ABSTRACT

Aim: To provide an original perspective on front line nurses' perception of senior managers who are not nurses.

Background: A key element of new public management had been the drive for 'hands-on' professional management within the NHS, meaning the employment of mangers with managerial experience but little or no healthcare experience.

Design: An interpretive qualitative study, based on a single case study design with semi-structured interviews.

Methods: Semi-structured interviews were carried out with 31 front line Scottish NHS nurses exploring their perceptions of the role of managers between July and September 2010.

Results/Findings: Nursing staff were often unsure of the responsibilities of managers and perceived that there were an unnecessarily high number of managers within the NHS. Nursing staff raised concerns over the non-clinical background of managers, including their ability to understand the pressures faced at the front line.

Conclusions: The main reason for conflict between managers and nursing staff was due to their differing foci. Managers were seen to concentrate on decisions surrounding targets, audits and budgets with little consideration given to the impact of these decisions on patient care.

Key Words (max 10): Workforce issues, adult nursing, management, policy, case study research

SUMMARY STATEMENT

Why is this research or review needed?

- Since the rise of new public management globally there have been significant changes in the structure of healthcare systems and there is a need to establish the effect these have had on front line nursing staff
- The relationship between managers and front line nursing staff is important and the reasons for tension between managers and professionals within healthcare, needs to be explored

What are the key findings?

- This study provides a unique perspective on front line (direct care giving) nurses views of senior managers.
- This study offers an understanding of the tensions between managers and nurses, as a result of perceived conflicting foci.

How should the findings be used to influence policy/practice/research/education?

- The findings from this study should be used as a way to understand the relationships of managers and nurses within healthcare settings in order to ensure an effective relationship.
- Managers need to involve nurses in decision making processes in order to ensure shared priorities and understanding.

‘Nurses perceptions of senior managers at the front-line: people working with clipboards’

INTRODUCTION

There has been little research focusing on how New Public Management (NPM) has influenced how direct care giving nurses perceive the role of senior managers. This is despite NPM styles having an influence on global healthcare (Christensen & Lægreid 2011, Pollitt & Bouchaert 2011). Like many other countries, the landscape of healthcare delivery in Scotland has changed significantly in the 20th century. However, since devolution there has reportedly been divergence in health policy (Hazel & Jarvis 1998, McEwan & Parry 2005, Jervis 2008, Greer 2010, Davies 2012, Mooney & Scott 2012, Stewart 2013). One of the key drivers of this change has been the shift away from bureaucracy towards more flexible forms of organisation; characterised by the business-style model of managerialism (Hood 1991, Harrison & McDonald 2008). This principle involves increases in efficiency; the use of ever-more sophisticated technologies; a disciplined labour force; an implementation of professional management roles and managers being given the right to manage (Pollitt 1990). In this paper the role that general managers (managers who have managerial experience in a variety of industries, but may have little or no experience of healthcare) as a central tenet within NPM, has had on shaping the relationship between nurses and their senior managers within a Scottish hospital is discussed.

BACKGROUND

With neo-liberal ideologies, in 1979 the then Conservative government within the UK envisaged a NHS that would move away from its public ethos and instead be run like a private business (Griffiths 1983) - NPM. The government introduced organisational changes

into the NHS such as drive for efficiency and value for money within policy guidelines and the introduction of general managers (Harvey 2005; Evans 2009). This led to fundamental changes to structures, cultures and practices of public sector organisations in the last three decades (Numerato *et al.* 2012). These developments have emerged in reaction to the challenges faced by healthcare systems in globally; such as the welfare state crisis, reinforced market requirements (Harrison & Ahmad 2000; Kuhlmann & Annandale 2012), more knowledgeable and demanding service users and scandals over care (Weick & Sutcliffe 2003). Therefore, governments and policy makers have sought for more effective and efficient healthcare services with a focus on accountability and transparency (Dent 2006, Kuhlmann & Burau 2008, Pickard 2009).

Internationally, health policies have been introduced in response to challenges within healthcare by introducing/reinforcing market mechanisms and managerial controls (Hunter 2011, Kuhlmann & Annandale 2012). Managerialism and marketization have achieved a global focus and have shaped policy reform in different healthcare systems and regions of the world (Hall 1010; Hunter 2011; Boyle 2011; Kuhlmann & Annandale 2012; Steel & Cylus 2012). The introduction of NPM (Hood 1991, Kitchener *et al.* 2000, Leicht *et al.* 2009) has led to management systems being put in place to govern professional practices such as auditing, clinical guidelines, protocols, standards, and incident reporting systems. Professional management (i.e. general manager roles) was introduced. This meant managers were to be appointed who had management experience but not necessarily health experience (Pollitt 1990, Exworthy & Halford 1999, Pollock 2005, Hunter 2007). For NPM, a lack of familiarity with healthcare was seen as preferable (Strong & Robinson 1992, Yu & Levy 2010). However, the reforms have not been successful in attracting or retaining managers from outside the NHS (Exworthy *et al.* 2009). Authors such as Mackie (2005) and Levy

(2010) argue that NPM peaked in the late 1990s and has been in decline and is now dead. However, as highlighted by De Vries & Nemec (2013: 5), the reality may be that the ideas behind NPM, the tools such as performance measures and the emphases on output and controls, are "very much alive". Issa (2012) suggests that NPM has become shorthand for a broad set of administrative doctrines which have come to dominate public administration since the late 1970's and therefore the components on NPM have evolved over the years. Authors argue that each country has implemented NPM principles in their own way, and there has been no uniformity in implementation (Bouchaert *et al.* 2009, Nemec 2011).

Managers and Professional Relationships

The characteristics of professionalism are: a focus on service user (patient) welfare over economic priorities and a degree of control over their work (Freidson 2001). Professional work is institutionalised, individuals are autonomous and professional associations regulate the clinicians. Managers however, are portrayed as people who are responsible and committed to the interests of the organisation; terms such as entrepreneurship, innovativeness, creativeness, and competency are characteristics assigned to managers (Spehar *et al.* 2012). Within the NHS there are differing levels of managers; there are junior managers who are responsible for staff but have no managers reporting to them (e.g. ward managers), middle managers who have at least one manager reporting to them (e.g. modern matrons) and senior managers who are normally in charge of a function across a hospital (Preston & Loan-Clarke 2000). The general manager role focuses on: "leadership, cost improvement, motivation of staff, the gearing of professional functions to the overall objectives of the service and consultation for major service reconfiguration" (Chambers 2009: 312). Managers in the NHS rely on consensus, particularly between managers and

clinicians; this is despite the advent of general management and a move away from a formal consensus management (The Kings Fund 2011).

There is a tension between managers' desire for a strong chain of command and the professional autonomy of clinicians. This leads to a "low trust relationship and a souring of relations" between clinical staff and their managers (Lynch 2004: 130; Brown *et al.* 2011). Focusing on the relationship between professionalism and managerialism, there has been a shift in the 'legitimacy' of management in the public sector. Furthermore, there appears to be animosity towards the number of managers within the NHS, with a view purported by the media that the increase in the number of managers has been at the expense of patient care (Steel & Cylus 2012).

Traditionally, managers have been seen as conformist, self-interested and career motivated, whereas professionals are often seen as altruistic and driven by an ethical commitment to their expertise/profession (Exworthy & Halford 1999). Qualitative studies highlight that nurses want to provide 'holistic care' (Woon Hau 2004, Hoyle 2010). These views reflect professionals values, but nurses report feeling unable to deliver this case due to the "production line style of care giving" (Cooke 2006: 225) and according to Traynor (1999: 141) nurses have differing values and priorities compared to managers. Similar findings have been found in other areas, for example with call-centres (Taylor & Bain 1999). This can lead to a 'them and us' mentality (Coupland *et al.* 2005). However, Vickers and Kouzmin (2001) discuss this polarised view, but suggested it is perhaps too simplistic. Both Thomas and Davies (2005) and Hoyle (2013) offer a view that employees are not passive recipients of decisions, but can challenge and shape them via mechanisms such as resistance.

THE STUDY

Aims

The aim of this paper is to explore how direct care giving nurses within Scotland view senior managers within the NHS. More specifically it addresses the question: How do front-line nurses perceive senior managers who are not nurses and is this a source of conflict? This article draws upon data from a single case study comprising of 31 qualitative interviews. Fieldwork was carried out over three months in the summer of 2010, within a large inner city Scottish hospital.

Design

This research project was a qualitative interpretivist (Denzin & Lincoln 2000, Crotty 2005) study grounded in the methodology of adaptive theory. Adaptive theory (Layder 1998; 2006) is an attempt to incorporate both the generation of social theory alongside on-going empirical research. Adaptive theory provides a useful conceptual framework as it attempts to use prior theoretical ideas and models; which then feed into and guide on-going analysis of data, as well as allowing for the generation of new theory from the data itself. The interpretive approach taken within this study did not seek to make claims of generalizability, but rather to offer a narrative from the front line perspective. The research was designed to capture both circumstances and conditions that are commonplace for nursing staff within the hospital arena.

Sample/Participants

In some areas the ward manager disseminated information sheets and then provided the researcher with the details of those willing to participate, whereas, in other areas participants were recruited face-to-face by the researcher. The information sheet contained a brief overview of the study for participants as can be seen in Figure 2.

(Insert Figure 1 about here)

Interviews were undertaken with registered nursing staff who met the inclusion criteria (Table 1), were willing to participate, were from various areas of the hospital, differing nursing levels, ages, gender and length of experience.

(**Insert Table 1 about here)**

Nine of the interviewees were from emergency arenas (emergency department, medical assessment unit and surgical receiving unit), thirteen from surgical wards and nine from medical wards. Twenty-two participants were female compared to nine male. Twenty were Band 5 nurses, four were Band 6 nurses and seven were Band 7 nurses. Staff ages ranged between 21 and 65, with more of the participants being below 40 than above (nineteen compared to twelve. Twelve participants had five years or less years of service, eight participants had between 6 and 15 years' experience and eleven had over fifteen years.

The mean length of the interviews was 45 minutes, but they varied from 20 minutes to 60 minutes. The interviews were audio recorded as it allowed for an accurate record of the discussion. However, some participants refused to be recorded and so hand written notes were made at the time of the interview detailing the discussion in order for it to be an accurate record of the discussion. Interviewees' notes and transcripts were made available to the individual nurses if they requested to view them.

Data Collection

A semi-structured interview guide was developed and used during the face-to-face individual interviews. For example, with regards to managers and management, questions such as: 'In what ways, if any, do you think that the NHS structure has change during your working life

in the organisation or profession? and 'In general, when thinking about management what do you see as the positive features of the relationship between nursing staff and management and what, if any, are the negative features of the relationships between staff and managers?'

Ethical Considerations

Ethical approval was obtained from both The University of Stirling Ethics Committee and the appropriate NHS Research Ethics Committee, and had all appropriate NHS governance clearances.

Data Analysis

QSR Nvivo was used as a data management tool for the project. Thematic analysis was employed within this study. This type of analysis allows the identifying, analysing and reporting of patterns (themes) within data (Strauss & Corbin 1998; Braun & Clarke 2006). A preliminary analysis of the data was integrated with the data collection process as part of a process of continual reflection. Once fieldwork had been completed, a set of thematic categories (cf. Ritchie *et al.* 2008) were developed. This involved the reading and rereading through the data set by set and identifying re-occurring themes. This meant that the development of thematic categories were an emergent and iterative process, which allowed first insight into connections between themes. The approach taken in this study incorporated both inductive and deductive methods of data analysis. Themes were also produced with theoretical concepts in mind. These themes were coded on the transcripts in Nvivo along with any links between the existing nodes and the new themes. This approach complemented the research questions by allowing analysis to be driven by the researchers theoretical and analysis interest in the topic while also allowing for themes to emerge direct from the data using inductive coding. Figure 2 shows the final thematic map.

(Insert Figure 2 about here)

Validity and Reliability/Rigour

The interpretive approach taken within this study does not seek to make claims of generalizability, but rather to offer a narrative from the front line. The purpose of interviewing in qualitative research is to focus on the phenomena they investigate and so repeatability and reliability is less important (Parahoo 1997). Recordings and transcripts and the ability for people to see the process of the production of the data and analysis help to ensure reliability (Silverman 2001). QSR Nvivo software allowed a research diary to be maintained and all decisions were recorded here. Nivivo also allowed for coding to be carried out more systematically as the coding could be checked and compared to how other data was coded (Bazeley 2008). Nodes could be seen and the coded information was traceable back to the original transcripts and so this meant that the original context in which the comments were made could be seen, producing an internal audit trail. Comments and memos were also attached to the coding, so the decision-making process could be seen and descriptions were offered for the different codes to show what they would and would not include.

FINDINGS

The problem with general managers

The respondents commented upon the professional backgrounds of senior managers, although they were not asked about this specifically. Many of the respondents argued that: 'management is now less likely to be nursing' (Female, Staff Nurse, 6-10 years). Several of the respondents highlighted that in previous years, managers were more likely to have experienced nursing:

> 'Management more than 15 years ago were still mainly nurses, now management aren't always nurses, they don't always have a hospital background and it can be

> difficult trying to explain what can work practically for us and still be within their budgetary restraints or whatever.' (Female, Ward Manager/Sister, 15+ years).

For several of the older nurses, there appeared to be a view that in previous years, managers would have come from medical or nursing backgrounds and this was seen as better. However, despite many of the respondents stating that managers did not have a nursing background, several of the nurses also talked about senior managers who did have clinical experience: 'I think managers away at the top don't work in the wards anymore, they're not under the same pressures' (Female, Staff Nurse, 6-10 years).

Resentment of Managers

There was a resentment on the part of some respondents towards their managers as they indicated that the manager's focus was not appropriate to what nurses' saw as the main focus of the NHS, this linked to their views of senior managers not having a clinical background:

> 'I think, you know, the nurses that are at the bedside – and not just the nurses, the medical staff, you know - the at-the-bedside care is the most important thing, and I think sometimes people, sometimes that's forgotten, and it's very important to remember that patients are number one, and that's why we're all here, and that gets forgotten in amongst it all, quite often' (Female, Ward Manager/Sister, 15+ years).

The respondents remarked that their role was: 'just delivering patient care generally on a daily basis' (Female, Staff Nurse, 3-5 years) regardless of budget and targets. Whereas they clearly viewed managers roles as being focused on budgets and targets, and therefore there were competing value systems. The nursing staff interviewed appeared to rely primarily on their own beliefs, values, knowledge and rituals to guide their practice:

> 'Decisions need to be left to integrity in some cases. The dangers are that people need to look beyond the standardised advice and need to use clinical decision-making skills; they are good as guidelines, but need to be interpreted' (Female, Staff Nurse, 15+ years).

Many of the respondents highlighted that a lack of understanding of healthcare by managers has led to a workload increase. This was due to having to explain decisions, report on targets and offer explanations if the targets had not been met:

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

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

> 'You try to be as responsible as you can and try to do as much for the patient as you can, but sometimes the time restrictions you can't' (Female, Staff Nurse, 2-3 years).

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

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

Too much emphasis on managers and manager roles

The majority of interviewees commented that there has been an increase in the number of managers and this was viewed as a negative: 'there is money wasted with 'people working with clipboards' but staff are needed on the wards' (Female, Staff Nurse, 15+ years). However, a few respondents were less critical about the apparent large number of managers:

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

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

Throughout the interviews, participants mentioned different types of managers with whom they had contact or were aware of within the hospital. Table 2 comprises the types of manager roles cited.

(Insert Table 2 about here)

All of the respondents identified at least one of the manager types listed, with many mentioning multiple managerial roles. Ward based managers were discussed as well as those who were thought of as more elevated in the nursing hierarchy. The respondents also referred to managers who were not viewed as part of the nursing hierarchy, but rather separate from it. These individuals were reported not to have any authority over the front line nurses, but were

responsible for other groups of individuals in the hospital who provide resources or services such as catering, security and pharmaceutical products.

The respondents were able to name the managers' roles, but most voiced the fact that they did not know what the positions involved or how they influenced nurses' day-to-day work. This lack of understanding was seen to lead to tensions for the staff, as this absence of understanding or lack of willingness to acknowledge the responsibilities of the managers created a discord, resulting in respondents resisting organisational changes and demands:

> 'Sometimes if you've got a lack of knowledge about what somebody's role is exactly, that can maybe undermine and I think that's my problem sometimes. I undermine Hospital Managers because I don't fully understand what their role is, you know, what they're supposed to do other than manage a budget' (Female, Staff Nurse, 15+years).

This suggests that there is a 'them and us' mentality. Respondents showed empathy towards the tensions they believed managers such as ward managers and lead nurses were under, and offered understanding: 'I know it's not the sisters on the wards making decisions. I know that it is coming from above' (Female, Staff Nurse, 3-5 years). This was compared with those managers not based at ward level, where the respondents not only stated that they had little understanding of their nursing roles, but the majority were also quick to argue it was those decisions that were having an adverse effect on the nurse's work:

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

Many respondents articulated that they would not actually want contact with other levels of managers. This strategy of limited contact was seemingly developed by the staff in order to limit the influence of such managers on their day-to-day work, and as a way for respondents

to cope with their workloads. Several of the respondents remarked that interacting with more managers further increased their workload and removed them from the patient's bedside:

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

Participants identified a clear chain of command for nursing; however outside of this immediate nursing hierarchy the respondents were uncertain of where managers fitted within the overall organisation. Despite this, nurses clearly identified managers as more senior as they had the ability to influence nursing care via policies, targets, audits and budgets, of which they had little control.

DISCUSSION

Throughout the findings, the respondents highlighted that they believed senior managers were more focused on efficiency as opposed to patient care. NPM ideology (Hood 1991, Hunter 2007) is reflected in management structures and manager decisions within NHS organisations. However, this ideology ran counter to what respondents viewed as important. Within an organisation, there can be different and competing values, which come from different professional groups having different views on the nature of their work and the business of the organisation (Davies *et al.* 2000). This is important to understand when looking at how managers and nursing staff interact, and can offer an explanation for the differing foci of the front line workers and the managers.

At the time of field work, there were many reports about the increasing number of managers in the NHS (e.g. BBC 2010, Ramesh 2010), and threats of a reduction in nursing staff levels

(e.g. BBC 2011). This could partly explain the animosity of the respondents towards the perceived high number of managers as they could have been influenced by the media reports. It could also be argued that the general negative public perception could be cause by politicians who have criticised the volume of managers in the NHS (The Kings Fund 2011). With regards to the actual number of managers in the Scottish NHS, The King's Fund (2011) report that between 1999-2009, the total number of NHS staff increased by approximately 35 percent, however, in Wales, Scotland and Northern Ireland the number of managers remained static or decreased.

A further reason for hostility towards managers could have been the perceived lack of clinical experience of managers. Learmonth (1997: 219) highlighted 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". This view is perhaps also held by the nurses interviewed. Several of the respondents commented that senior managers lacked clinical experience and so the legitimacy of their decisions were questioned. This in turn led to strategies such as resistance being employed by the nursing staff. However, there was a contradiction, as when the respondents discussed their views of the backgrounds of senior managers, the same respondents would also talk about senior managers who had been removed from practice for too long to remember what it was like to work on a ward. So, although initially nurses claimed that managers did not have a nursing background, the data actually indicates that the respondents may not in fact know the backgrounds of some, or even all, senior managers.

Despite the aim of managers being removed from the clinical sphere as advocated by Conservative governments in the 1980s and beyond, within hospitals there remained (and

continue to remain) managers, who have a clinical experience. This means that professionals at the immediate and higher levels are frequently managed by fellow professionals (Freidson 1994, Evans 2010). However, simply because a manager has previously been a professional, does not mean that they retain the values of the professional. The respondents in this research commented that even if individuals had a clinical background they were often too far removed to understand what it was like at the front line. On the one hand, they may be more aware of the experiences at ward level and allow this to guide their decisions, but on the other, they may be pressurised to conform to managerial strategies. Evans (2010) in his study found that local managers were critical about the policies they were to implement and did not simply accept organisational priorities – there was conflict between practitioners and the organisation regarding their role. Parand *et al.* (2010) in their study found that there were divergent views between clinical front line staff and their managers on different aspects of Safer Patient Initiatives. Davies (2013) highlights the need for senior managers to engage with the front line for the benefit of both staff and patients. One of the recommendations from the Francis Report[1] was that there should be increased visible leadership within the NHS. One way in which this is being addressed is for senior managers 'to go back to the front and experience first-hand the realities of care delivery from the perspectives of patients and staff' (Davies 2013). This is thought to be a way for senior managers to become more visible and to be seen to take nurses views and patient care into account when making decisions.

Limitations

Due to the focus of this research being specifically on front line qualified nursing staff at the ward level, the potential solutions and reasons for tensions have largely been understood within this narrow context. Further research is needed to understand the tensions at a wider

[1] The Francis Report (2013) is an enquiry into the poor care at Mid Staffordshire NHS Foundation Trust in England. This inquiry has highlighted many failing within the NHS and proposed recommendations to improve care and patient safety.

level and in more depth. An exploration of the motivations of more powerful actors such as politicians, civil servants and senior managers, who ultimately control and define the broad environments under which the nursing staff work and policy function, would help to enhance understanding. Therefore, further research needs to be carried out in order to gain a fuller picture. Furthermore, the sample size of this research was relatively small, and the main focus of the research was not on nurse/manager relationships. Rather the tensions between nurses and managers were identified as a theme within the larger project. Despite this, this article raises some important issues in relation to NPM approaches and their influence on nursing relationships and practices which can then influence patient care.

CONCLUSION

If nurses do not see the decisions being made by mangers as legitimate or indeed the need for the manager then this can lead to conflict and resentment, leading to a difficult working environment. Evidence suggests that the working environment can have an influence on the quality of patient care and having management support is necessary for a health work environment (Schmalenberg & Kramer 2009). If relationships are improved and maintained between managers this can lead to an improved workplace for staff and this will also enhance patient care.

The introduction of managerialism and NPM have not been uniformly introduced globally, rather there will be different policies and implementation throughout all health systems (Kuhlmann & Annandale 2012). However, NPM has had a significant influence within healthcare in Scotland. It is important to recognise the influence of NPM and how it has shaped management and professional/manager relationships within the NHS. It is important understand how the professional/manager is relationships perceived by front line nursing

438 staff. In doing this, tensions and difficulties between front line staff and senior managers can
439 be identified. The strategies employed by nurses to overcome these difficulties can also be
440 seen. This is necessary in order to determine how an effective relationship can be pursued and
441 to ensure excellent patient care.
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TABLES AND FIGURES

Table 1: Inclusion Criteria

Band 5 nurse or above
Contracted to work in a specific area (no bank or agency staff)
Minimum of 2 years' experience as a registered nurse
Minimum 2 years' experience in hospital site

627 Table 2: Types of managers identified by respondents

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

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647 Figure 1: Information provided to participants on the purpose of the study

What is the purpose of the study?

Within nursing there have been manage changes to the management structures that impact on how nurses undertake their work. This study aims to examine how qualified nurses perceive their relationships with mangers, with other members of staff and with patients, following management changes due to the introduction of New Public Management (NPM). NPM focuses on improving costs, efficiency, accountability, increased market orientation and competition within the NHS. This research aims to investigate the impact that management structures and the managerial approaches of NPM have on nursing staff relationships in order to establish how these groups interact and work together. Participant in this study will include answering questions relating to your day-to-day work, the structure of the NHS, your role, issues of auditing, accountability and monitoring and working conditions.

Figure 2: Final thematic map, showing main themes for how nurses perceive non-nursing managers in the NHS