FRONT LINE MANAGERS AND THE DELIVERY OF EFFECTIVE PEOPLE MANAGEMENT

A study of front line managers in the NHS

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The views expressed in this report are the authors' own and do not necessarily reflect those of the Department of Health.

List of Abbreviations

AfC	Agenda for Change
CIPD	Chartered Institute of Personnel and Development
FLM	Front line manager
KSF	Knowledge skills framework
HRM	Human Resource Management
WERS	Workplace Employee Relations Survey

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1. INTRODUCTION

This report details the findings from a detailed study of front line managers (FLMs) in the NHS. The research was commissioned by the Department of Health and undertaken by Bath University[1] during the period March 2005 to March 2008. The research is case study based and focuses on seven Trusts from the NHS acute and ambulance sectors. Both qualitative and quantitative methods were employed to provide insights into the role of FLMs. This involved extensive interviewing, and in total 168 interviews were conducted with NHS staff: 117 of these interviews were with FLMs, and the remainder with more senior managers and other key players in the Trusts studied such as Directors, HR specialists, Heads of Nursing and staff side representatives.

The main purpose of the research was to explore the role that FLMs play in the effective delivery of people management in the NHS. In exploring their role we also sought to determine whether FLMs made a difference to service delivery and performance. The term 'people management' is used to refer to all aspects of how people are managed and includes HR management (such as recruitment, selection, appraisal, reward, training and development) and leadership skills more generally. At the start of the research we sought to define the target population and concluded that FLMs would be at the lower end of the management hierarchy and have clinical staff reporting to them who tended not to have management responsibility themselves. A crucial requirement was that these managers had some people management responsibility which we defined to be, at a minimum, responsibility for conducting performance appraisals/reviews. It was anticipated that these managers would typically be at band 7 under the Agenda for Change (AfC) pay and grading framework, but could also cover some band 6s and possibly band 8s.

FLMs play a crucial role in the success of the modernisation of the NHS, and in delivering HR in the NHS Plan. This is confirmed in very recent research in the NHS

[1] Although the contract has always remained with Bath University the two researchers involved in the study left the University during the course of the research to take up positions elsewhere. Most of the field work was undertaken whilst these researchers were employed by Bath University, but the analysis and writing of the report took place afterwards when both researchers had other commitments. Section 3 of the report provides further details.

which shows line managers to have a key role in delivering Human Resource Management (HRM) and in linking HR strategy to practice (Boaden *et al*. 2007). HRM or people management is very much part of the role of FLMs in the NHS. In facilitating the skills development of their staff, for example, FLMs are required to use personal development plans (PDPs) and conduct appraisals in order to identifying learning needs, provide advice, and manage expectations of increased job responsibility and career development (McBride *et al* 2006). Developing the capacity and capability of staff in this way ultimately links to the patient experience.

To understand FLMs' people management responsibilities it was important to consider their roles more widely and explore how the different responsibilities interacted and meshed with each other. In order to examine their potential impact on service delivery and performance it was necessary to explore FLMs' attitudes and behaviours and identify any positive and negative experiences. This required us to ask about how FLMs were managed, what support was available, and if there were barriers or inhibitors to effective management. Most of our interviews concluded with a question about 'what makes a good front line manager' which allowed us to identify the important qualities and behaviours required in an effective line manager. We explored these issues with both FLMs and senior management and were particularly interested in any differences between senior management expectations and the front line manager experience.

The report begins with a review of the relevant literature and considers the changing role of FLMs and why these managers are important, particularly within the NHS, and sets the context for subsequent analysis. The next section details the aims of the research and the methods used, noting the particular challenges encountered during the research process. Section 4 presents the key findings from the survey of FLMs and shows the reality of managing at the front line. This begins with an overview of the key characteristics of the managers who participated in the survey, before considering FLMs' perceptions on what the role entails. Perspectives on support, including FLMs' experiences of HR policies and practices and their relationship with more senior managers, team members, and colleagues are then explored, before an analysis of the constraints facing FLMs in people

management, and management more generally. The next part of this section considers line managers as employees, in terms of perceptions of workload, stress, and job influence plus outcome measures such as job satisfaction and commitment. In the final part of this section some conclusions are made, by the FLMs themselves, on what makes a good line manager. Section 5 considers these issues from the perspective of senior managers, noting any gap in perceptions between senior managers and FLMs. Section 6 draws on secondary data from NHS national performance data, the NHS staff survey and our own survey of FLMs to make some observations about links with performance. The final two sections draw together the key findings from the study to reach a conclusion and raise some important learning outcomes.

Throughout the analysis comparisons are made, where possible, with health sector managers from the Workplace Employee Relations Survey (WERS) 2004, which is considered one of the most authoritative sources of information in Great Britain on the state of employment relations and working life. It should be noted, however, that the WERS comparator group covers all managers, and includes directors and managers in support areas, not just those at the front line, and therefore strict comparisons cannot be made. Quotes from the interviewees are used throughout to illustrate points being made.

2. BACKGROUND

There is increasing evidence to suggest that front line managers (FLMs), those at the lower end of the management hierarchy, play a crucial role in the delivery of organisational performance by the way in which they enact HR policies and influence employees' attitudes and behaviours. Within the NHS the line management role has extended and been given heightened significance under such initiatives as the NHS Plan (2002), AfC, the Skills Escalator and the approach to New Public Sector Management (Bach and Kessler, 2007; McBride *et al* 2006). However, until recently, this group of managers had been a relatively neglected area of study and within organisations it remains rare for these managers to be identified as a special group worthy of attention (Purcell and Hutchinson, 2007). In healthcare research has tended to focus on top management or medics (Procter, Currie and Orme, 1999) and some have criticised this focus as being at a level which is too high to impact on behaviours at operational level (Ferlie *et al*, 1996).

In this background section we review some of the relevant research on FLMs, focussing on the Human Resource Management (HRM) literature, and consider why they are important, particularly within the context of NHS organisations. This sets the frame for subsequent analysis.

Who are the FLMS

Within existing literature various terms have emerged to describe this body of managers including 'first line', 'supervisors', 'front line', 'junior' and 'team leader' and distinctions between them are unclear, with the terms often used interchangeably (Hales, 2005). In addressing this problem some researchers favour a pragmatic approach and suggest that the solution needs to be context specific (Dopson and Neumann, 1998; Currie 2006).

A growing body of research defines this group of managers as those who have direct supervisory responsibility, normally for non-managerial employees, and are placed at the

lower levels of the management hierarchy, often the first line level (Hutchinson and Purcell, 2003). They tend to be responsible for the day to day running of their work area rather than strategic matters and are normally engaged in general management work, but could also be specialists in a functional area, such as sales or finance. Whilst recognizing that there may be variations in the role according to the organisation and workplace context, it is possible to identify some further common characteristics among FLMs. (Purcell *et al*, 2008).

Firstly, the scope of their job typically covers a combination of traditional management duties such as providing technical expertise, monitoring performance, planning, work allocation, providing leadership and more recent activities in the form of people management and cost control /budgeting. FLMs, therefore, are no longer traditional supervisors who provide support and expert advice to the staff they manage, although there is still an element of this in the role. In many organisations these newer activities have been taken on without relinquishing the old roles, with consequences for their workload (Hutchinson and Purcell, 2003). Secondly, these multiple duties inevitably create tension in the role (McConville and Holden, 1999). In particular, pressure to manage the business aspects of the job and meet service or production targets invariably conflicts with the softer people management requirements of the job, and it is often the more pressing 'harder' priorities which dominate (Cunningham and Hyman, 1999, Gratton *et al* 1999, Whittaker and Marchington, 2003, Hutchinson and Purcell, 2007).

Thirdly, in many organisations these FLMs are individuals who have been promoted from the ranks of the shop floor, which can create further tension as managers find themselves 'caught between the opposing forces of management and the shop floor, torn by competing demands and loyalties' (Child and Partridge, 1982: 8). This may be more complex in the health sector. McConville and Holden, in their study of line managers in two trust hospitals, refer to participants in their study as 'being "piggy in the middle'', caught between the directives of their seniors and the exigencies of the service on the one hand, and the demands and problems of their staff and consumers of the service on the other' (McConville and Holden, 1999 p421). Furthermore, these people are members of a

team, often doing the same work as other team members in addition to their own management duties, and it is not uncommon to hear of managers having to cover for sick team members or unfilled vacancies in the team (Purcell et al, 2008).

FLMs and People Management

Numerous studies have observed, how, over the last decade, line managers have played a more prominent role in the delivery of people management. (Hutchinson and Wood, 1995; Larsen and Brewster 2003; Hutchinson and Purcell 2007; Perry and Kulik, 2008). Today most FLMs, regardless of their functional specialism and sector, are expected to undertake some HR or people management activities At the very minimum this will cover some sort of performance management role, such as conducting performance reviews and managing poor performers. This is not a new phenomenon. Line managers have always had some responsibility for people management – back in Victorian Britain supervisors enjoyed extensive delegated powers including responsibility for hiring and firing employees and the docking of pay (Child and Partridge, 1982). What is new, however, is that we are witnessing a broadening and increasing depth of involvement (Hutchinson and Purcell, 2007). Today, in many organisations, it is common practice that many of the traditional day to day activities associated with a specialist HR function are now in the hands of FLMs, such as appraisal, absence control, recruitment and selection, communication and involvement, training and development and discipline and grievance handling.

There are clear advantages to involving FLMs in people management (Renwick, 2006; Larsen and Brewster, 2003; Whittaker and Marchington, 2003). These managers are best placed to deal with such issues, being closest to front line employees, communicating with them regularly, and with direct responsibly for the management of employees on a day to day basis. They are, therefore, more likely to take ownership of people management and be committed to these activities. Managers should be able to make speedier decisions that are more tailored to the needs of individuals, the workplace and therefore in tune with business realities. Changes in the role of the HR function have also

contributed towards this shift. 'Human Resource Management' (HRM), which emerged as a concept in the 1980s, argues that the management of people should be increasingly 'integrated' and shared with line management rather than being the sole responsibility of some specialist function (Storey 1992). The HR shared services model, which has become increasingly popular, firmly places day to day responsibility for HR matters with the line, allowing the HR function to become a centre of expertise and strategic business partner (Ulrich, 1997). This has been facilitated by the growth in e-HR. Other factors such as decentralisation of decision-making, organisational restructuring, the growth of teamwork, pressure on costs, and the trend towards individualism in the employment relationship, have further influenced the trend towards devolution of people management to the line manager (Hutchinson and Purcell, 2007).

However, whilst there are clear benefits many studies suggest negative consequences and raise concerns about the effectiveness of line managers in supporting and delivering people management (McGovern *et al*, 1997; Marchington, 2001; Hutchinson and Purcell, 2007; CIPD, 2007). Numerous studies point to a difference between formal intended HR practices and those which are experienced by employees – with the gap often explained by FLMs variability in behaviour (Marchington, 2001, Hutchinson and Purcell, 2003, McGovern *et al*, 1997). In a study of performance appraisal McGovern *et al* found that, 'management implementation was uneven within organisations and that the actual quality of practice was also subject to significant variations' (McGovern *et al* 1997, p26). Their study suggests that FLM involvement in people management roles relies on the manager's own personal motivation and commitment for fulfillment. People management is, therefore, more likely to be discretionary than other aspects of FLMs' duties. This may be down to the organisation's failure to rate people management highly, by, for example, placing it in any formal or informal performance criteria (Gratton *et al*, 1999). One consequence of this is that people management is often seen as a poor second to the more 'harder' business priorities (McGovern *et al*, 1997; Whittaker and Marchington 2003).

Lack of the appropriate skills and competencies, insufficient training and support, high volumes of work and competing priorities are further key factors which inhibit FLMs'

ability to perform their people management role effectively (Cunningham and Hyman, 1999; Hutchinson and Purcell, 2007; Whittaker and Marchington, 2003). Some observers also suggest that HR specialists are not always eager to relinquish responsibility for people management activities to the line (Harris et al, 2002).

Thus, whilst there are obvious advantages to involving line managers in people management activities, in practice this may be subject to considerable constraint. As Perry and Kulik rather pessimistically point out 'Organisations that adopt a devolution strategy are taking a big risk: They are placing responsibility for the 'care and feeding of their most important assets (their employees) in the hand of managers who may have received little or no formal training' (Perry and Kulik, 2008, p262).

Why are FLMS important

One of the emerging themes in the HRM literature is the critical role of line managers in HR or people management. A growing body of literature argues that organisational performance outcomes are influenced by FLMs by the way in which these managers translate HR policies into practice. Research examining the link between people management and performance (Purcell *et al*, 2003; Hutchinson and Purcell, 2003; Purcell and Hutchinson 2007) shows that the way these managers implement and enact HR policies, and show leadership plays a major part in influencing employee attitudes towards the organisation and their jobs. Positive employee attitudes, such as job satisfaction, organisation commitment and motivation, encourage or induce positive discretionary behaviours, sometimes referred to as working 'beyond contract' (Applebaum *et al*, 2000) which will impact on individual and organisational performance. Discretionary effort is behaviour which employees choose to engage in and cannot be forced, such as helping new starters, sharing ideas, good attendance, working extra hours, or co-operative behaviour in dealing with customers. It is particularly important in the context of healthcare, where the response of front line staff is vital – since it is these people that actually deliver patient care and are required to 'go that extra mile' to deliver improved productivity and better patient outcomes.

In other words, employees' experiences of people management are linked to their attitudes and behaviour towards their job and employer, thence to performance. Crucially, line managers can make a difference to these attitudes and behaviours by the way in which they interpret and implement people management practices, or 'bring policies to life' (Purcell *et al*, 2003). This emphasis on implementation has also been observed in the strategy literature. As Barney notes 'the ability to implement strategies is, by itself a resource that can be a source of competitive advantage' (Barney, 2001, p503). Others refer to this as Organisational Process Advantage (Kinnie et al, 2006).

The importance of the role of FLMs has also been recognised by earlier work on the 'forgotten supervisor' (Thurley and Wirdenius, 1973) and 'lost managers' (Child and Partridge 1982), and in the development of informal practices (Terry, 1977). Others have also observed that employees' perceptions of FLMs' leadership behaviour influences organisation commitment and job experiences (Purcell and Hutchinson 2007). Research on the psychological contract (Guest and Conway, 2004) shows that supervisory leadership was the strongest factor associated with organisation commitment. Supervisory leadership was also the strongest, or amongst the most important factors, explaining positive psychological contracts, work satisfaction and customer loyalty. A study by Kidd and Smewing (2001:37) found that 'respondents who saw their supervisor as engaging in feedback and goal setting behaviours were more committed to their organisation, as were those whose supervisor trusted them and gave them authority to do the job'. A longitudinal analysis of the Workplace Employee Relations Survey (WERS) shows a strong relationship (Cox *et al* 2007) between line managers' approaches to employee involvement and the commitment and satisfaction of employees, arguing that the informal way in which line managers deliver formal involvement processes is key to improved employee attitudes.

Further evidence of the importance of line management behaviour is found in the work on social exchange theory, which emphasises the importance of leadership behaviour through the concept of 'leader member exchange' (LMX). This highlights the critical

relationship between the employee and his or her boss and shows that 'more effectively developed relationships are beneficial for individual and work unit functions and have many positive outcomes related to firm performance' (Uhl-Bien *et al*, 2000, p209). Research on perceived organisational support (Eisenberger *et al*, 2002) also lends support to the critical role of line managers, and other studies find a stronger relationship between commitment to supervisor and performance than between commitment to the organisation and performance (Becker *et al*, 1996).

Clearly, organisations need to understand the FLM role, in particular how and why FLMs implement HR or people management. This is likely to be influenced by the way in which FLMs themselves are managed, since this will impact, positively or negatively on their discretionary behaviours and those they manage. If, for example, FLMs experience 'good' people management or HRM, this should trigger higher commitment to their job and the organisation and positive discretionary effort. It is vital, therefore, that further research also explores the way in which FLMs are supported and managed (Boselie *et al*, 2005, Purcell *et al* 2008).

The context of the NHS

In the health sector recent research has sought to understand how HRM contributes to performance. The work of West *et al* (2002, 2006), for example, finds a relationship between bundles of HRM practice and performance outcomes (although, as with other studies on HRM and performance, the direction of causality remains to be established). In a study of 52 hospitals in England, they found that a complimentary set of HR policies and practices, which emphasised training, performance management, participation and involvement, decentralised decision making, teams and employment security, may contribute to high quality healthcare (West *et al* 2006). More recently Boaden *et al* (2007), sought to explore how HRM can help NHS organisations achieve their goals. In their findings they highlight the importance of line managers in delivering HR strategies, policies and practices, and emphasise the need for organisations to support line managers to address issues of competing priorities and lack of managerial capability.

Another body of research has linked leadership and performance in healthcare, although this has predominantly focussed on the leadership role of top managers, which some have criticised as being at a level which is too high to impact on the attitudes and behaviours of employees working at operational level (Procter, Currie and Orme, 1999, Ferlie *et al*, 1996). In the NHS Plan, leadership at all levels is considered to be an important element in contributing to the NHS becoming a model employer (NHS Plan, 2002) and delivering improved performance and productivity, although it is not clear what makes good or effective leadership or what roles are particularly important. There is also some evidence that middle managers in the health sector, such as nurse managers, play a vital role in terms of linking strategic and operational management, as agents of change and mediating organisation's relations with clients and suppliers (Currie, 2006, McConville and Holden, 1999, Floyd and Wooldridge, 1997). Other research on nurse managers shows strong correlations between leadership behaviour, work climate and job satisfaction, concluding that it is important that organisations put effort into recruiting competent nurse managers (Sellgren *et al* 2007). McBride et al, (2006), in a study on skills development in the NHS, found that the support of line managers is critical to the success of the Skills Escalator. Our own previous research on the link between people management and performance showed how, in one NHS trust, improvements in front line management was associated with improved employee attitudes and reduced vacancies (Purcell *et al*, 2003).

A number of researchers have emphasised the need for studies on line managers to be industry and organisation specific (Dopson and Stewart 1993, Currie, 1999). Certainly the role of FLMs in the NHS is distinctive, and they work in complex environments. In the last 10 years the role has extended significantly in the wake of public and health service policy changes, Government performance targets and changes in trusts' management practices. The traditional role of providing leadership and support for front line clinical staff has become more complex and challenging as managers have taken on responsibility for budgetary matters, people management and quality and policy implementation (Willmott, 1998; Bolton, 2003; Bolton 2005). These managers face

multiple and conflicting responsibilities (Dopson, 1996; McConville and Holden, 1999), and are exposed to complex interactions between and across professional work groups both within the organisation and externally (Dopson and Fitzgerald, 2006). Furthermore, as professionals, they experience competing loyalties: to patients, team, the organisation and their profession (Buchanan, et al 2007). Work overload, and lack of resources impose additional constraint on their ability to manage (McConville and Holden, 1999). Research has shown that FLMs within clinical areas are less likely to be career managers than in other sectors, since they probably entered the NHS in order to undertake therapeutic or caring roles (McBride et al, 2006), and this may further inhibit their management role. Boaden *et al* (2007) report concerns over the relative priority given to HRM by line managers compared to other aspects of their role, particularly those with clinical backgrounds. In a study of the ambulance service Woollard, Lewis, and Brooks (2003) find perceived lack of ability and knowledge among managers, and poor communications between staff and managers to be barriers to the implementation of high performance management systems.

Clearly, therefore, whilst FLMs have a key role to play in the NHS, there role is subject to considerable constraint.

Conclusion

Recent studies have drawn attention to the critical role of FLMs in the way they implement and enact people management activities, and influence employees' attitudes and behaviours to contribute to effective organisational performance. In the NHS FLMs have a prominent role to play in the delivery of people management and in influencing productivity and patient outcomes, yet their role is complex and challenging. Little is known about the roles of these managers in this context, in particular their perceptions of their role, their reactions to HR policies that are applied to them and the support they receive. This research aims to partly fill this gap.

3. OBJECTIVES AND METHODOLOGY

3.1 Aims

The main purpose of the research is to consider the role that FLMs play in the effective delivery of people management in the NHS. The term 'people management'[2] is used to refer to all aspects on how people are managed including HR management and leadership skills more generally.

In the very early stages of the research we sought to define the FLM population, and concluded that they should be at the lower levels of the management hierarchy and have clinical staff reporting to them who tended not to have management responsibility. A critical requirement was that these managers had some people management responsibility, which at a minimum, was defined as conducting performance appraisals. It was felt that this definition enabled us to draw a distinction between the often confusing terms of 'first-line manager' and 'supervisor' (Hales, 2005) since supervisors did not generally undertake a significant people management role. We also expected managers to have clinical supervisory responsibility although, as reported in the findings, some trusts were experimenting with separating the clinical and management aspects of the role and in these circumstances both positions were covered. It was anticipated that these managers would primarily be band 7 under the AfC national pay and grading structure, but might also cover some band 6s and band 8, depending on the organisational and workplace context.

3.2 Research questions

The key research questions were to identify the following[3]:

- What role do FLMs play, in particular in the delivery of people management policies and practices?

[2] A term originally coined by the CIPD when commissioning earlier work by Bath University on People Management and Performance (Purcell et al 2003).
[3] These questions were refined during the course of the research, as is often the case.

- How do these people management roles interact and mesh with the other roles FLMs carry out?
- How effectively are these responsibilities delivered and are there barriers to effective implementation of people management policies and practices by FLMs?
- How are FLMs managed? Which HR practices make a difference to FLM behaviour?
- What support do FLMs receive to help them undertake people management effectively?
- Do FLMs make a difference to the way a service is delivered both in terms of cost effective performance and patient care, or more broadly the 'patient experience'?

3.3 Research Methods

A multiple case study approach was adopted. Case study research involves in depth examination of an issue in its real life context (Yin 1993) and is suited to understanding complex issues in complex organisational systems such as healthcare and/or those characterised by continual and rapid change (cited in Addicott et al 2007:93), and was deemed appropriate to meet the research aims. A multiple case study approach was chosen for comparative purposes to help us understand similarities and differences in management practices in different organisational contexts. Seven case study organisations were selected, five acute trusts and two ambulance trusts in the South of England (this was one more acute trust than proposed in the original tender document). The trusts were selected on the basis of a range of factors including trust type, performance (the trusts were intended to represent a diverse spectrum in terms of performance – see Table 7, Appendix 1), location and access. The limited budget for the research meant we were only able to focus on a certain trust types, namely acute trusts, as the main employers of FLMs in the NHS, and ambulance trusts which appeared to have been under researched. A minimum of two ambulance trusts were needed in order to conduct a comparative case study approach. It was not our intention to cover FLMs in primary care, mental health, children's trust and other non acute settings, and this was stated in the research brief, although it was recognised that this limits the generalisabilty

of the findings for the NHS as a whole. Similarly the size of the budget limited the geographical spread of the case studies which were all located in the South of England.

All of the trusts were going through varying degrees of change and uncertainty at the time of the research. The ambulance trusts were being restructured across England through a process of mergers, and some of the acute trusts were in severe financial deficit which necessitated redundancies. At the same time all of the acute trusts faced staffing shortages in some of the areas studied**.** AfC was being rolled out and a new pay and reward system had been recently determined in all trusts. Undoubtedly these changes were very much in the minds of some of the individuals we interviewed.

In five organisations two units of analysis were chosen (selected by the case study organisations themselves), one better performing than the other. Two trusts (one acute and one ambulance trust) were small enough to allow us to include all FLMs in our sample – in other words the unit of analysis was the trust. In the five larger organisations the units of analysis were identifiable areas within the bigger organisation (directorates, such as medicine, in the acute trusts and stations in the ambulance trusts), which allowed us to drill down into the organisations and focus on areas in some depth. It also meant that we could interview a significant proportion of the total number of managers in each unit (all FLMs were invited to participate). By selecting sub units of the organisation it was our hope that we would be able to make comparisons both within and between trusts. However the small numbers surveyed in some of the units limited the final analysis.

The research methods combined both qualitative and quantitative techniques. Primary data was gathered through interviewing a range of staff, supplemented by the collation of secondary data which included trust documents, WERS 04, findings from the NHS staff survey, and NHS national performance data. In addition to the interviews and presentations required to gain access to the seven case study organisations, two types of interviews were held:

1) Initial interviews (face to face) with key players in trusts and in the units of analysis

such as Directorate Directors, HR Managers, Heads of Nursing, Operational Managers and staff side representatives. The intention was to gather organisational contextual information about the trust, and insight into the FLM role - to clarify who were the FLMs, explore perceptions and expectations of the role, and understand what factors constrained the role. These interviews covered 51 key staff in total, each one lasting between 50 and 90 minutes. None of the interviews were taped, but recorded in note form and written up by the researchers in detail after the interviews.

2) Structured interviews with FLMs in the units of analysis using a detailed questionnaire which sought to explore the role of FLMs in people management and management more generally, and the way in which they themselves were managed. A detailed questionnaire was developed based on previous research (eg Hales, 2005) including an employee survey used in our earlier research which sought to examine the link between people management and performance (Purcell *et al* 2003).

The key themes to the survey were:

- Employee characteristics
- Job role and responsibilities including people management
- Attitudes to the job (work intensity, influence, job satisfaction, satisfaction with HR policies and practices)
- Management support, including line manager, senior managers, peers, team and HR function
- General views on working in the trust such as commitment, organisation citizenship behaviour and intention to quit

Some of the questions used validated scales from the employee survey in the WERS 2004 and this allowed for comparisons to be made both nationally and by occupation and sector. However, the closest occupational and sector comparator group was ‘managers and senior employees’ in health and social care, which included senior managers as well as those at the front line. Any comparisons should therefore be made with caution.

The questionnaire combined closed and open ended questions. The open ended questions allowed us to explore some responses in more detail and put more detail behind the findings. The questionnaire was piloted in one trust and among some colleagues with experience of working in the health sector.

Our preference was to conduct the interviews on a face to face basis, on site, so that we could gain a better understanding of the environment in which managers worked. Our experience from previous research (Purcell *et al*. 2003) had shown this to make a valuable contribution to the research process. However, practical difficulties in releasing staff for interview meant that we had to supplement this approach with a postal survey (although only for a minority of the sample). All FLMs in each unit of analysis were invited to participate, and given written assurances on confidentiality and disclosure of information. The overall response rate varied between 30% and 95% according to the trust.

Access

Early discussions with key managers in the research organisations was necessary to seek agreement on research access. Some trusts asked us address meetings and make presentations on the research in order to get 'buy in' from department heads and the FLMs themselves. In one trust members of the research team were required to attend directorate meetings, departmental meetings and a ward managers forum to present on the research project. Whilst recognising this was a vital part of the research process this was a lengthy and time consuming exercise and one which had been underestimated in the original planning of the research design.

Advisory Group

An advisory group, comprising representatives from the participating trusts, met early on in the research process to discuss the research approach, including the design of the structured questionnaire. The original research timetable had planned for a second

advisory group meeting to discus initial findings, but this never took place because of a lack of continuity in personnel – with some of our key contacts moving out of their roles.

Ethics

NHS research ethics approval was sought and granted (ref: 05/Q2001/199) by the Bath Research Ethics Committee in October 2005 for multi centre research. The only concern of the ethics committee was about consent. Prior to the interviews all possible respondents were given a letter and information sheet about the research plus a consent form. The letter emphasised the voluntary nature of the study and confidentiality. In practice, however, respondents often made it clear that this was unnecessary.

In addition to seeking national multi site ethical approval, some trusts required approval with their local research and development committees - a process which was far from clear not only to the research team but also our key contacts in the trusts themselves. The requirement to seek additional local approval varied among the trusts with some not considering it necessary and others requiring the researchers to be appointed as non stipendiary staff.

Data analysis

All the data gathered was analysed in a structured and methodical way. Quantitative data was analysed using the SPSS software package, and the qualitative data was summarised according to the research questions and emergent themes.

In the analysis that follows differences are discussed between the two types of trusts (i.e. acute and ambulance), the individual case study organisations themselves, and between managers (such as differences based on pay banding) but only were it is shown to be important. Comparisons are also provided, where possible, with health sector managers from WERS 2004, although as already noted, the WERS comparator group contains all managers not just those at the front line.

3.4 Research challenges and limitations

A number of additional difficulties presented themselves during the course of the research which impacted on the research design and timetable. Briefly these were:

- The budget limited the staff resources that could be devoted to the project. All of the contracted researchers were part time with additional teaching and management/administration duties. The original team of 4 researchers from Bath University was reduced to two because of resource constraints. Part way through the research programme these two individuals moved to other institutions to take up new roles but agreed to continue with the research despite the contract remaining with Bath University. However growing job commitments brought on by these job moves created extreme difficulties in their ability to complete the research within the original time scale.

- All the managers we sought to interview (FLMs and more senior managers) had extremely demanding jobs and gaining access to them was problematic. As previously stated our preference was for all interviews to take place on a face to face basis, on site. Nevertheless, even with an appointment to interview many failed to turn up. For example, in one acute trust, a researcher traveled to the site for 5 interviews, but just one turned up during the whole day. Furthermore, communication from HR (usually our main contact point in a case study) to FLMs was difficult, and it was often necessary to use intermediaries to make contact. Greater difficulties in accessing FLMs compared to senior managers meant that a disproportionately higher number of senior managers were interviewed.

- The small number of FLMs interviewed in some units of analysis, partly because of the size of the unit but also for the reasons stated above, restricted our ability to make valid statistical comparisons within trusts.

- A lack of continuity in terms of access to senior management with some of our

key contacts leaving (there was a high turnover of senior managers).

- The original intention to survey a sample of front line employees (i.e. those managed by the FLMs) in the units of analysis proved over ambitious and unrealistic in light of the problems encountered and, with the agreement of the sponsors, was dropped and we decided to use the NHS national staff survey instead.

Despite these considerable limitations however, in total 168 in depth interviews were conducted which produced valuable and illuminating findings.

4. VIEWS OF FRONT LINE MANAGERS

Key findings are presented here based on the results of the survey of front line managers. The analysis begins with an overview of the key characteristics of the managers who participated in the survey, before considering the range of responsibilities performed including their role as implementers of people management policies and practices. The following section considers FLMs' perceptions of what qualities are needed to perform this role before exploring the support FLMs receive, including their relationship with more senior managers, team members, the HR department and the trust as whole. This leads to a discussion on the barriers these managers face, predominantly in performing their people management role but also more generally as managers. The final section on the survey considers FLMs as employees, in terms of the extent to which HR practices are applied to them, perceptions of workload and stress and job influence plus outcome measures on job, satisfaction, commitment, and intention to quit.

4.1 Profile of sample

In total 117 managers were interviewed using a structured questionnaire, the vast majority of whom (83%) worked in acute trusts. Table 1 provides a summary of the attributes of the survey respondents. The sample identified were managerial staff whose jobs included people management responsibilities at the lower levels of the management hierarchy. This covered first line management level and some middle managers. In the acute trusts the majority were ward or theatre managers, but others covered included unit managers, modern matrons, clinical nurse managers, plus some specialist managers for example in physiotherapy, psychology and technicians. A few were nurse practitioners – junior sisters who had some people management duties attached to their role such as conducting performance appraisals and absence management. In one trust, for example, the official title used for manager of a ward was 'clinical lead' but the common language was 'ward sister' or 'charge nurse', and occasionally team leader, or ward manager. This was reported to be misleading and confusing to both staff and patients, but also meant that categorising the surveyed population by job title was difficult. In the ambulance

trusts where job titles (and job content) also differed between the two trusts, the target population were operations managers, clinical supervisors, paramedic supervisors and assistant divisional officers (ADOs). Among the acute trusts there were wide variations in job titles for the same type of job, and even differences in titles for the same position within the same trust.

A more appropriate categorisation for analysis purposes was considered to be the AfC banding for pay purposes, although many staff interviewed still referred to the traditional grading structure ('F' 'G', 'H' and so on). The majority (60%) were banded 7, 19% band 6 and 18% band 8, with a few bands 5 and below. A minority reported that they were appealing against their pay level which, for most, had only recently been determined. The largest group effected were operations managers (band 7) from one ambulance trust who were in dispute over their grading – claiming that they received less total pay than the staff they supervised.

The managers interviewed were predominantly permanent employees, over two thirds (69%) were female and half claimed to have dependents who they looked after or gave special help to (such as children or elderly relatives). This was a fairly old workforce (just over three quarters were over 40 years old), with long tenure. Over 80% had 5 years or more service in their Trust, and 62% had worked in their organisation for 10 years or more. There was greater variation in terms of length of time in the current job - almost 40% had worked in the same job for more than 5 years, and 10% had less than one year in the job.

Most (94%) were members of a trade union and/or professional association, with the Royal College of Nursing (RCN), nursing's professional body, having the largest representation (65%). Other bodies represented included Unison, Amicus, Royal College of Midwives, National Association of Theatre Nurses and Chartered Society of Physiotherapy. Many held multiple memberships, typically a union and a professional association.

Table 1 Profile of survey responses (N=117)

	N	%
Type of Trust		
Acute	97	83
Ambulance	20	17
Job Title		
Gender		
Male	36	31
Female	81	69
Age		
Less than 20	-	-
20-29	3	3
30-39	25	21
40-49	55	47
50-59	32	27
60 or over	2	2
Length of service		
Less than 1 year	2	2
1 to 2 years	5	4
2 to less than 5 years	16	14
5 to less than 10 years	22	19
10 years and over	72	62
Years in current job		
Less than 1 year	12	10
1 to 2 years	27	23
2 to less than 5 years	31	27
5 to less than 10 years	22	19
10 years and over	25	21

	N	%
Job banding under AfC		
Band 4 -5	4	3
Band 6	22	19
Band 7	70	60
Band 8	21	18
Job status		
Permanent	110	94
Temporary – no agreed end date	3	3
Temporary – agreed end date	4	3
Dependents		
Yes	58	50
No	59	50
Employment Contract		
Full time	102	87
Part time	15	13
Work overtime		
Yes	106	91
No	11	9
Shift work		
Yes	67	57
No	50	43
Take work home		
Yes	69	59
No	48	41
Union membership		
Yes	110	94
No	7	6

The educational level varied. Most, but perhaps significantly not all, held GCSEs or their equivalent (90%), 46% A levels, 26% a first degree, and 11% a higher degree. In addition all held some form of professional qualification, the most common being nurse registration, reflecting the fact that many of these managers had come through the ranks

of nursing. Other qualifications gained were usually job specific such as driving instruction, manual handling and lifting, IT, and teaching.

Working hours

Most (87%) worked full time, and for those working part time hours ranged from 18 to 34 per week with just under half (44%) holding contracts for 30 hours a week. Long hours working was prevalent. Nearly all worked overtime on a regular basis (91%) and well over half (60%) regularly took work home - with most reporting that this was in addition to their reported levels of overtime. Of those working overtime half worked between 1 and 5 hours a week on a regular basis, 37% between 6 and 10 extra hours, 11% between 11 and 15 hours a week and 3% reported working over 16 hours a week overtime on a regular basis.

Differences between trusts

There were marked differences in the characteristics of managers according to the type of Trust. Those surveyed in the ambulance trusts were mostly male (95%) in contrast to acute hospitals were the gender split was 50/50, older (45% were over 50 years of age compared to 26% in acute trusts) and tended to have longer tenure in both the organisation and the job. For example, 80% of managers in ambulance trusts had worked for the organisation for over 10 years, in comparison to 58% in the acute trusts. The educational base was also much lower for ambulance service managers, and 40% had no GCSEs or their equivalent, some having come straight into the service after leaving school at the age of 15. Among the individual acute trusts there further marked differences in terms of experience in the current role. In one acute trust over half of those surveyed had less than 2 years experience (62%) compared to between 18 and 38% in the other acute.

4.2 Roles of Front Line Managers

All had responsibility for managing staff and for most (92%) this was for both people management and clinical purposes. In a few areas, however, reporting relationships had been split between clinical and non clinical duties and 8% of respondents reported supervisory responsibility solely for people management purposes. One trust had recently split the first line management role into two positions in certain specialty areas to create a 'lead' person with clinical supervisory responsibility and a 'services manager' who focused on budgets, rotas, and other non clinical management activities. Both, however, undertook performance appraisals for the same individual(s). In practice the boundary between these two jobs was blurred, with the example given of who should allocate training. In the particular case cited the services manager had approved training only to have it removed by the clinical 'lead'. This raised questions about who is the front line manager.

Spans of control varied enormously from just one person to 130, with the majority having large spans of control. Taking the main team, just under a quarter (23%) had responsibility for 40 staff or more, and 44% supervised between 16 to 39 people. Less than half (43%) had spans of control that were narrow (1 to 5) or moderate (6 to 15). Furthermore, over one third were responsible for multiple teams – ranging from 2 to as many as 7, with the higher banded positions tending to have greater responsibility in terms of the number of teams. Most of the band 8 managers, for example, were unit managers or modern matrons overseeing the running of several wards or departments. In the ambulance trusts ADOs and operational managers could have responsibility for up to 9 ambulance stations, each with its own team of staff. It was, however, the band 7s who, on average, tended to have the larger teams. Most (83%) had some practical support in their management responsibilities, and it was in the smaller teams were support was absent. On the wards assistance was usually provided by a ward clerk or administrator who would typically keep the diary, notes, and arrange meetings, whilst junior sisters often shared responsibility with their ward manager for certain people management duties such as appraisals, and absence management, and would sometimes deputise at meetings

or be expected to manage the off duty roster. One senior theatre practitioner, who managed 5 theatres plus a recovery team, described her support:

> *I have a level 6 who helps in the clinical day to day work and some management work such as the off duty rota, policies for the department, appraisals, and health and safety.*

In one of the largest wards – a 38 bed ward with 80 staff - responsibility for appraisal and sickness management was shared between the ward manager and 9 more junior nurses. In addition to lightening the workload of FLMs, this arrangement offered a developmental role for the band 6s.

In comparison to FLMs studied in other sectors these are very large roles in terms of both spans of control and number of teams supervised. In our earlier studies of line managers across of a range of private and public sector organisations (Purcell and Hutchinson, 2003, Hutchinson and Purcell, 2007) the average team size was 10-15 people. Another study of first line managers in 135 organisations showed that in only 30% of organisations did FLMs have spans of control greater than 10 (Hales, 2005).

Upward reporting relationships for these managers was usually to one senior manager, but this was not always a clinician which was a cause of frustration to some. A few reported to two managers, one for clinical supervision and the other for non clinical or management purposes, and this was reported to a source of confusion and an impediment to the role.

Front line manager tasks and responsibilities

> *I have day to day responsibility for the running of the station, supervising staff, sorting out daily problems – personnel/staff, vehicle maintenance, ordering stores*

and drugs, the monthly time sheets, patient report forms… and I'm also a paramedic on a daily basis.
(Operations manager, ambulance trust)

I am a joint ward manager responsible for the running of the ward which includes effective patient care, effective staff management within financial constraints, meeting trust objectives and our own objectives and the patients.
(Ward manager, acute trust)

These remarks describe the wide range of responsibilities undertaken by these managers. In the questionnaire we divided the likely areas of responsibility into six, partially overlapping, categories:

- People management
- General performance/quality issues
- Planning and scheduling of work
- Managing operational costs
- Dealing with clinical work
- Communication outside immediate team

Nearly three quarters (71%) had responsibility in all six areas, 21% in 5, 7% in 4 and only one had responsibly in just three areas. All had responsibility for people management and general performance (Figure 1a), suggesting that these were core activities of the role.

Figure 1a: Responsibilities of front line managers (% of respondents)

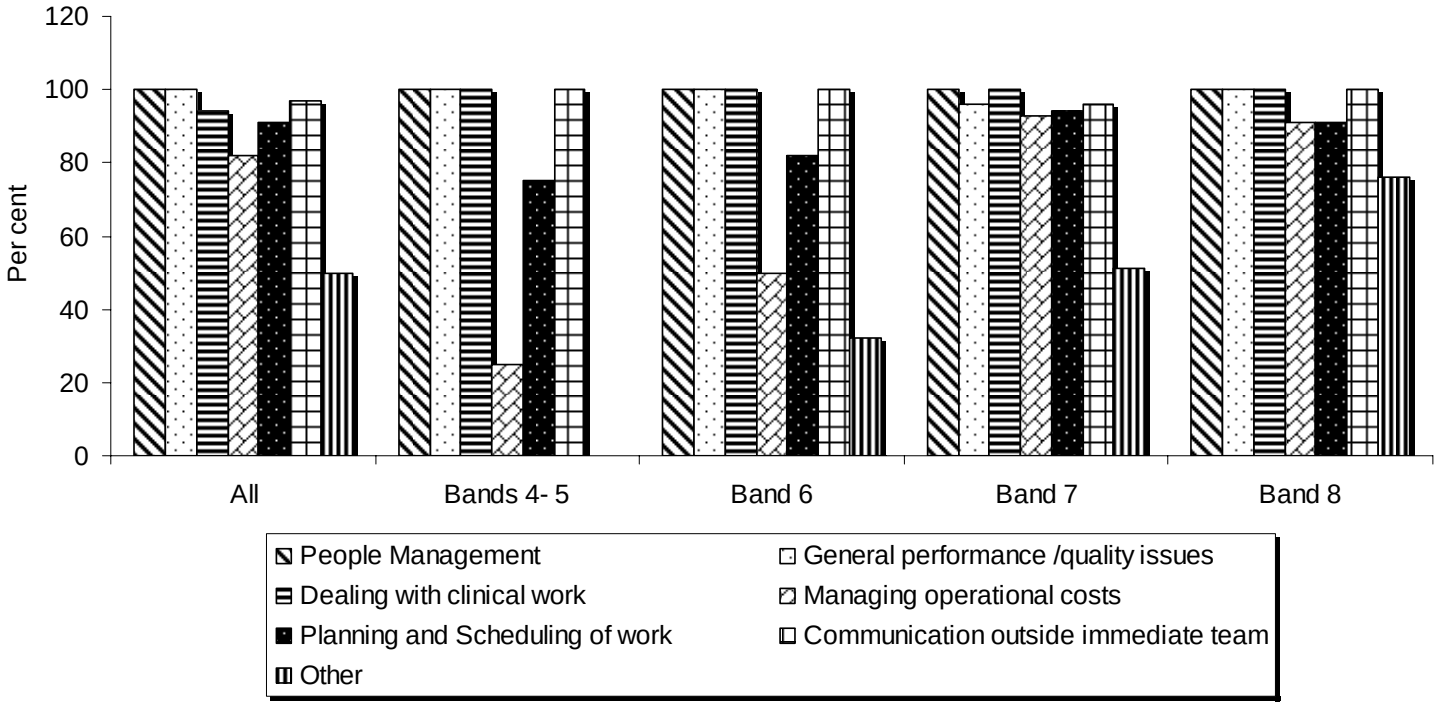
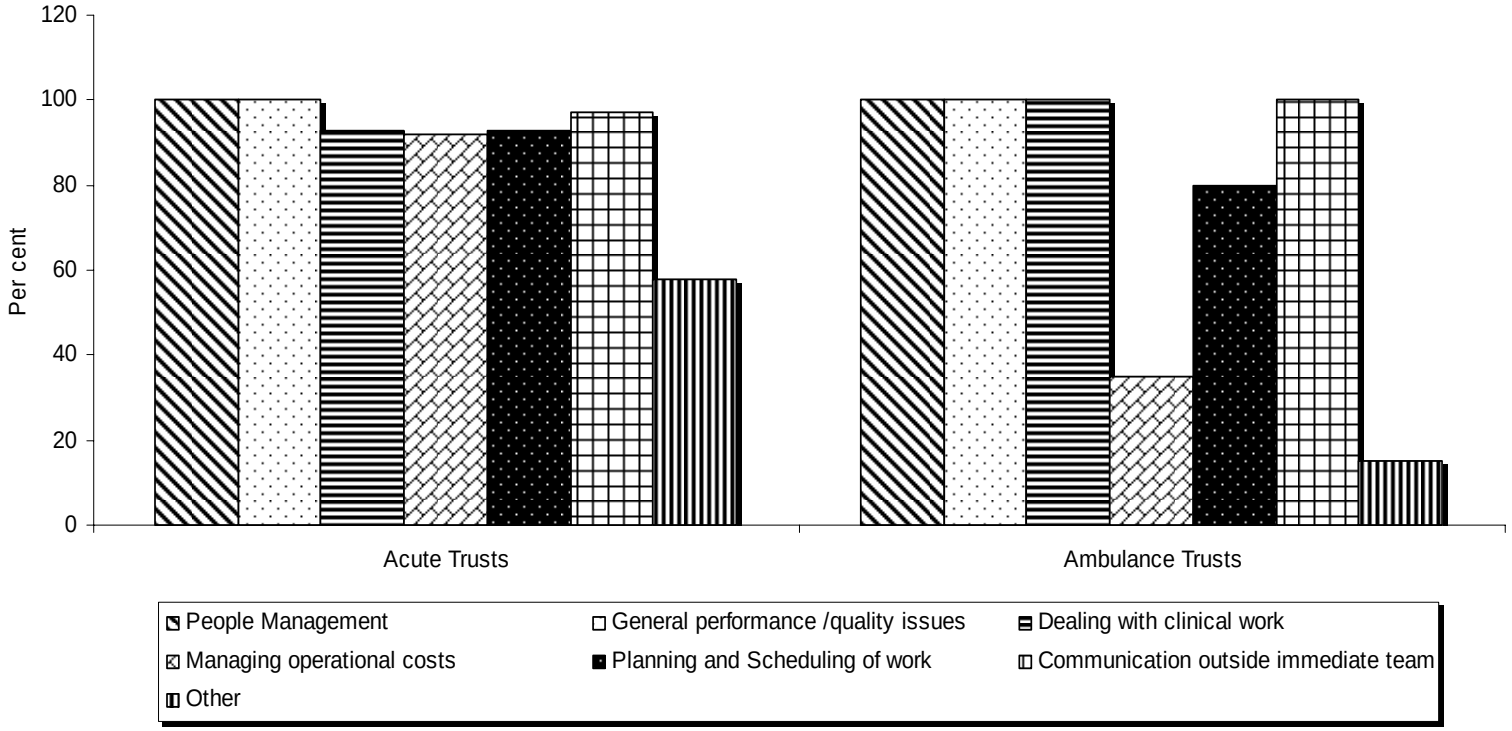


Figure 1b: Responsibilities of front line managers (% of respondents)



The people management role is explored in more detail in the next section. Tasks relating to general performance concerned ensuring quality of care for patients, conducting audits, risk assessment, health and safety, dealing with complaints (patients, relatives and staff) and conducting investigations. Closely linked to this was clinical work, covering the day to day direction and support of the team or work group, maintaining and improving staff skills and also doing the job of those they supervised - helping out on the team if need be when short staffed. A more recent responsibility for many was managing operational costs which meant operating within a set budget and taking decisions on staff costs and levels, (such as the use of agency staff) plus expenditure on supplies and equipment.

Another key element to the role for most, and one associated with a traditional supervisory role, was the planning and scheduling of work, covering management of the duty rota on a daily basis, ensuring the right skill mix, and off duty rostering including the booking of annual leave. The ambulance trusts had a different approach to this particular activity. A recent review of the FLM role in one of these trusts had resulted in the creation of a new role - that of area administrator - specifically designed to undertake the planning and scheduling of work. In addition these administrators provided full time support to the FLMs, a move which appeared to be welcomed by most managers, allowing them to focus on their clinical leadership responsibilities. The advantages were also clear to the trust's Director of Operations, who considered this former task to be an inefficient use of managers time and now meant they were not, in his words, *'in the office hiding away do paper work'*. In the other ambulance trust much of the rostering was handled by the control room, leaving line managers the task of tweaking the rotas on a day to day basis to cover for short term absences. One of the acute trusts was piloting a similar approach in some departments.

All the activities outlined here clearly involved extensive communication on the part of managers beyond their immediate team, both internally within the Trust, and externally (including GPs, PCTs, pharmacists, emergency services, and suppliers of equipment), and all FLMs acknowledged this to be a core aspect of the role. Other researchers have

referred to these managers as ‘boundary spanners’, mediating between organisations, their customers and suppliers (Floyd and Wooldridge, 1997).

Other elements of the job not captured in these six categories included project work, promoting the profession externally, supporting students, counselling relatives, and in the words of one ward manager:

> *Being a general dog’s body…which includes flower arranging and moving the furniture!*

There were clear differences in the role according to job band and trust types (Figure 1b). Below band 7 it was unusual to find managers having any budgetary responsibilities and, to a lesser extent, responsibility for the planning and scheduling of work. Financial accountability was lower for some managers in the ambulance trusts where paramedic supervisors could only make limited decisions on costs such as ordering stocks and equipment, although ADOs and operational managers did have budget responsibilities. Also, for reasons already mentioned, managers here were less likely to undertake workload planning and scheduling activities.

Respondents were also asked to rank these activities in terms of how important a part of the role they were (i.e. what they were expected to do). Clinical work, general performance and people management came out top of the list of priorities, although most respondents found this ranking activity hard to do, mainly because priorities could change on a regular basis as staff reacted to different pressures and crises. When asked if any of these activities had become more important in recent years budgetary responsibilities were at the fore, identified by 60% of respondents, followed by people management issues (44%), performance (41%), communications outside team (33%), planning (22%), and lastly clinical work (17%). As one manager explained:

> *We are constantly under scrutiny with the budget – and have to find ways to manage with less money. We can’t use agency staff and can’t overspend.*

However when asked if any activities had become less important, 80% replied none, implying increased workloads and pressure. Of the 20% who said yes, nearly all identified clinical work as the key activity that had suffered, as this manager explains:

> *There is less emphasis now on quality of care from the trust – they don't allow time for it. Everything is around proof and evidence but they don't allow for quality of care- the emphasis is on getting people out quickly – discharging and delivery of care is inhibited…it might be acceptable to the trust as a cost saving but not to me and my clinical staff. It causes great stresses.*

Defining the roles in this way indicates the range of activities that managers have to perform but fails to reflect which aspects of the job take up the most time. We tried to capture this aspect of the work in our pilot interviews but it proved to be an impossible task for managers to do. The best way we could get a picture of the division of responsibilities in terms of workload was to ask for a simple split between clinical and non clinical activities, or to use the language of our interviewees between 'management' and 'clinical supervision'. Even then, however, the definition of 'management' was rather ambiguous. More than a few managers said that 'management' was something they took home with them suggesting how 'management', for them, was a paper based activity associated with bureaucracy.

There were wide variations in this division of responsibilities, with 44% feeling that their clinical role dominated, 41% the non- clinical and 15% who felt their work to be evenly split between the two. Where the clinical role dominated the most common ratio was 80/20, equating to 4 days a week clinical work and one day 'management'. Where the non clinical aspect dominated, 70/30 was the most common division. Nevertheless, many FLMs found this relationship hard to quantify, despite the fact that some trusts had clear guidelines on the division of responsibilities. There were even variations within trusts for the same job role. In one Trust, where senior managers spoke of ward managers having one day a week for 'management' purposes, the FLMs themselves reported on

widely different experiences ranging from a 95:5 ratio in favour of clinical work to 45:55 in favour of non clinical work. A range of factors is likely to influence this division of work, and thus explain these widely different experiences, such as changing targets and deadlines, staffing levels, financial constraints, lack of role clarity and personal choice. One respondent gave the example of how the workload could vary according to the level of sickness, with her clinical work increasing from 50% to 90% because 3 people were off sick. A further consideration is that some of these 'management' activities, particularly people management, are discretionary and not subject to the same levels of scrutiny and measurement as the clinical activities. We return to many of these issues in section 4.4, when barriers to effective front line management are considered.

People management role

Numerous studies testify to the increasing devolution of people management activities to the line over the last few decades, as discussed earlier, and the health sector has not been immune from this trend. We sought to explore, in some detail, the main components of this aspect of FLMs role. Based on previous research, plus our initial interviews with key players in the trusts, we identified 24 people management activities as follows:

1. Recruitment of staff, including bank and agency staff
2. Selection of staff
3. Maintaining staff records
4. Induction
5. Conducting appraisals
6. Agreeing PDPs
7. Deciding and planning training and development needs of staff
8. Providing formal training
9. Providing informal training, coaching and guidance
10. Acting as a mentor
11. Giving recognition
12. Grading/pay banding decisions
13. Upward communication

14. Downward communication
15. Listening and responding to suggestions from staff
16. Co-ordinating the work of teams
17. Maintain effective teamwork
18. Discipline and grievance handling
19. Monitoring and managing sickness and absence
20. Improving working lives i.e. flexible working
21. Counselling staff
22. Other forms of motivation
23. Health and safety
24. 'Other'

Areas of HR policy and practice that were not explored included responsibility for determining financial rewards, pensions, and other aspects of the benefits package which are shaped by trust or national policy, and as such are issues which line managers have little delegated authority over.

It was clear, however, that managers had extensive delegated powers in all other areas. From the list of 24 activities, all had responsibility for a minimum of 18 activities, and 90% reported responsibility for 20 or more of these practices. The most common activities were selection, induction, appraisal, personnel development plans, training, providing recognition, communication and involvement, co-coordinating and maintaining effective teamwork, absence management, discipline and grievance handling and health and safety. Each of theses activities was undertaken by 90% or more of respondents. A very slightly smaller percentage (80-89%), but still a significant proportion, had responsibility for recruitment, maintaining staff records, activities associated with the 'improving working lives' initiative, and counselling (usually informal). The least common areas of involvement were mentoring, although 70% said they did this on an informal basis, and job banding decisions. Overall managers in the ambulance trusts had less involvement in people management activities, most notably appraisal, performance development plans (PDPs), mentoring and recruitment and selection.

Nearly all managers in the acute trusts had extensive responsibility for recruitment and selection and were expected to write job descriptions and job adverts, review applications, short list applicants, arrange and conduct interviews and make the final selection. In the ambulance trusts, overall, managers had less extensive powers to recruit and select, and this was normally an activity confined to a pool of managers who had undergone specific training in this area. A critical part of the role for all managers was performance management, covering a range of activities including performance appraisals, PDPs, handling disciplines and grievances and absence management. The shift over the last decade within the NHS towards a performance management culture as a means to improve efficiencies and achieve targets, has given increased emphasis to these activities, although senior managers in some trusts voiced concern over their trusts' poor performance culture. In one ambulance trust, despite all managers undergoing extensive training in conducting appraisals, the performance management process had yet to be implemented, a year later. The battle to reduce sickness absence levels and deal with poor performers was a constant theme in all our interviews, as this theatre manager explains:

> *I spend a lot of time on poor performance, sickness absence and the interplay between staff in terms of who works with who …..on the people side I have to be a psychologist, a mediator and a diplomat*

As already reported, in some of the larger teams appraisals, and some aspects of sickness management such as return to work interviews, were often shared with more junior members of the team.

Involvement in training and development extended beyond the formal structured activity of identifying the needs of staff through the performance appraisal system to informal activities such as on-the-job training, coaching, facilitating knowledge sharing and providing regular feedback. Induction, informal mentoring, delivering formal training,

providing access to training, and developing training programmes were also part of this role, as these FLMs suggest:

> *It's important to be an effective facilitator who empowers staff through training and development opportunities and arranges feedback, reinforcing desired behaviors.*

> *You need to be a good people coach, a motivator and be able to bring a team of diverse skills and knowledge to a common vision or goal*

There was unanimous recognition that communication and involvement were important priorities – in keeping staff up to date with recent developments, providing staff with a chance to comment on changes, in listening to staff and responding to suggestions. To a few it also meant conveying a vision or goal. As one manager commented:

> *You need to be an effective communicator who conveys vision but listens to staff.*

Critical to these activities was the need to create and maintain effective teamwork, requiring FLMs to communicate, share knowledge, and support team members.

Managers had less discretion in rewarding staff other than through recognition. Nevertheless, this was considered to be an extremely effective way of motivating staff, and included a range of activities such as praising good work (a simple 'thank you' or 'well done'), involving staff, giving access to training, providing more challenging work or flexible working.

FLMs were generally positive towards their people management role and the vast majority (80%) strongly agreed/agreed with the statement 'I give emphasis to the people management aspects of my job'. Certainly training, both formal and informal, appraisals, communicating and involving staff, and maintaining effective teamwork were seen as

essential components of the role and recognised as activities that could impact on the efficiencies and performance of the unit or department.

There was some dissent, however, over other aspects of people management, such as dealing with sickness absence and poor performers - which some FLMs considered to be the duty of the HR function, as these managers testify:

> *I shouldn't have to deal with sickness absence – it's for HR or occupational health. I spend an awful amount of time on this and have to do everything from writing letters to return to work interviews.*

> *I generally spend a lot of time managing difficult people – this could be a full time job altogether…it's just like looking after children.*

Some also expressed resentment at the administrative side of their work, particularly on the recruitment side.

> *So much of the ward managers' job is about paper chasing and mundane staff management. There's little time for proper focused staff training and support on the wards.*

Also, accommodating requests for flexible working (such as part time work, job shares, career breaks, return to work policies and maternity leave), whilst recognised as an aid to recruitment and retention, was unwelcomed by some and described as a nightmare to manage.

In summary, FLMs account of their key responsibilities (as it actually is, as opposed to what it should be) shows some common core activities, although there were wide differences in the time devoted to these activities. At the core was responsibility for actively managing performance and providing effective and efficient patient care, and

most FLMs seemed to recognise that this should include giving priority to people management. Compared to FLMs in other sectors, however, their range of responsibilities is huge and growing, particularly in people management and budgetary matters. This has obvious implications for workload, and the evidence presented here suggests that working extra hours, both at work and home, seems to be the norm.

4.3 Managing the managers: supporting their people management roles

In section 2 it was noted how some researchers observe a clear gap between formal HR policy statements and practice (Marchington, 2001, McGovern *et al.* 1997, Hutchinson and Purcell 2003). One explanation for this lies in the way FLMs themselves are managed, and there is increasing evidence to show that this has a direct effect on the way that FLMs, in turn, manage. If, as previous research suggests (Purcell *et al* 2003), the secret to linking people management to performance is to 'unlock' or trigger positive discretionary behaviour in employees in the way they do their work, then this must also be true for FLMs- in fact it may be more important since it will impact on those they manage.

Our concern, therefore, was to understand how FLMs believed they were being managed and how this influenced the way they managed. In this section we consider managers' experiences of HR practices that are applied to them, their perceptions of satisfaction, their relationship with their line manager, and other support such as senior management, team members, peers and the HR function.

The correlations referred to in this section can be found at Table 10a in Appendix 2.

Satisfaction with HR practices

Numerous studies have found an association between sets of HR practices and improved organisational performance (Arthur, 1994; Huselid, 1995; MacDuffie, 1995). Within the NHS, for example, a complimentary set of HRM practices including sophisticated

appraisal, training, and team working, have been linked to positive patient outcomes (West *et al*. 2002). As explained earlier, how employees perceive HR practices is important in the HR casual chain model explaining the link between people management and performance (Purcell *et al* 2003). Social exchange theory (Coyle-Shapiro *et al*. 2004) helps us understand this in the HR context - in short 'HR practices are viewed by employees as 'personalised' commitment to them by the organisation which is then reciprocated back to the organisation by employees through positive attitudes and behaviour' (Hannah and Iverson 2004 p339).

In recent years HRM in the NHS has focused on developing a range of HRM policies aimed at making the NHS a model employer and improving staff morale and attitudes. The focus has been on adopting a best practice, universal model of HRM to policy initiatives in this area, but this ignores the diverse range of organisations within the NHS and the fact that employees in different occupations have different needs and respond in different ways to HR practices. Recent research (Kinnie *et al*. 2005) has shown that the commitment of different groups (managers, professional and non managerial employees) is actually influenced by different HR practices. Managers, for example, were more concerned and motivated by career development and involvement; professionals were influenced by performance appraisal, involvement and 'openness'. We sought to explore this to try and discover to what extent HR practices are applied to FLMs, their perceptions of satisfaction and what associations there were with employee outcomes.

Using previous research (Purcell *et al*. 2003) we identified 13 critical HR practices:

- Training (clinical and non clinical)
- Coaching, guidance and mentoring
- Performance appraisal
- Career opportunities
- Pay
- Fringe benefits
- Recognition
- Banding

- Team working
- Job information
- Opportunity to express grievances
- Work life balance
- Involvement decision making

Most of the HR policies among the trusts were broadly shaped by national policies although the implementation and priorities given to different practices varied. In the ambulance trusts, for example, communication was a constant issue and the focus of attention, partly because of the dispersed nature of working. In those trusts either seeking or recently achieved foundation status (trusts C, D, and E) it was reported that emphasis was given to involvement and the need to have an inclusive management style.

Table 2: Managers' satisfaction with certain HR practices (%)

How satisfied are you with…	**Very satisfied**	**Satisfied**	**Neither satisfied nor dissatisfied**	**Dissatisfied**	**Very dissatisfied**
Training –clinical	13	48	21	14	3
Training- non clinical	4	26	37	20	5
Coaching, guidance & mentoring	7	35	29	25	4
Performance appraisal/PDP	7	34	22	27	7
Career opportunities	10	40	24	21	6
Pay	8	43	19	16	14
Fringe benefits	17	56	23	3	2
Recognition	10	36	30	21	4
Banding	11	52	10	17	10
Team working	24	57	10	6	1
Information about job	6	46	31	17	1
Opportunity to raise grievances & issues of personal concern	10	56	22	10	1
Work life balance	4	32	34	20	9
Involvement in decision making in the trust	2	29	36	21	12

Satisfaction levels were highest with team working, which was interpreted as the immediate team (Table 2), followed by fringe benefits, the opportunity to express grievances, and clinical training. Managers were least satisfied with their overall amount of involvement in decision making in their Trust, work life balance, followed by non clinical training and performance appraisal. Some of these HR practices are considered in more depth.

Training, coaching and guidance

Nearly all (98%) had received some form of training in the previous year, with 44% receiving 5 days or more training and 42% between 2 and 5 days. By far the most popular method of delivering training was through taught courses, although there was evidence of other approaches such as self learning (reading, attending workshops), mentoring, e-learning, learning sets, on the job training and work shadowing. The majority of the training was for clinical needs, and a significant proportion (37%) claimed not to have received any management/non clinical training in the previous year. Not surprisingly, satisfaction was highest for clinical training (61%) although 17% expressed dissatisfaction. In contrast just 31% were very satisfied/satisfied with the provision of non clinical training, and a quarter felt very dissatisfied/dissatisfied. A significant proportion said they were neither satisfied nor dissatisfied suggesting either ambivalence or that they felt unable to comment either way because they had never received any clinical training (in fact this was confirmed in some comments made during our interviews). A quarter admitted that they had experienced difficulties in accessing training in the last 12 months. Low levels of satisfaction were also shown with coaching, guidance and mentoring (which would mostly be provided by more senior managers) with under half, just 43%, showing satisfaction.

Satisfaction with training, coaching and guidance was lower for managers in the ambulance trusts. Both these trusts reported difficulties in giving managers access to training, and in one the training budget had been slashed because of financial difficulties. Trust D showed considerably higher levels of satisfaction compared to the other acute

hospitals which could be an effect of its small size and/or the specialist nature of the hospital.

Satisfaction with clinical training, and coaching, guidance and mentoring were significantly correlated with job influence, and commitment (Table 10a, Appendix 2). Whilst we cannot say, without doing further analysis, that training is likely to enhance or promote positive employee outcomes, it seems logical to argue that employers who are prepared to invest in their staff through training and development are likely to see this behaviour reciprocated through increased commitment.

Performance appraisal and development reviews

Just over half had been appraised (57%) in the previous 12 months, a similar figure to the average in the NHS 2006 national survey, but only two thirds of these had agreed personnel development plans (lower than the NHS national average), and a smaller proportion again - just half - reported receiving training, learning and development which had been identified in the plan. Some remarked that they had not been appraised in the previous 4/5 years. Perceived levels of satisfaction were low in comparison to how other HR practices were viewed- 41% were satisfied with their performance appraisal, one third were dissatisfied and a significant proportion - 22% said they were 'neither satisfied nor dissatisfied'. These findings suggest that it is not only failure to have an appraisal that accounts for low levels of satisfaction but that they are poorly conducted, and, for the majority, there is no tangible output in the form of training.

Among the trusts there was a wide range of practice with, at one extreme, 91% of managers reporting being appraised (trust C), and at the other (trust 2) just 13% (Table 3). In trust 2 it was widely acknowledged that the performance culture was poor with the performance management system yet to be implemented (although managers had received training in its use). A similar pattern for all staff was found in the 2005 NHS staff survey which shows trust C to be in the top 20% of trusts and trust 2 in the bottom 20% of trusts (Tables 8, Appendix 1).

Table 3: Percentage of managers appraised in the last 12 months

	Trust A	Trust B	Trust C	Trust D	Trust E	Trust 1	Trust 2
Appraised in the last 12 months	52	62	91	62	39	73	13

There was a strong positive correlation between the incidence of appraisal and satisfaction with appraisal.

Reward and recognition

Fringe benefits such as pensions, and sick pay were rated highly by staff with almost three quarters claiming to be satisfied and just 5% dissatisfied. In contrast, however, less than half felt satisfied with their pay, although 63% were satisfied with their pay banding under AfC. A common view was that pay failed to recompense managers sufficiently for their work load and level of responsibility, as these comments suggest:

> *Proper financial recognition for the vast amount of work would be much appreciated- it's terrible especially compared to managers in other professions and business.*

> *There is no incentive for ward managers- you're responsible for everything – a lot is put on your plate but the money is not good – that's the general feeling.*

Overall satisfaction with pay was similar to the WERS comparator groups (Table 9, Appendix 1), although there were wide variations among the trusts. Satisfaction with all aspects of reward - pay, recognition and fringe benefits was highest in the ambulance trusts reflecting the fact that in one ambulance trust paramedic supervisors had received an average 30% pay increase under AfC plus additional holidays. As one paramedic supervisor remarked:

> *I've never been so well off – I got £6000 under agenda for change and it went straight into the bank.*

There were variations among the acute trusts with managers in trust C having significantly lower levels of satisfaction with pay compared to the others. Given that there was little difference in pay bands this might be explained by the fact that managers in this trust showed the highest levels of work intensity and some of the lowest levels of job discretion. There where very wide differences in terms of recognition – from 85% feeling satisfied in trust E to just 28% in trust C. Strong positive correlations were found between recognition and the relationship with the immediate line manager, and support from senior managers, HR support and the trust as a whole.

There were positive correlations between most aspects of reward satisfaction and overall job satisfaction, job influence and commitment. There was also a strong negative correlation between stress and all aspects of reward (Table 10a, Appendix 2).

> *I have always enjoyed working for the trust and have always endeavoured to give 100% but after the result of my banding I have felt very demotivated, which is a feeling that I have never felt in all my 23 years of service.*

Involvement and communication

One of the more striking findings was the very low levels of satisfaction with involvement in decision making in the trust. All but one trust (trust D) showed significantly lower levels of satisfaction in comparison to the WERS 04 dataset, although as already noted, this includes more senior managers who we would expect to have greater involvement. The small size of trust D, with its family atmosphere and 'first name mentality', to use the words of one senior manager, and recent achievement of foundation status could account for the higher than average findings for this trust.

At a more local level, however, perceived satisfaction with involvement and communication was high. 81% reported they were very satisfied/satisfied with their immediate team (i.e. their clinical team), which could be taken as a measure of involvement. Nearly all managers agreed that that their team provided mutual support,

shared knowledge effectively, helped solve problems, introduced new team members well and worked effectively with other teams. It was managers in the ambulance trusts who were most satisfied with their team working. The importance of team working in the health sector has been emphasized in numerous studies and policy documents. Other indicators of involvement were seen in the opportunity to express grievances and issues of personal concern – nearly two thirds expressed satisfaction here; and with information about their job which 52% felt satisfied with.

Involvement, based on all the above measures was strongly positively related with at least one or more employee outcomes measures as seen in job discretion, commitment and satisfaction (Table 10a, Appendix 2).

Not surprisingly, given the heavy work load and pressures facing FLMs, satisfaction with work life balance was low in comparison with other HR practices, with just 36% expressing satisfaction. There were negative correlations between this variable and measures of work intensity and stress (Table 10a, Appendix 1).

Support from immediate line manager

Other research has noted the fundamental importance of managers' immediate line manager in providing support and enabling FLMs to perform their role effectively (Hutchinson and Purcell, 2003). Further analysis of our data shows that aalmost three quarters were very satisfied/satisfied with their relationship with their line manager and the support they received from their boss. Overall they rated their managers best at 'giving me the authority I need to do my job', demonstrating trust and respect, understanding responsibilities outside work, and treating people fairly. However they felt less satisfied in terms of providing guidance, developing career, coaching and guidance, and agreeing goals (Table 4).

Table 4: Managers' perceptions of their managers (%)

The person I normally report to :	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Has good listening skills	30	43	17	7	4
Frequently holds formal and informal discussions with me	25	45	10	15	4
Keeps me informed about events higher up or outside the Trust	18	46	17	15	4
Asks for my opinion before making decisions that effect my work	22	36	19	17	5
Is sincere in attempting to understand my views	31	37	18	10	4
Can be counted on to help me with a difficult task at work	28	40	19	9	4
Gives me clear feedback on my work	17	37	22	17	6
Gives specific guidance as to how I can improve	12	29	33	20	5
Agrees goals and objectives to measure my current performance	12	33	33	18	4
Helps me in developing my career	13	30	31	20	6
Supports me in dealing with senior management	24	39	22	11	4
Demonstrates trust and confidence in me	35	44	7	9	4
Gives me the authority I need to do my job	29	51	14	4	3
Has expert knowledge of the job I do	17	8	24	12	9
Provides me with coaching and guidance	15	27	31	20	6
Respects me as an individual	36	44	10	4	4
Serves as a role model for me	21	30	24	18	6
Understands about having to meet responsibilities outside work	25	50	16	4	4
Encourages me when I am effective in my job	26	40	15	16	4
Encourages those who work for her/him to work as a team	24	44	13	17	3
Treats people fairly	25	51	13	7	1
Is a good leader	25	39	22	10	4

Managers in the acute hospitals had the highest levels of satisfaction with their relationship with their line manager (75%) compared to two thirds in the ambulance trusts (67%). Comparing the individual trusts shows managers in trust C to have the highest levels of satisfaction with their manager (91%) and trust 1 the lowest (60%).

There were strong positive relationships between perceptions of good management behaviour and job satisfaction. Significantly there were no associations with commitment and organisational citizenship behaviours.

Other support

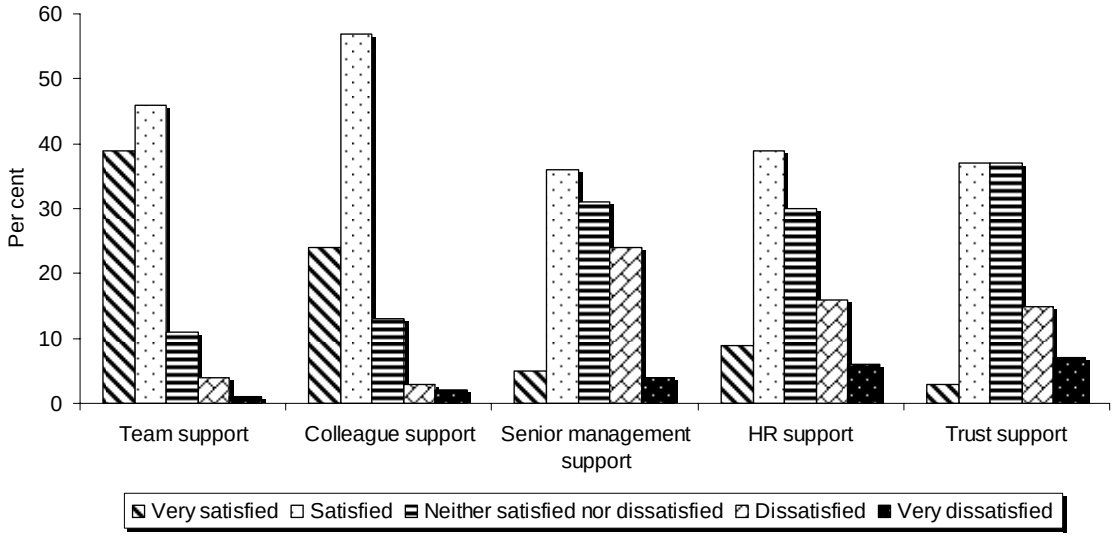
Our previous research on line managers (Hutchinson and Purcell, 2007) also observed the importance of senior management support in terms of providing recognition, access to training and development opportunities and the need to act as role models or champions. This, and other research, (Boaden *et al* 2007) has also noted that the HR function has an influential role to play in the design of particular people management strategies which are most appropriate for managing FLMs, in clarifying the role and providing simple policies for FLMs to implement. Others have highlighted the supportive role of colleagues and teamwork.

Figure 2 shows that managers valued support from their team and colleagues most, with 84% expressing satisfaction with their team and 81% satisfaction with colleagues. Just less that half however were satisfied with the support from the HR function (48%), and even fewer were satisfied with support from the trust as a whole (40%). A similar percentage expressed some satisfaction with senior management support, although the proportion who were dissatisfied was higher (28%).

Ssome considered KSF to have been helpful, although it was not clear whether this was perceived as support from HR, the trust or from elsewhere.

> *KSF is useful – I have a good team so it's OK anyway. If I didn't it would have helped me pull them up in a systematic way. For nursing it's useful – it gives you a better language to 'wrap it up 'and put messages across.*

Figure 2: Managers' satisfaction with support (5)



The key differences between types of trust were in regard to views on senior management. Just 21% of managers in the ambulance trusts felt satisfied with senior management support in comparison to 45% in the acute trusts.

Overall views on management behaviour were particularly poor when compared with the WERS 04 comparator group (Table 9, Appendix 1) and in all trusts respondents felt senior managers to be less good at seeking the views of employees, responding to suggestions and allowing employees to influence final decisions in the workplace. Again there were marked differences between the type of trust with those in the ambulance sector rating senior managers worse, reflecting the command and control culture prevalent in these trusts.

Significant relationships existed between organizational commitment and support from senior management, HR and the Trust, and views on management behaviours. There was no relationship between organisational commitment and support from the team and work colleagues.

In summary, these findings show a positive and strong relationship between certain outcomes as seen in FLMs' commitment to the organisation, and job satisfaction, and the way certain HR practices are applied to them, support from managers higher up the organisation, HR and the trust as a whole. The only HR practices not to show an association with FLMs' attitudes were performance appraisal and non clinical training. Furthermore, there was no evidence of any significant correlations between FLMs' commitment and job satisfaction and their immediate line managers' behaviour, or support from work colleagues or the team. This would seem to contradict other research. This suggests that the important influences on FLMs are outside the boundary of their immediate work area. A more detailed analysis of the data however could shed further light on theses findings. Other sources of support are discussed when we consider the views of senior managers in section 5.

4.4 Barriers to effective line management

Despite line managers' apparent willingness to take responsibility for people management, FLMs perceived there to be numerous obstacles which prevented them from performing their people management role effectively. We have already discussed (section 2) how other researchers have found line managers to be lacking in skills and knowledge, suffer from work overload and competing priorities which negatively impact on their people management role, and how there are likely to be additional issues in the health sector. Here we report on the views of line managers to discover their perceptions on the difficulties they face. We asked an open ended question about the challenges which prevented them from doing their job effectively. Although the focus was on their people management duties many of the inhibitors raised were relevant to their role more widely. All the quotes are from the line managers themselves.

The key issues were seen to be:

- Role conflict and ambiguity
- Lack of resources (staff, time, money)
- Lack of training
- Work overload

- Poor HR support
- Lack of senior management support
- Management structure

One the biggest issues confronting FLMs was the conflict in priorities which arose because of the dual nature of the role in terms of providing management and clinical care.

> *There's a clear conflict of interest between patient care and achievement of targets.*

Further contradictions between the multiple roles in management, such as budgeting, staffing levels and people management, added to this complexity and ambiguity.

> *In the ideal world we need more staff to provide clinical services- this means we could provide more of a service on wards but I can't because the budget would increase.*

> *I'm constantly asked to meet a budget in staffing but cannot make it. I'm asked to reduce the number of staff on duty or staff are moved to other wards.*

Financial constraints and a general lack of resources (time, money and people) were clearly a source of frustration, with implications for the work load.

> *One of the biggest problems is lack of time due to staff shortages – I'm trying to recruit but there's little time to go through application forms which now have to be done on line - so that means at work.*

> *Management only allows one me 1 day a week to do non-clinical activity. Therefore, most of the work is done out of paid hours in our time.*

Time management and prioritising multiple tasks is increasingly difficult. There always seems to be insufficient time to do some aspects of the job.

Some felt more practical support would help with these issues:

My only deputy is my senior staff nurse of my own ward who is part time. I have no deputy to cover my absence, to deal with any other aspect other than my own ward.

Inadequate training to develop management skills in both people management and financial management was identified as a key barrier. There appeared to be no formalised approach to developing these skills, and even where training was available financial constraints and releasing managers often prevented access to this type of training. There were no shortage of comments on this:

Lack of training is one of the main inhibitors – there is nothing I can do about it- the budget just does not cover it

The limitations are that I am a clinician but also a manager – and I have never been trained on that

I'd like more formal training on the staff management side …and support –my line manager is great but I could learn more in terms of guidance in relation to the management side of job.

As a manager, I learn a lot of people management on the job but I'd like to see more management courses – there are very few of them. Mandatory managerial courses would help and also help with managing the budget in terms of training.

Of course formal training based activities are insufficient on their own to skill managers (Hutchinson and Purcell 2007), and other less formal approaches were in evidence by

way of coaching, guidance and mentoring although, as reported in the previous section, these were far from adequate. Learning by doing seemed to be the most common approach or 'learning from mistakes', as one manager put it, but this requires a performance culture in which staff can openly admit to errors, something that was notably lacking in some trusts.

Some were critical of the HR function, who were perceived to be slow to act, bureaucratic (one manager noted how the absence policy was 26 pages long), provide impractical advice, and frequently changing their policies.

> *The recruitment team is not very strong and I end up doing it myself – you can be waiting a long time to communicate with applicants – it's a very bureaucratic process.*

> *It's very difficult to keep up to date with HR policies and procedures and how to apply them- I've not the time to do this. After you've been given the advice the policy changes… this week we have contract renewals to deal with – it's hard to find the right place to go to get advice. You have to put own interpretations on the policies.*

Just a few FLMs questioned the extent of their people management responsibilities, feeling that some of the work should be undertaken by HR or other functions:

> *HR support – they're OK in what they provide but I feel they could do more- I shouldn't have to deal with sickness/absence - HR or occupational health should- and I spend an awful lot of time on this. I have to do everything from writing letters, return to work interviews etc. Long term sickness also is very time consuming.*

Not all managers were critical of HR, as we reported in the previous section, and other research reports contrasting findings. Some confirm the negative views expressed here

(see Marchington and Wilkinson 2008) depicting HR as being out of touch with business realties, unresponsive and slow to react, impractical and reluctant to give up control. Others, however, portrays a more positive image of the relationship between line managers and the HR function. In their study of HRM in the health sector, Boaden *et al* (2007) find that line managers mostly experienced supportive relationships with the HR function, not only in implementing HR policies and procedures but also from the HRM infrastructure that is in place, such as written policies and the intranet.

Of fundamental importance to many, was support and recognition from senior management, and there were some strong views expressed here.

> *I feel unsupported by senior staff and misunderstood and unrecognized.*
>
> *I love being a nurse and most of the time a ward manager. But senior managers make my job very difficult to do – it's too stressful at times. It appears now that whatever ward managers do it is not good enough for XX*
>
> *My main frustrations are the senior managers who are controlling and stifle you. My opinions don't count. Keep quiet and get on with it is my response, don't rock the boat. If they want to pay me band 7 and expect me to work at band 5 4 out of 5 mornings per week then that's very disappointing and very frustrating. Innovations, audits, development are done in my own time or in the afternoons when more band 5 staff can relieve me from doing simple tasks. I <u>do</u> prioritise but will not leave patients waiting for direct care, medicines, discharge planning etc.*
>
> *I love my job - <u>but</u>- senior management break the rules regarding recruitment and retention strategies. They close wards and relocate staff without proper regard for what they want. They redeploy staff from our unit to help staff the wards even when we have none to spare. If we wanted to be bank nurses we would join the bank…….. Nobody ever offers us help when we are struggling. Time is not given to us for performing administration tasks – we have to manage IPRs/appraisals as*

best we can – priority is not given to performing IPRs but it's seen as vital when audits are carried out that they are done.

Some also felt senior managers to be out of touch with the reality of working on the front line.

Management are interfering – general managers are interfering when they don't know what they are doing. For example, a lot of government targets are unachievable. General managers come down and say we have to see these people today – on the last day of the month so we have to cancel patients to get them in. If managers took time to see – and come down to the department they would understand.

What hinders me in my work is the constant daily interference in my daily work - ineffective changes initiated by those who DO NOT work or have a reduced knowledge of the practice area.

Clearly some of these complaints targeted at senior managers were associated with lack of time and pressures to meet targets.

There were additional issues which related to the management structure, particularly in terms of having to work with senior clinicians who were not subject to clear lines of hierarchical control.

It's the NHS structure. The fact that doctors are not line managed makes life difficult. If there was a proper structure throughout it would be much better.

They disempower staff. They take no notice of staff …managing doctors ought to happen – they get paid for 11 sessions and carry out 7 sessions – in the meantime they do private work.

Doctors and surgeons should get their act together – be on time and finish work when they say they do (paperwork not done until last minute). The majority of time they are late – means the op. lists are late and paperwork is not done…

For just a few there were concerns about reporting to a non clinician (a practice in just a few areas), and inefficiencies in other departments.

.

The management structure is difficult – in terms of who is my line manager-she doesn't know clinically what we do. If I want help I just tend to sort it out myself.

Other departments doing their job properly eg elective admissions. We have to do pre-checking sessions twice a week. If they got their lists to us on time then we wouldn't need to waste time looking for notes. We feel incompetent if there are no notes.

Additional issues related to the frequency with which trust objectives and national priorities changed.

I enjoy my job and caring for patients and colleagues but the political constraints we are under are making life very frustrating and although we have to work with the rules I do feel now that people forget these are sick people reliant on us giving them safe care. I know how I would feel if it was a relative of mine in hospital.

I feel lost in this change process ….there is an absence of a sense of what we are dealing.. these political targets also shift- last year it was waiting lists – this year its financial so we need to make staff savings. It's hard to be innovative managerially, and there are lots of rhetoric around the modernisation agenda but reality is that this is not possible to deliver. It's hard not to be cynical.

There were further frustrations with the IT infrastructure and the mass of paperwork

The hospital bought a computer system (rostering) but the hospital can't use it – only one person is trained on it.

Having to do less paperwork and administration would let me concentrate on my team and help me perform well.

For managers who are already over worked it is clear that there are a range of additional issues which hinder them in their work. As others have also noted, role conflict and ambiguity present considerable challenges to FLMs working in the health sector, and this is exacerbated by financial constraints and problems of under resourcing. Additional constraints in the form of inadequate training, lack of support from HR and senior management, and the hierarchical structure compound the problems.

4.5 Managers' experiences of work

As discussed in section 2, in the growing body of research on HRM and performance one of the emerging findings is the link between positive employee attitudes and behaviours and high performance. Attitudinal outcomes include job satisfaction, levels of morale and commitment. Behavioural outcomes which often stem from these include engaging in work beyond contract such as organizational citizenship behaviour, or attendance and quit rates (Boxall, Purcell and Wright 2006).

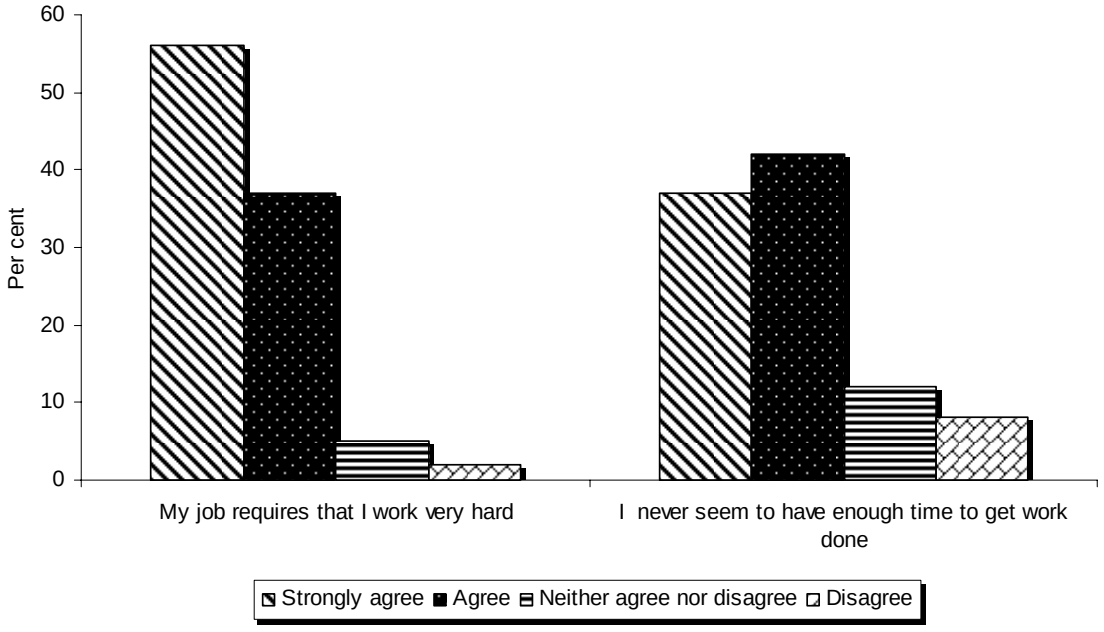
This research is considered in more depth in the background. Here we report on managers' outcomes in terms of perceptions of work intensity, stress, job influence, job satisfaction, job security, commitment, intention to quit, and organizational citizenship behaviour. Some of the correlations referred to here can be found in Table 10b, Appendix 2.

Work intensity

The long hours working and the need to take work home, which characterize this group of managers (section 4), are reflected in managers' perceptions of work intensity (Figure 3). For example, 93% of managers either agreed or strongly agreed that their job 'required them to work very hard', while only 2 % disagreed with this statement, and over three quarters (79%) felt they 'never seem to have enough time to get their work done', and only 9% disagreed/strongly disagreed with this statement. It is no surprise that the higher the levels of overtime working, the greater managers' perception of work intensity. WERS 04 finds that work intensification is higher amongst employees working in the health sector (health and social work) and, on an occupational basis, it is highest in the managerial and professional occupations. However, the managers in our sample showed even higher levels of work intensity than their WERS sector and occupational counterparts (Figure 3). As one FLM remarked:

The main problems is the workload and the pressure - ..I'm just a filling in the sandwich

Figure 3: Managers' perceptions of work intensity (%)



Managers in acute hospitals showed significantly higher levels of work intensification with 96% feeling they had to work very hard, and no one disagreeing with the statement. There were also variations among the trusts with all or virtually all managers in four trusts (A, B, C, & E) agreeing that they worked very hard. Looking across the job bands it was band 7 managers who had the highest levels of work intensification – 97% strongly agreed/agreed that their job required them to work very hard and again no one chose to disagree with the statement.

Managers were also asked about satisfaction with their workload and a surprisingly high proportion - 37% expressed satisfaction although a larger percentage (44%) were very dissatisfied/dissatisfied. A strong negative correlation was found between satisfaction with work load and work intensification as measured on both scales (Table 10b). Higher levels of work intensity were also strongly associated with lower levels of satisfaction with work life balance.

Staff shortages, the sheer enormity of the role in terms of range of responsibilities, continual pressure to meet targets (financial and patient care) are just some of likely contributors to these excessive workloads. The consequences for patient care and staff morale were clear, as these managers indicate.

> *My workload has increased and staffing levels have reduced. Additional targets, both nationally and locally, constantly present challenges to delivering high quality care. They also mean that the organisation resorts to short term planning which impacts on staff morale and quality of care.*

> *We don't give the quality of care because of pressure to meet targets and we are understaffed to do what we ought to do.*

Research has also shown how long working hours over a sustained period are associated with poor health and safety at work (Sparks et al, 1997), as testified by this manager

I love my work but it will have a very harmful effect on my health

Stress

Given the workload demands placed upon these managers it is perhaps not surprising to find high levels of stress among this group of managers. Perceptions of stress and pressure were captured in two measurements:

- My job is stressful
- I worry a lot about work outside working hours

80% strongly agreed/agreed that their job was stressful with only 6 % disagreeing with the statement; just under half strongly agreed/agreed that they worried about work outside working hours, with a quarter disagreeing. As one manager remarked:

I feel burnt out and continually stressed.

These are similar findings to WERS 04 for 'I worry about work outside working hours' (the only question asked in WERS).

Variations among trusts were similar to those found for work intensification with those working in acute trusts displaying significantly higher levels of stress on both measures. Managers in two trusts (C & E) displayed markedly higher levels of worry compared to their WERS counterparts. Band 7s worried most, and exhibited some of the highest levels of stress. Not surprisingly, a strong relationship existed between stress/worry and workload levels (Table 10b), with those reporting high levels of stress and worry having greater levels of work intensity.

Table 5: Managers' perceptions of work stress and worry (%)

% of managers agreeing that…	My job is stressful	I worry about my work outside working hours
All managers	80	47
Type of Trust:		
Acute	85	51
Ambulance	53	26

It is widely recognized in the literature that work place stress is associated with negative individual and organizational consequences (HSE, 2005). In this study perceptions of stress and worry were strongly linked to levels of job satisfaction. Significant negative correlations were found between satisfaction with sense of achievement, job influence, responsibility, job security and workload, and stress (Table 10b) – in other words the greater the levels of stress, the lower the levels of job satisfaction. These findings are supported by this manager:

> *Maybe I worry about things too much but you plan to do things one day and they just get carried on to the next day…You can't perform at your best. what I produce is not satisfactory and work is often interrupted.*

Stress and worry can be attributed to similar pressures as increased workload. Bach explains how most health professionals 'want to make a difference' (2004) and are genuinely concerned about service delivery. When unable to deliver an effective service, they tend to internalise their feelings resulting in high levels of stress or engage in bullying type behaviors.

Job influence

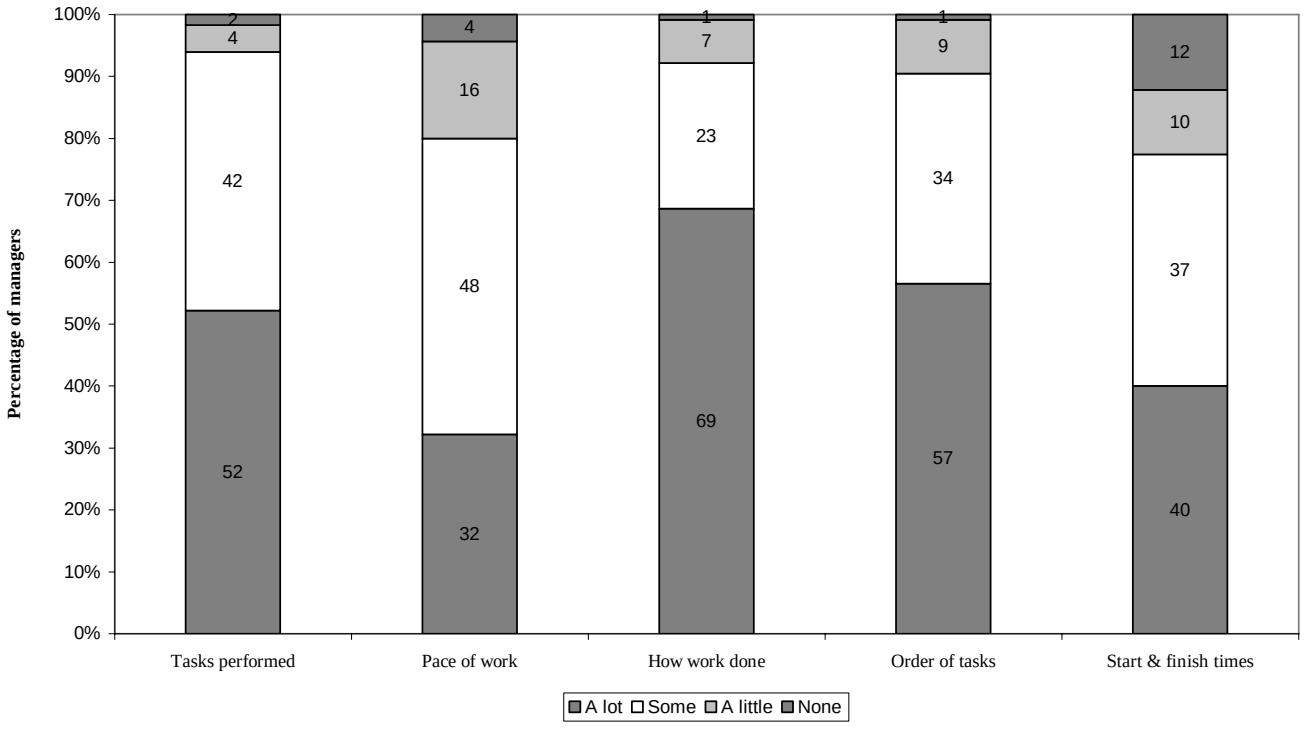
The degree of influence and discretion employees have over how they perform their tasks and responsibilities has been closely linked with motivation, engagement and 'organisational citizenship behaviour' (Coyle – Shapiro *et al*, 2004) – in other words the tendency for people to help one another and work beyond contract.

Increasingly research has focused on the potential to improve job influence or discretion as a means of securing a competitive advantage (Applebaum *et al* 2000, Purcell *et al*, 2003). Furthermore, this same variable is also frequently associated with higher levels of staff satisfaction and well being.

Job influence or discretion was explored in the survey by asking managers about the degree of influence they had over 5 aspects of their job:

- the task they performed;
- the pace at which they worked;
- how they did their work;
- the order in which they carried out task;
- the time they started or finished their working day.

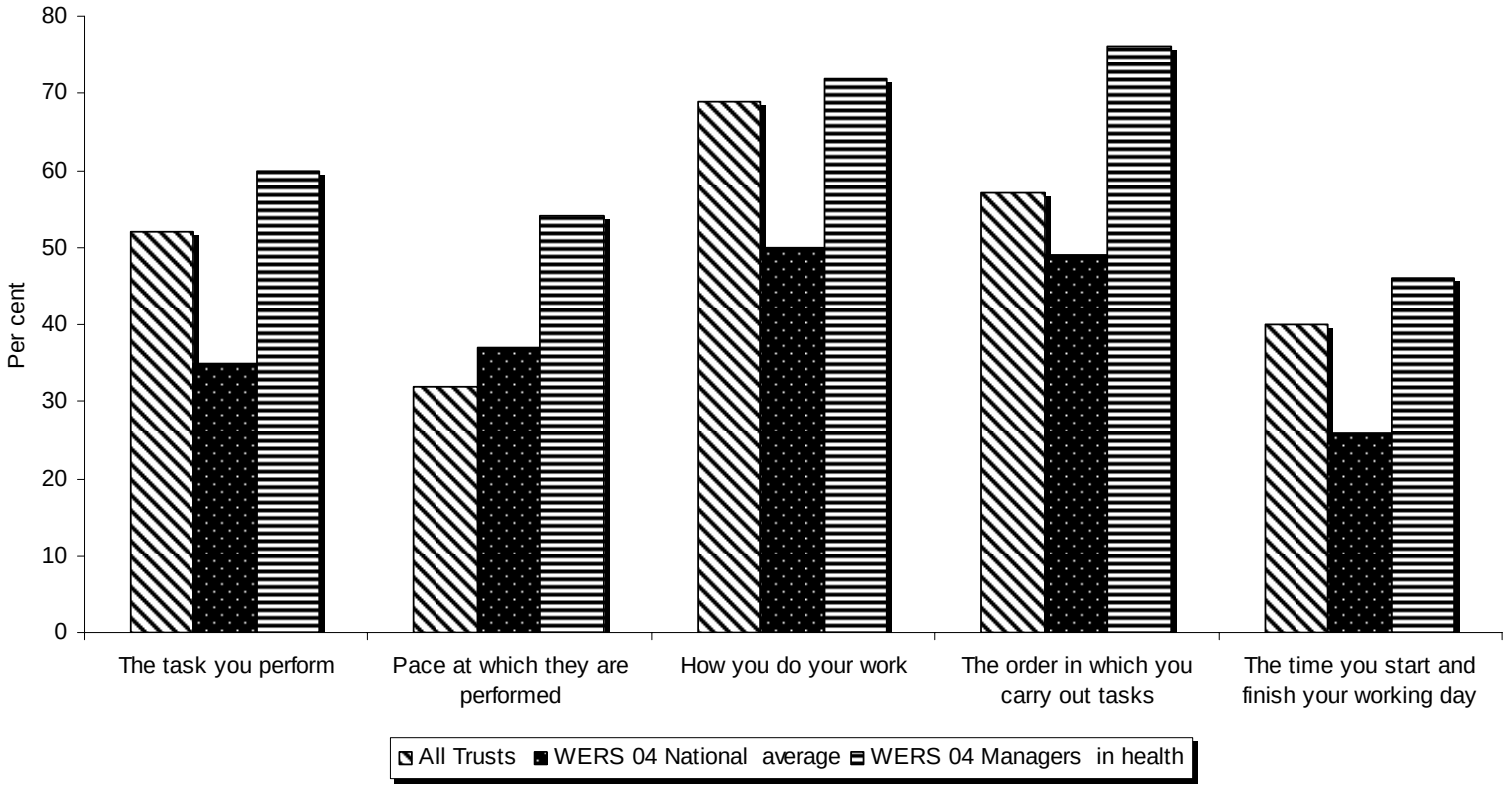
Figure 4: Managers' perceptions of job influence



The results show fairly high levels of autonomy in the job, with influence highest in respect of how these managers do their work, the tasks they perform and the order in which they carry out their tasks (Figure 4). Over two thirds (69%) had a lot of influence over how they do their work, and over a half claimed to have a lot of influence over the tasks they performed and the order they were carried out. Managers had least influence over the start and finish times of their working day and the pace of work, with influence lowest over the pace of work. Only a few managers claimed to have no influence over these aspects of their work, the exception being the start and finish times where 12% said they had no influence.

Like other professions, health sector professionals are considered to have high levels of autonomy and discretion since their work involves specialist knowledge and expertise (Mintzberg 2003). Comparing managers' views here with the national average from the WERS data set (Figure 5) confirms this for all measures of influence except the pace of work. In other words managers exhibit high levels of autonomy over job content but lower levels of influence over the speed of work possibly because they are constrained by job rotas, shift patterns and the often unplanned nature of some of their work. However, these figures are considerably lower than the WERS comparator group, although as noted earlier this group covers all health sector managers and is likely to reflect the fact that the more senior mangers have higher levels of discretion.

Figure 5: Managers' perceptions of job influence – comparison with WERS 04



The degree of overall influence (i.e. based on all 5 aspects of managers' jobs) was markedly higher for full time employees, and among older employees than among younger employees. There was also a significant relationship with job bands - with the higher the job banding, the greater the level of influence. Considerable variations were also evident among the trusts with managers in one ambulance trust (trust 1) reporting significantly lower levels of influence compared to the others. This is likely to reflect the command and control culture prevalent in this organisation, and the fact that paramedic supervisors, who made up a significant proportion of the managers surveyed here, had more limited responsibility in the role. In three trusts, however, managers reported higher levels of influence on three or four of the measurements compared to the WERS dataset, signifying exceptionally high levels of job discretion.

Managers were also asked to rate their levels of satisfaction with the amount of influence they had over their job, and the scope for using their own initiative in their job (table 6). Overall, 64% said they were satisfied/very satisfied with their influence and just 13% claimed to be dissatisfied/very dissatisfied. Satisfaction with scope for using initiative was higher with 80% stating they were satisfied/very satisfied and only 4% reporting dissatisfaction. With the exception of influence over the pace of work, all other aspects of job influence were strongly positively correlated with levels of satisfaction on at least one measure. In other words, managers with greater levels of influence over their tasks, how they did their work, the order in which they carried out their tasks and the start and finish times of their working day reported higher levels of satisfaction with influence and/or scope for using their initiative. Influence over the pace of work showed a significant negative correlation with work intensity, in other words lack of control over the speed of work was associated with working hard and was associated with stress.

Strong positive correlations were also found between levels of influence and some other aspects of job satisfaction, confirming the work of other researchers (Guest and Conway, 2002). For example higher levels of satisfaction with sense of achievement were associated with higher levels of influence over tasks, the order of tasks and how they did their work; satisfaction with level of responsibility was positively associated with influence over how the work was done, the order of work and the timing of the working day. Also the greater the level of influence the more likely individuals were to be satisfied with their workload, or, put another way, the greater their control the more acceptable the workload. Interestingly, there were no associations between degree of job influence and other aspects of job satisfaction, namely the opportunity to use skills and abilities, satisfaction with line manager and the work itself.

Job security

Our interviews took place at a time of widespread job cutbacks in the health sector, and this was reflected in managers' perceptions of job security. Less than half - 44% said they felt their job was secure although a similar percentage said they were satisfied with their job security. These figures are markedly lower than the WERS comparator groups were

almost three quarters felt their job was secure reflecting high levels of security which have been a feature and key strength for the NHS in the past.

Not surprisingly perceptions on job security and associated levels of satisfaction were lowest in those acute hospitals were redundancies had been recently announced (trusts A, B and E) – in two cases less than a third felt their jobs were secure. Despite going through a period of merger, however, managers in the ambulance trusts showed the highest levels of job security suggesting that they did not perceive this re-organisation to be a threat to their job (which was confirmed in senior manager interviews who expressed concerns about their own jobs). Perceptions about job security were positively correlated with length of service, and certain aspects of job satisfaction such as job influence, and scope for using initiative. There were strong negative associations between notions of job security and perceptions of work intensity and stress, so the higher the workload and stress levels, the greater the levels of insecurity. It is likely that managers would associate the need to work harder with financial hardship and cost cutting exercises and thus feel security is threatened. An embargo on the use of agency staff, for example, because of financial constraints would necessitate managers covering on the team and increase the work load.

Job security was also strongly positively associated with satisfaction with many HR practices. Not surprisingly managers associated satisfaction with training, coaching, and career opportunities with job security – it is likely that employers who are prepared to invest in their employees through providing these opportunities are perceived to be sending messages of commitment to staff. Strong positive associations were also found between notions of job security and satisfaction with performance appraisal, opportunity to express grievances, information and involvements, work life balance and reward (pay, banding, fringe benefits) giving credence to the notion of bundles of HR practices (Pfeffer, 1998; MacDuffie, 1995). There were also strong correlations between job security and positive employee outcomes seen in commitment and job satisfaction. Others have drawn attention to the importance of employment security as a means of enhancing mutual commitment and yielding greater cooperation (Pfeffer, 1998).

Job satisfaction

There is clear research evidence to show a link between job satisfaction, employee behaviours and organisation performance, and in the health sector a link has been established between the average level of nurse satisfaction in hospitals and patient satisfaction, which has a positive impact on health (West *et al*. 2006).

There are a host of factors which may determine employees' satisfaction with their job. Earlier we explored this in the relation to satisfaction with HR practices and support. Here we consider job satisfaction on a number of other measures:

- sense of achievement,
- scope for using your own initiative,
- amount of influence of job
- amount of responsibility given
- workload
- opportunities to use your skills and abilities,
- relationship with line manager
- the work itself.

Table 6: Managers' perceptions of job satisfaction (%)

How satisfied are you with…	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied
Sense of achievement	29	57	10	5	
Scope for using initiative	30	50	16	4	
Job influence	15	49	24	12	1
Responsibility	20	60	12	6	2
Workload	7	30	17	40	4
Skills and abilities	20	59	11	8	2
Relationship with line manager	37	36	14	9	4
Work itself	30	54	12	3	1

Levels of satisfaction were highest for the work itself and sense of achievement, reflecting the potentially highly rewarding nature of nursing and medical care, followed by scope for using initiative, level of responsibility and satisfaction with relationship, with their line manager with almost three quarters or more expressing satisfaction with these aspects of their work.

> *I feel the role I undertake within the department is a very fulfilling one. I have a great deal of autonomy and good support from my manager when required.*

Satisfaction was lowest with the workload, were more where dissatisfied (44%) than satisfied (37%), reflecting the heavy demands placed upon these managers discussed earlier. Comparison with WERS 04, which is only possible for some of these variables (Table 9), shows this sample of managers to have slightly higher levels of satisfaction with the work itself and slightly lower with the sense of achievement and influence over the job. These managers, who are at the front end of clinical care, are more likely to find aspects of their job rewarding than more senior managers, some of whom will work in support areas, yet more frustrated with lower levels of control - as discussed earlier.
When combined into one factor[4], overall levels of job satisfaction were highest in the acute trusts. However, this masks the wide variations amongst these trusts which are discussed in section 6 when we consider performance.

Overall job satisfaction was significantly positively correlated with measures of commitment and job influence, but showed a strong negative relationship with stress.

A more detailed analysis of some of aspects of job satisfaction is explored in other sections of this report.

[4] Cronbach's alpha for the construct of these questions is 0.813, and combining the variables in this way is therefore considered reasonable

Commitment

High levels of commitment have been a feature of the NHS, as confirmed by the WERS survey (Kersley *et al.* 2006). In this survey organisational commitment is captured using three questions (these are validated scales from WERS 04):

- I share many of the values of my trust
- I feel loyal to the trust
- I feel proud to tell people who I work for

The highest of these measures was loyalty to the trust (Figure 6) with nearly three-quarters (74%) expressing loyalty to their trust, and only 9% disagreeing with the statement. Around two thirds said they shared the values of their trust and felt proud to tell people who they worked for. These figures however are lower on all accounts when compared to the WERS 04 dataset (Table 9). This comment from one manager suggests a likely explanation for these findings:

> *Loyalty was unquestioned until the recent NHS changes and job losses*

and went on to add later

> *The NHS is no longer felt to reward loyalty. Poor conditions were balanced by security and pension. This is no longer the case.*

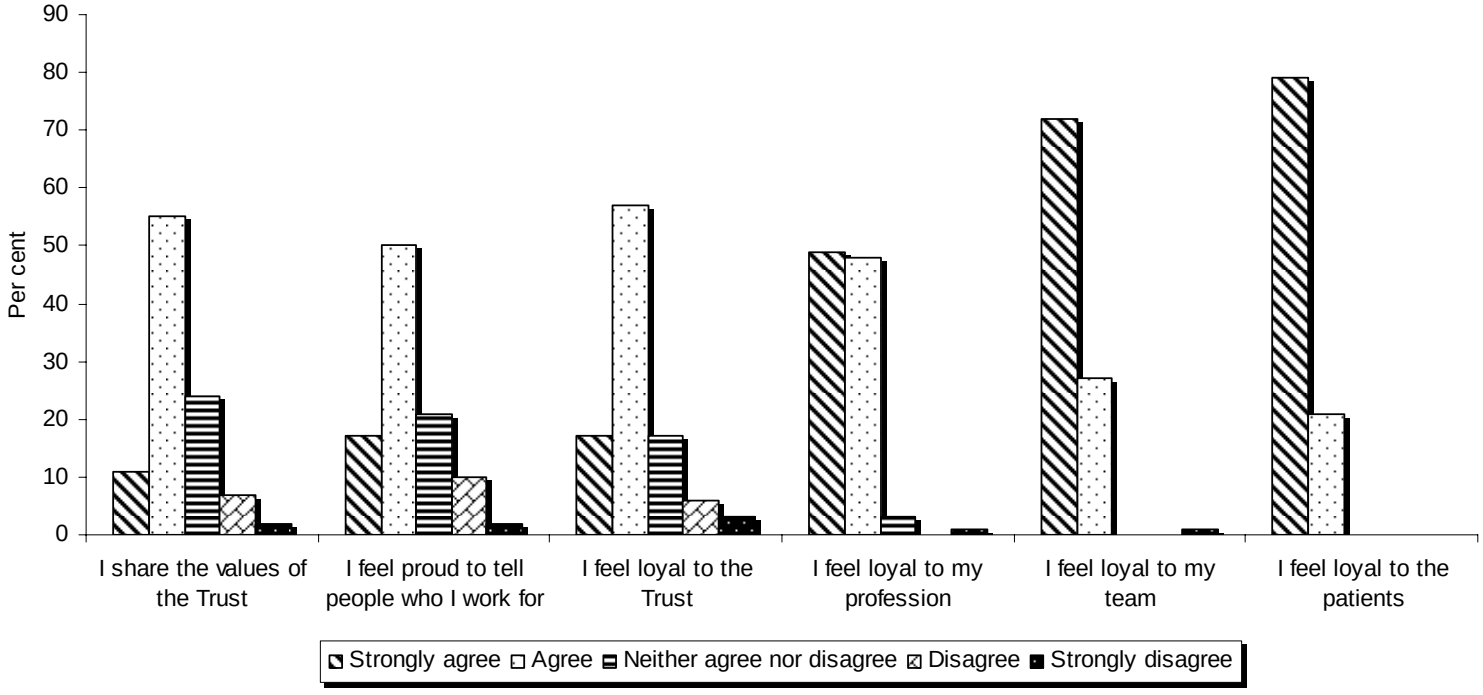
When the three measures are combined into one as a measure of commitment[5], strong correlations are found with perceptions of job security, job influence, job satisfaction and certain HR practices such as career opportunities, reward and recognition and employee involvement and communication. These were explored earlier. A range of factors promote and sustain commitment. Correlations, although not an indication of causality, suggest that job security is one element. Other research suggests that organisational

[5] Cronbach's alpha for the construct to these three questions is .769. The combination of these variables into a single construct is therefore deemed reasonable.

commitment may also reflect managers' views of a range of HR practices such as provision of a decent income, recognition, involvement, discretion or job influence. Strong correlations were shown for all these constructs. There was also a strong relationship between senior management behavior[6] and commitment confirming the findings of other studies, for example Lok and Crawford's (2001) investigation of seven large hospitals in Australia.

There were wide variations across the trusts, with four trusts showing consistently lower ratings on all three measures. Two of these (trusts A & B) had recently announced job losses suggesting that this may be a significant factor which managers considered in making their response to these questions. However trust E, with one of the highest commitment ratings was also suffering staff losses although not in the units of analysis studied. Further interpretation of this data is considered in section 6.

Figure 6: Commitment (% of managers)



[6] Measured using three variables:
How good are managers are seeking the views of employees
How good are managers art responding to suggestions from employees
How good are managers at allowing employees to influence final decisions

Among the managers themselves commitment was negatively correlated with age, with those over 50 showing higher levels of commitment than other age groups, and permanent employees displayed higher level of commitment than temporary counterparts did.

Our earlier research indicated that employees can have multiple commitments or identities (Purcell *et al*. 2003), particularly health professionals who may experience divided and competing loyalties between the patient, their team, the trust and their profession. Exploring these differences (Figure 6) revealed that loyalty was strongest towards the patient, with all managers strongly agreeing/agreeing with the statement, followed by loyalty to the team or work group. There was little variation among the trusts, everyone expressed loyalty to the patient, and between 97-100% towards their team and 93-100% to their profession. When asked to prioritise these loyalties (which most found difficult to do), over half said that loyalty to patients was the most important (51%), and 35% their team. This would support other research on professionals (Buchanan *et al*. 2007) which finds greater loyalty to the professions and client rather than their employer.

Managers were particularly vocal about this aspect of their work and the impact of recent changes:

> *I feel loyal to the department I work in and my line manager. I do not particularly feel loyal to the trust or the NHS. My priorities are my team and the patients we provide a service to.*
>
> *Nurses do not feel valued at XXX. I feel that the trust is fortunate to have strong and loyal teams on the wards that care for one another. If this wasn't the case then the trust would be struggling to provide the standard of care that it does. I'm sure I speak on behalf of all to say that 'we are proud to nurse'. But we are not proud of who we nurse for. Sadly the senior nurses have lost sight of how the*

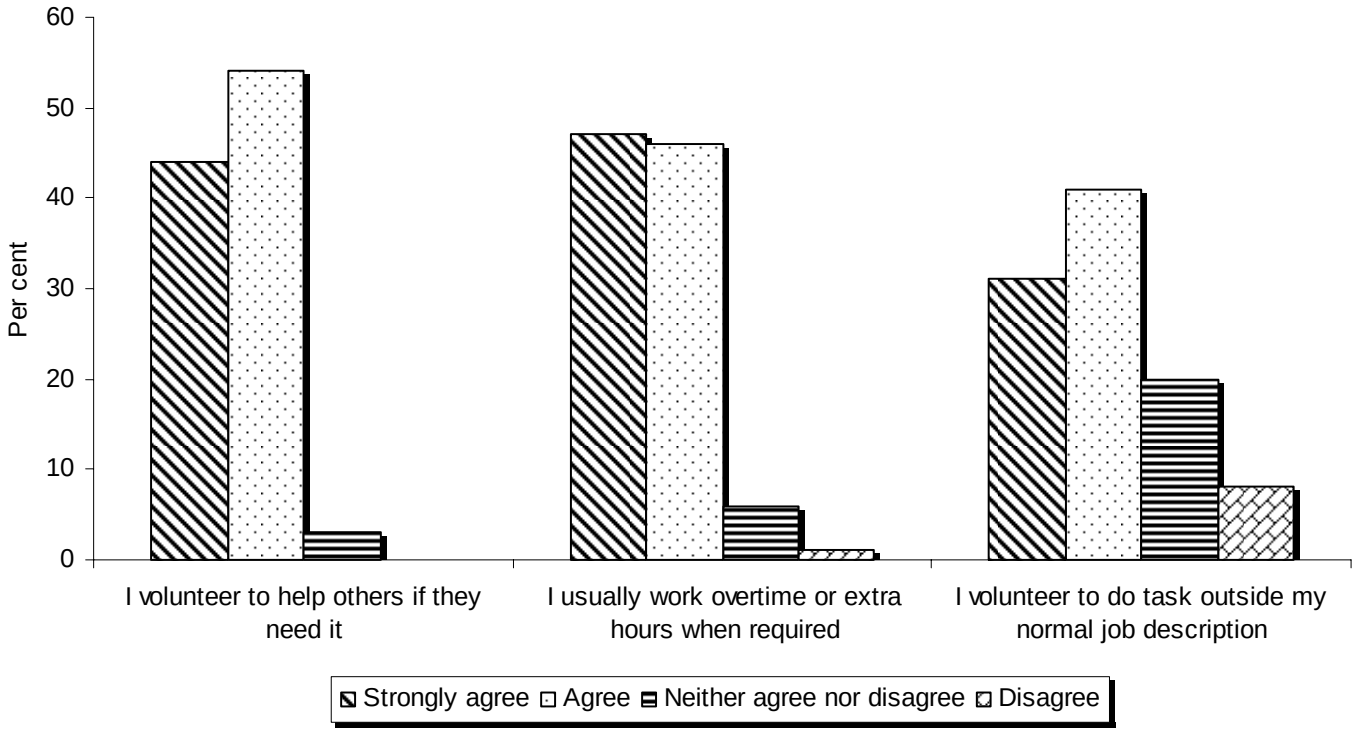
pressures have changed the wards. They don't seem to care that we work on a bare minimum of staff. Something terrible needs to happen in order for them to sit up and listen to us. We are all absolutely tired and need to see some change.

I love my job and my ward but feel sad that after 23 years I feel that although some changes are good more and more 'cost' is the leading theme. I believe that bit by bit the NHS is being privatised and I worry about healthcare for the elderly and deprived patients in our future who cannot afford healthcare. I believe that foundation status will break up the NHS that I have been proud to work towards

Some (Eisenberger *et al*. 2002) argue that the real test of loyalty and positive commitment is the extent to which employees exhibit organisational citizenship behaviour – in other words are prepared to go the extra mile for their organisation, by working beyond contract in terms of perhaps working extra hours or working outside normal job boundaries. This was measured by asking three questions:

- I volunteer to help others if they need it
- I usually work overtime or extra hours when required
- I volunteer to do tasks outside my normal job description

Figure 7: Organizational Citizenship Behaviour (% of managers)



Almost all respondents indicated that they would be willing to help others if needed, and work overtime when required. A slightly lower percentage, but still a significant number (72%) said they would volunteer to work outside their normal duties. To pledge such commitment and dedication is particularly noteworthy, given that these are managers who work excessive hours and are under heavy pressure and stress.

Organisational commitment has been found to be a predictor of turnover, job search behavior and absence frequency (Michie and West 2004). A similar indicator of these types of behaviours is 'intention to quit', which was measured in our survey. Organisational commitment, on all 3 measures, was strongly inversely correlated with intention to quit.

In summary theses managers experience very high levels of work intensity, and stress, yet have considerable job autonomy, and clearly derive high levels of satisfaction with

the sense of achievement they get from their work and find the work itself rewarding. However, there is a suggestion that levels of organisational commitment, which have been a key strength for the NHS in the past, are starting to erode in the face of staff cutbacks and increased workload and pressure. In spite of these adversities however, all of these managers remain devotedly attached to providing an effective, quality service as seen in their unstinting loyalty to the patient and their team.

4.6 Managers' perception of what makes a good line manager

Managers were asked an open ended question about what they felt were the most important behaviours required to fulfill this plethora of activities. A vast array of views were gathered and the most commonly identified behaviors seen as crucial to the role were as follows:

- **Communication.** As one manager remarked *'You need to communicate at all levels, upwards and downwards - with the patient, staff and relatives, careers'*, and another *'you need to be a good communicator, to be able to reduce barriers between disciplines'*. Another described the role as *'You are a mediator, often you have to be a negotiator.*

- **Adaptability and flexibility,** for example being flexible with staff, particularly in terms of their working patterns, and recognizing individuals needs in addition to the service needs. One manager gave the example of how he had turned a ward around and reduced sickness and high labour turnover through allowing staff to work flexible work patterns. Adaptability is important in terms of having to deal with changing (and conflicting) priorities.

- **'Be Firm but fair'** which one manager described as *'80% democratic and 20% autocratic.* One individual remarked on the need to have good parenting skills in terms of being able to put your foot down. Another observed how *'directness is*

appreciated and people like boundaries' and another how *'you need to find that line between being too dominant and too easy going'*

- **Approachable and listen.** As one respondent remarked *'staff need to know that you will listen and try and do something about it'*. This was seen to be particularly important given the emotional nature of the work.

- **Be a good role model** – which was often interpreted as *'never asking someone to do something you are not prepared to do yourself'* or leading by example – *if you don't do it right then you can't expect others to'*. Another described it as *'role modeling standards of practice and professional behavior'*. And another observed *'you can't expect staff to go the extra mile if you don't'*.

- **To be able to prioritise and organize** and *'not feel guilty about leaving tasks because something urgent has come up'*

- **Clinically competent**, and able to *'inspire confidence by showing you know the job'*. Another commented that *'you must be knowledgeable and up to date for your team to respect you'*. Significantly, only a handful of mangers felt the need to be an expert clinically.

- **Being a team player,** sharing ideas and facilitating knowledge transfer

Other comments included the need to be trustworthy, to be inspirational, to have clear expectations, to delegate and empower staff, the need for diplomacy, the ability to multi-task, be open minded and receptive, and one noted the need to have a sense of humour! A handful talked about the need to have a holistic view and *to 'see the service as a whole rather than each section separately'*. Other views expressed were:

You need not to be afraid of taking risks, to be able to challenge the process when it adversely affects your staff – you are their champion.

You need to have very broad shoulders – not only do your team come to you but so do the surgeons.

It's important to be the spokesperson of the staff- part of the role is sticking your neck out for the staff.

Being able to see the whole picture including outside your team – outside the box.

You have to be visible, friendly, approachable, practice what you preach, be confidential, a good listener, have care, respect, be a good knowledge resource, and be an expert practitioner.

You need to be fair, know your staff, have a reasonable level of knowledge, be clear, precise, and objective – people need to feel empowered – this is hard to achieve. You have give people the tools to find solutions to their own problems – give them the forum to allow them to make ideas and listen.

You need to be able to diffuse situations – keep calm and deal with difficult situations with poise and confidence

Clearly, FLMs' perceptions of a good line manager are rooted in their responsibilities to their immediate work area, and are not associated with wider views of the organisation. As we will see this is in contrast to the views of senior managers and other key players.

5: VIEWS OF SENIOR MANAGERS

This section reports on the views of senior managers and other key players in four key areas: the role of front line managers, what support is provided to help FLMs in people management, what are the main barriers to effective people management and their interpretations of what makes a good line manager. The discussion also draws attention to any reported differences between senior management expectations and front line managers' experience. Understanding perceptual differences is important because any divergence in views may impact negatively on the performance of line managers and ultimately service delivery. Previous research detailing perspectives on line manager involvement in HRM between line managers and HR specialists suggests a possible link between perceptual differences and business performance (Maxwell and Watson, 2006).

Many of the senior managers interviewed had a nursing or paramedic background and spoke knowledgably, and often passionately, about the role having been front line managers themselves in the past. Only very occasionally did an interviewee appear remote from the front line, normally non clinicians. What was often interesting in all these interviews, however, was what was not said.

The early interviews in each trust sought to establish who is the front line manager and it was clear that in two trusts there was some ambiguity. Within one acute trust, for example, the management role in one professional area had been split and a non clinician had been appointed to cover the 'management' aspect of the role, (such as budgets, planning and scheduling of work) whilst the 'lead' manager undertook responsibility for clinical supervision. Both, however, were expected to appraise the same individuals and therefore fulfilled our criteria of a 'front line manager'. In one ambulance trust it became apparent early on in the interview process that respondents had different perceptions as to who was the FLM (the paramedic supervisor or assistant divisional officer), something that was also reported to be unclear to front line ambulance staff.

Most trusts reported that these were not difficult positions to recruit into, partly because the post had some kudos, and turnover was generally low. All trusts reported a preference

to ‘grow their own’ managers and in practice most tended to come from their own resources, having come through the role of deputy as a grade 5 or 6 where they might have exposed to some management activities such as performance reviews, training and development, and quality initiatives. Where external recruitment took place this was normally for a clinical specialty.

5.1 The vital role of FLMs

There was unanimous agreement that front line managers played a vital role in delivering performance, and one of the most obvious ways was in their ability to affect the quality of patient care in a work area. This could be seen in the incidence of complaints, record keeping, and general standards of cleanliness and tidiness. As one senior manager remarked:

> *You know when you walk into a ward if it is good*
> (Director, Human Resources)

It was widely believed that line managers behaviour as leaders and deliverers of people management practices could significantly influence the attitudes and behavior of the staff they managed. Levels of motivation, morale and commitment were frequently attributed to the quality of the line manager, and reflected in turnover rates, absence levels, vacancies, the use of agency staff and even the success of student placements. This description of a poor ward manager captures these views

> *Poor ward managers are the ones who let everyone take their holiday at the same time so they have to employ agency staff, they have high absence rates, more patient complaints, have role confusion and show poor leadership. They have poorly committed staff, more disciplinary incidents and high staff turnover.*
> (Director, HR)

Additional illustrations of the vital role of FLMs were provided in how they could impact on national performance indicators. In acute trusts, where ward managers managed the patient pathway from admission to discharge, they had a clear impact:

> *One of the critical roles for ward managers is to reduce the length of stay. It's absolutely critical to be able to estimate the date of the discharge and to monitor changes to that. The date of discharge requires negotiation with the clinical medical team and some ward managers…. Some are flabby about it and some don't want to stand up to the clinicians… This is where self confidence becomes important.*
> (General Manager Medicine)

> *It's front line managers who are having to manage the problems of discharge and therefore waiting lists on a daily basis and it's a very tough job for them.*
> (Modern Matron)

In the context of the ambulance service, line managers could influence response times through their management of absence, leave and turnover which directly impacts on staffing levels and the rostering system. Managing the performance of individual staff has also been shown to produce significant reduction in response times (Woollard, Lewis and Brooks 2003).

As leaders of teams, FLMs can also impact on performance. Team working has been shown to be a good predicator of the quality of patient care in certain healthcare settings and hospital performance (Borrill *et al.* 2002; West *et al.* 2002). FLMs also have responsibilities beyond their immediate team, and some considered the FLM to be a crucial link person, networking across organisational boundaries and improving the dialogue between patients and patient experts. They were also required to establish good relationships with non clinical staff who came into contact with their work area such as cleaners, housekeepers and porters. Other researchers have referred to these managers as

'boundary spanners', who perform a crucial co-ordinating role (Floyd and Wooldridge, 1997).

Line managers were also seen to be critical to the success of the knowledge skills framework and facilitating the skills development of their staff. This included the use of appraisals, developing PDPs and less formal approaches to learning and development such as on the job training, coaching and informal mentoring. Recent research, however, suggests that whilst line managers are not engaging in the concept of the Skills Escalator they are encouraging staff to engage in learning and development opportunities (McBride *et al*. 2006).

Some managers highlighted the increasing need for FLMs to play a role as change agents, particularly pertinent to those seeking foundation status. In another example of wards merging, line managers had a key role to play in managing the change process. Some of the more senior managers interviewed also aspired to a more strategic role for these FLMs but recognised that was impractical given existing work loads.

In general, senior managers' perceptions of the broad content of the role was consistent with those of the FLMs themselves, in other words day to day responsibility for the quality of patient care, budgeting, allocating work, and people management.

> *They are responsible for all aspects of clinical care, for staff in their area, for budgets in their area, and for the environment which includes cleaning, health and safety and clinical care*
> (Director, HR)

Many noted how the role had changed and developed in recent years as managers took on greater responsibility for staffing, budgeting, governance issues such as record keeping and the management of the patient pathway from admission to discharge. One senior HR manager commented how managers were 'actually running mini business units', and in

one ambulance trust operational managers were likened to ‘mini chief executives in their patch’

Key differences between senior managers’ and the FLMs’ perspectives were evident, however, in relation to the division of responsibilities between clinical and non clinical or ‘management’ work. In three trusts (A, B & 1) this was clearly stated as 80% clinical 20% non clinical (although one trust was piloting 100% clinical in some areas), allowing one day a week on average for management activities. In another trust the split was 50/50. In some of these trusts managers were encouraged to come into work in mufti to give a clear message to everyone that this was a ‘management’ day when managers did rostering, purchasing, sickness management, appraisals and various form filling activities. This symbolic gesture was seen as necessary to prevent management time being taken over by clinical work. In one trust it was reported that sometimes ward managers went away from the ward on their ‘management day’ to prevent them being dragged in to do clinical work ‘as everyone wants to deal with the boss including the patients’. Just two trusts preferred not to specify any clear division between the work, arguing that there could be no ‘one size fits all’ approach to the role which depended on the context of the work area. Workload could vary according to the structure, size, and particular pressures facing a work area. In theatres, for example, the intensity of the working environment, and multidisciplinary nature of surgical teams presented particular challenges in terms of managing people. In addition there was a national shortage of experienced theatre nurses which, in one trust, had led to the recruitment of overseas nurses. Whilst easing the pressure on staffing this brought new problems, in terms of managing conflict.

Comparing these perspectives with those of the line managers themselves shows wide discrepancies with line managers reporting significantly greater involvement in the non clinical aspects of the role than senior managers. In terms of priorities, however, it was the clinical role which came first and this implies that much of the non clinical work was done at home in personal time. Some managers recognised the problems:

It's very hard to have dedicated office days with managers frequently pulled back into the ward to complete their clinical tasks – if you're short on the ward then the manager has to do the operational work alongside other nurses.
(Director of operations)

Too much is expected of G grades. They must do clinical roles as well as administrative roles. In practice the administrative roles are eaten away by clinical priorities and by patient requirements and as a result most G grades take work home with them
(Senior nurse manager)

Significantly only a few felt able to prioritize the work in any further detail – an indication of the inherent conflict and ambiguity in the role.

In terms of priorities these are firstly, delivering safe patient care and to demonstrate that to other nurses on the ward. Secondly the management of resources meaning people and money, and third is about maximizing the patient experience, helping the patient to learn and getting the patient involved in their own self management
(Head of nursing)

5.2 Support for FLMs

When questioned about what support was available to help line managers in their people management role the most immediate response was to turn to the role of the HR function. As reported earlier some line managers were critical of the HR function, viewing it as slow to respond, bureaucratic, too distanced from the clinical workforce and producing volumes of policies which were difficult to implement. In all but two trusts the structure of HR mirrored the directorate structure with HR managers located in a specialty having an advisory and facilitative role, akin to the business partner model. Typically a dedicated

HR manager/advisor would work closely with a Directorate paying particular attention to absence, complaints, use of bank and agency staff, turnover, and providing line managers with advice on implementing day to day HR policies and practices. In the two smallest trusts HR was provided as a centralised service. All the HR professionals we interviewed were clear that HR or people management was the responsibility of line managers and that the role of HR was primarily one of advise and support

> *The HR role is to advise on issues like disciplines and grievances but it's rare to get actively involved. It's mostly guiding people through and making sure the appropriate policies are followed.*
> (Associate Director, HR)

> *In terms of HR it is critical to provide support to line managers rather than to manage on their behalf and to provide efficient services to support.*
> (Director, HR)

Additional areas of HR support were seen in the provision of training, monitoring the appraisal process including the implementation of appraisals and PDPs, and training needs analysis. HR also had a role in raising awareness of HR policies and practices, although several HR professionals admitted that they struggled to do this in an effective way and that the weaker or less able managers would do things by the book.

> *HR needs to be less transactional and more transformational. One of the problems with policies is that managers just read the policy and don't adjust it to local circumstances and therefore it becomes rather bureaucratic and unhelpful.*
> (Assistant Director, HR)

This problem was also echoed by one staff representative:

> *It doesn't matter how well you write a policy it's always open to interpretation such as leave. We just put a policy on the internet and expect people to implement it, but when it's a change we need to make more of it.*
> (Union representative)

Another common response when questioned about support was to focus on training – or the lack of it. There was widespread recognition that not enough attention was paid to developing management skills, not just in people management, but financial and time management. Some noted the limitations of KSF which do not specify the management and leadership qualities required of a manager, nor link management skills to a development gateway. Crucially, there was no firm evidence of line managers being assessed in any detail on their people management skills and thus development needs failed to be clearly identified. Recent research in six relatively high performing NHS Trusts (Boaden *et al*. 2007) found that although appraisals were widespread, specific appraisals about people management were less common and only 37% of line managers reported being appraised on the implementation of HR policies or people management skills. An important consequence of this failure is provided by other researchers who suggest that line managers give people management a low priority if organisations do not value these management activities highly by including them in any formal or informal performance expectations (Whittaker and Marchington 2003; Hutchinson and Purcell 2007). In the absence of organisational incentives or pressures effective people management depends on line managers' personal motivation (McGovern *et al*. 1997).

The general impression gained by the research team was that there were no coherent strategies on developing people management skills. Training tended to be conducted in an ad hoc and reactive way, and unless there was a capability issue this type of training was patchy. In one trust there were even reported differences in approach between directorates with some using the local HR manager to deliver training, others adopting a 'learning from each other' approach and encouraging the sharing of best practice.

Examples provided of formal training activities included workshops on issues such as recruitment and retention, core management leadership, handling absence, performance management and managing teams. These could be delivered internally by HR or a specialist training function or by an external provider such as a local further educational institution or consultancy. In one trust these workshops were specifically targeted at newly appointed managers.

Nevertheless, even when training was available, there were practical problems in terms of releasing managers and financial constraints. Partly as a consequence of this most trusts preferred to give emphasis to other methods of delivering training, learning, and development. On the job learning was considered invaluable, particularly the need to gain exposure to difficult people management problems such as dealing with poor performance, and having that 'difficult conversation' with staff. Other approaches included coaching, either by the line manager such as the modern matron, HR or a specialist training function, and mentoring – often informal. One acute trust was successfully piloting a project based on action learning for a group of mixed ability ward managers who met monthly to share experiences, diagnose problems and develop solutions. Each manager was allocated a senior mentor or coach. This project was the initiative of the Director of Operations, and ex Head of Nursing, and aimed to give confidence to ward managers and help them work together as a team. Although the focus was on solving patient problems, leadership and people management was a key part of this.

Networking through regular meetings, formal and informal provided further opportunities to learn and develop. Numerous examples were given of providing access to vertical and horizontal support in this way. In the acute trusts there were regular meetings for ward managers which provided the opportunity to share best practice and discuss hot topics, Directorate meetings, multidisciplinary meetings and other professional networks. Ambulance trusts recognized they were less good at this, were communication was generally considered poor because of the dispersed nature of working.

Practical support was available from ward administrators, or in, the ambulance service, area administrators, who took some of the administrative burden off the shoulders of line managers. In one acute trust a new role of ward administration manager was being pioneered in three wards with the aim of taking away much of the administration associated with ward management such as budget forms, off duty rotas, purchasing etc. An additional advantage in creating this role was that it could provide a career pathway to general management. Ward housekeepers were also considered valuable in ensuring the ward was clean and attending to patients' non clinical needs. An important role in larger wards in acute hospitals was the support of more junior staff in undertaking some of the development reviews, and helping with absence management.

Further support was available from other areas, such as occupational health and finance. One example given was of long term sickness in a large ward where occupational health organised case conferences with HR and the ward manager to deal with problems on a one to one basis. Support with financial management was being addressed in two acute trusts in which ward managers had an accountant to help them understand the budgetary process.

The development of role models was seen as crucial, in order to provide an anchor for leadership types and thus influence management style. This was seen as a key role for FLMs own line manager who also needed to provide more general support in terms of coaching, guiding, mentoring, listening and responding to problems. This is how one senior nurse manager matron saw her role:

> *I am there as leader to them. I am able to support them. I have to have a wider picture and as modern matron I am a role model*
> (Senior nurse manager)

Having a strong performance culture in which good performers were recognized, and capability or conduct issues dealt with efficiently and fairly was seen as an essential backdrop to enable line managers to perform effectively. The importance of providing a

positive performance culture has been emphasized in other research on line managers (Hutchinson and Purcell, 2007). In most trusts, however, it was widely reported that there was a general reluctance to manage under performers. As one senior manager remarked:

> *We are very nice to people…we keep people we don't want*
> (Director of nursing)

Linked to this was the need to develop a blame free culture, noted in at least three trusts, where staff could talk openly about 'near misses', capability issues, and grievances could be triggered without fear of reprimand so that, as one senior manager explained, 'people aren't beaten up if they do something wrong'.

Significantly what was not referred in these interviews, but seen as critical by the line managers themselves, was support from the top of the organisation such as providing recognition, time, clarifying goals, listening and communicating, improving the management structure and allowing FLMs greater discretion. Other research points to lack of senior management commitment as a key barrier to effective people management and shows how active top management support is essential in terms of providing recognition, role clarity, realistic targets, and in positive role modeling and access to learning and development opportunities (Hutchinson and Purcell 2007).

5.3 Barriers to effective people management

Many senior managers talked of the variable quality of FLMs particularly in the area of people management and voiced concerns about the effectiveness of their management skills. Inconsistency in implementation of HR policies is supported by the NHS staff survey findings for the individual trusts (Table 8a-8c). In 2005, for example, the percentage of staff surveyed who had not been appraised by their line manager in the last 12 months ranged from 31% and 83% depending on the trust. The quality of appraisals also varied with between just 11% and 35% of staff feeling they had a well structured review, and between 7% and 53% reported receiving a PDP in the last 12 months. The

NHS is not alone in reporting such variability, with other researchers also finding considerable unevenness in the implementation of HR policies and practices (McGovern *et al*. 1997; Hutchinson and Purcell 2003). In their study of 'leading edge' organisations McGovern *et al*. (1997) found management implementation of performance appraisal to be patchy within organisations and the quality of the practice varied significantly.

There is other research evidence of line manager involvement in people management being problematic, which is discussed in section 2. As indicated previously (section 4) line managers themselves perceive their people management roles to be challenging and difficult, and raise concerns at their lack of skills, work overload, role conflict, budget constraints and insufficient staff. The senior managers interviewed clearly recognised and sympathised with these views, and also identified additional challenges. These are addressed briefly here.

Whilst no one questioned the clinical ability of FLMs, there was a widespread perception that some FLMs lacked the necessary skills and competencies to perform their people management role effectively. This was largely attributed to inadequate experience (for many this was their first line manager appointment) and poor training, learning and development. A few also recognized a failure at the selection stage to identify skills and behaviors that were appropriate for good people management. All trusts admitted to selecting managers almost exclusively on their clinical ability and giving 'management' skills a low priority whilst at the same time recognising that a good clinician does not necessarily make a successful manager. A few senior managers, however, signaled their intention to give higher priority to the non clinical aspect of the job, such as people management.

Of key concern was the potential for conflict between providing good patient care, managing a budget, staffing levels and managing staff. These roles could contradict each other and stand in opposition. The perception was that generally it was the non clinical aspects of the role that suffered and were afforded a low priority, as managers retreated into their comfort zone of being a clinician when under pressure.

There's always tensions to do with the level of service relating to the patient, relating to the budget and relating to time
(Senior nurse manager)

Some managers find the role tough and retreat into silos. They develop a coping mechanism by retreating into the team and emphasizing only the clinical role
(HR Manager)

Resource constraints imposed by tight budgets and lack of staff compounded these difficulties.

There is a tension between managing the budget and meeting staffing levels and local managers will always want to get agency staff to make sure they have the full complement, but my role, and that of others in the centre, is to question such decisions as it leads to financial difficulties…….If you're short of a critical member of staff then they have to be replaced somehow. But this tension between patient care and critical budgetary performance is at the heart of hospital management, especially if you are trying to become a foundation hospital.
(Medical Director)

The view of one non clinician, however, was clear:

We are paying them to be a manager not a clinician …but the comfort zone is being a clinician
(Head of Learning and Development)

Heavy workloads, insufficient time and lack of role clarity added to these tensions. This was notable in one ambulance trust were significant role changes had created some ambiguity.

There is now a degree of confusion among the paramedic supervisors because of the change in the role emphasising full clinical responsibilities
(Director of Operations)

These are amongst the hardest jobs in the Trust yet potentially very rewarding. They are hard partly because it is often the first person's managerial role and there are no particular terms of reference about the role and little framework- the Trust needs to be clearer about what is the nature of the role
(Director of HR)

Additional problems came to light which were not raised by the FLMs themselves. The implementation of AfC was said to have had negative effects on the workload of managers and staffing levels. One manager reported on how the impact on annual leave was to remove the equivalent of a whole time nurse in each ward. Improvement in working lives created huge challenges in terms of rostering and managing flexible workers. Many FLMs had also been involved in putting staff forward for regrading which generated extra work.

Most line managers had been promoted from the ranks of the shop floor, having been former nurses or paramedics, and this could create further tension in their role as they faced competing demands and loyalties (Child and Patridge 1982). Others have noted this contradictory position (McConville 2006) which more than one senior manager referred to as the 'piggy in the middle' effect. When applying for regrading under AfC, in practice most FLMs tended to back staff in their application to be friendly and retain loyalty. Some senior managers considered this poor management in terms of failing to manage staff's expectations. This role dilemma was a particular issue in the ambulance trusts where managers worked closely with those they had to supervise.

When they are in the office they are hiding away and when they were in the ambulance they took their pips off in order to be one of the team.

You want to be everyone's friend but can't. They have a foot in each camp – they get all the flack – they're first in the line for any flack

Some (but a minority) questioned line managers' commitment to people management and whether they saw it as part of the role. There was a suspicion that, whilst accepting of the role, some managers just saw it as compliance with policy as opposed to any deeper understanding or passion for people management. One example given was of a manager in a ward with high levels of sickness and turnover who had allowed clinical work to take precedence, whilst blaming HR for their inability to manage the problems. The managers' view was that 'HR is not my job it's the job of HR'. This lack of commitment was also attributed to a fear of getting things wrong, and having to face an investigation or employment tribunal.

As a result the weaker line managers do everything by the book and they throw the problem back at HR saying their procedures don't work
(Assistant Director, HR)

Other common problems included the use of agency staff, which, whilst alleviating staffing problems placed additional pressures on line managers to familiarize these temporary staff with procedures and policies. It was also felt that, in recent years, patients had heightened expectations and were more likely to complain. This also added pressure on both staff and managers.

Some problems were context specific. Managers within the ambulance service faced particular challenges because of the widely dispersed nature of work. The shift systems and crewing levels meant that front line staff were not directly supervised a lot of the time. In the two trusts studied, it was also reported that FLMs were reluctant to take on board the performance indicators, and many did not feel comfortable with pressures to meet response times. These findings concur with the CHI report in 2002/03 on the ambulance service which found clinical supervision to be lacking and the sector to be behind other parts of the NHS in developing clinical governance arrangements.

Communication, a key issue in all ambulance trusts, was a further challenge to these managers. In one trust, for example, despite an abundance of communication channels such as the intranet, weekly bulletins, two way communication, consultation, JCCs, and staff representatives, staff still did not feel consulted.

> *Communication is a big issue – it doesn't matter how much information you communicate down- the tools are there but just not used.*
> (Assistant Chief Ambulance Officer)

This also raised issues around how to communicate new policies and procedures to managers– as one senior manager from the ambulance service remarked in relation to health and safety procedures:

> *They are often not aware of what they should be doing or how they should be doing it*
> (Health and Safety Manager)

In some theatres, the employment of a significant number of overseas staff to overcome shortages of nurses required FLMs to be culturally aware and allow staff time off to engage in language and conversion courses. In one example 'clan' warfare had broken out between some Philipino staff with staff refusing to work with each other, adding to the complexity of managing a diverse workforce.

The general consensus was that all these managers had extremely demanding roles with high volumes of work, needed high levels of support but often felt quite isolated.

5.4 What makes a good line manager?

Towards the conclusion of each interview senior managers were asked for their interpretation on 'what makes a good line manager'. The response to this question elicited a long list of qualities. The need to be a good role model, have excellent

leadership skills, operate fairly, have the ability to motivate and delegate, be approachable ('but not be everyone's pal'), develop people and be able to deal with poor performers (when it happened rather than wait for the annual appraisal) were commonly expected behaviours. Having credibility as a clinician was also seen as critical although the interpretation of this varied. To some this meant clinical excellence, but others considered it sufficient to be competent and that it was not necessary to have better clinical skills than the staff they supervise.

> *Critically there is a need for leadership skills and to develop loyalty with a capacity to go the extra mile by developing a type of field commander role, to be able, for example, to deal with difficult patients in a role model sense.*
> (Director of Operations)

> *They can hold together the clinical team with the ability to motivate and develop staff both individually and working together*
> (Head of Nursing)

> *A good grade 7 is able to deal with the poor performer and knows when and how to get support when it's needed. A good grade 7 is can be quite firm but can provide advice and is able to build a team model. They are a role leader in terms of learning and developing and can engage in mentoring/coaching… and will also work with the medical director when he or she comes to do his or her walk about.*
> (HR Manager)

The ability to be an effective communicator, respond to questions, and listen to others were also considered essential behaviors, as implied in this description of a poor manager:

In contrast, the bad sister hides away, does not get back to you when you have asked a question, makes assumptions, has prior agendas and believes that she or he is the top dog, and lacks humility.
(RCN Representative)

Being able to deal with pressure and stress were also key:

In order to run a ward efficiently they have to rise above the pressure and that makes a big difference if they can see the bigger picture and not get stressed
(General Manager, Medicine)

They have to be able to de-personalize issues and they need to be able to walk the floor in order to achieve a balance between the different types of roles they have to undertake.
(Modern Matron)

These were all behaviours also identified by the line managers themselves. But there were additional qualities highlighted by these senior managers. Of critical importance was the ability to deal with the conflict between clinical and non clinical responsibilities and the need to be able to mix these roles relatively easily.

A good line manager has the ability to balance the financial side and the clinical side and to develop their non clinical roles for example good management skills.
(HR Manager)

A significant number of senior managers talked about the need to be able to engage in a 'visualising' activity, and to have a view of the bigger picture meaning the needs of the trust as a whole and not just their patch. This required the ability to stand back 'so that they could cope with complexity in the use of resources', understand the trusts goals, and appreciate the link between operational and strategic matters

To be effective they need to be able to link organisation strategy with operational delivery….they must have awareness of trusts objectives, be clinically excellent, put the patient first and staff second, be a good communicator skills, and have a high level of employee involvement.
(Director of Corporate Affairs)

They can link together the organisational needs with the patient needs and also the particular needs of the directorate.
(General Manager)

A good line manager wants to do the job, wants to make a difference – has vision and knows the impact they can have on the organisation…and is good at team working, budget awareness, good planning, and has knowledge of the team.
(Director of Nursing)

Someone who understands the big picture and can translate this to the front line.
(Clinical Care Director)

They need to be advocates of the organisation – they need to have a wider vision of what their job is and how they should undertake it.
(Director, HR)

Some gave specific examples of good ward managers who had made distinctive differences. One manager for example talked of how a ward manager had been put into a disruptive ward where there had been a lot of bullying and untidiness:

She turned it around within 3-4 months by being out there with them, by being visible, by being a field commander doing everything with them, never delaying anything. She was brilliant at time management and the staff adored her because she was consistent, she was firm and had clear expectations'
(Head of Nursing)

In another example a General Manager described one ward which had been in difficulty because of over spending. A new ward manager turned the ward around through reducing absence and turnover, partly through the introduction of flexible working initiatives, resulting in a good financial balance.

In summary, the vital role that FLMs play in improving healthcare and helping organisations achieve their goals was widely recognised by all those interviewed. This was seen in the way they could impact on the quality of patient care, performance indicators, and the attitudes and behaviors of those they managed. There were considerable areas of commonality in line managers' and senior managers' perceptions of the role but also some significant differences. All managers had a shared understanding of what the core responsibilities entailed, and there was some consensus on what support was available, the constraints, and the characteristics required of an effective line manager. However, there were some striking differences between senior managers' expectations and FLMs experiences. This was notable in senior management demands for FLMs to have a view of 'the bigger picture' and trust wide perspectives. FLMs however were too busy and concerned with their immediate work area to undertake this. There were also gaps in perceptions of the balance of work between clinical and 'management work' with FLMs reporting a heavier workload in the 'management' aspect of their role, some of which had to be done at home. One consequence of this was that senior managers were lacking in the support they provided to FLMs.

6. THE LINK WITH PERFORMANCE

Performance Profile of the Trusts

Table 7 details the performance history of the case study organisations from 2004 to 2006/07. Prior to 2005 a 'star rating' system was used in the NHS with organisations being awarded up to 3 stars. Two trusts had three stars, three two stars and two one star. From 2005, following an external assessment, a new system was introduced, described as the 'Annual Health Check. This provides a more rounded assessment on how trusts are performing by scoring trusts on a number of aspects of their performance, including quality of services, and the management of resources. Scores are based on a range of information gathered throughout the year. Assessments were not available for the ambulance trusts in 2005 because of re-organisation and mergers across the service.

Three acute trusts could be considered good/excellent on one or more ratings over the three year period: Trust D had consistently high ratings for all the 3 years, trust C performed very well in two of the years, and trust E. Trust A showed consistently poor ratings, and trust B showed performance to have declined after 2004. All, however, had satisfactory patient ratings. Comparing the two ambulance trusts shows trust 1 to be slightly better than trust 2.

An alternative source of information on performance is the NHS staff survey. Tables 8a, 8b & 8c show selected data for 2005 and 2006 respectively. In 2005 four trusts - C, D, E, and 1 - had better than national average scores on all or most measures, and three trusts lower than average scores on all or nearly all measures, - A, B, and 2. Trust D showed mixed attitudes. In 2006 Trust A showed significant improvements in some attitudes compared to the previous year, whilst in trusts D and E some attitudes declined.

Taking all these measures into account it seems reasonable to conclude that trusts C, D, E and 1 were the better performing trusts, trust A, B and 2 weaker performers.

Front line managers' attitudes

Comparing attitudes among the trusts (Table 9) shows a number of trends:

- Among the acute trusts, managers in two – D & E - had higher than average scores on all or nearly all measures for job influence, job satisfaction, satisfaction with HR practices, management behaviour and commitment. These were two of the better performing trusts.

- In trust B managers had the poorest attitudes towards management behaviour, and commitment. This was one of the poorer performing trusts.

- Among the acute trusts, managers in trust C had the lowest levels of influence and job satisfaction. They also displayed the highest levels of stress and worry and felt they worked the hardest. Commitment was relatively low compared to the other trusts. However, managers in trust C had markedly higher levels of satisfaction with their relationship with their line manager than all other trusts. This was one of the better performing trusts.

- Four trusts had exceptionally poor attitudes towards senior management behaviour, A, B, 1 and 2. Three of these were poorer performing trusts. In the ambulance trusts these views are likely to reflect the command and control culture. The three better performing acute trusts (C, D & E) showed more positive attitudes towards their senior managers.

- Perceptions of job security were lowest in trust A, B and E where redundancies had been announced.

- Managers in ambulance trust 1 were more satisfied with their job compared to ambulance trust 2, but had much lower levels of influence over their job.

Attitudes towards front line managers

The NHS staff survey (Tables 8a, 8b, 8c) can give some indication of staff attitudes towards line managers:

- In 2005 trusts C, D, E, 1 & 2 perceived support from line managers was above the national average, but below average in trusts A & B.

- In 2005 the percentage of staff having been appraised by their line manager and the perceived quality of these appraisals were either the same or above average in trusts C, D, E and 1, below average in trusts A, B and 2

- There were significant changes in attitudes between 2005 and 2006 in two trusts: in trust A 2006 the number of staff appraised, the quality of the appraisal and support for line managers improved significantly in trust A. In trust E attitudes towards team working, support from the line manager and intention to leave had significantly declined. Performance data for 2007 will reveal if these changes had a lag impact on performance.

Conclusion

Whilst it is not possible to draw firm conclusions from these findings, in general line managers in two of the better performing trusts have more positive attitudes compared to the poorer performing trusts suggesting that there may be an association between organisational performance and line management attitudes. The exception is trust C were managers have relatively low levels of commitment, job satisfaction and job influence but the highest levels of stress and work intensity. This trust also exhibited the highest levels of satisfaction with the work itself and their relationship with their line manager, and above average perceptions on senior management behaviour. A likely explanation for the variation in trust C is that in the drive to achieve foundation status (the application was being considered at the time of our interviews), managers were working

exceptionally hard and were under tight control over there work, yet FLMs supported senior managers in their application.

Staff also rated their managers better in the higher performing trust in terms of support and appraisals, suggesting a possible link between line management behaviours and organisational performance.

In sum, the better performing trusts showed better relationships with both senior managers and FLMs, in other words there was strong upward and downward line management support. The reverse was true for the poorer performing trusts. Senior management support helps the FLMs manage which in turn impacts on how they manage. This gives emphasis to the crucial role of line managers.

7. CONCLUSION

This section draws together the main findings of this study and outlines some learning outcomes. The fundamental aim of the research was to explore the role of front line managers in the effective delivery of people management in the NHS. This was undertaken through case study research in seven trusts from the NHS acute and ambulance sector.

The vital role that front line managers play in explaining the link between people management and performance has come to the fore in the HRM literature in recent years, yet little is known about the detail of what these managers do in practice, what factors inhibit line managers' effectiveness, what supportive conditions are necessary to help them deliver their roles effectively, and what are the qualities of a good front line manager. Within the NHS, these managers, typically found at band 7, are key to the successful modernisaton of the service. They are recognised as critical in bringing HR policies to life, and in linking HR practice to strategy. Crucially, they can make a difference to the way service is delivered – to patient experience, and to the performance of organisations.

The powerful impression gained in all our interviews was that these managers were highly dedicated professionals with demanding, stressful and complex roles. They undertook a wide range of activities, some of which conflict, and had large spans of control. Yet they were generally unsupported in the critical roles they undertook. Five key conclusions emerged which are now considered.

Firstly, the heavy work loads and substantial responsibilities performed by these managers were far greater than equivalent managers in other sectors. They had large numbers of reports - the average team size was 30 - and many were responsible for multiple teams. This is much larger than the 'norm' of 10-15 recommended for good management practice. Their duties have moved beyond traditional supervisory tasks such as work allocation and rotas, responsibility for quality and performance and providing expertise, to include newer management activities like managing costs and people

management. One senior manager remarked how these managers are ‘actually running mini business units’. Pressures to achieve performance targets, and the associated drive towards performance cultures, plus recent HR initiatives in the NHS Plan such as AfC and KSF have given heightened attention to these roles.

Our research found that at the core of the role is responsibility for actively managing performance and providing effective and efficient patient care. Managers, most of whom had come from the ranks of nursing, accepted their management role, and were not, as others have suggested, keen to disassociate themselves from it. People management was very much part of the role, taken on willingly, and recognised as a key contributor to the patient experience and performance. Training, both formal and informal, performance appraisals, communication and involvement, including teamwork and managing absence were seen as essential parts of the job. There was less support, however, for some of the administrative side of the work, especially paperwork, and some clearly felt discomfort at handling conflict and managing poor performance. The range of responsibilities was higher in acute trusts than ambulance trusts, where managers received greater administrative support for work planning rostering duties.

Our interviews revealed striking differences between senior managers’ perceptions and expectations of the role and front line managers’ experiences of the job. Critically, in practice, the ‘management’ workload, such as budgeting, purchasing, rotas, and people management, was far greater than perceived of by senior managers, and prescribed for in job descriptions. As a consequence, managers had to take work home, or the work simply did not get done. Some senior managers interviewed also had higher demands, expecting front line managers to engage in ‘visionary’ type activities with a view of the bigger picture – in other words, the needs of the trust as a whole, and not just their own patch. Some felt an increasing need for line managers to be change agents.

The second key theme to emerge from this research is the critical role these managers play. Other studies have shown that FLMs can significantly influence employees’ attitudes and behaviours by the way in which they apply people management practices. In

the casual chain linking people management practices to organisational performance it is the response of front line employees which is so vital. For it is these staff that actually deliver patient care and are required to work beyond contract or 'go that extra mile' and deliver better quality of care and help meet performance targets. This is discretionary behaviour and has been seen as the key connection between HR policy and practice and performance outcomes (Applebaum *et al*. 2000; Purcell *et al*. 2003). The annual NHS staff survey is testament to the increased recognition given to the importance of these types of behaviours. These findings from other research are reinforced by our own study. In the case study organisations, staff levels of motivation, morale and commitment were frequently attributed to the quality of the line manager. These attitudes were reflected in levels of turnover, absence levels, vacancies and the use of agency or bank staff.

However, it is not just in the way in which FLMs implement and enact people management policies that they make a difference. All their duties are critically important to organisational performance. Interviews with senior managers emphasised how FLMs influence the ability of trusts to meet national targets such as waiting lists or response times through their management of resources. As financial managers they contribute to the cost effective performance of the trust. FLMs are also critical to the success of NHS national initiatives such as KSF and AfC, and the drive to become a model employer. Analysis of nationally available data for each trust, which is presented in this report, suggests that the better performing trusts have higher levels of staff satisfaction and more effective line managers as seen in say conducting appraisals, reaffirming the important role of FLMs. This secondary analysis together with evidence from the case studies provides powerful confirmation of the vital role of these managers.

Our findings suggest that, increasingly, trusts are relying on these line managers to deliver not only good people management but performance. In spite of this, however, both line managers and senior managers felt FLMs involvement in people management to be problematic. This brings us to the third key message from these findings – that substantial barriers exist which prevent front line managers from performing their people management role effectively. Senior managers spoke of the variable quality in line

management behaviour and voiced concerns at FLMs lack of skills, not just in people management but management more generally. The attitude survey provides strong evidence of work overload, pressure and stress amongst this group of managers which impose further constraints on their ability to manage. A key issue facing all managers was role conflict and ambiguity created by the multiple roles FLMs had to perform. Not only were there tensions between the clinical and management aspects of the job, but within the management role there was conflict. As one senior manager commented 'managers have to be able to judge and juggle resources', balancing good patient care with efficient financial management, whilst trying to maintain staff levels and morale. As former nurses or paramedics, many managers faced the additional dilemma of competing demands - torn between loyalty to their former colleagues and management. All these difficulties were compounded by financial constraints, staff shortages, lack of time and heavy workloads. When under pressure it was usually the people management aspect of the role that suffered as managers retreated into what they felt they did best - provide good clinical care. Yet paradoxically, giving emphasis to clinical work, and allowing people management to take second place, is counter productive to the target of improving patient care.

The fourth conclusion concerns support – or lack of it. Fundamentally, these line managers felt unsupported, isolated, and were overlooked as vital group. Managers with such heavy and important responsibilities and work load need constant and consistent support and resources. Lack of skills and knowledge in people management, due to poor investment in training and an absence of any structured approach to developing these skills was of key concern. Where formal training was available managers often failed to attend due to financial constrains, understaffing or just the sheer volume of work. Because of this some trusts preferred to focus on other, less formal, methods of learning such as coaching and mentoring, although this was still far from adequate. As a result most gained their experience by 'learning by doing' but this required a blame free culture in which managers could openly admit to mistakes, something that was lacking in some trusts. Some line managers were also critical of the organisation structure which allowed

them to work with more senior clinicians who had no clear lines of hierarchical control, and the lack of IT support.

Of fundamental importance to the line managers interviewed, however, was the need for senior management support, particularly from top management in terms of providing recognition, role clarity, time and realistic targets. There was also a perceived need for senior managers to act as good role models or champions, to have a more inclusive management style, to communicate and listen to their line managers and involve them in the design of policies which they must implement.

Significantly, this lack of support from the top was not something recognised by the senior managers themselves, who perceived the HR function to be the main source of support to line managers within the organisation. One possible explanation for these stark differences in expectations and perceptions is senior managers underestimating the management workload and thus doing little to help. Certainly, the HR function has an influential role to play, and just under half of the line managers interviewed felt positive about the role of HR, which has primarily seen as one of offering advice and guidance. Nevertheless, not all line managers shared this positive view, criticising HR for being too distanced from the workforce, producing volumes of policies which were impractical and difficult to implement, bureaucratic and often slow to respond. However more practical support was available in terms of administrative help, housekeeping and more junior staff helping with some people management such as appraisals, training and absence management. This was recognised as a very positive way in which trusts could help and was something some trusts were exploring further.

It was clear that, in all trusts, there was a failure to give attention to the people management roles of FLMs, by, for example, not placing it in any formal or informal performance expectations. Other researchers have observed how this results in people management being afforded a low priority in the role. Failure to appoint people based on their ‘management skills’ was a further problem. All trusts admitted to selecting managers primarily on the basis of their clinical skills but at the same time recognised

that a good nurse or paramedic does not necessarily make good manager. The typical behaviours associated with a good nurse or paramedic such as having empathy, caring, and nurturing are not sufficient to be a successful manager. The most successful managers, according to our interviewees needed to be good role models, fair, good communicators, be approachable, develop people and be able to deal with poor performers.

The final point relates to the attitudes and behaviours of the managers themselves. The survey shows that, despite the complex and challenging role of FLMs, these managers remain a highly committed and dedicated group of professionals whose loyalty to the patient and their team cannot be questioned. However their commitment to the organisation, which has always been a key strength for the NHS appears to be eroding. No doubt this is due to the constant pressure and demands placed upon these managers, who certainly should not be expected to routinely work extra hours and take work home with them. An additional factor must be the growing sense of insecurity, which was very much in the minds of some of those interviewed (redundancies were taking place in some trusts at the time of our interviews) leaving managers to question some of the fundamental tenants of working in the health sector.

LEARNING OUTCOMES

- Organisations in the NHS need to recognise the vital role of front line managers and the potential impact they can have on employee engagement and organisational performance and service delivery. These managers need to be recognised as a unique occupational group, who have complex and demanding roles and need special treatment and support.

- People management is an essential part of the role of front line managers in the NHS, but subject to considerable constraint. In particular, these managers experience considerable role conflict, high workload, resource constraints, plus pressure to deliver trust targets.

- Trusts need to encourage line management commitment to people management by clarifying their responsibilities through job descriptions, the performance management process, and communicating the importance of this aspect of the role.

- Front line managers need time and practical support to carry out their people management activities. In larger teams (for example, 15 and above team members), junior staff could assist in some people management duties such as performance appraisals, and return to work interviews. This also provides a development role for these staff. Administrative support should also be considered for some of the paperwork.

- A clear strategy should be developed to provide training, learning and development in order to provide line managers with the necessary skills and knowledge to carry out their people management role. This will enable line managers to gain confidence in delivering the role. Training could include formal courses and workshops, and less formal methods such as coaching and mentoring.

Less formal methods are particularly valuable where there may be financial and time constraints preventing managers from attending courses.

- Organisations need to provide meaningful feedback to front line managers about their performance in people management activities.

- Senior management commitment is essential and leaders need to act as role models, provide role clarity, and realistic targets for line managers to deliver. They also need to ensure there is a strong performance culture in which good performing people managers are recognised and rewarded.

- HR policies which are to be implemented by FLMs need to be designed so that they are clear and relatively simple to deliver.

- Line managers should be selected on the basis of the behavioural competencies necessary for good people management, not just their clinical skills. A good clinician does not necessarily make a good line manager. Competency frameworks should be developed with this in mind.

- The HR function must work closely with front line managers, providing advice, listening to them and involving them in the design of HR policies. The HR function also needs to consider how they can raise awareness of HR policies and practices which line managers have to deliver.

- Senior policy makers need to consider, and give emphasis to, which particular HR policies and practices influence front line managers' attitudes and behaviours in a positive way.

- Clarity needs to be given to the line management structure of front line managers and senior clinicians.

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Appendix 1: Background to case studies

Trust A

Based on a single site on the edge of a main city this Trust provides traditional 'district general hospital' services including medical, surgical, pediatric and diagnostic services, plus a considerable volume of cancer related services. At the time of the research the main pressures on the Trust were financial; with a £7.3 million overspend which necessitated some redundancies.

Trust B

As one of the largest providers of healthcare in the region, this trust provides a range of services from two large acute hospitals on different sites. The trust was formed in 1999 through the merger of two former trusts both with quite different cultures**.** The trust had been in financial difficulty for a number of years with a £44.3 million overspend in 2003. Since then its financial position has improved with small surpluses each year. The trust is applying to become an NHS foundation trust in 2008.

Trust C

Located on the outskirts of a city, this trust provides a range of clinical care including general acute and emergency services to a population of 200,000 across three counties, plus some specialist services to a much wider population. A new Chief Executive was appointed in 2003, and in 2006 the trust was granted foundation status.

Trust D

This is a small specialist hospital offering regional and national referrals. In 2005 it was awarded foundations status. At the time of the research the trust was heading for a deficit but had a recovery plan in place. The culture was described as 'friendly with a family type atmosphere'.

Trust E

Formed in 1994, the trust provides health services to a population of 300,000 from a number of sites although the research focused on its main site of the district general hospital. This hospital moved to a new site in 2002 and provides a range of services including emergency care surgery, diagnostics, pediatrics, maternity, outpatient and day case services. The trust works with private sector partners who maintain the building and provide services such as portering, security and catering. The trust hopes to achieve foundation status in 2008.

Trust 1

At the time of the research the trust provided an ambulance service to three counties and covered one of the largest geographical areas in the UK, although the population size was fairly small in comparison to many other trusts. Whilst embracing the need to change and modernise a 'command and control' culture still dominated. The HR function was very new having been established 18 months ago. In 2006 the trust merged with one other.

Trust 2

Servicing one county this trust was focused on its imminent merger with 2 other local trusts at the time of the research, which was completed in 2006. There was a strong command and control culture, little empowerment which top management were trying to change. The HR manager/director was a seconded from another trust, and on a temporary appointment.

Appendix 1 Table 7: Profile of the case study organisations

Trust	Organisation type	Popu-lation served	Number of staff	Units of analysis	Performance rating 2004	Quality of service 2005/06	Use of resources rating 2005/06	Quality of service 2006/07	Use of resources rating 2006/07	Patients rating 2006	Other comments
A	Acute	450,000	3500	Medicine & surgery	One star	Fair	Weak	Weak	Weak	Satisfactory	
B	Acute	500,000	8,500	Medicine & Musculoskeletal	Two stars	Fair	Weak	Fair	Weak	Satisfactory	
C	Acute	200,000	3773	Medicine and critical care	Three stars	Fair	Fair	Excellent	Excellent	Satisfactory	Foundation status awarded in 2007
D	Specialist		400	All	Three stars	Excellent	Good	Excellent	Good	Satisfactory	Foundation status in 2005/06
E	Acute	300,000	3300	Medicine & anesthetics/surgery	Two stars	Good	Weak	Fair	Good	Satisfactory	
1	Ambulance		1430	Two areas	Two stars			Fair	Fair		Merger in 2006
2	Ambulance		332	All	One star			Weak	Weak		Merger in 2006

Selected National staff survey results

Table 8a: Selected Staff Attitudes by Acute Trust, 2005

Organisation:	Trust A	Trust B	Trust C	Trust D	Trust E	National scores for acute trusts Median scores 2006
Staff job satisfaction	3.31**	3.35*	3.55+	3.47++	3.54+	3.39
Work pressure felt by staff	3.25+	3.18++	3.05*	3.11	3.07*	3.11
Staff intention to leave jobs	2.73++	2.69++	2.49**	2.65*	2.54**	2.66
Staff appraised last 12 mths	49%**	50*	69+	57	58%	58
Staff receiving well structured appraisal	24%**	24**	36+	32++	35%++	30
Staff with PDPs in last 12 mths	36%**	35**	53++	47++	49%++	46
Staff working in structured team environment	36%*	36*	44+	40++	42%++	39
Support from immediate manager	3.36**	3.36**	3.53+	3.48++	3.52+	3.45

** Lowest 20% of acute trusts in England ++ Above average of acute Trusts in England

* Below average for acute trusts in England + Highest 20% of acute trusts in England

Table 8b: Selected Staff Attitudes by Acute Trust, 2006

Organisation:	Trust A	Trust B	Trust C	Trust D	Trust E	National scores for acute trusts Median scores 2006
Staff job satisfaction	3.4++	3.35*	3.47+	3.43*	3.39++	3.37
Work pressure felt by staff	3.33+	3.30+	3.22++	3.17+	3.13*	3.16
Staff intention to leave jobs	2.81++	2.68*	2.5**	2.49-**	2.84++	2.74
Staff appraised last 12 mths	61++	53	63++	46*	53%	54
Staff receiving well structured appraisal	27%*	26*	33++	28*	30%++	29
Staff with PDPs in last 12 mths	52%++	39*	52++	40**	45%	45
Staff working in structured team environment	37%	39++	44+	51+	32%**	37
Support from immediate managers	3.46++	3.37*	3.5+	3.40**	3.44++	3.42

** Lowest 20% of acute trusts in England ++ Above average of acute Trusts in England

* Below average for acute trusts in England + Highest 20% of acute trusts in England

Table 8c: Selected staff survey results for Ambulance Trusts 2005 & 2006

AMBULANCE TRUSTS	Trust 1 2005	Trust 1 2006[7]	Trust 2 2005	Trust 2 2006[1]
Staff job satisfaction	3.22++	3.29++	3.17*	3.10*
Work pressure felt by staff	3.05*	2.87*	3.16++	3.23++
Staff intention to leave jobs	2.56 (Ave)	2.29*	2.72++	2.77++
Staff appraised last 12 mths	65+	59++	17**	17*
Staff receiving well structured appraisal	24+	25++	11**	7*
Staff with PDPs in last 12 mths	48++	46++	21*	7*
Staff working in structured team environment	23++	20++	24+	17 (ave)
Support from immediate manager	3.06*	3.12++	3.03*	2.89*

Note: no national comparisons available

[1] Both Trust merged with other Trusts in 2006 to form new Trusts

Table 9: Comparison among Trusts and with WERS 04 data (managers and senior staff in health) for selected questions

Managers' perceptions	**Trust A**	**Trust B**	**Trust C**	**Trust D**	**Trust E**	**Trust 1**	**Trust 2**	**All Trusts**	**WERS 04**
To what extent do you agree with (% strongly agree/agree):									
My job requires that I work very hard	97	97	100	85	100	82	75	93	89
I never seem to have enough time to get my work done	87	86	91	62	69	64	75	79	71
I worry a lot about my work outside working hours	43	48	73	39	69	18	38	47	45
My job is stressful	90	83	91	85	77	46	63	80	n/a
I feel my job is secure	30	41	55	54	31	73	63	44	73
How much influence do you have over: (% agree 'A lot')									
The tasks you perform	43	48	46	69	77	36	63	52	60
Pace at which they are performed	30	38	18	39	31	9	63	32	54
How you do your work	73	62	46	85	92	36	88	69	72
The order in which you carry out tasks	57	62	46	69	77	36	25	57	76
The time you start or finish your working day	47	21	46	62	46	27	50	40	46
How satisfied are you with (% very satisfied/satisfied)									
With sense of achievement	87	83	73	92	92	100	63	85	83
Scope for using your own initiative	83	72	73	85	100	73	75	80	86
Influence over job	70	55	55	77	85	91	50	64	78
The work itself	87	76	91	77	85	100	88	84	81
Relationship with line manager	77	69	91	62	85	60	75	74	
Training *[8]	68/38	62/35	64/36	75/45	58/15	55/27	38	62/31	63
Coaching, guidance and mentoring	33	39	55	69	62	27	13	42	n/a
Performance appraisal	45	46	46	46	42	36	0	41	n/a
Career opportunities	38	48	55	69	62	36	50	49	n/a
Pay	43	54	27	62	54	64	63	51	50
Recognition	43	28	46	46	85	64	25	45	n/a
Team working	93	86	64	69	85	91	100	82	n/a
Work life balance	37	21	27	50	62	27	63	37	n/a
Amount of involvement	20	17	27	75	54	27	25	30	69
View on managers (% very good/good):									
Seeking the views of employees/reps	47	29	55	54	62	36	13	42	70
Responding to suggestions	27	17	55	54	54	27	38	34	61
Allowing employees/reps influence final decisions	13	14	36	54	46	18	-	24	47
Employee commitment (% strongly agree/agree):									
I share the values	70	35	55	85	92	73	100	66	81
I feel loyal	70	62	64	92	92	82	75	74	85
I feel proud to tell people where I work	53	52	64	77	92	82	88	66	74

[1] Clinical/non clinical

Tables 10a (measures of HR practices and employee outcomes) Appendix 2

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1.Satisfaction with training – clinical	-																		
2. Satisfaction with training – non-clinical	.021	-																	
3.Satisfaction with coaching, guidance, mentoring	.449**	.052	-																
4. Satisfaction with performance appraisal	.320**	.342**	.527**	-															
5. Satisfaction with career opportunities	.325**	.006	.477**	.307**	-														
6. Satisfaction with pay	-.020	-.048	.138	.063	.354**	-													
7. Satisfaction with fringe benefits	.115	-.049	.068	-.015	.158	.514**	-												
8. Satisfaction with WLB efforts	.382**	-.016	.418**	.239*	.405**	.360**	.352**	-											
9. Satisfaction with recognition	.392**	.081	.440**	.449**	.452**	.345**	.408**	.517**	-										
10. Satisfaction with banding	.035	-.026	.220*	.169	.321**	.561**	.258*	.402**	.351**	-									
11. Satisfaction with team effectiveness	-.023	.299**	.053	.096	.128	.168	.173	.128	.238*	.123	-								
12. Satisfaction with information re job	.245**	.183	.340**	.244**	.325**	.188*	.217*	.421**	.431**	.367**	.253**	-							
13. Satisfaction with express grievances	.352**	-.029	.364**	.220*	.423**	.174	.231*	.487**	.649**	.245**	.044	.453**	-						
14. Satisfaction with involvement in decision making	.363**	.033	.490**	.334**	.506**	.374**	.251*	.556**	.503**	.386**	.011	.361**	.424**	-					
15. Influence overall	.275**	-.039	.219*	.065	.138	.116	.245**	.354**	.233*	.059	.265**	.378**	.291**	.214*	-				
16. Commitment	.212*	-.176	.231*	-.008	.321**	.362**	.380**	.383**	.413**	.230*	.167	.209*	.399**	.331**	.306**	-			
17. Job satisfaction	.024	.002	.182	.129	.220*	.239*	.057	.107	.263**	.270**	.187*	.187*	.081	.086	.020	.013	-		
18. Intensity	-.086	.098	-.052	.125	-.105	-.317**	-.181	-.225*	-.076	-.083	.094	.094	-.140	-.002	-.132	-.082	-.124	-	
19. Stress	-.068	-.006	-.049	-.038	-.160	-.414**	-.268**	-.298**	-.258**	-.298**	-.121	-.121	-.198*	-.126	-.132	-.092	-.153	.538**	-

*p<0.05
**p<0.01

Table 10b: Bivariate Correlations for certain variables (employee outcomes)

Appendix 2

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1. My job requires that I work very hard	-																									
2. I never seem to have enough time to get work done	.496**	-																								
3. I worry a lot about work outside working hours	.375**	.432**	-																							
4. My job is stressful	.486**	.431**	.535**	-																						
5. Influence over tasks	-.174	-.134	-.174	-.173	-																					
6. Influence over pace	-.323**	-.203*	-.231*	-.163	.343**	-																				
7. Influence over how do work	-.125	-.068	-.092	-.141	.468**	.405**	-																			
8. Influence over order of tasks	-0.35	-.090	-.008	-.088	.238*	.359**	.600**	-																		
9. Influence over times	.041	.043	-.006	-.049	.295**	.354**	.378**	.358**	-																	
10. Satisfaction – sense of achievement	.072	-.202*	-.192*	-.198*	.199*	.102	.191*	.254**	-.006	-																
11. Satisfaction – scope for initiative	.019	-.028	-.101	-.168	.322**	.177	.309**	.244**	.229*	.338**	-															
12. Satisfaction – job influence	.004	-.083	-.216*	-.273**	.220*	.158	.345**	.291**	.320**	.447**	.549**	-														
13. Satisfaction – job security	-.225*	-.296**	-.208*	-.424**	.070	-.008	.177	.087	.125	.179	.186*	.383**	-													
14. Satisfaction – responsibility	.033	-.079	-.172	-.270**	.154	.139	.260**	.225*	.317**	.471**	.347**	.626**	.269**	-												
15. Satisfaction – workload	-.246**	-.321**	-.226*	-.356**	.255**	.328**	.177	.076	.122	.305**	.292**	.460**	.319**	.504**	-											
16. Satisfaction – opps use skills/abilities	-.065	-.105	-.071	-.146	.092	.018	-.023	-.045	-.078	.036	.040	.017	-.050	.044	.121	-										
17. Satisfaction – rel with line manager	-.088	-.096	-.056	-.130	.086	.023	-.025	-.057	-.084	.014	.036	-.009	-.041	.008	.111	.993**	-									
18. Satisfaction – work itself	-.066	-.099	-.071	-.129	.076	.027	-.042	-.058	-.080	.062	.029	-.001	-.068	.029	.107	.994**	.991**	-								
19. I share many of the values of the Trust	-.183	-.022	-.045	-.135	.252**	.075	.363**	.111	.206*	.198*	.333**	.325**	.312**	.196*	.237*	-.028	-.015	-.023	-							
20. I feel proud to tell people who I work for	-.035	-.087	-.020	-.196*	.031	.187*	.113	.089	.195*	.201*	.168	.225*	.405**	.274**	.209*	-.112	-.113	-.109	.493**	-						
21. I feel loyal to the Trust	-.046	-.004	-.048	-.112	.092	.278**	.146	.137	.318**	.282**	.214*	.312**	.215*	.323**	.348**	-.004	-.006	.000	.425**	.659**	-					
22. I feel loyal to my profession	.193*	.066	-.023	-.032	.121	.121	.146	.238*	.088	.245**	.198*	.118	-.105	.256**	.117	-.064	-.081	-.052	.059	.291**	.356**	-				
23. I feel loyal to my team	.170	.106	-.020	.062	.176	.091	.118	.227*	.137	.284**	.134	.214*	-.184*	.287**	.106	.137	.123	.148	.026	.175	.279**	.591**	-			
24. I feel loyal to the patients	.230*	.129	.143	.247**	.085	.050	.143	.188*	.113	.198*	-.047	.105	-.069	.069	-.052	-.048	-.036	-.028	.058	.127	.150	.386**	.369**	-		
25. I volunteer to help others	.212*	.081	.122	.056	.052	-.093	.044	.148	-.120	.124	.255**	.049	-.077	-.029	.033	.083	.083	.078	.193*	.162	.152	.267**	.151	.229*	-	
26. I usually work overtime when required	.298**	.214*	.187*	.094	.124	.059	.289**	.300**	.118	.118	.108	.075	-.086	-.011	.087	.070	.069	.062	.122	.141	.199*	.351**	.210*	.246**	.515**	-
27. I volunteer to do tasks outside job description	.161	.024	.121	.020	.133	-.115	.233*	.088	.003	.003	.206*	.150	-.079	-.074	.161	.026	.017	.014	.259**	.081	.097	.244**	.213*	.164	.443**	.462**

*p<0.05
**p<0.01