Trust status, Purchaser/Provider split) on the productivity of English hospitals [Soderlund et al, 1997]. In this study the authors report that real productivity gains were apparent across the study period for NHS hospitals on average. Hospitals that became Trusts were more productive than those that did not. However, this study failed to even begin to address the issue related to the perceptions of the health workers to the reforms. A more recent study [Soderlund, 1999] evaluating increased managerial input upon productivity in the NHS internal market found an inverse relationship, however once again there was a conspicuous lack of observations regarding the effect that the reforms may have had on the health workers and no discussion relating to the effect that altered morale or motivation within the NHS could have had on productivity. However in fact it may not have been easy to obtain such information as a four year study designed to identify the emotional state of NHS managers by using managers' drawings to express their feelings about change commented on how managers in an attempt to protect other managers and staff from the complexity, uncertainty and messiness of change issues hid their own feelings about what was facing their organisation [Reddiford, 1996]. I believe that these examples demonstrate the overall general lack of attention that has been paid to the examination of the health workers' views and perceptions towards the recent NHS reforms.

It would be worth pausing to consider if the investigation of the health workers' and in particular NHS managers' views and perceptions towards the NHS reforms are so important? As with most major changes, the support of the staff affected by the changes is generally considered to be paramount for its effective and successful

implementation [Carnall, 1995, Burnes 1996] and to ensure support for the changes, the involvement of staff in decisions affecting them is considered paramount [Kotter & Schlesinger, 1979]. The effective implementation of change doesn't only depend on the support of the key staff but also on how the process of change is effectively managed and implemented by the change agents. Change agents are crucial to the effective implementation of change and are defined by Rosenfeld and Wilson [1999: pg 294] as "individuals or groups of individuals whose tasks is to effect the desired change". The NHS managers, charged with the responsibility and power for implementing changes determined at government level, are to act as the main change agents [Dept of Health & Social Security, 1983] and it could therefore be argued that the successful implementation of the various reforms depends upon the commitment and support of NHS managers as this will determine the extent to which they are able to successfully and effectively manage the change process. While Lewin's model [Goodstein, 1993] in general terms provides a useful theoretical framework to understand, manage and implement the process of change it has been criticised by Hatch [1997] as being too simplistic in its principles of "Unfreezing", "Movement" and "Refreezing" in order to achieve effective and permanent change. Furthermore Dunne [1996] describes two types of change processes identified as "first-order" and "second-order" change; the former is change which takes place on an incremental basis whilst the latter is more transformational. According to Dunne's paper, managers are also involved in the "transitional" aspect of change where providing support and information to employees affected by change becomes paramount to the successful implementation of the change. Individual contributions towards ensuring the effective implementation of change would obviously be dependent upon the responsibility, sphere of influence and power awarded to the managers.

The issues of Power and Politics are fundamental within any organisation and in his book "Images of Organization" Morgan uses the metaphor "Organizations as Political Systems" to provide an insight and an understanding of the complexity of interrelationships among actors in an organisation [Morgan, 1997]. Organisational Politics is defined by Pfeffer [1981:pg 7] as "involv(ing) those activities taken within organisations to acquire, develop and use power and other resources to obtain one's preferred outcome in a situation where there is uncertainty or descensus about choices". Power on the other hand is defined by Robbins [1998: pg 396] as "a

capacity that A has to influence the behaviour of B so that B acts in accordance with A's wishes". As a consequence of earlier NHS reforms, managers within the NHS exercise an increased level of Legitimate power [French & Raven, 1958] and the degree of this power is dependent upon their responsibilities, expertise and level of occupancy within the organisational hierarchy. It is therefore relevant to seek to understand the activities of managers within the NHS in terms of Power and Politics since an insight into the political activities of managers also helps to understand and gain an insight into how managers use power to achieve their preferred outcomes.

Weick believes that once the perceptions of organisational members are affected, action consistent with these perceptions will follow automatically [Weick, 1969]. Whilst some of the reforms awarded considerable amount of power to managers [Dept of Health & Social Security, 1983], it is also widely reported that NHS managers have subsequently been blamed and regarded as convenient scapegoats by the government for the lack of success of many of the reforms [Warden, 1995]. Furthermore, the government reinforced this view that managers were the scapegoats when it announced that it would axe numerous NHS jobs mainly in the managerial sector in order to cut bureaucracy and save the NHS £130 million in costs [ibid]. Such accusations and actions would not be expected to improve the morale of the managerial workforce. In such an environment it would also be useful to test Weick's enactment theory [Weick, 1995] by considering the extent to which the NHS managers believed that the environment created by the NHS reforms was one which was personally positive or negative and assessing if this in turn influenced their enthusiasm to implement change. I have therefore attempted to address the question "What are the managers' perceptions of the recent NHS reforms"?

The issue of perception is linked to that of organisational culture as the "beliefs of members are seen as the key elements of organisational culture" [Williams et al, 1989]. Culture from a modernist perspective has been defined by Rosenfeld and Wilson [1999: pg 270] as "the basic values, ideologies and assumptions which guide and fashion individual and business behaviour..." and perceptions therefore plays a key part in influencing the attitudes, values and beliefs of individuals, it would therefore be interesting to explore the extent to which the beliefs, values, attitudes and assumptions of managers may have changed as a result of the previous NHS reforms

and then go on to assess the extent that the existing NHS culture is supportive as regards the implementation of the new reforms.

At this point it is also worth pointing out that the above views on organisational culture held by Williams et al [1989] and Rosenfeld and Wilson [1999] attract criticisms particularly from postmodernists for the unstated assumption that workers "inherently" share common beliefs and values. Hatch [1997] from a fragmentist perspective embraces a post-modern view and holds that allegiances to subcultures may constantly shift with the issues of debate or discourse, this view is interesting since it advocates that coalitions in a subculture will be determined by the agreement or disagreement on salient issues rather than being based on common beliefs and values i.e. "subcultures are re-conceptualised as fleeting, issue-specific coalitions that may or may not have a similar configuration in the future" [ibid: pg 231]. Similarly, culture can also be viewed through the paradigm of ambiguity whereby coalitions within the organisation are based upon agreement or disagreement on salient issues as they emerge i.e. "...individuals share some viewpoints, disagree about some and are ignorant of or indifferent to others...individuals are temporarily connected by shared concerns..." [Meyerson & Martin, 1987: pgs 637-8]. It is therefore clear that understanding and defining organisational culture is a complex issue which depends upon how individuals in groups perceive and enact their reality and thereby define the organisation's culture. This culture may evolve and change reflecting changes in the organisation and its environment. In my research I have therefore attempted to examine whether the NHS managerial culture shares common beliefs and values over a range of issues, or alternatively is more fragmented and based upon coalitions determined by issue agreement or disagreement?

It would appear that there was no explicit plan on the part of the government to change the culture of the NHS and the "first wave of post-Griffiths studies found little evidence of culture management in action" [Hughes, 1996: pg 291]. This approach to achieving change may be criticised on the basis that desired fundamental changes cannot be achieved purely on the basis of a structural change (such as the introduction of General Managers across the whole NHS structure). This view is underlined by Fincham & Rhodes [1999: pg 414] who argue that "instead of changing the structure, real change must mean changing the corporate ethos, the images and values that

inform action...". It is in fact believed that "the only way to change organisations... (is)...to change their cultures" [Bennis, 1966: pg 201]. It would therefore be interesting to see if with the structural changes there has been a simultaneous cultural change in the managers' subculture and if so to assess the extent to which the culture underwent a successful transformation.

Fincham & Rhodes [1999: pg 417] crystallise the significance of cultural change when they write "indeed if real change is to occur in organizations - rather than cosmetic or short lived change - it has to happen at the cultural level". On the other hand defining organisational culture and the extent to which change in an organisation's culture can be measured is far from being straightforward. The modernist contention that an organisation's culture can be changed and indeed measured by analysing changes in performance and profitability (this assumes a direct link between culture and performance) [Peters & Waterman 1986; Ouchi 1981] may be easier said than done because this contention throws up some major difficulties. For example Johnson and Gill [1993: pg 101] regard culture to be "something an organisation is rather than something an organisation has", furthermore organisational culture has been viewed as something that is deeply embedded within the organisation and largely cannot be influenced or managed [Dyer, 1984; Martin et al, 1985].

It has also been asserted that resistance to attempts to change cultures is likely to be very strong and that the desired cultural changes are unlikely to be permanent [Ackroyd & Crowdy, 1990]. Robbins believes that "culture is transmitted to employees in a number of forms, the most potent being stories, rituals, material symbols and language" [1998: pg 610] and then goes on to suggest how these four factors can be influenced in order to bring about successful cultural change [ibid: pgs 610-613]. If one accepts the modernist contention that cultures can be changed then another major problem relates to the difficulties in how to assess cultural change. As alluded to earlier the excellence school [Peters & Waterman, 1986], by making a direct link between culture and performance, advocates that successful cultural change can be measured through identifying positive gains in organisational performance. As far as public service organisations are concerned, Colville [1993] has emphasised the importance of bringing about cultural change in order to support the successful implementation of organisational reforms. On the other hand, authors such

as Schein [1985] regard culture to be an "unconscious and largely invisible entity which by definition is almost impossible to measure, study or change". This view is echoed by Johnson and Gill [1993: pg 102] who vehemently regard culture as "something, that, largely cannot be influenced...". Whilst in the latter case the difficulty of studying and measuring cultural change is clearly highlighted, in the former, the ambiguity in defining organisational performance makes it difficult to measure change in organisational culture. Some of the issues thrown up by these differences in definitions of culture, and the ambiguity about the extent to which culture can be studied or measured are addressed by Weick [1969] who puts forward the contention that the symbolic-interpretative view of culture provides a useful insight into studying and understanding culture. He emphasises the value of ethnographic observation and analysis and stresses the importance of entering the cultural context of the organisation and learning to understand it from inside by studying artefacts and symbols in the situations and locations in which they naturally occur, and by trying to adopt a native view thereby understanding the unique interpretations of the symbols and artefacts by the workers within the organisation.

Despite these inherent difficulties of assessing and measuring cultural change this study has tried to address the question "Do the managers believe that there been a change in the managerial subculture within the NHS following the recent reforms?". This question could be approached by assuming a modernist view that cultures can be manipulated and changed, and in attempting to answer this question this research has tried to uncover the extent to which, if at all, there has been a change in the managerial culture of the NHS and if there exists a culture which is supportive of the various new reforms and ensures their successful implementation. At the same time this question could also be considered from the postmodernist view that instead of being commonly held values, subcultures can be "re conceptualised as fleeting, issue-specific coalitions that may or may not have a similar configuration in the future" [Hatch, 1997: pg 231]. This viewpoint holds that instead of assuming commonly shared values, coalitions within the organisation can be based upon agreement or disagreement on salient issues as they emerge i.e. "...individuals share some viewpoints, disagree about some and are ignorant of or indifferent to others...individuals are temporarily connected by shared concerns..." [Meyerson &

Martin, 1987: pgs 637-8]. This study explores both these avenues of enquiry in order to build a fuller understanding of the issues involved.

Another major factor that influences the behaviour of organisations and actors within them is the expectation of their environment [Meyer & Rowan, 1991]. The value of examining areas such as these has been propounded by Hirsch and Lounsbury [1997] who believe that multiple approaches should form the basis of understanding organisations through the application of institutional theory. It is argued that environmental expectations are a strong influence upon the way in which organisations function and behave, as they wish to be seen to conform to society's expectations [Meyer & Rowan, 1991; Thompson & McHugh, 1995]. Public attitudes towards NHS managers should therefore influence the behaviour and attitudes of the managers. Previous research in this area has indicated a somewhat negative view of NHS managers by the public and a "clear lack of sympathy for NHS managers (by the public)" [Learmonth, 1997: pg 215]. In this paper the author argues that it appeared unlikely that NHS managers would ever be popular with the public because NHS managers tended to share an ideology about the nature of the NHS and the role of management within the NHS which was at odds with the belief of most members of the public on this issue. The author concluded that "it could be that there is a commonly held view by members of the public that a service which managers are trying to make ever more efficient, rational and controlled cannot at the same time be caring and people centred" [ibid: pg 219]. In a recent paper the NHS managers' own perceptions of how others saw their role led to the conclusion that managers are very aware of the largely negative perceptions that surround them [Preston & Loan-Clarke, 2000]. In the light of these observations this study also attempts to address the question "What are the managers' perceptions of society's expectations of their role"? An answer to this question may go some way towards explaining and understanding the behaviour and attitudes of managers with respect to the latest reforms which they have currently been given responsibility to implement.

SECTION 3: METHODOLOGY

Introduction

At the start of this section it would be useful to restate my research aim so as to set the context for the rationale behind the process of examining, adopting and refining an appropriate methodology for this study. This research aims to investigate the perceptions of NHS managers towards the recent NHS reforms and their effects on the NHS managerial culture. Determining an appropriate and suitable research methodology was obviously a critical task since this would reflect the extent to which the research question would be successfully addressed and answered. This process involved a practical determination and selection of research methods and tools appropriate to the research aim, supported and underpinned by a consideration and examination of the various philosophical approaches to social sciences and their underlying assumptions relating to epistemology, ontology and human nature [Burrell & Morgan, 1979].

Selection of the NHS Trusts & Managers

Even before evaluating how the specific research questions could be accurately answered it would be useful to discuss the approach which was adopted in the process of selection of the NHS Trusts which employed the NHS managers who participated in this study. The starting point for this was an evaluation of different NHS Trusts. Were all NHS Trusts similar or did they have major differences? Through informal discussions with medical NHS staff at consultant level it was apparent that it would be incorrect to assume that all NHS Trusts are essentially similar. NHS Trusts differ depending upon the function that they are intended to serve in their community and on this basis NHS Trusts could be broadly divided into Acute Care NHS Trusts (i.e. a Trust where hospitals ran Accident & Emergency departments, Acute in-patient services and out-patient services all within the physical confines of the hospitals) and Community Care Trusts (i.e. where the Trust concentrates on providing intermediate and long term care to patients within the community. Community Psychiatry, Geriatrics and Paediatrics are important and heavily represented areas). As it was clear that each category of Trust would have differing priorities, strengths and

problems it was decided to target NHS Trusts from each of these two categories. By studying both categories of NHS Trust this study could in effect be said to form a cross - case analysis of NHS Trusts within London. Regardless of the final chosen research methodology the question of generalisability of the outcomes of the research is an important issue [Miles & Huberman, 1994] and the inclusion of managers from both types of NHS Trusts would increase generalisability of the research outcome. As Silverstein [1988] put it "we are faced with the tension between the particular and the universal: reconciling an individual case's uniqueness with the need for more general understanding of generic processes that occur across cases".

Several London based NHS Trusts were contacted in March 1999 with the intention of being able to carry out my research in at least one Acute Care Trust and one Community Care Trust. The Chairperson of each Trust was directly written to with an outline of my research and permission was sought for access to at least ten NHS managers from their Trust. Only two conditions were applied, firstly that the managers should have been working in the NHS for at least one year so that they would have some insight into the implementation of the recent reforms, and secondly that the managers who participated in this research would come from a variety of seniorities so that the views would represent a broad picture once again increasing generalisability. Seeking access directly from top management is an approach supported by Crompton and Jones [1988] and this proved to be valuable because once access had been approved at the top level, my admission to the organisation became legitimised and supported by formal authority.

Barnet Healthcare NHS Trust (which is a Community Care NHS Trust), and the Hammersmith hospitals NHS Trust and Guy's and St Thomas's NHS Trust (both of which are Acute Care Trusts) agreed to allow me access to ten managers each. The managers would be volunteers and would need to be assured of anonymity. Permission was granted for me to have an hour's time with each of the managers. It was confirmed that the managers would come from different levels of seniority. It therefore became possible to carry out this study with managers of varying levels of seniority from both categories of NHS Trusts.

Research Design and Methodology

Bryman [1995] makes a clear distinction between research designs and methods of data collection. A number of research designs needed to be considered before determining the most appropriate approach to be adopted. The nature of the research question played a crucial part in determining the research design(s) which was/were finally selected as the two main types of research (i.e. Qualitative and Quantitative) seek to answer different types of questions, collect different types of data and produce different types of answers [Barbour, 1999]. Qualitative methods are often appropriate for addressing questions of process while quantitative methods are usually more appropriate for addressing questions of prevalence, causality, the relationship between variables, measuring outcomes, etc. - i.e. analysing the structure of a phenomenon. It was therefore important at this point to once again clearly restate my research topic since this significantly influenced the choice of my adopted research design: "An investigation of the perceptions of NHS managers towards the recent NHS reforms and their effects on the organisation's managerial culture".

At the outset the relative merits and limitations of various research designs for this study were considered and it would be useful to outline the thought process behind selecting the final design.

The Case study research design seemed an attractive way to proceed with this study. It has been defined as "a research study which focuses on understanding the dynamic present within a single setting" [Eisenhardt, 1989: pg 534] and "an extensive examination of a single instance of a phenomenon of interest" [Hussey & Hussey, 1997: pg 65]. For reasons of generalisability (discussed above) this research focused on NHS managers from three NHS Trusts representing the two categories of NHS Trusts rather than focusing entirely on a single organisation. Bryman [1995] points out that although case study analysis usually involves an in-depth study of one organisation, a study of two or more organisations is not uncommon and according to Miles and Huberman [1994: pg 435] "looking at multiple actors in multiple settings enhances generalisability; the key processes, constructs, and explanations in play can be tested in several different configurations. And each configuration can be considered a replication of the process of question under study. Multiple cases also

identify configurations (of actors, of working arrangements, of causal influences) that hold in some settings but not in others".

The qualitative approach appeared attractive as it "involves a much greater emphasis on seeing the world from the point of view of the subjects who participate in it" [Bryman, 1989]. On the other hand it is acknowledged that this approach relies on data obtained from potentially time consuming interviews and dialogues with the possible consequence of data overload.

In contrast to this a survey design using completely structured questionnaires/ interviews would allow for the gathering of data within the time framework of an hour which had been allowed. Subsequent quantitative data analysis obtained by this method could, if necessary, be performed using one from a number of computerised software quantitative analysis packages.

The final decision on research design and methodology was arrived through:
1. An examination of the theoretical issues involved in this research study and
2. A practical assessment and evaluation of the preferred designs and methods through two pilot studies.

A Theoretical examination of issues involved in this research study

My research centred around gaining an insight into understanding the various effects that the recent NHS reforms have had upon the perceptions of NHS managers. A study of "perceptions" would seem to be almost automatically allied to the anti-positivist assumption that knowledge is subjective and that the world can be best understood "by occupying the frame of reference of the participant in action..., by understanding from the inside rather than from the outside" [Burrell & Morgan, 1979: pg 5]. Using interviews as a basis for a qualitative research design and methodology therefore seemed an attractive way to allow one to "gather descriptions of the life world of interviewee with respect to interpretation of the meaning of the described phenomena" [Kvale, 1983: pg 174]. On a wider epistemological scale such an approach would be regarded as being allied with the school of German idealism which espouses an anti-positivist tradition in which knowledge is assumed to be

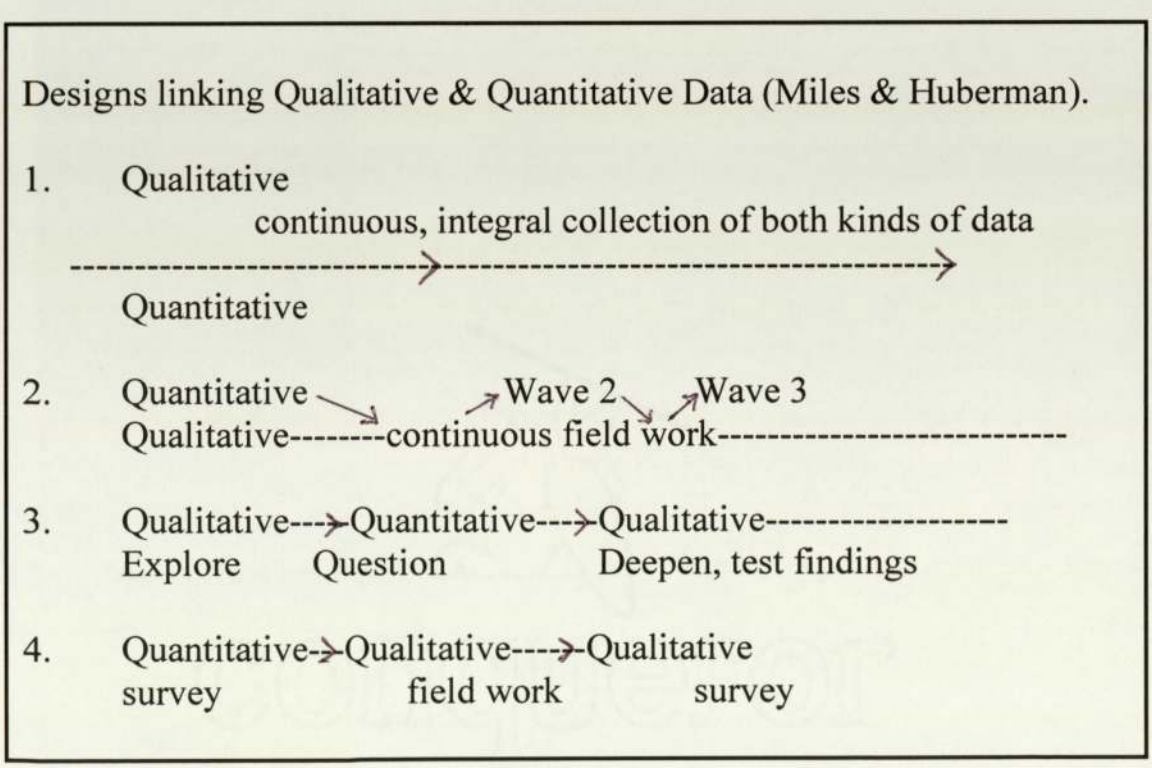
subjective and the social world is regarded as "essentially relativistic and can only be understood from the point of view of the individuals who are directly involved in the activities which are to be studied" [Burrell & Morgan, 1979: pg 5]. Furthermore this research proposal is underpinned by the beliefs that reality is enacted or reified [Weick, 1995]; that this subjective reality is socially constructed by the actors involved [Hatch, 1997]; and is the product of an individual's cognition, therefore the most effective way of studying this question appeared to be by entering into a dialogue with each manager and trying to understand and share their social construction of reality through obtaining an insight of their world. Such an approach would favour the view of the nominalist rather than the realist and it seemed clear that an inductive approach would need to be used in this study.

Careful consideration was also given to pursuing an objectivist approach to the research question. Could this study be approached from a stance that social science can be studied assuming the positivist epistemology that knowledge is objective and quantifiable? If this view was accepted to be the case then perhaps the research aims could be achieved using carefully constructed closed questionnaires, or a rigidly structured interview. The replies obtained could be evaluated using quantitative methods looking for significant convergence in the replies of managers within each category of NHS Trust and significant convergence and/or differences across the categories of NHS Trusts.

Finally it appeared that it was becoming increasingly acceptable (and in fact, some may say fashionable) to adopt a more pragmatic multi-method approach in research design. In fact such an approach has often been used in relation to research in the health service [Barbour, 1999]. Bryman [1988] has argued that the distinction between quantitative and qualitative methods is really a technical matter, with choice dependent upon the specific question one wishes to answer, and Ong [1993] observed that the quantitative-qualitative divide is a "smoke-screen" because in reality researchers do not adopt "pure methods", instead they combine the two approaches either explicitly or implicitly. Adopting a combination of qualitative and quantitative methods could also lead to a source of triangulation by methodological data type [Miles & Huberman, 1994] which could help to corroborate the findings.

After consideration of these theoretical perspectives and discussion it was decided to adopt the multi method approach because for the reasons discussed above this seemed appropriate and relevant for the purpose of this research. The combination of qualitative and quantitative approaches needed to be relevantly used to tackle the research question and not merely as a token bolting together of two techniques. Towards this end a structured questionnaire was devised which would initially aim to identify demographic details of each manager, length of service in the NHS and background experience followed by closed questions relating to the how the NHS managers viewed the recent NHS reforms and what they perceived as the effects of the NHS reforms especially upon the NHS management culture. This was then to be immediately followed by a semi-structured interview seeking to elaborate on issues identified from the questionnaire and focus directly on the issues that were of relevance to the research question. This design conformed to Miles and Huberman's Design I [1994] (see Figure 1).

Figure 1



The questionnaires could be analysed using quantitative techniques while the interviews could be analysed by qualitative techniques thereby increasing generalisability. When determining the research design and methods of data collection

the concepts of validity and reliability need to be considered as the degree or lack of degree of reliability and validity in one's research will have an impact on the credibility of the research outcomes or conclusions. Reliability relates to the degree to which research findings can be repeated using the same methods whereas validity relates to the extent to which research findings accurately represent what is happening in the situation [Hussey & Hussey, 1997]. Since the main method of data collection in this study was through the use of semi-structured interviews, it could be argued that this lends itself to relatively high validity since it extracts and captures data that is rich in explanation and analysis. With regards to the notion of reliability within a phenomenological paradigm, according to Hussey and Hussey [ibid: pg 57], "the criterion for reliability may not be given so much status". However, the use of structured questionnaires could be said to improve the general degree of the reliability of this study. As suggested earlier it was thought that the data from the questionnaires would, through the process of triangulation, be useful to corroborate views expressed during the semi structured interviews (while acknowledging that triangulation of quantitative and qualitative data needs to acknowledge the fundamentally different underlying assumptions behind the approaches).

I was aware that this methodological approach could stand charged by staunch anti-positivists as not going far enough in attempting to understand the interviewer's world. Anti-positivists would suggest that an ethnographic approach may allow such an understanding and that the use of semi structured interviews would be labelled soft nosed positivism (as defined by Miles & Huberman, 1984) because to some extent it may be expected that the interviewee may react passively in response to preset questions. Asbury [1995] believes that creeping quantification has done considerable disservice to the credibility of the qualitative research enterprise. This involves the inserting of bogus quantitative trappings, such as graphs, into accounts of very small scale studies. In response to these views I was persuaded by Miles and Huberman's [1994: pg 41] well balanced arguments that led them to conclude that "we believe that the quantitative-qualitative argument is essentially unproductive...we see no reason to tie the distinction to epistemological preference…quantitative and qualitative methods are 'inextricably intertwined' not only at the level of specific data sets but also at the levels of study design and analysis".

The pilot studies

This proved to be pivotal in deciding my final research methodology.

The pilot studies were was conducted on the 11th August 1999 at the Barnet Healthcare Trust and involved two managers. As will be seen the pilot studies through the notion of reflexivity [Lawson, 1985] was useful in challenging some of my assumptions that underpinned the questions on the original questionnaire and interview schedule. It proved extremely useful in refining some of the questions in the questionnaire and in aiding the logistics of the interview schedule. The first pilot study resulted in an increase in the number of questions on the questionnaire from 14 to 20 and the revision of many questions such that they were framed more precisely while at the same time allowing respondents to use their own words rather than be constrained by the use of management jargon. For example the revised questionnaire included question number 6: "Please briefly list the values (such as common beliefs and attitudes) you think are shared by NHS employees" as opposed to asking respondents to "list their cultural values". In the second pilot study a very important finding emerged - it became clear from comparing the replies in the pilot questionnaires with the discussion in the interviews that followed that some of the most central issues were inappropriate for the constrained and closed questionnaire. In a review of both the pilot studies it became obvious that the answers in the questionnaires relating to some of the interviewees' perceptions, and the perceived personal effects, of the recent NHS reforms (questions 10-20 in the questionnaire) were at odds to the views that they expressed in the face to face interviews. For example a manager who ticked the box on the questionnaire to indicate strong disagreement with the statement that "The most recent reforms introduced by the Labour government were necessary and vital for the NHS" a few minutes later in the interview stated that:

> *"I know I ticked the box saying that the reforms were not vital or necessary, but some of them were actually quite a good idea and although they were not vital I do support them".*
>
> *Middle Manager*
> *Barnet*

There were several other examples in the same vein. This led me to the conclusion that the questionnaires could only act as a guide to the areas which were to be explored in the interviews and that regardless of how the questionnaires were modified it could not, in some very important areas, be relied upon to reflect a true picture of the NHS managers' perceptions of the effects of the NHS reforms. Therefore the questionnaire was modified by the additional inclusion of two open questions which allowed for completely unconstrained answers where respondents were able to include issues they felt were personally significant which could then be discussed in more depth during the interviews. The final questionnaire (see Appendix 1 for a sample questionnaire) included five questions (Q1-5) which focused on building a profile of the interviewee - age, sex, level of seniority, number of years in the NHS/Trust and professional background were concerned; three questions (Q6-8) relating to what the interviewees believed were the values shared by NHS workers and any values unique to subcultures within the NHS; one question (Q9) relating to how the interviewees felt they were perceived by the general public and ten questions (Q10-20) attempting to identify how managers perceived the NHS reforms, recent and past. The responses to these various issues in the questionnaires proved a useful starting point for discussion in the interviews with the aim of expansion and clarification in further depth (see Appendix 2 for an outline of the interview questions).

The pilot studies also led to a revision in the points raised in the interviews which allowed greater flexibility in the way respondents could approach issues that were brought up. Furthermore, the pilot studies prompted me to re-evaluate the selection of areas to be explored during the interview and to identify specific objectives for each question on the schedule. This ensured that every question had been considered carefully for its value in terms of the information it would potentially provide. It also helped on a practical level involving microphone placement and other technical factors relating to interview recording.

Field Work

My field work was conducted at each of the three NHS Trusts between August 1999 and May 2000. The field work took longer than initially estimated mainly due to some

interviews being postponed numerous times due to the interviewees' personal and work pressures. Each session of field work involved the NHS manager completing the questionnaire at the beginning of the interview which took approximately 10 to 15 minutes and this was then followed by the semi-structured interview that lasted about 45 minutes. Each interview was tape recorded following permission from the interviewee. The assurance of total confidentiality and the consistent availability of a private interview room contributed to the interviews being carried out in an informal and frank atmosphere. Each of the twenty-eight interviews were subsequently fully transcribed.

Data analysis

As mentioned in the earlier sections NHS managers from three NHS Trusts viz. Barnet Healthcare NHS Trust (which is a Community Care NHS Trust), and the Hammersmith Hospitals NHS Trust and Guy's and St Thomas' NHS Trust (both of which are Acute Care Trusts) participated in this study. The managers were initially given a questionnaire to fill in which apart from providing certain basic data was used to provide entry points and a frame work for the semi-structured interviews which followed. The questionnaires were useful in providing a profile of the respondents from each NHS Trust and these profiles were quantitatively analysed using the Excel spreadsheet software package in an effort to look for any significant differences between the managers from the two categories of NHS Trust and between the managers from the three different NHS Trusts. As discussed earlier following the findings in the pilot study it was apparent that the restricted format of some of the "important personally searching" questions in the questionnaire were only useful for providing a framework for discussion in the subsequent interview but the answers in the questionnaires themselves were often misleading and therefore by themselves inappropriate for further analysis.

The interviews generated a large amount of information which was analysed using a coding system (described below) with the intention of capturing both the recurrent and interesting isolated emerging themes. The process of coding used the approach recommended by Miles and Huberman [1994]. The codes (in the form of a shorthand label relating the concept it was describing e.g. NCVR = no change in values because

of the reforms) were used as tags or labels assigning units of meaning to "chunks" of words, phrases, sentences or whole paragraphs in the transcribed interviews. These "chunks" were then categorised and organised so that they could be clustered to a particular research question or theme so as to develop a pattern. Coding was done by hand and the process of coding was started immediately after the interview following transcription. The data was manageable by this method and hence a qualitative computer package did not need to be used. When, on a few occasions, it was found that the same code was being repeated too often the code was broken down into subcodes (e.g. NCVR was broken down into NCVR-MD (= no change in my/my department values because of the reforms and NCVR-OD (=no change in other managers/departments values because of the reforms). The data was also detextualised in a form which made it appropriate for analysis and presentation, this was necessary because otherwise the volume of interview material would prove to be dispersed, sequential and extremely bulky. I followed the advice given by Miles and Huberman [1994a: pg 11] who use the dictum "you are what you eat" might be transposed to "you know what you display". The data was displayed in a series of causal network displays with associated explanation in the text.

As has therefore been explained in this section the final choice of research design and methods was formulated following an exploration of the theoretical principles underpinning research methodologies, practical factors including the time frame available for this study were taken into account and the final chosen research methods were refined following the pilot studies.

SECTION 4: RESULTS

The three NHS Trusts included in this study were the Hammersmith Hospitals NHS Trust, Guy's & St. Thomas' Hospital Trust and Barnet Healthcare NHS Trust. It would be useful at the outset to briefly provide some background information on these NHS Trusts.

The Hammersmith Hospitals NHS Trust is situated in West London and includes the larger Charing Cross Hospital and the somewhat smaller and more specialised Hammersmith Hospital, the two hospitals are merged into a single Trust. Both these hospitals are world famous centres of excellence and they provide Accident & Emergency, outpatient and inpatient care. As both hospitals concentrate on treating patients within their physical boundaries (as opposed to within the community) the NHS Trust is referred to as an Acute Care Trust. In addition the hospitals have a longstanding and high profile commitment to medical education and provide training to medical students from Imperial College, London. The Hammersmith Hospital has a prestigious centre for Postgraduate medical education which attracts students from all over the world. The hospitals also house a nursing college.

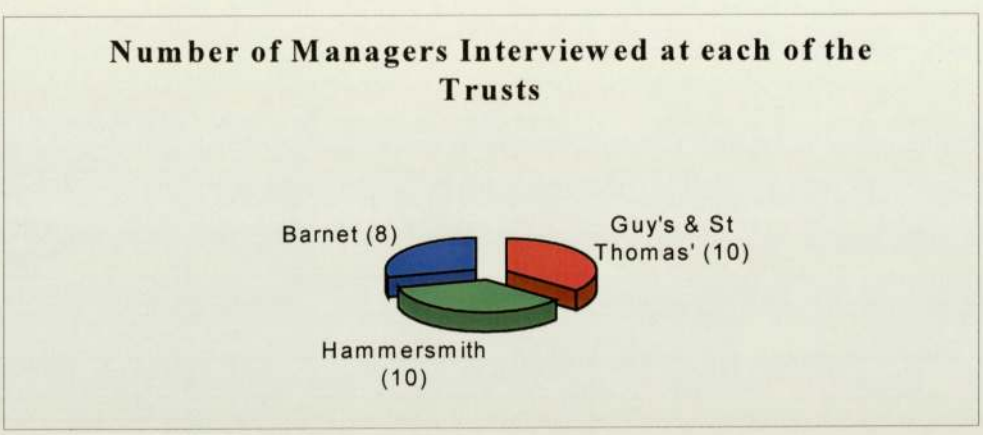
Guy's & St. Thomas' Hospital Trust is also an Acute Care Trust. It incorporates Guy's Hospital at London Bridge and St Thomas' hospital situated on the banks of the Thames directly facing the Houses of Parliament. Both these hospitals are regarded as being of the highest standard nationally and internationally; they are well regarded and reputed centres with long and proud legacies. The hospitals are involved in the training of medical students and nurses from the Guy's and St. Thomas' medical/nursing schools.

The Barnet Healthcare NHS Trust is situated in North London and provides care to the local community in the areas in and around Barnet and Edgware and is much lower profile than the other two Trusts described above. In contrast to the Hammersmith and Guy's & St. Thomas' Trusts it is a Community Care Trust implying that the Trust concentrates on providing intermediate and long term care to patients within the community. Community Psychiatry, Geriatrics and Paediatrics are important and heavily represented areas.

By selecting these three Trusts (covering Acute and Community Care), as explained in the section on Methodology, a cross sectional study of NHS Trusts in London was made.

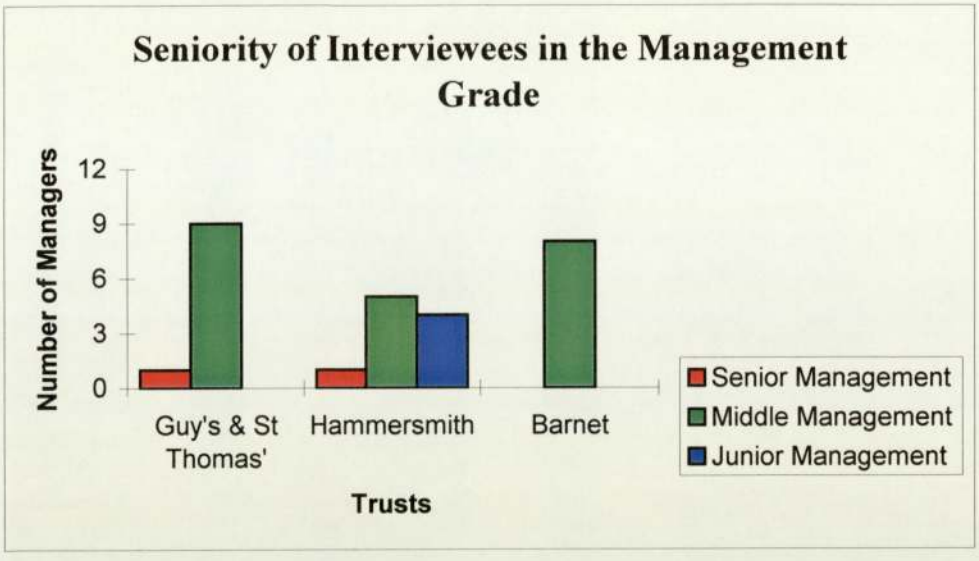
In total twenty-eight managers were interviewed and as is shown in Figure 2 below ten managers were from the Hammersmith Trust, ten managers from Guy's and St. Thomas' NHS Trust and eight managers from Barnet Healthcare NHS Trust.

Figure 2



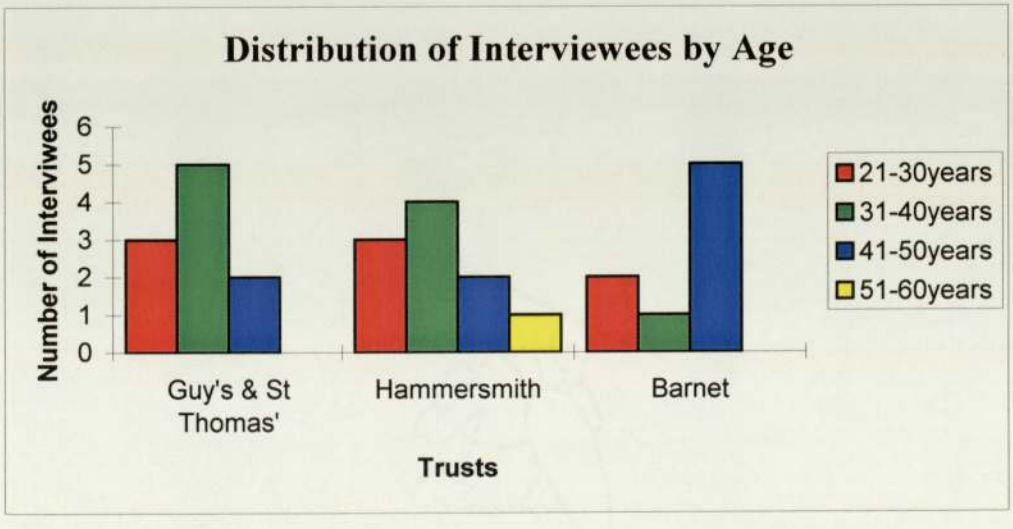
Determining a consistent definition of managers' seniority proved difficult. Dopson & Stewart [1990] believe that from extensive previous research, it is apparent that no real satisfactory definition for standard managerial seniority in the NHS exists, however for the purposes of this study, management seniority in the NHS was defined in line with that suggested by Preston & Loan-Clarke [2000]: "Junior managers" have been classified as those responsible for staff but did not have managers reporting to them whilst "Middle managers" were those managers who had at least one manager reporting to them. "Senior managers" on the other hand were those in charge of a function across the Trust. On the basis of this definition Figure 3 provides an indication of the seniority levels of the managers who participated in this study and shows that the majority of managers from all three Trusts were from middle management.

Figure 3



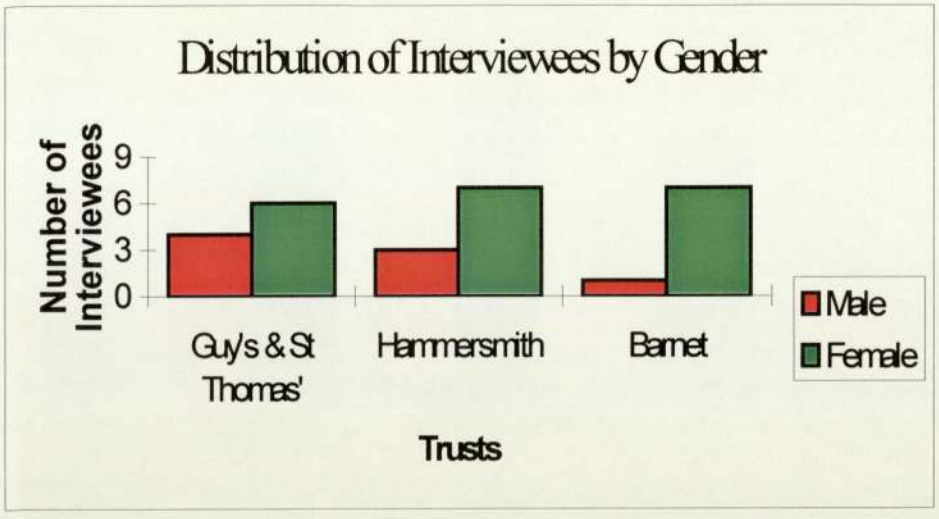
The majority of the managers interviewed at the Acute Care Trusts of Hammersmith and Guy's and St.Thomas' were in the age group of 31-40 years while the majority of those at Barnet Healthcare NHS Trust were in the age group of 41-50 years as is illustrated in Figure 4 below.

Figure 4



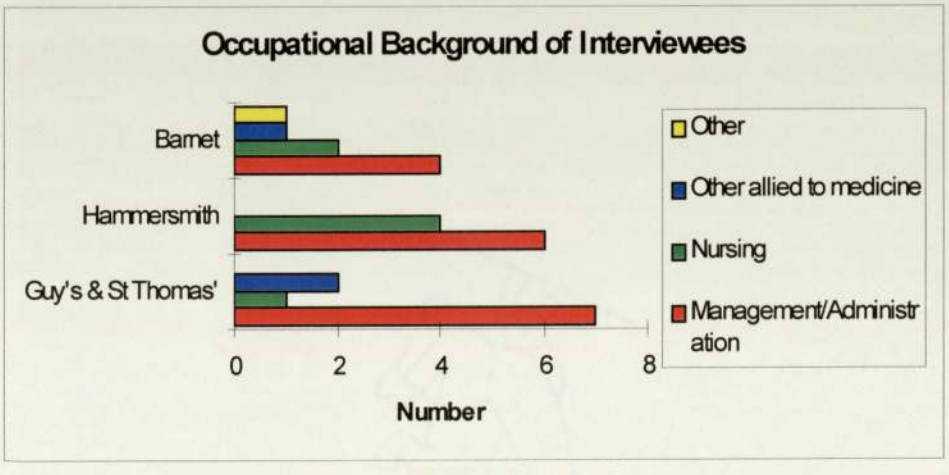
As is evident from Figure 5, the majority of the mangers from all three NHS Trusts were women. Therefore as can be seen the age groups, gender and levels of seniority of the NHS managers who participated in this study were similar in all three Trusts.

Figure 5



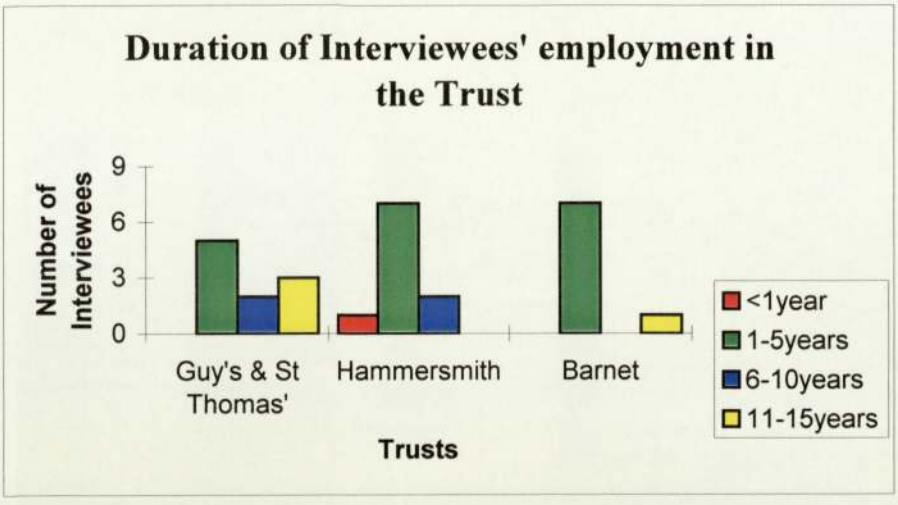
As shown in Figure 6 more than half of the mangers interviewed came from a management/administration background, the next most common background was nursing or professions allied to medicine and this held true in the case of each NHS Trust.

Figure 6



Furthermore it is evident from Figure 7 that the majority of the managers interviewed had spent between 1-5 years in the Trust in which they were currently working. Therefore there were no obvious differences as regards backgrounds or duration of employment between the managers from the different Trusts which could be thought to be major confounding factors when making comparisons on their views.

Figure 7



This Section will aim to separately address the following four interrelated research questions. The significance and value of asking these questions have been previously outlined in Sections 1 and 2:

1. What are the managers' perceptions of the recent NHS reforms?

2. Is there a managerial culture within the NHS and if so does the NHS managerial culture share common beliefs and values over a range of issues or alternatively are they more fragmented and based upon coalitions determined by issue agreement/disagreement?

3. Has there been a recent change in the managerial subculture within the NHS?

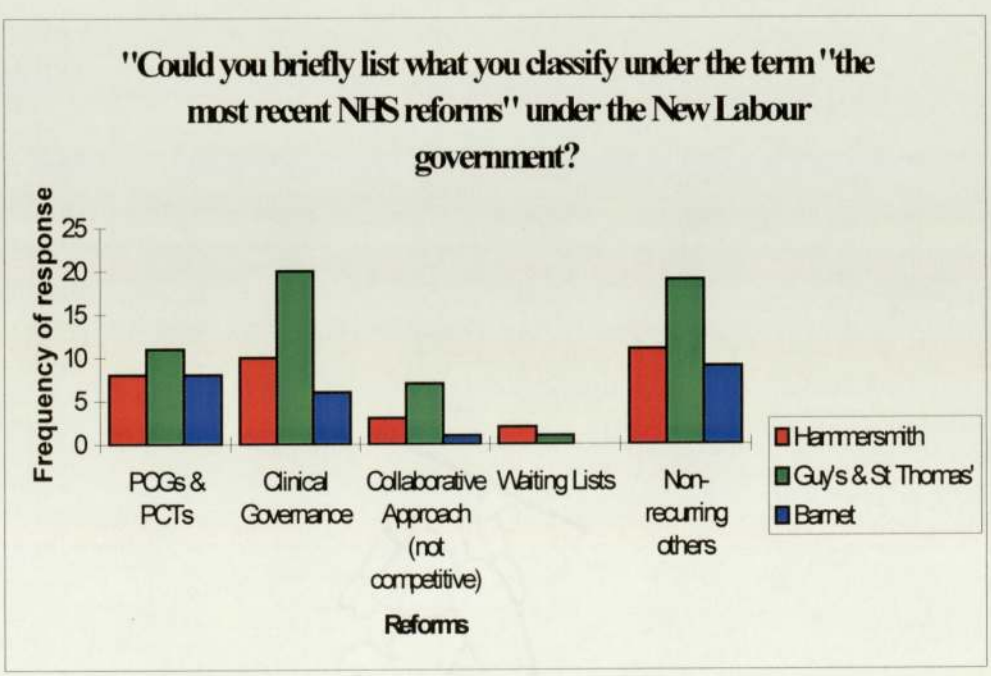
4. What are the managers' perceptions of society's expectations of their role?

In this section the research findings related to each of these four questions will be presented, the relevance and importance of the questions and the findings will be subsequently discussed.

1. What are the managers' perceptions of the recent NHS reforms?

At the outset it was useful to clarify what the managers perceived as the "recent reforms". Question 11 (see Appendix 1 for a copy of the questionnaire) in the written questionnaire dealt with this issue by asking managers to list what they would "classify under the term the most recent NHS reforms...". Figure 8 illustrates the responses to this question and as is evident the managers in all three Trusts commonly indicated "the most recent NHS reforms" to constitute: a) the setting up of Primary Care Groups (PCGs) and Primary Care Trusts (PCTs); b) Clinical Governance and issues related to improving clinical care in the NHS including the setting up of bodies such as NICE and CHIMP and c) the abolition of the internal market with a view to fostering collaboration and not competition within the NHS market.

Figure 8: Response to Question 11 in the Questionnaire



Managers working in the Barnet Healthcare NHS Trust also listed separate (non-recurring) aspects related to the modernising of mental health and the setting up of Mental Health Specialist Trusts since these issues emerged to be of particular concern with regard to the future of the Barnet Healthcare NHS Trust and will be discussed later. A brief background explanation of the commonly cited recent reforms identified by the managers may be useful at this point [World Wide Web]:

Primary Care Groups

Primary Care Groups (PCGs) were introduced by the Labour Government in 1997 to replace the previous system of GP fundholding where GPs and Health Authorities were the purchasers of healthcare from Hospital Trusts who were healthcare providers. This system was criticised for creating an internal market that was highly competitive leading to a two-tier system of patient care whereby some patients got preferred treatments because they were registered with a fundholding GP. PCGs were introduced to remedy some of the drawbacks of the internal market by emphasising a collaborative approach between purchasers and providers rather than a competitive one. PCGs work as a partnership which includes the Local Authority, GPs and Providers of healthcare (both Primary and Secondary) in charge of providing an effective and efficient delivery of healthcare for its local population. There are at present 481 PCGs covering populations from 46,000 to 257,000.

Primary Care Trusts

A Primary Care Trust (PCT) is usually a developed stage of a Primary Care Group. PCTs have the legal capacity to act as both purchasers and providers of healthcare to patients. A PCT is granted legal status as long as there is local consensus among GPs, nurses and the local community for its functions. The Trusts are accountable to the Government via the Health Authority and are required to produce annual accounts. It is expected that there will be at least 60 Primary Care Trusts set up by the end of 2000.

Clinical Governance

Clinical Governance is a system put into place as a result of the Health Act 1999 which requires NHS organisations to ensure that quality care is provided to patients and that this quality care is continuously improved and monitored. The need for Clinical Governance became clear as a result of a number of clinical errors in the 1990s that led to wide negative media coverage. Clinical Governance aims to ensure that quality care is delivered throughout the NHS through the provision of clear quality guidelines. The Government has set up bodies such as the National Institute

for Clinical Excellence (NICE) which provides such quality guidelines whilst the Commission for Health Improvement (CHIMP) monitors the implementation of these guidelines.

In several stages of the interviews, all managers from all three Trusts, with only extremely few and isolated exceptions generally perceived the recent reforms favourably and appeared to be genuinely personally committed to the general principles of the recent reforms. This common belief is exemplified by the view of a middle grade manager who said:

> *"I feel very strongly that Clinical Governance is probably the best thing that has happened to the NHS in twenty years...PCGs I think are a marvellous idea, and the idea of including General Practice which is what will happen as a result of PCGs eventually is marvellous. I think to have quality service both in the community and everywhere else as a result of Clinical Governance is just absolutely superb".*
>
> *Middle Manager*
> *Barnet*

As was predicted from the pilot study this view at times appeared to be at odds with the responses to question 20c in the written questionnaires where in response to question 20c some managers disagreed or were not sure that the "most recent NHS reforms...were necessary and vital for the NHS". The anomaly between the responses in the questionnaire and what the managers immediately afterwards said in the interview appeared to be due to the managers' reluctance to unreservedly endorse the reforms as "necessary and vital" (as was the wording in the questionnaire) whereas the interviews gave them an opportunity to spell out what they actually felt. An unreserved analysis of the questionnaires would therefore have given an incomplete picture and highlights the limitations of the use of questionnaires where restricted format and constraints of language may lead to incorrect conclusions. Instead emphasis was given to exploring the issues during the interview.

At this point it would be of interest to also analyse the reasons why a few managers were unenthusiastic about the recent reforms. In all these few cases it appeared that the managers were suffering from "reform fatigue" rather than disagreeing with the

contents of the recent reforms. The following extract from an interview clearly makes the point:

> *"No we are quite used to sort of bobbing around waiting for the next wave [of reforms] to hit us...you probably just about see one [wave of changes] and the next one comes along".*
>
> *Middle Manager*
> *Guy's & St Thomas'*

An interesting commonly recurring theme which came up in the course of the interviews, particularly with the managers from the Acute Trusts, was that the managers specially singled out and supported the reforms related to the setting up and implementation of "Clinical Governance". This support from all levels of management is evident in the interview extracts displayed below in Table 1:

Table 1: Extracts from interviews indicating support for Clinical Governance

Senior Manager Guy's & St Thomas;	Middle Manager Guy's & St Thomas'	Junior Manager Hammersmith
"... Clinical Governance and the thrust to address the management of clinical performance and clinical quality I think is probably for me the most important thing to come out of the reforms...".	*"...I can see the benefits that Clinical Governance can have longer term...".*	*"Clinical Governance...It's good to actually see that clinicians' work is actually being looked at closely and audit...[sic]".*

The reason behind why this particular reform attracted such significant support became evident with further exploration in the interviews. It was often strongly implied that the introduction of Clinical Governance was seen by the managers as a tool which would empower them by providing the basis for having a legitimised framework which made clinicians accountable to managers. This point is straightforwardly discussed in the following extract from an interview:

"...I think it (Clinical Governance) will empower managers a bit more to go to Consultants and, you know, medical staff and say, you know, can you just explain this to me you know I've got these figures but before you had nothing really...".

Junior Manager
Hammersmith

It became clear that managers felt that doctors were perhaps undeservedly unaccountable for their actions and used their privileged positions to "get their own way". Clinical Governance was seen as having the potential to redress this position and could allow managers to have an input into altering consultants' behaviour. The implication that the managers' role would become more powerful and important will be discussed in the next section.

An interrelated issue, which was repeatedly raised during the interviews, could be traced back to the long standing consistently harsh attacks against the managers from the media. At this point it may be worth pointing out that Clinical Governance was introduced in the aftermath of several highly publicised cases of clinical malpractice such as the scandal involving the paediatric cardiovascular unit at the Bristol Royal Infirmary. Clinical Governance has been intended to provide a regulatory framework for governing clinical activities and to expose inadequacies. The message coming across during the interviews was that managers may support Clinical Governance not only because of its inherent value but also because it provides a mechanism which shifts the much unwanted negative media attention away from managers onto incompetent clinicians through newspaper and TV programmes with lurid titles such as "Doctors on Trial" (Channel 4 TV, October 2000). It was clear that the majority of managers were frustrated and irritated by this negative and unfair imagery portrayed by the media. This view was highlighted by several middle managers in the interviews:

"It irritates me with the government and the media more. Managers are a very easy target, its very easy to slag off the men in grey suits whereas actually, anybody who's actually ever had any contact with that side of the organisation knows actually that managers do work very hard...".

Middle Manager
Guy's & St Thomas'

Another manager particularly identified popular TV soaps as being the main culprit:

> *"You only have to watch Casualty and managers...that's the sort of thing that really, really shakes the public perception of anything really. The kind of media and particularly that popular mass media, and any kind of programme where the manager is always the big bad wolf who is trying kind of make people close things down, cost savings, who is uncaring and you know, but there is [sic] a few exceptions to that but that is essentially the image that's promoted".*
>
> *Middle Manager*
> *Guy's & St Thomas'*

Interestingly Clinical Governance did not raise as much passion in managers from Community Care Trusts as it did for the managers from the Acute Care Trusts. This appeared to be because managers from Community Care Trusts were more preoccupied with aspects related to the formation of Primary Care Groups which is of more of an immediate relevance for Community Care Trusts such as Barnet. This enthusiasm for PCGs is reflected in the quote from an interview with a manager at Barnet:

> *"Clinical Governance is all very well but the idea of including General Practice which is what will happen as a result of PCGs eventually is marvellous I think to have quality services in the community...".*
>
> *Middle Manager*
> *Barnet*

There was no evidence from the interviews that managers at Barnet had a more genuinely co-operative relationship with the clinicians which could have led to reduced concern about shifting the power balance through Clinical Governance.

It was also interesting to note how managers perceived the effects of the reforms on their day to day workload. In the majority of the written questionnaires in response to questions 13, 17 and 18 managers from both types of Trusts (Acute and Community) indicated that their workload on a day to day basis had increased. When this point was explored in further detail in the interviews the Community Care managers' responses were consistent with the answers expressed in the written questionnaires and in fact one could often sense a feeling of negativism related to these increasing workloads. On the other hand managers in the Acute Trusts, who had also generally indicated in the written questionnaires that their work load had increased as a result of the recent

reforms, almost invariably contradicted this view in the interviews and on reflection felt that there had not actually been an increase in their every day work loads. These views of managers are identified in some of the interview extracts shown in Table 2.

Table 2: Extracts from interviews relating to perceived impact of reforms on managers' day to day workloads

Community Care Trust	Acute Care Trusts
"Yeah, I do get exhausted with [work created as a result of the recent reforms]...there's a lot of overlapping areas and I certainly feel that it is more difficult to do my job". *Middle Manager* *Barnet*	*"No [impact on my workload] not yet".* *Middle Manager* *Guy's & St Thomas'*
"...(now) it's more bureaucratic than ever...". *Middle Manager* *Barnet*	*"Their impact is fairly limited at the moment".* *Manager* *Guy's & St Thomas'*
	"To be honest not a huge amount as yet". *Middle Manager* *Hammersmith*

This once again emphasises the value of the qualitative interviews since reliance placed on the answers in the written questionnaires would not have provided an accurate picture of the effects of the reforms upon managers' day to day work.

In order to further analyse the extent to which the attitudes, beliefs and values of managers support the implementation of the recent reforms, it would be of value to now move to the second question.

2. **Is there a managerial culture within the NHS and if so does the NHS managerial culture share common beliefs and values over a range of issues or alternatively are they more fragmented and based upon coalitions determined by issue agreement/disagreement?**

Assuming the existence of a definable management subculture, it would at the same time be worth considering the third interrelated question:

3. **Has there been a recent change in the managerial subculture within the NHS?**

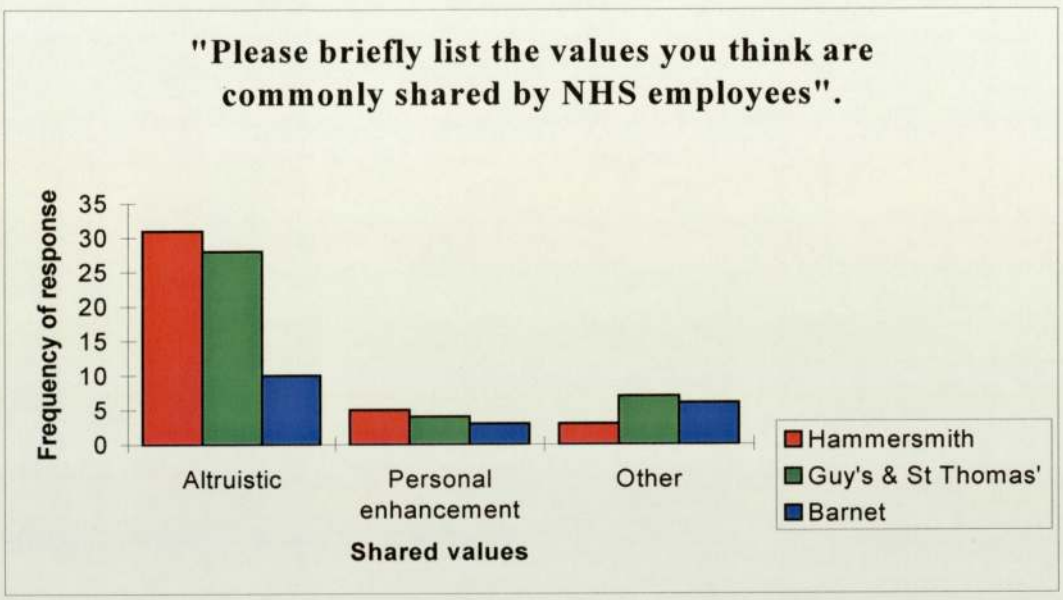
In order to begin to get an insight into the NHS managerial culture it was useful to first identify what the managers believed were their core values. These were identified from the managers' responses to question 6 in the questionnaire which asked managers to "Please briefly list the values (such as common attitudes and beliefs) you think are shared by NHS employees". Their responses could be grouped under three categories: "Altruistic", "Personal Enhancement" and "Other" (see Table 3).

Table 3: Categories of values identified by managers

Altruistic	Personal Enhancement	Other
Patient Care	Desire to work in an interesting field	Morale low in clinical areas due to staff shortages
Commitment/Value of NHS to Country	Working in a multi-disciplinary team environment	Government expectations probably unrealistic
Public service/Service to the community	Secure job	Constant change
Improving health	Demanding job	Efficient effective use of tax payer's money
Helping others	We know best	Professional codes of conduct
Commitment to education	Employment safety	Trying your best
Belief in free healthcare for all	Sense of achievement from responding to crises	Resources required for safe environment should be adequately funded
Vocation/self-sacrifice	Variety of work	
Value driven	Team work & Peer support	

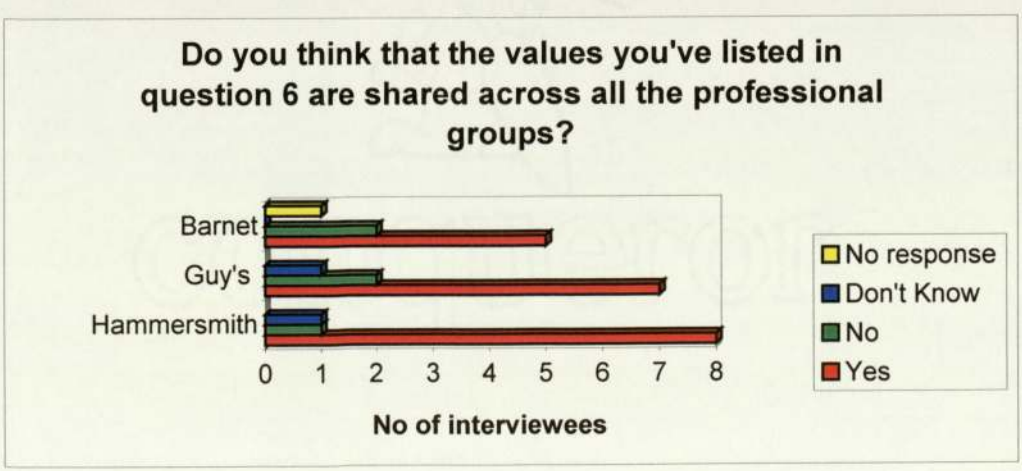
Figure 9 illustrates the absolute frequency of the managers' responses as regards each shared value category and as is evident the majority of the managers believed that the values which were shared commonly by NHS employees were mainly altruistic in nature.

Figure 9: Response to Question 6 in the Questionnaire



This sharing of core values across all professional groups in the NHS was confirmed in responses to question 7 in the questionnaire. As can be seen in Figure 10 below the majority of NHS managers believed that the values they had listed were shared across all professional groups.

Figure 10: Response to Question 7 in the Questionnaire



This viewpoint was repeatedly confirmed in the interviews as demonstrated in the following representative extracts from the interviews:

> *"I think most people in healthcare have core values which are common to all of us...or they wouldn't be working for the NHS".*
>
> *Middle Manager*
> *Barnet*

> *" You know I mean I think you can still find cleaners on the wards who have that kind of motivation as well, so its not something that is purely the clinicians that come with that kind of point of view and I know many managers that have that kind of angle to why they came into the health service. You know rather than just go into commercial enterprise, so yes I don't' think its something that is only a clinical preserve but I think it is something that we can all potentially have [sic]".*
>
> *Middle Manager*
> *Guy's & St Thomas'*

> *"I think so. Especially I've worked with administration staff and I've found that those sort of people although they do not have a medical qualification [but] they are certainly a caring type of person".*
>
> *Middle Manager*
> *Barnet*

It is interesting to flag up and contrast the few dissenting viewpoints. In a few cases while the managers perceived a common organisation wide culture, they pointed out that there may be one or two pockets of groups of workers (mainly subcontracted employees) who held differing values. These employees were perceived not to share the inherent altruistic values of the majority of the groups within the NHS as is suggested in the following narrative from an interview:

> *"Cleaners in the hospital, they don't actually work for the NHS, they work for a cleaning company so whether that's a value [referring to the altruistic values] held by them I don't know...".*
>
> *Middle Manager*
> *Barnet*

If anything this only emphasises the view that the managers in fact considered anyone directly employed by the NHS as sharing the core values identified.

Enquiry as to the reasons which led managers to choose to work in an environment which they perceive to be "value laden" led to responses which were commonly similar in tone. A section of conversation with a middle manager at Hammersmith makes this point:

> *Manager: "...I am in management in the NHS because I chose I wanted to work in a value driven environment, and I wanted to be doing something where the output was something I agreed with in that case I've chosen health care. I've actually chosen to work in health care as an area".*
>
> *Interviewer: "...sorry could you tell me what you mean by value driven"?*
>
> *Manager: "...we are motivated by different agendas, its not to say that you can't be motivated by your own professional ambition but it means that ultimately you're there because you believe in the output of the organisation which in our case is improving health outcomes".*

Such personal statements of commitment were commonly repeated and it was clear that the sentiments expressed were regarded as a bonus which their work provided. One manager provided an eloquent overview of the position and an unedited section from that interview follows:

> *"I think in the past ten years or so there has been a significant change in terms of, for example, management in the NHS in that the profession has become better paid largely as a consequence of the introduction of general management in the late eighties and that has coincided with a generation of graduates who are looking for rewards other than simple benefit in terms of what they are looking for from a career. So a more vocational focus, a concern around health and social issues which makes a career in the health service more attractive and we are now finding those people are coming through. They have those values at an early stage and they retain them as they continue up the management chain. And I think it's particularly noticeable to when you look at the number of applications for the management training scheme in the NHS and the values and beliefs of those who are taken onto the scheme".*
>
> *Middle Manager*
> *Guy's & St Thomas'*

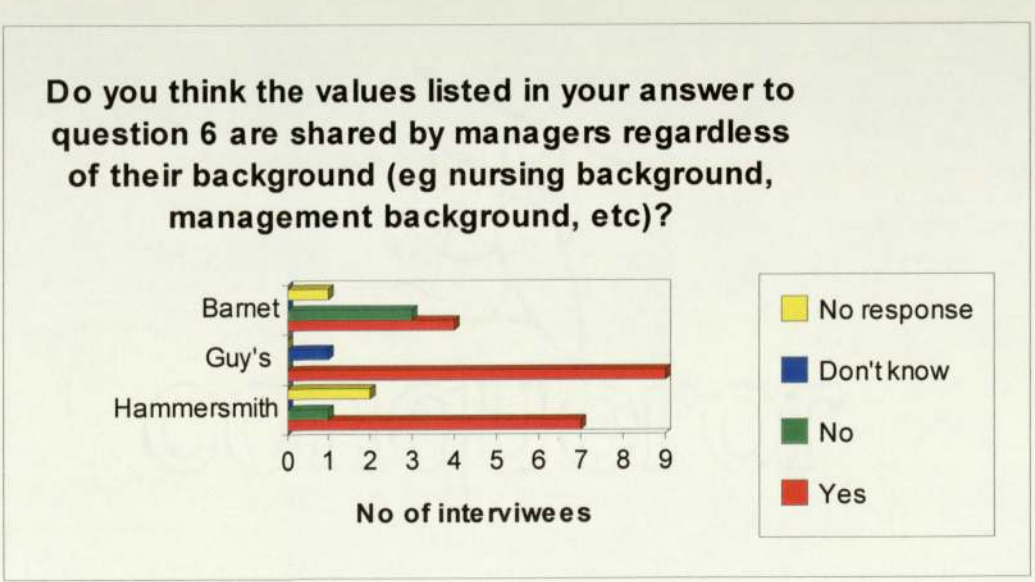
Whilst the majority of managers repeatedly spoke of altruistic values within the NHS there were exceptions which provide fleeting insights into issues not commonly articulated. One such view was related to a NHS management position being seen as just a stepping stone in a career pathway in public sector management. It was seen as a way of rapidly gaining experience in a challenging, changing and demanding

environment, the idea being to gain experience and leave for a less stressful area of employment. A manager put forward this view clearly:

> *"I worked in the Charity sector and I got to a level where I was really wanting to earn more money and have more responsibility and middle management jobs do not exist so much in the Charity sector so to get a decent operational managerial job I needed to come into somewhere like the NHS where you do get a lot of experience very fast. It's a stepping stone. Also I would say operational management in the NHS is difficult, it's horrid. It doesn't need to be because I've worked in overseas development where you're dealing with floods and crises and death. I think that people don't actually respect you quite often and that's quite hard to keep going when you think well I'm working very hard here...".*
>
> *Middle Manager*
> *Hammersmith*

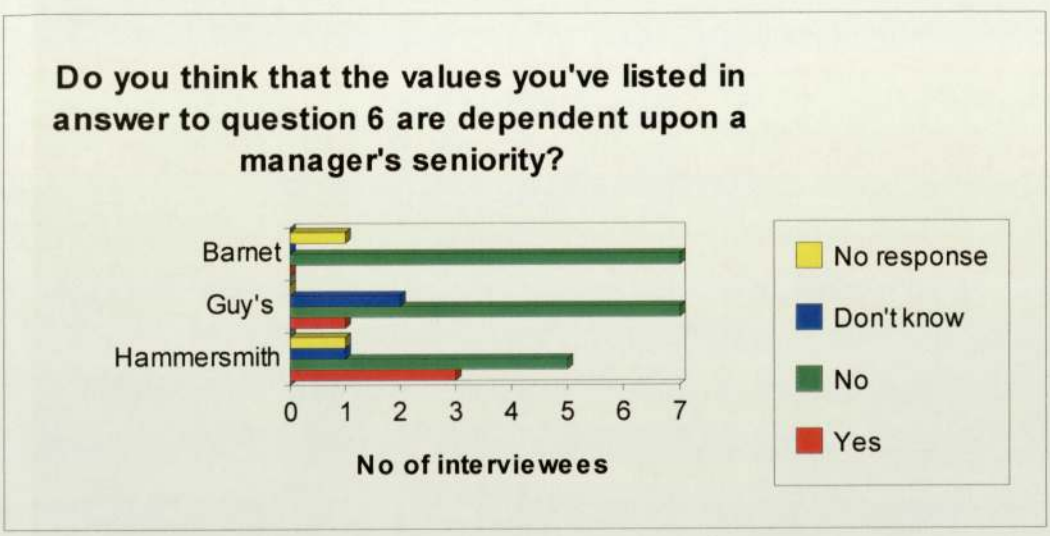
The finding presented so far indicate that managers believed that there were basic core values that were shared in the main across all professional groups. Question 8a in the questionnaire gives an indication in identifying if the managers believed that there may be overt or subtle differences in managers' values dependent on their background (e.g. nursing background, a background in management etc.) The response to this question is illustrated in Figure 11:

Figure 11: Response to Question 8a in the Questionnaire



Once again as is evident from Figure 11, the majority of the respondents believed that the values they had identified were shared by managers regardless of their background. Furthermore as far as the managers' seniority is concerned, responses to question 8b in the questionnaire illustrated below in Figure 12 also indicated that the majority of managers thought that the shared values were independent of a manager's seniority.

Figure 12: Response to Question 8b in the Questionnaire



The common view illustrated in Figure 12 is exemplified in the following extract below from one of the interviews with a manager at Barnet Healthcare NHS Trust:

> *Interviewer: "You mentioned that these values are not necessarily dependent on a manager's seniority. Do you feel that these values you know are shared regardless of their backgrounds"?*
>
> *Manager: "Yes. Yes. Absolutely. Well certainly with my colleagues and the managers that I would have to liaise with would be very much at the fore of their minds with the first and foremost patient care and also kind of working within a resource allocation and that would be the two main areas that I would say I would have to deal with all the time".*
>
> *Middle Manager*
> *Barnet*

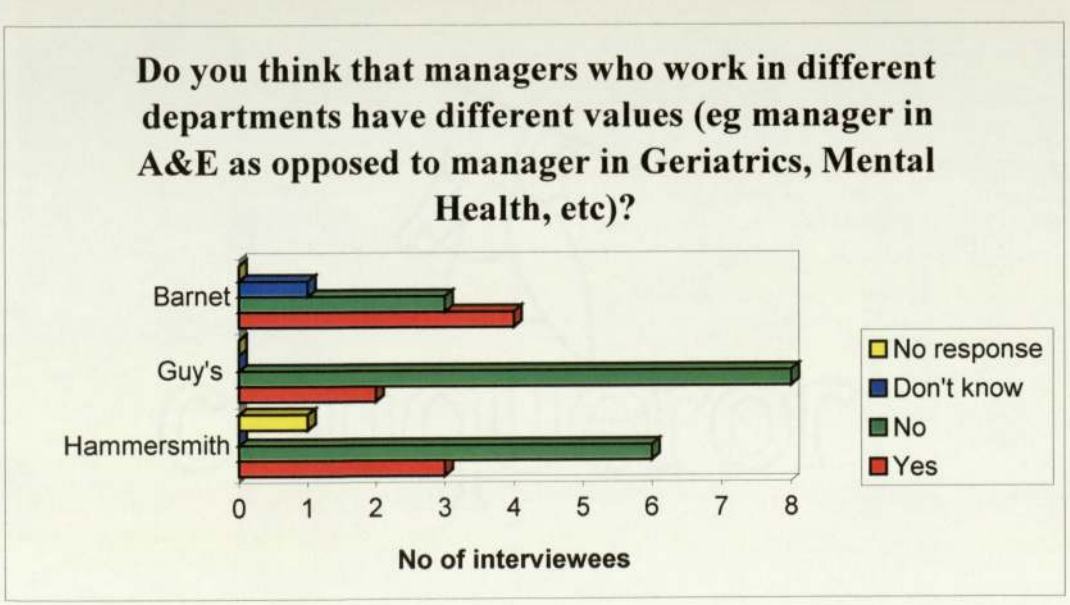
On the whole the managers' responses reinforce the view that most of the managers interviewed perceived a pan-managerial culture.

There were however a few managers who were convinced that managers in the NHS do not share identical values mainly because individuals have different agendas and objectives, however they put this down to individual differences not related to a particular category or type of manager:

> *"No, no I don't think [managers in different departments all share the same values] they do. I think people's values vary depending upon what their role is within the overall system and some people may well not feel those values at all. I think we're all, people are within organisation for different reasons and they have different goals. I wouldn't say we're all in the NHS for the same reason...".*
>
> *Middle Manager*
> *Barnet*

Interestingly responses to question 8c illustrated in Figure 13 below indicate that managers at Guy's and at Hammersmith NHS Trusts (both Acute Trusts) believe that managers who work in different departments do not have different values whereas most managers at Barnet (a Community Care Trust) perceived that managers in different departments did have different values.

Figure 13: Response to Question 8c in the Questionnaire



The reason for this apparent inconsistency as far as Barnet Healthcare NHS Trust is concerned became evident in the interviews. Barnet, which is a Community Care Trust does not have an Accident & Emergency department and because the question contained the wording "e.g. manager in A&E as opposed to manager in Geriatrics, Mental Health, etc" the Barnet managers explained that they tended to presume and anticipate that such a hypothetical department would probably be foreign to their known environment.

Whilst the findings suggest that managers on the whole hold common beliefs and attitudes which are mainly altruistic in nature, it is also interesting to note that at times the managers do realise that there is dilemma relating to an unreconcilable tension between their values and their actions. This is evident in the following telling extract from one of the interviews:

> *"I suppose the main thing is that most people that go into the NHS...have a very strong belief about serving the public. You don't really get rich by working in the NHS really. You really have to have a sense of duty, feel a sense of duty that you want to serve the public and in doing so it is about providing the best quality care that one can and one is able to do so and also having the best value for what the public is giving us. So I think that is the base line of how most people feel. But you may find a slight distinction or difference between clinicians and management. Being a clinician is at times, especially consultants, quite devoid of the financial constraint or in fact I call it reality of the situation. They do want best quality care, they do want providing patients with all kinds of services but as a manager you need to balance that out. How much you have in the budget and how much you can afford to do that. And if you pay for all the services for one patient it means less for another patient. So that is a difficulty from my point of view".*
>
> *Middle Manager*
> *Barnet*

Regarding the issue of whether there have been any changes to the managers' values over the last few years is concerned, the extracts from the interviews shown in Table 4 sum up the views of most of the interviewees. As can be seen from the Table, values have survived over the last few years and the reasons behind their survival appears to be the intrinsically rewarding nature of the work which they perceive themselves to be allied with.

Table 4: Extracts from interviews representing managers' common views on NHS values and the survival of these values

Have the values changed in the last few years?	Why have these values lasted?
"I've been in the NHS, I came in in '86 and I have left and come back, I haven't noticed that things have [changed]...". *Middle Manager* *Hammersmith*	*"I don't imagine that managers in the NHS work any harder than any other group of managers but the pay you get is roughly half of what you would get for equivalent responsibility in the private sector and you know I don't think that anybody is saying that's a good or bad thing. It's just that you get paid in a different, in a different way in that you feel that you are doing something that is a bit more satisfying potentially and also one aspect of it I suppose is that there isn't a pressure of having to deliver a profit. So I can't get motivated by trying to create wealth for a bunch of nameless shareholders whereas striving for greater efficiency and putting the hours in to make sure in my speciality that more people get cardiac operations does motivate me".* *Middle Manager* *Guy's & St Thomas'*
"I suspect that people's values have remained fairly consistent". *Middle Manager* *Guy's & St Thomas'*	

While the views shown in Table 4 suggest that managers believe that common values held by NHS managers have survived over a long period of time it is of some interest to report the view of one dissenting manager who did feel that there had been some erosion in values. He said:

> *"...now I think that that's what's been eroded and I've watched it being eroded quite quickly in the organisation that I came from and I'm beginning to see the same erosion in the NHS...".*
>
> *Senior Manager*
> *Hammersmith*

As is evident in the rest of the extract below from this interview, the manager went on to explain that this was a society wide erosion of values rather than an erosion of NHS values in particular, and seemed the judgement was generally directed against "younger people" who no longer reflect the commitment and service ethos of the older generations.

"...particularly amongst younger people who no longer have those service mentality and it's much more a business mentality that says you know I'm contracted for a thirty eight hour week, thirty eight hour week is what I do. I'm contracted for this number of hours, this is what I do, these are the things I do, those are the things I don't do and if I happen to be in the middle of a task when time is up [claps his hand loudly] *I'm finished you know I'm out of here...".*

Senior Manager
Hammersmith

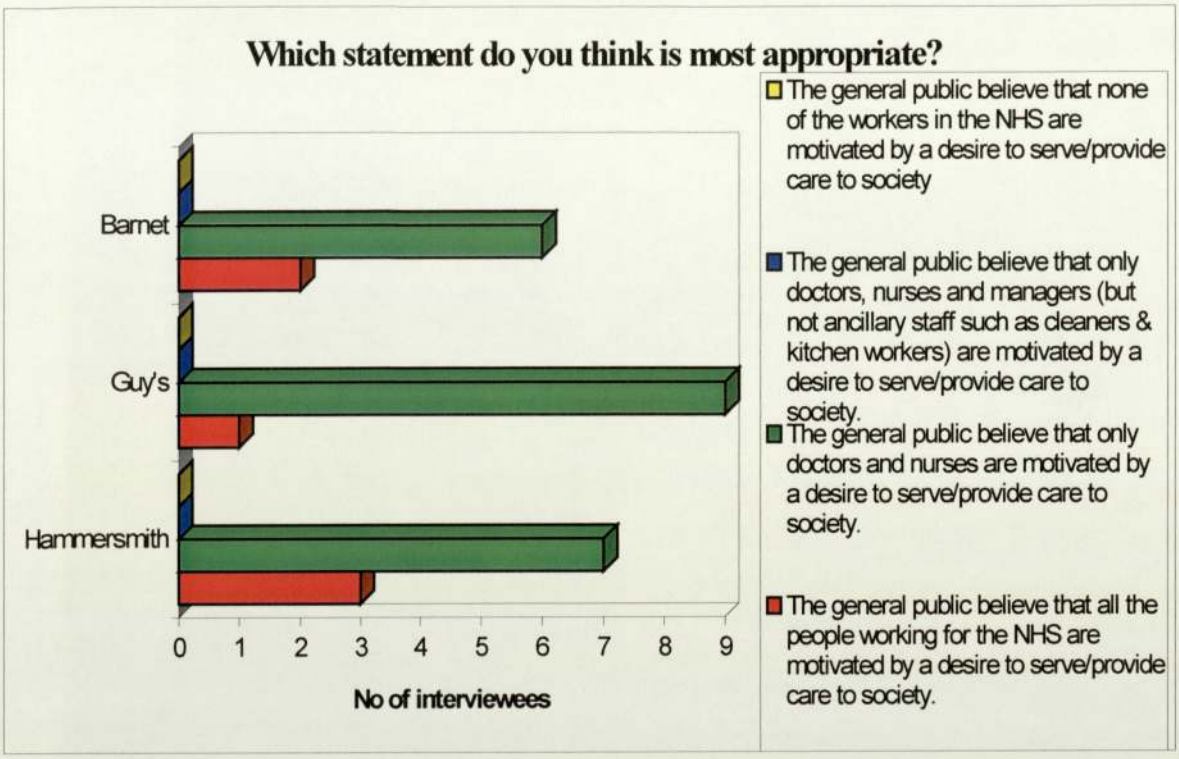
The findings discussed so far indicate that most of the managers appear to regard the recent reforms favourably and the managers on the whole believe that their values, which are shared across all the professional groups in the NHS, are mainly altruistic in nature and have remained unchanged over the last several years.

The final research question in this study led to interesting findings:

4. What are the managers' perceptions of society's expectations of their role?

The issue of what the managers believed was the public's perception of their role was investigated in question 9 of the questionnaire where managers were asked to choose one statement which they thought most appropriately reflected how the public perceived the values belonging to the various groups of NHS workers. The responses to this question are summarised in Figure 14.

Figure 14: Response to Question 9 in the Questionnaire



From the figure above it is apparent that the majority of the managers were convinced that the general public believed that doctors and nurses are the only professionals in the NHS who are motivated by a desire to serve/provide care to society and they alone have an altruistic service ethos. This finding was repeatedly supported in the interviews; some of the managers interviewed put this down to the low profile nature of their job and an unfavourable comparison with the more glamorous and emotive image conventionally attached to the doctors and nurses' public image. A summary of interview extracts in Table 5 make this point.

Table 5: Extracts from interviews indicating the managers' perception of public opinion about NHS managers

Relating to managers' low public profiles:

"...the public don't see us unless they are making a complaint or whatever, they don't see work that goes on behind the scenes. What they see are our services at the point of delivery".
Middle Manager
Barnet

"...in public contact with hospitals they [the public] don't have contact with managers and they see the nurses working, they see the doctors working but the manager's job is sort of at the back isn't it? Backstage".
Middle Manager
Barnet

Relating to poor comparison of managers with doctors and nurses:

"Well if I say to friends I'm an NHS manager they say "ooh, that's a hard job". I'm not sure whether they immediately think gosh, she's serving her society in the same way (as) a doctor...".
Middle Manager
Hammersmith

"...doctors and nurses do have some sympathetic reception from the public that they are working very had and try to maintain a good service but us managers I think are seen as bureaucrats. Creating administrative barriers for the clinicians...".
Middle Manager
Barnet

Exploration of factors which led to these public beliefs revealed that the managers saw clinicians and politicians, with the assistance of the media, as actively propagating this poor public image of managers. The managers believed that the clinicians saw this as an opportunity to increase their power and to shift responsibilities for inadequacies in the system, while politicians were engaged in cynically and unfairly manipulating this public perception in an attempt to find a convenient scapegoat who would take responsibility for the failures in the NHS (see Table 6).

Table 6: Extracts from interviews indicating the reasons for the poor public opinion

Relating to propagation of this view by clinicians:

"And the clinicians play on that because in many ways it would suit them and if I were a clinician I would do the same thing I'm sure. And I think it's a very easy one for Joe and Jane public to latch on to and agree with because it's pretty soft target. Most people can shout at the managers and that's fun".
Senior Manager
Hammersmith

"I think managers are very easy targets. It's easy for clinicians to, when they have to say no to a patient, to turn around and say it's the manager and that happens all the time in my own service. In that you know when something's going well with the patients then it's the clinician who's fixing it, if you have to say no to a patient, no we can't buy this care then nine times out of ten it will come down to me to say to the patient no we can't get you NHS funding for this".
Middle Manager
Hammersmith

Relating to propagation of this view by politicians in government:

"But I think largely the message has always come about you know managers equals bad. We [the government] are going to chop up layers of bureaucracy, we are going to reduce the red tape, we are going to cut out huge swathes of you know these useless managers, etcetera, etcetera and of course on a diet like that it isn't long before everybody joins the band wagon and says the only reason I can't have this is because of some bureaucratic manager who doesn't understand".

Senior Manager
Hammersmith

"I think there's been some political expediency in scapegoating managers and there were the fat cat salaries and the grey suits and all those other stereotypes which...are propagated by politicians who then help promulgate it by television programmes...I think, I feel that it's an easy view that is promoted for political purposes".

Senior Manager
Guy's & St Thomas'

Relating to propagation of this view by the media

"They see that the media is always highlighting doctors and nurses and even my colleagues in the therapies will say well everyone knows that the NHS is made up and run by doctors and nurses and there is nobody else in the NHS. So I think it is a perception because we are not seen and it is one perpetuated by the media".
Middle Manager
Barnet

The managers were therefore convinced that the general public viewed them in a generally poor light and did not confer upon NHS managers the service driven values that were ascribed to doctors and nurses. At the same time this view was constantly underpinned by the firm belief that this public perception was misguided and driven by several unfair and politically motivated agendas.

Interestingly the few managers who believed that the general public held a positive perception of managers believed this view to be restricted to the older generation as is reflected in the extract below:

> *" I mean obviously it's very general but I have found that people who talk about, you know I hear relatives and friends, perhaps a little of more the older generation talk about "oh she works down the hospital you know, she's nice". You know very much that attitude and its not just that you're a nurse it could be that you're the librarian or an ambulance man...you know I've certainly come across a lot of attitude towards of "oh he's you know he does whatever down the hospital".*
>
> *Middle Manager*
> *Hammersmith*

In brief summary, these findings indicate that the majority of the managers appear to perceive the recent NHS reforms favourably. As far as their values and beliefs are concerned most of the managers believe that their values are mainly altruistic in nature and similar values are shared across all professional groups (including different managerial groups) in the NHS. With regards to the final research question, the research findings indicate that most of the managers, with very few exceptions, are convinced that the general public view them in a generally poor light and do not confer upon the NHS managers the service driven values that are ascribed to doctors and nurses. These findings are discussed within a theoretical framework in the next section.

SECTION 5: DISCUSSION

In this section the findings outlined in the section relating to the Results will be discussed within a theoretical framework and related to each of the four research questions that this study is seeking to address.

1. What are the managers' perceptions of the recent NHS reforms?

As identified both in the answers to the questionnaires and in the various stages of the interviews, managers from all the three Trusts, with very few exceptions, generally perceived the recent reforms favourably and appeared to be genuinely personally committed to the general principles behind the recent reforms.

When discussing the relevance of the managers' overall favourable perceptions of the recent reforms it is important to address the notion of perceptions and how they influence individual behaviour. Huczynski and Buchanan emphasise that "...human behaviour is influenced by our perceptions of the world and other people and events in it" [1991: pg 36]. Clearly therefore the way managers perceive the recent NHS reforms can be expected to influence their behaviour and attitudes towards these reforms. Further support for the importance of managers' perceptions about change and reform comes from Carnall [1995] and Burnes [1996] who believe that in change management the support of the staff affected by reforms and changes is generally considered to be paramount for the successful and effective implementation of the changes. On this basis it would seem reasonable to expect that the successful implementation of the various recent NHS reforms depends upon the extent of commitment and support by the NHS managers and it therefore follows that the relative enthusiasm and support for the recent NHS reforms indicated by the managers interviewed in this study should have positive implications for the ways in which managers will behave when it comes to the implementation of these reforms. Of importance was that the few managers who were less enthusiastic about the recent reforms felt this way because of "reform fatigue" due to repeated waves of reforms rather than from an antagonism to the recent reforms per se. It is also worth pointing out that managers do not necessarily just react passively to their environment but they "socially construct the reality of their environment and enact what they take to be the

objective world" [Hatch, 1997: pg 42]. As has been outlined in the Literature Review section, managers have in the past been targeted by the government to explain inadequacies of previous reforms [Warden, 1995] and have been threatened with redundancies and job losses. However despite this, on the basis of the findings in this study, it would seem reasonable to suggest that because the managers support and positively agree with the recent NHS reforms they are therefore more likely to behave and act in a manner consistent with these perceptions in so far as they can positively influence their implementation and overall success. This would be in line with Weick's enactment theory [Weick, 1969] and Berger and Luckmann's concept of the social construction of reality [Hatch, 1997: 42] which focuses attention on the notion of perception and how managers reify, socially construct and enact their perceived reality. Weick believes that once the perceptions of organisational members are affected, action consistent with these perceptions will follow automatically [Weick, 1969].

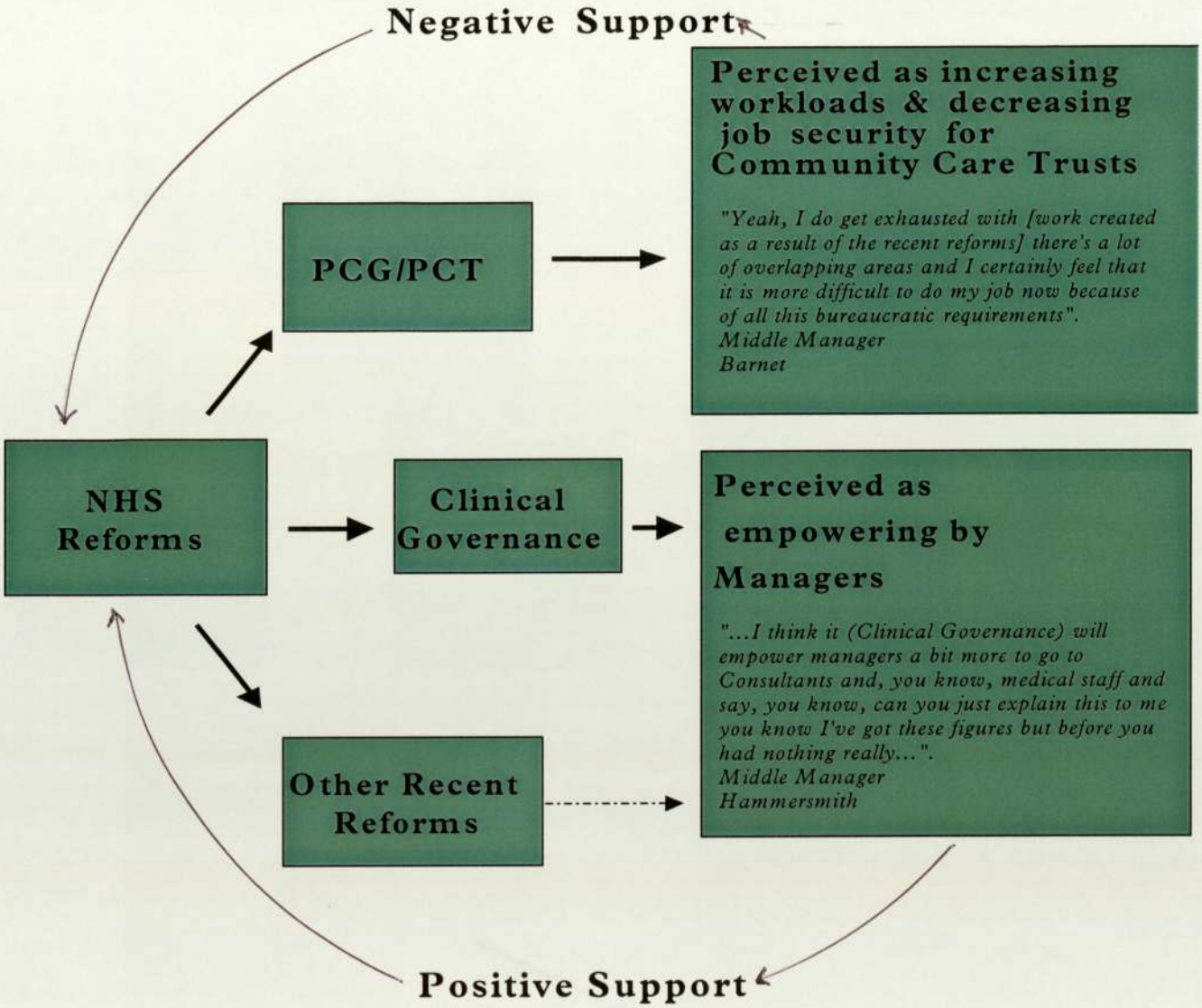
A consideration of the issues related to Power and Politics is useful when discussing the extensive support displayed by the managers for Clinical Governance and also provides an insight into related underlying issues. The introduction of Clinical Governance emerged as being very commonly seen by NHS managers as enhancing their Legitimate Power (as defined by French and Raven [1958]) at the expense of the Expert Power of clinicians. The managers appear to perceive that Clinical Governance will directly or indirectly bestow power upon them as it will enable them to be able to hold clinicians accountable (either voluntarily or otherwise) for their activities. This would lead to a situation where managers become more powerful (where Power is defined by Robbins [1998: pg 396] as "a capacity that A has to influence the behaviour of B so that B acts in accordance with A's wishes) and provides an understanding of the Political activities of managers and additionally gives an insight into how NHS managers may see the reforms as enhancing their personal power. This attitude of NHS managers to Clinical Governance gives life to Morgan's metaphor of "Organizations as Political Systems" [Morgan, 1997] and provides an insight and an understanding into the complexity of interrelationships among actors in an organisation. This finding is an example of Pfeffer's [1981: pg 7] definition of Organisational Politics as "involv(ing) those activities taken within organisations to acquire, develop and use power and other resources to obtain one's preferred outcome

in a situation where there is uncertainty or descensus about choices". This point of view is a useful framework for understanding this issue.

In contrast managers who had already begun to see an increase in their personal workloads in relation to the setting up of PCGs, but without any simultaneous obvious political gain or increased power, were rather less enthusiastic about the personal benefit they might derive from the new reforms. This was restricted to some of the managers in the Community Care Trust who were involved in the formation of PCGs.

As already pointed out in the Literature Review section there is a relative poverty of research examining NHS managers' perceptions of the recent NHS reforms. From this study the picture emerging suggests that whilst the majority of the managers generally perceived the recent reforms favourably, they seem to be more likely to show strong support for the implementation of those reforms such as Clinical Governance that led to direct personal benefit for the managers (which as explained earlier appeared to be perceived to increase their power base) as opposed to those reforms which were perceived to increase managers' workloads without direct personal benefit. This point is illustrated diagrammatically overleaf.

DIAGRAM 1: Flowchart showing factors influencing the managers' support for the recent NHS reforms



2. **Is there a managerial culture within the NHS and if so does the NHS managerial culture share common beliefs and values over a range of issues or alternatively are they more fragmented and based upon coalitions determined by issue agreement/disagreement?**

Assuming the existence of a definable management culture, it would at the same time be worth considering the third question:

3. Has there been a recent change in the managerial subculture within the NHS following the recent reforms?

Culture from a modernist perspective has been defined by Rosenfeld and Wilson [1999: pg 270] as the "basic values, ideologies and assumptions which guide and fashion individual and business behaviour...". An examination of the managers' perception of the existing NHS managerial culture as reported in the Results section shows that the majority of interviewees did not appear to perceive a separate managerial subculture but instead believed that the values and beliefs (i.e. the organisational culture) were in fact shared across all the professional groups in the NHS. This finding differs from an earlier report by Jackson [1997] who identified clearly defined subcultures within the NHS. It may be worth at this stage examining the concept of subcultures. Johnson and Gill [1993: pg 98] define subculture as "a subset of an organization's members who interact regularly with one another, identify themselves as a distinct group within the organization, share a set of problems commonly defined to be the problems of all, and routinely take action on the basis of collective understandings unique to the group". The differentiation and fragmentist perspectives of culture as postulated by Meyerson and Martin [1987] holds the view that there are clear defined groups within organisations who espouse values that are unique to them, the fragmentation perspective (which is a postmodern approach) views organisations as not necessarily sharing common values but as having cultures that are inconsistent and ambiguous. In contrast the findings in this study appear to uphold the integration perspective of organisational culture [ibid] which emphasises organisation wide consensus and the sharing of common values and beliefs by all organisation members. In fact the few managers who did not endorse this view of a pan-organisational culture disagreed only because they thought that contracted non-NHS staff (such as cleaners) may not subscribe to the common NHS values!

An examination of what these common values encompassed showed that the managers on the whole believe that their values, which are shared across all the professional groups in the NHS, are mainly altruistic in nature. As was perhaps only to be expected there were also values identified which were related to personal enhancement and career development. Only a single manager saw her job as a stepping stone to a career outside the NHS, tellingly this was to be a career in the

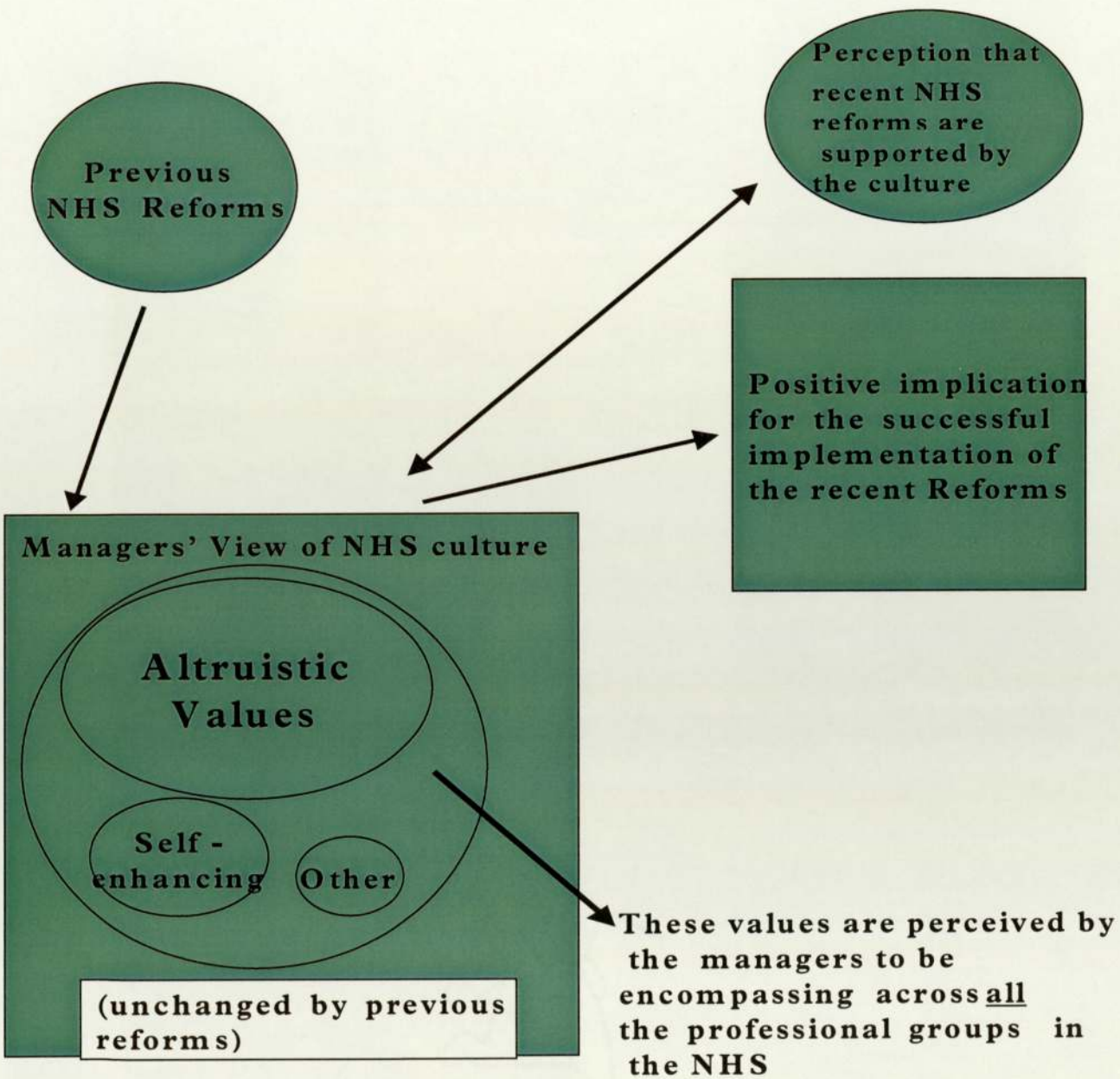
charity sector with similar perceived service ethos. The majority of managers felt that the value system in which they operated was an important quality of their work. Career development was co-existent with altruistic ideals. As shown in the Results section the managers did not generally think that these values had changed as a result of the past or the recent NHS reforms. This perception would be in line with Hughes's [1996] observation that there had been a lack of clear strategy to manage or change the NHS culture during the implementation of the reforms in the 1980s. As previously discussed the managers generally were in favour of the recent reforms because they felt that they were intrinsically useful. As illustrated in Diagram 2, this in turn suggests that the NHS culture (as perceived by the managers) should therefore be conducive to the successful implementation of the recent NHS reforms as long as the managers continue to perceive these recent reforms to be supportive of their altruistic values.

The final research question in this study led to some interesting findings:

4. What are the managers' perceptions of society's expectations of their role?

The relevance of addressing this question is based on the view that professional groups consciously or unconsciously behave in a manner in which they have come to be expected in order to "increase their legitimacy and their survival prospects" [Meyer & Rowan, 1991: pg41]; [Scheid-Cook 1992]. Furthermore according to Deephouse [1996: pg 1025] "...public opinion [as perceived by the actors within an organisation]...has the important role of setting and maintaining standards of acceptability [within professional groups]". The notion of organisational conformity to what is believed to be accepted is explained and discussed by Scheid-Cook [1992] who makes the point that organisations conform to the rational myths in the institutional environment to which they belong and this conformity is termed as "isomorphism". These rational myths (which include the rules and purposes which exist for professions, programmes, policies, etc) are derived from groups in society who believe in them for specific social purposes. The behaviour of professional groups such as NHS managers could therefore be influenced by the public's expectations of their role.

DIAGRAM 2: Relationships between the managerial culture and the recent NHS reforms



This public expectation may have an effect on the managers' institutional role which in turn may have an influence on their enthusiasm for successfully implementing the recent reforms. As reported in the section on Results the findings from the questionnaires and the interviews very strongly indicate that the managers believe that the public view them in a generally poor light and do not confer upon the NHS managers the service driven values that are ascribed to doctors and nurses. The view that managers recognise that their public image is poor is also emphasised by Learmonth [1997: pg 214] who quotes from an interview with a NHS chief executive who said "People used to think we did an admirable if rather humdrum job…now they think we're all fat cats…". Learmonth [ibid] believes that the ideology of managerialism is in general unpopular with the public and the traditional core values of the NHS as perceived by the public are seen as being violated by the efficiency seeking, cost cutting ethos of neo-Taylorist managers. He sees this violation as being the principle cause for the low public esteem in which NHS managers are currently held.

It is very important to emphasise that although the managers held this view it was constantly underscored by the firm belief that this public perception was incorrect and was misguided and was driven by several unfair and politically motivated agendas. As reported in the previous section (see Figure 9), the NHS managers themselves believed that their core values were, along with other professional groups in the NHS mainly altruistic in nature. It therefore appears that despite the managers' opinion that the public perceives them to have an uncaring attitude, the managers themselves do not believe this to be a correct assessment and therefore have not allowed this attitude to become institutionalised in their role.

In summary this research investigation leads to the conclusion that NHS managers on the whole welcome the recently introduced NHS reforms and see them as being workable and conceived in a genuine effort to improve the NHS. In those instances where the reforms received a relative lack of support it did not appear to be because they were thought of as being ill founded, but rather because of a feeling of reform fatigue brought about by successive waves of reforms over the last couple of decades. The relative degree of enthusiasm for the different components of the reforms appears to depend upon individual managers' perceptions of the potential impact that each of

the reforms may make on them personally. Clinical Governance was viewed particularly favourable by managers in the Acute Trusts because, apart from its intrinsic value, it is seen as providing a tool to strengthen managers' own political authority and therefore is viewed as potentially personally empowering. At the same time the managers were encouraged by the belief that Clinical Governance, by placing clinicians under public scrutiny, may provide the managers with a relative respite from unwanted and unfairly biased media attention. On the other hand the formation of PCGs and PCTs though generally welcomed was commonly viewed with some circumspection by the managers from the Community Care Trusts, this was because these managers had already noticed increases in their day to day workloads related to new administrative responsibilities.

It was interesting to find that most of the NHS managers identified themselves as belonging and contributing to a work environment where altruistic ideals were strongly prevalent right across the organisation regardless of professional group. This was despite the manager's common view that the public as a whole did not include NHS managers (in contrast to doctors and nurses) as being motivated by caring values. The managers however did not appear to allow this perceived public opinion to affect how they viewed their own roles and in fact offered various reasons to explain why this public opinion was misguided and misinformed. The setting up of PCGs and PCTs will fundamentally change the structure of the managers' working environment; GPs, district nurses and a host of administrators from allied and related organisations will be involved. It will be interesting to see if the managers' views on "NHS values" will remain unchanged as a result of these organisational changes especially as Dunne [1996] emphasises that the views of individual participants involved in the change are important factors in the change process.

On the face of it these findings may seem universally rosy. It would appear that the NHS managers perceive the NHS (themselves included) as being driven by altruistic values, and they generally see the recent NHS reforms as being a component of the same value system. It would seem that the NHS in contrast to other public organisations [Colville, 1993] has a unique culture which is facilitative of reform providing that the reforms themselves are perceived to be in line with the existing cultural values. The managers have been able to maintain this degree of idealism

despite acknowledging, and then shrugging off as unfounded their perception that the public do not believe that managers have a place in an altruistic NHS value system. All of these views would be expected to have positive implications for the successful implementation of the new reforms by the managers in their role as change agents. As things stand this may well be the case, but only if this status quo is maintained. Should NHS managers change their perceptions and should they actually begin to see themselves in the popular concept of uncaring faceless men in grey suits whose role and values do not include any commitment to society, then this position may well quickly change. With continuing public, media and political attacks future managers could begin to enact a new and uglier reality and establish a new institution. In order to prevent the birth of such a Frankenstein, NHS managers will require acknowledgement of their worth and contributions with support coming both from within their own senior ranks and more publicly from their political masters.

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PPENDIX 1: SAMPLE QUESTIONNAIRE SHOWING FREQUENCY OF RESPONSES

hese questions are related mainly to the recent NHS reforms.

lease answer all questions, entering information/ticking the boxes as appropriate.

Your age group:

6 - 20	0	41 - 50	9
1 - 30	8	51 - 60	1
1 - 40	10	61 +	0

Number of years you have worked in the NHS:
1year =0; 1-5 years=7; 6-10 years=7; 11-15 years=6; >15 years=8

Your Present Job Title:
enior management = 2, Middle management = 22;
unior management = 4.

Number of years you have worked at your particular Trust:
1year =1; 1-5 years=19; 6-10 years=4; 11-15 years=4.

Do you come from a background of:

) Management/administration	17
) Nursing	7
) Other medical (please specify)	3 _____
) Other (please specify).	1 _____

Please briefly list the values (such as common beliefs & attitudes) you think are shared by NHS employees.

See Figure 9

_____
_____
_____
_____
_____

Do you think that the values you have listed in question 6 above are shared across all the professional groups in the NHS (eg Doctors, Nurses & Managers)?

Yes	No	Don't Know
20	5	2

* NR = 1

*NR = No Response

a) Do you think these values are shared by managers regardless of their background eg. nursing background, management background, etc)?

Yes	No	Don't Know	
20	4	1	* NR = 3

) Do you think these values are dependent upon a manager's seniority?

Yes	No	Don't Know	
4	19	3	* NR = 2

) Do you think that managers who work in different departments have different values (eg a manager in A&E as opposed to a manager in Geriatrics, Mental Health, etc)?

Yes	No	Don't Know	
9	17	1	* NR = 1

. Which statement below do you think is most appropriate (please tick one):

) The general public believe that all the people working for the NHS are motivated by a desire to serve/provide care to society. 6

) The general public believe that only doctors and nurses are motivated by a desire to serve/provide care to society. 22

) The general public believe that only doctors, nurses and managers (but not ancillary staff such as cleaners & kitchen workers, etc) are motivated by a desire to serve/provide care to society. 0

) The general public believe that none of the workers in the NHS are motivated by a desire to serve/provide care to society. 0

0. Do you think you are aware of the main principles of the following:

	Yes	No	
) The Griffiths Report	13	13	*NR = 2
) The concept of the "Purchaser" and "Provider" as outlined in the White Paper "Working for Patients"?	26	1	*NR = 1
) The concept of Primary Care Groups as outlined in the White Paper "The New NHS".	25	2	*NR = 1
) The concept of Clinical Governance.	25	2	*NR = 1

1. Could you briefly list what you classify under the term "the most recent NHS reforms" under the New Labour government:

See Figure 8

_____

_____

_____

_____

***NR = No Response**

2. Do you feel that the NHS reforms in the 1980s & early 1990s made a significant impact on you:

	Yes	No	Not sure	
a) Personally	14	10	3	*NR = 1
b) On other people working in the NHS	25	0	2	*NR = 1

3. Do you feel that the more recent NHS reforms in the late 1990s have made a significant impact on you:

	Yes	No	Not sure	
a) Personally	16	9	3	
b) On other people working in the NHS?	22	0	4	*NR = 2

4. Do you think the NHS should provide (Please tick one box):

) Every possible medical service available (including so called "non-essential" ervices such as In vitro fertilisation, Viagra & cosmetic operations).	3
) Most medical services (excluding the non-essential services)?	25
) Emergency services and only some routine services.	0
) Emergency services only.	0

5. In your opinion have the most recent reforms introduced by the Labour government increased:

	Yes	No	No Change	Not Sure
) Availability of information to patients?	12	3	11	2
) The ability to promote a genuinely better service?	8	7	6	7
) Improved NHS management?	1	12	7	8

6. If you have answered "Not sure" to any parts of Question 15 above, then in your opinion do you think the most recent reforms introduced by the Labour government will have the effect of increasing:

	Yes	No	No Change	Not Sure
) Availability of information to patients?	2	0	0	0
) The ability to promote a genuinely better service?	5	1	1	0
) Improved NHS management?	3	0	3	2

*NR = No Response

7. Do you feel that the most recent reforms have created a situation where:

	Yes	No	No Change	Don't Know
There is increased red tape?	9	7	8	4
Management is more efficient and responsive?	7	9	8	4
Decisions are made with patient welfare in mind?	8	2	12	6
Cost constraints outweigh patient needs?	11	3	10	4
The NHS will become more accountable & regulated?	16	1	6	5

8. If you have answered "Don't Know" to any parts of Question 17 above, then do you think that the most recent reforms introduced by the Labour government will have the effect of creating a situation where:

	Yes	No	No Change	Don't Know
There is increased red tape?	3	0	0	1
Management is more efficient and responsive?	0	0	0	4
Decisions are made with patient welfare in mind?	1	0	0	5
Cost constraints outweigh patient needs?	2	0	0	2
The NHS will become more accountable & regulated?	2	0	0	3

9. Do you agree or disagree with the following statements (please tick appropriate answer):

The most recent NHS reforms have/ will result in a knitting together of clinical care and management to the betterment of patient care.

Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't Know
1	22	5	0	0

My opinions of the most recent NHS reforms are shared by the majority of my work colleagues.

Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't Know
2	13	5	0	8

The most recent NHS reforms have/will challenge my professional authority.

Agree strongly	Agree somewhat	Disagree somewhat	Disagree strongly	Don't Know
0	8	13	2	5

0. Which one of the following statements do you believe to be most true (Please tick one box):

	Yes	No	Not Sure
All the reforms since the 1980s were vital and necessary for the NHS.	4	10	11
			*NR = 3
The reforms in the 1980s and early 1990s were necessary and vital for the NHS.	10	6	11
			*NR = 1
The most recent reforms introduced by the Labour government were necessary and vital for the NHS.	9	6	9
			*NR = 4

*NR = No Response

Thank you for taking the time to complete this questionnaire.

APPENDIX 2: Outline of Interview Questions

1. Explore answers to Questions 6-8 in questionnaire related to perceptions of common shared values & establish reasons for answers.

   Have the values outlined in Question 6 always been the same or have they changed?

   If so, why do you think this may have occurred?

2. Explore answers to Question 9 relating to the public's perception of common shared values within the NHS.

3. Explore answers to Questions 15 to 18 (all to do with most recent reforms).

4. Have any of the recent NHS reforms been responsible for any changes to common shared values? If so, how have they been responsible?

5. Have the recent reforms affected your work directly in any way? If so, in what way (e.g. shift in power; restructure; etc)?

6. Do you perceive any further changes to your work? If so, what?

7. How do you feel about these changes (micro and macro)?