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University of Hertfordshire Business School
College Lane
Hatfield
Hertfordshire
AL10 9AB
United Kingdom

Nurse Managers, Agency Nurses and Control?

Michael Pye University of Hertfordshire

Mary Broomfield University of Glamorgan

Joanna Cullinane University of Greenwich

INTRODUCTION

The focus of this paper is on the low trust employment relations that apparently were manifest between frontline nurse managers and their superiors in one National Health Service (NHS) Trust. These were uncovered during research that was primarily focused on the use of agency nurses. The study on which this paper reports, began as a preliminary exploration of the intersection of two separate and related interests – first, in agency nurses as a fraction of the nursing labour force and second, in the work lives of frontline nurse managers. The aims of the study were to investigate the responses of frontline nurse managers in a NHS Trust to the use of agency nurses in their wards and departments and to contribute to an increased understanding of the role and function of front line nurse managers in the provision of health and sickness care. The investigation focused firstly on how nurse managers respond to the use of agency nurses and how specifically they understand their relationships with them as ‘human resources’ in producing health and sickness care in the context of a changing environment wrought by structural and managerial reforms. A secondary focus was to identify themes and issues worthy of further research in a more structured in-depth study in the two areas of interest identified above.

An initial review of the literature revealed very little published material that focussed on the particular relationship of interest namely agency nurses and frontline nurse managers. The literature review was extended to cover published material relating to the work lives of nurse managers, managerial and related reform in the NHS and to attitudes towards/about agency nurses. The publications reviewed provided a wealth of material on these topics, which allowed a tangential insight into the relationship of interest. It also provided an interesting set of views about the changing nature of the work of frontline nurse managers in the context of continuing reforms of the NHS. One of the key elements arising from the literature reviewed was the presentation of frontline nurse managers as ‘new’ managers, leaders and change agents in this continuing process of reform. The second key element was the questioning of the preparation of these workers for such roles. Issues relating to these themes were explored as part of the research.

The research method involved the use of semi-structured interviews with a group of frontline nurse managers working in one Directorate of a NHS Trust. The stories collected were subject to a thematic analysis filtered through radical structuralist – radical humanist methodological lens (Burrell and

Morgan 1979; Alvesson 1987). The participants' stories were deconstructed and reconstructed into a number of thematically consistent narratives. One key theme addressed was the participants themselves both as individuals and as a group of workers involved in the production of health and sickness care. In particular, an emphasis was given to the level of preparation for their managerial role. The second theme relates to the actual usage - the how, the why and the wherefore - of agency nurses in the wards and departments. The third theme while related to the use of agency nurses has more to do with the nature of the relationship between frontline nurse managers and their superiors as experienced through the issue of the use of agency nurses which it is argued are based on the premise of low trust employment relations. It is this third theme that is the focus of this paper and which it is argued provides a number of questions for further research amongst frontline managers in the NHS.

FRONTLINE NURSE MANAGERS IN THE NHS

The role of the frontline nurse manager and their relationship to their clinical and managerial superiors has undergone numerous changes in the twenty years since the publication of 'The Griffiths Report' (DHSS 1983) into the management of the NHS. The first set of key drivers that have caused changes in the role of frontline managers have been those associated with the shift from the bureau-professional (Clarke and Newman 2000) to the general management mode of management (Bolton 2000; Williams, McGee et al. 2001). This shift has been described as being from a consensual and custodial form of management to a more consciously commercial mode of management, a reflection of the private, for profit, sector from which the 'Griffiths Report' drew its inspiration (Bolton 2000). A second set of drivers that caused change to the role of the frontline nurses managers was the introduction of quasi-market mechanisms into the NHS following the publication of 'Promoting Better Health' (DHSS 1987) and 'Working for Patients' (DoH 1989). These documents provided the framework for a further development of 'private sector' models of management and organisation in the NHS (McConville and Holden 1999; Bolton 2000; Williams, McGee et al. 2001). One of the main effects for frontline nurse managers of the changes wrought by the organisational and managerial reforms was that, in many instances, they became not only the frontline nurse managers but also the 'last line' of nurse managers. Much of the middle management of the NHS, including many of the 'senior' nursing positions has been lost (McGibbon 1997) during the various reforms. Where replaced many of the 'new' positions were either non-clinical managerial roles or non-managerial professional advisory roles. The Ward Sister and Sister roles that had previously reported up through a multi-level (depending on the size of the organisation) combined professional/management hierarchy to a Matron were now often the only effective level of 'nurse' management. In these new roles, they were acting as the interface between the new managers (frequently not clinicians of any sort) and the staff who cared for patients.

“The nurse manager is central to effective, quality patient care. The nurse’s manager has become a more visible position within the healthcare institution, serving as the vital link between the vision of the healthcare institution and the unit based delivery of effective, high quality patient care”.

(ANOE, 1992 cited in Oroviogicoechea, 1996 p.1274)

By the beginning of this millennium, the changes to the roles of the frontline nurse managers had progressed further. The ‘Making a Difference’ document (DoH 1999) puts the nursing leaders including the frontline nurse managers at the forefront of the further reform programme for the NHS. The modernisation programme for the NHS instituted by the current Labour Government (DoH 2001) reinforces the developing role of nurse managers and nurse clinicians as central to the reform process by treating them as pivotal figures around which the way care will be delivered will change (Bolton 2000; Williams, McGee et al. 2001).

Before the processes of reform discussed above, the ‘traditional’ role in ‘their’ ward or department, of the Sister and Ward Sister had essentially been focussed on professional clinical nursing. They were the focus of all ward based clinical activity. All information and decisions relating to patient care passed through them. All members of staff turned to them when seeking and/or when giving direction and instruction. Attached to these core roles were a number of related administrative tasks that were secondary to the primary role as clinical nurse ‘leader’ (in its authoritarian sense) of ‘their’ ward (Willmot, 1998; Oroviogicoechea, 1996).

With the reforms, the primary focus of the role has shifted away from managing nurse’s clinical activities to managing nursing, and further to managing units of production that encompass many non-nursing functions (McGibbon, 1997; Willmot, 1998; Bolton, 2000). The role has shifted away from having a clinical focus to that of managing and maintaining an environment within which lower grade nurses and others should be able to provide high quality care in a more autonomous fashion (Oroviogicoechea, 1996; Bolton, 2000; Williams et al., 2001).

In these new roles frontline nurse managers continued to have responsibility for the clinical actions of others and they also took on a wide variety of managerial tasks and duties that were previously within the scope of other roles. These include responsibility for budget management (Willmot, 1998; Williams et al, 2001), physical resource management, purchasing, planning, organisational liaison, (Oroviogicoechea, 1996; McGibbon, 1997) and human resource management. Along with these, there has been an increased emphasis on ‘leadership’, ‘mentorship’, teaching, research, audit and evaluation (Edmonstone and Chisnell 1992; Willmot 1998) as well as a requirement that they become change managers and reformers (Bolton, 2000).

The changing nature of the role of the front line nurse manager was not without its unintended consequences and difficulties for the people that held those positions or moved into them during the period of reform. Many of the authors who have studied nurse managers during this period for instance,

Bolton (2000), Cook (2001), Willmot (1998), Cunningham (1997) and McGibbon (1997) report degrees of success in the transition and high levels of job satisfaction with their new roles amongst many of the frontline nurse managers. There are also reports of initial and continuing difficulties that arose out of the transitions that affect the attitudes of this group of workers to their jobs and the relationships they have with others (McConville & Holden 1999).

Willmot (1998) and McConville and Holden (1999) report on difficulties caused for front line nurse managers with the management of change itself. Some of these nurse managers, particularly those who had held positions under the earlier bureau-professional management model and/or had experienced multiple reorganisations, were disillusioned with their new roles and the process of change. Many frontline nurse managers expressed concerns about the clash of cultures between the professional nursing culture and a new managerial culture, which appeared to many not to be compatible (Hunter, 2002; Currie, 1997; Willmot, 1998). The clash of cultures between managerialism and nursing is a widespread theme in the literature. For example Cooper (1996) and Williams et al. (2001) comment extensively on the problems faced by nurse managers from having to wear two 'hats' and the contradictions between the imperatives of management and the imperatives of clinical nursing as causing nurse managers to suffer from role dissonance. Williams and McGee et al. (2001) further comment that some nurse managers felt that the expectations placed on them by senior management to act as managers rather than as clinicians put them in difficult positions when they had to take on a clinical load simply because there were insufficient staff to do the job required. Others (Cooper, 1996; Cook, 2001) reported that nurse managers felt a need to retain and maintain clinical skills and a clinical load as part of retaining their credibility as nurses which they perceived as being their primary work identity (Reedy and Learmonth 2000).

Another significant impact on the role of the frontline nurse manager, or more precisely on their ability to perform their role, is the lack of preparation and training in performing many of the 'new' non-nursing components of the job. Bolton (2000), McGibbon (1997), Williams et al. (2001) and Gould, Kelly, Goldstone and Maidwell (2001) all identify lack of training as being a key issue for nurse managers particularly in the area of budget management and human resource management. This was particularly highlighted by (Cooper 1996) as impacting on F Grade Nurses, who are the immediate support of the Ward Managers [generally G Grades] and 'act up' as Ward Managers as well as undertaking managerial roles within the ward especially work allocation and staff management on a day to day basis.

FRONTLINE NURSES MANAGERS IN 'THE TRUST'

Much of the discussion above about the changes that had occurred for frontline nurse managers was reflected in the experiences of those who participated in this study, all of whom had spent their entire nursing lives in the post 'Griffiths' era. A convenience sample of twelve frontline nurse managers' from seven ward's, (out of a population of 24 people, from 12 ward's) in one Directorate of the Trust was interviewed. The sample consisted of five 'F'

Grade Sisters and seven Ward Managers, six of whom are employed at Grade G and one at Grade H.

THE F GRADE SISTERS

All members of the Sisters group are women who reported having undertaken their basic nursing training in nursing schools in the local region. All of them had trained in the pre-Project 2000 'apprenticeship model' era and had been nursing (with breaks of various lengths mainly family/domestic reasons) for between 11 and 33 years. They had all been employed for all their respective working lives in hospitals and related services in local region. Only one reported having worked in another occupation (which was health related) and this was before commencing their nurse training. They had held their current posts for between 10 months and 8 years; one had held their current post for two years and a previous F Grade post for a period of four years. None had held higher posts in the past, and all had held E Grade Staff Nurse posts for varying times before appointment into their current position.

They all reported having undertaken a variety of post registration education and training courses. These ranged across the gamut of courses that have been available to nurses over the years in specialist clinical skills, teaching and assessing, English National Boards courses, Enrolled Nurse to Registered Nurse conversion courses and a post registration Bachelor of Science in Nursing (BSc.N). One of the Sisters reported having had no formal management education or preparation, one reported having undertaken the nursing management module in the BSc.N, the others reported having undertaken short in-house employer organised courses on specific aspects of management.

THE WARD MANAGERS

This group was somewhat more diverse than the Sisters group, the most obvious example of diversity because two of them were men, one of whom has had a very different career experience in nursing than the remainder of either group. Of this group, five reported that they had undertaken their basic nurse training in local nursing schools in the pre Project 2000 era. One had undertaken their training whilst overseas in a training system that was very similar to the pre Project 2000 model. These six had been nursing for between 11 and 31 years (all but one, a man, reported having had breaks of varying lengths again usually for family/domestic reasons). One participant had been nursing for only 4 years and while s/he did train under the Project 2000 'higher education' model, graduating with a Diploma in Nursing, s/he did not go through a standard Project 2000 course. The programme in which s/he trained (which only had two cohorts) was an experimental conjoint Diploma in Nursing/Masters in Social Policy Management open to people who already had an undergraduate degree.

This entire group reported having undertaken post registration education and training of various sorts. One had undertaken a post registration Diploma in Nursing that had included a management module; another had a Diploma in Professional Studies and a Certificate in Teaching and Assessing. One had

completed a BSc.N that included a management module while another is currently enrolled in the same. One had a Diploma in Tropical Medicine and others reported having undertaken specialist clinical education. All had participated in employer organised, in-house management training of various types though there appeared to be no consistency in the type and depth of management education experienced across the group. Only one had undertaken any form of general academic management education and this had been before registration as a nurse. All, bar one of this group, had spent their nursing working lives in local region; the person who had trained overseas spent some of their time post registration working there. The two men in the group reported having worked in other occupations of various kinds before commencing nursing; one as an indentured tradesman. One of the women reported having worked briefly in the hotel and hospitality sector. The members of this group had held their current posts for between six weeks and 10 years; six had been in F Grade posts for between six months and 10 years before commencing their current position and one had been in a previous G grade post for four years. The shortest period reported being spent in a front line nursing management post (combining time spent in F then G/H grade positions) was eight months; the longest period was 12 years.

THE MANAGERIAL ISSUES RAISED BY THE USE OF AGENCY NURSES

The participants in the study collectively reported that their ward's use agency staff on between seven and 21 shifts per week (equivalent to an extra 2 to 2.5 FTE) subject to variance over time due to seasonal and other factors. They also report that in many cases there can be two or more agency nurses on any one shift. The question was put - why are agency nurses being employed? The answer in simple terms is that agency nurses are employed to fill empty spaces in the ward's 'off-duty roster'. These answers posed more questions, first why are there empty spaces in the roster and second why are agency nurses used to fill those spaces?

The number of nurses on duty at any one time in any one ward is determined by the ward's staffing establishment, which essentially contains two sets of figures. The first of these is the number and type of staff who should be on duty for a given shift. This figure is the daily establishment, that at some point in the past, was determined as being the appropriate to produce the requisite levels of care for the 'average patient load'¹ that the staff in the ward would be required to care for. The second set of figures is the total number of full time equivalent staff of each grade needed to ensure that the daily establishment can be maintained, taking into account such items as annual leave, statutory holidays, education leave etc.

None of the participants was able to identify how these figures had been arrived at, other than it through some historical event. A number of the participants also reported that there had been a 'large' project undertaken 'two years ago' (2000?) which had looked at nursing workloads and establishment figures. None of the participants reported having had a significant input into this project. As far as the participants were concerned, the results of this project had to all intents and purposes not been implemented with only some minor re-jigging of numbers i.e. the substitution of a registered nurse post for

a health care assistant post. All of the participants who reported on this project indicated their belief that the results had not been implemented by senior management due to 'budgetary considerations'. While not specifically followed up in the interviews most participants gave the impression that they were not happy with the establishment as it is currently configured believing that it is inadequate for the workload their wards routinely experience.

Each ward has then a 'daily' establishment which limits the number of spaces in the off-duty roster for each shift on each day that have to be filled with staff of the appropriate grade. Each ward also has a 'total' establishment figure that is equal to the number of full time equivalent staff of each grade necessary to fill the spaces in the 'daily' establishment.

The participants in the study identified three reasons for spaces appearing in the off-duty roster. The first of these is the existence of 'vacancies' in the ward's total establishment. This is identified as being the primary reason that empty spaces, which need to be filled to ensure the daily establishment, appear in the off-duty roster. The second cause for empty spaces is staff on 'long term sick'. These staff(s) appear on the total ward establishment but are not available to fill spaces on the off-duty roster because at the time the roster is prepared they are 'off sick' and it is anticipated that they will remain 'off sick' for some or all of the period of time the roster covers. The respondents reported because of the two situations above that in virtually no case are they able to prepare a prospective off-duty roster that does not have some empty spaces in the daily establishment. The third cause for empty spaces appearing in the off-duty is unanticipated absence, usually sickness, when a member of staff who is already rostered to fill one of the spaces in the daily establishment calls in and reports that they are unable to work.

From the participant's answers there appear to be a number of structured responses to the appearance of spaces in the roster. In the case of spaces appearing during the preparation of the roster because of vacancies and/or long term sickness two strategies are used. Initially the permanent staff on the ward are made aware, by the Nurse Manager of the empty shifts that need to be filled and those who wish to do extra hours, over and above their contract hours, can do a 'bank shift' and fill the spaces in the roster as it suits them. The second strategy is to notify the Trust's 'Nurse Bank' of the available shifts, the Bank can then attempt to find nurses who are employed by the Trust, but not in the ward concerned, to fill the empty spaces in the particular ward's off-duty roster. Generally, these are nurses in permanent full or part time employment with the Trust who have signed up to the Bank as being available for extra shifts. There is also a second smaller group of nurses who have no fixed or minimum hours of work who are employed by the Trust purely as Bank nurses. At the completion of these two processes, if any spaces still remain then the Bank will ask the Ward Manager or their designate (usually one of the Sisters) whether the remaining empty spaces can be put out to the agencies. An impression was gained from some of the participants that this final process may occur only days and sometimes hours before the shift is to be worked. The Ward Manager (or designate) is then required to seek permission from senior management in the Directorate before authorising the placing of the shift with an agency (discussed below).

In the case of an unanticipated space opening in the daily establishment due to a member of staff not being able to attend their rostered shift, two similar strategies appear to be used. First, depending on the amount of notice given by the staff member that they will not be attending work, some of the participants report offering the shift as a bank shifts to their own staff that might be available. If this strategy fails to fill the shift then the person in charge at the time who may be the Ward Manager, the Sister or a Senior Staff Nurse (usually an E Grade) will request that the Bank try to fill the shift. If the Bank is unable to supply one of the Trust's staff, it gets back to the ward concerned and requests authority to place the shift out to an agency. Again, the Ward Manager or their designate on duty at the time has to gain permission from senior management before authorising this.

Agency nurses are used to fill empty spaces in the off-duty roster when for the reasons outlined above, Trust staff either those permanently employed in the specific ward's or those employed in the Bank are apparently not available to maintain the daily establishment. The qualification 'apparently' is used as a number of the participants reported their impression that the Bank only utilised Trust staff that had specifically indicated their availability for particular shifts. They felt that the Bank is not 'assertive' enough in 'chasing up' the staff on its books that had not previously indicated that they are available for particular shifts in the same way that the agencies do. A number of the participants felt that agency usage could be reduced if the Bank was more active in phoning and following up on Trust staff availability.

The participants were asked a series of questions related to the management of agency nurses working on their wards. The responses raised a number of issues about the degree of managerial control these frontline managers have over the use of this section of the workforce who are engaged in the productive activity for which these managers are responsible. The issues raised can be divided into two broad areas, first the management by frontline nurse managers of the numbers of staff on duty and second, the performance management of agency nurses when they are actually at work on the wards. Overall, the general response was that the managers had effectively no managerial control over the numbers and very limited control over the performance of agency nurses when compared with their own staff or indeed bank staff.

The first management issue raised is that the participants reported having no effective control over the numbers of staff on duty on any particular shift and limited, if any, control over which agency nurse from which agency came to their ward to fill those numbers. The placement of agency staff on any given ward is arranged by the Bank in response to the requests from the ward as discussed above. One aspect of the process to obtain agency staff is particularly revealing about actual degree of managerial control over the human resource factor of production that these frontline nurse managers have.

The decision to fill the empty space in the off-duty roster is made simply to bring the actual numbers of staff on duty up to the daily establishment, no other criteria such as workload assessment is used. The daily establishment is a figure that none of the participants reported having any control or

influence over. Those participants who had been in positions to influence the outcome of the workload study discussed above felt that irrespective of the finding of the study, senior management had not implemented the recommendations of the report because of financial considerations. For the participants who had come into post subsequent to the study their establishment was handed to them as a fait accompli when they took up their post, the indication given by them was that the establishment was not negotiable at the time². This group felt they had little, if any, influence on strategic decisions that affected their ability to do their job.

The next issue is most revealing and one that is of obvious irritation for the Ward Managers who were interviewed. The use of an agency nurse to fill an empty space in the off-duty roster is simply to bring the numbers up to the daily establishment; a figure set by senior management, over which they have little if any influence. In addition, despite the fact that the use of an agency nurse is to ensure that the production of care for which the frontline nursing managers are responsible and accountable can continue they have to get permission from senior management to use an agency nurse. They are not allowed to manage their own staff numbers even within the boundaries set previously by their senior management.

The evident irritation of the Ward Managers is compounded by two further factors. Firstly, that on no occasion that anyone can remember has the request for permission to use an agency nurse been ultimately denied, in which case the participants report wondering why they have to go through the process anyway. Secondly, they report that the process of making contact with the appropriate senior manager from whom to get the permission often takes up valuable time and energy in what one described as "...an undignified procedure to get the inevitable result". It was difficult to gain a good estimation of the amount of managerial time taken up with this process due in part to the strong feelings that were expressed about this matter. There are suggestions that it can take anything up to hour or more on each occasion. Whether these suggestions are exaggerations arising out of the depth of feeling or not, it is clear that the process is seen by the participants as unnecessary time wasting and demeaning.

Once the Ward Manager or their designate has received permission for the use of an agency nurse the Bank is informed, the Bank then puts the shift out to the Agencies and it is reliant on the agencies decision as to which nurse they send in response to the request. The agency's decision will largely be dictated by which nurses it either has available on its books or who they can persuade to be available for the particular shift required. While the front line manager may desire a nurse who is experienced in the speciality of the ward, what they get is determined by others over whom they have no control and more often by the randomness of individual's availability. Effectively, the front line manager has control over just two aspects of this process, first whether to fill the space at all [discussed above] and second whether to request a registered nurse or a health care assistant.

A number of the participants indicated that they used strategies designed to increase the probability of getting the agency nurse they wanted. The first of these is at the time of making the request to the Bank they would suggest that

the Bank try to get nurse A, someone known to the manager as one of the 'good' agency staff, from agency Y. The second strategy involved letting agency nurse B, who is currently working on the ward, know that there is an empty space coming up in the off-duty roster. If interested, agency nurse B can then indicate to their agency their availability for that particular shift so that when the Bank put out the request the agency would be more likely to approach nurse B first when making the assignment. In these ways, some of the participants are able to gain an occasional degree of control over which agency nurse turns up on the ward at the beginning of a shift, although they also gave an impression that somehow these strategies are "...bending the rules..." and "...not quite legitimate". For the most part, who turns up at the beginning of the shift is described as "...a being a bit of a lottery".

This 'lottery process' has direct consequence on the next issues raised by the participants, which relates to the situation when an agency nurse with whom the participant is not familiar, rather than one of the regulars, arrives on the ward, a frequent experience. The first issue is how the participants assess the level of competence and skill of the agency nurse with whom they are unfamiliar, when they arrive on the ward. The second issue is how the participants then assign work to these nurses.

On the first matter, the universal response was a qualified "...we can't other than checking their PIN". The qualifications added to this statement covered a range of possibilities, a number of participants indicated that they relied on the professionalism of the agency nurses. Many reported questioning the agency nurses about their qualifications and recent experience, on whether they have a substantive post as well as being an agency nurse and what that post is. Another strategy reported is listening to the type of questions asked and comments made by the agency nurse during the handover. One of the participants indicated that, if the nurse said nothing at all during the handover, it raised her index of concern as to whether the nurse is actually thinking about the job to be done. Others reported cases where the nurse's comments or questions had raised concerns about their basic knowledge and understanding of the matters being discussed during the handover and the possible consequences of this for patient care. In all cases, the participants reported that essentially they had to trust the system - that the agencies had done the proper pre-employment checks, that the Trusts relationship with the agency included some active quality assurance mechanism and that the individual nurses are 'professional'.

Otherwise, the assessment of agency nurses competency on arrival on the ward is up to the participant's experience and intuition. A number expressed concern about this when on occasions a less experienced member of the permanent staff may be in charge when agency nurses are working, but felt that there is little that could be done about this given the current system. Most of the participants indicated that they would prefer that there was a standard quantifiable way in which the relevant competency and skill of agency nurses could be documented and indicated to the ward before (or at least as) they arrived on the ward.

On the question as to how work is assigned to agency nurses with whom the participants are unfamiliar, there were two main responses. The first

response is simply that they are given the workload of the person, actual or nominal that they are replacing. There is very little choice about this as the reason the agency nurse is there is because that person is missing, the ward is busy and that the work needs to be done. Most of the participants clearly felt that the "...they [agency nurses] are here to do a job and that they just have to get on with it".

Having said this, many of the participants indicated that they attempted to assign the agency nurses to the areas with the 'lightest' workload and/or if possible to work alongside or at least spatially near one of their own experienced registered nurses. If this were not possible, they would assign the most experienced health care assistant/s to work with the agency nurses. Some of the Ward Managers expressed discomfort at this strategy feeling that the health care assistants are effectively being put in a supervisory and surveillance role which is really not theirs to be in, particularly given the disparity in remuneration between them and the agency nurses. If the participants themselves were able to 'free', themselves from their immediate responsibilities they would offer help or engage in supervision of the agency nurses' work, though the impression given was that this is more a desire than an actuality given the workloads the participants themselves often carry. Given this proviso it is only in the immediacy of the minute-by-minute performance of clinical work that the majority of participants felt they had any real tangible control over the work performance of agency nurses.

In all cases, the participants expressed additional concern about workload allocation if there are more than one agency nurse and/or health care assistant on duty at the same time. Most reported that they would attempt to allocate work so that two agency staff would not be working together if possible though on late shifts, for which the daily establishment figures are low anyway, this situation is sometimes unavoidable. On night shifts the issue of having two agency nurses on duty is of particular concern to the participants as this usually means that on most wards there are none of the wards permanent registered nursing staff available. In this case, the participants report that often one of the permanent staff on the late shift will stay on for an additional period to ensure the agency nurses are conversant with the ward's over-night requirements. Alternatively, attempts will be made to 'shuffle' agency and permanent staff around the wards in the Directorate to ensure that there is at least one permanent Trust staff member on each ward even if they are not in their own ward. One Ward Manager reported having had to come back into work to do an extra shift rather than leave the ward covered only by two agency staff.

It is the area of dealing with agency nurses when things 'go wrong' that particularly highlights the differences in the way frontline nurse managers manage the performance of agency nurse compared with their permanent staff. The participants reported that if any complaint is made about, or any incident reported involving an agency nurse, this is reported to the Bank and the agency nurse is then effectively banned from working in the Trust. It is unclear from the participant's discussion whether the bans are permanent or for varying lengths of time. It is also not clear that if the latter applies what criteria have to be met for the ban to be lifted. It is apparent from the discussion that bans are applied irrespective of the seriousness or triviality of

the complaint or incident. The role of the frontline nurse manager in this process appears limited to actually making the complaint and/or reporting the incident. The matter is then taken out of their hands and dealt with between the Trust and the respective agency. One of the participants recounted a story in which they were not even made aware of an issue that had apparently occurred on their ward when they were off-duty until after the agency nurse had been banned.

Clearly, this is very different from the performance management strategies that the frontline managers would normally be expected to engage in when dealing with problems with their own staff. Arguably, this is not performance management - it is dealing with a problem by simply excluding the individual concerned. Further, the exclusion is not done by the manager who has responsibility for the area in which the alleged problem occurred but by senior management. The only opportunity the frontline manager may get to performance manage the agency nurse in these situations is by not reporting the matter. In so doing, they put themselves in potentially difficult situations. First, they risk difficulties with their own staff by managing the 'outsider', the agency nurse, differently from the way they deal with their own. Secondly, they put themselves in difficulties with senior management for not managing the risk to the organisation appropriately.

DISCUSSION

The issue that appeared to be of most significance to this group of frontline nurse managers that arose out of this study was only tangentially associated with the use of agency nurses. It has to do with issues of power and control, of influence and autonomy, of being held accountable but not allowed to manage the matters for which they are held to account. This is most tellingly represented by the requirement for the Ward Managers to have to seek permission from either, the senior management of the Directorate or in their absence the senior nurse on duty in the hospital to use an agency nurse. They have to seek permission despite the fact that the use of an agency nurse is simply to fill an empty space in the off-duty roster, to bring the numbers up to the daily establishment; a figure set by senior management. They have to seek permission despite the fact that the use of an agency nurse is to ensure that the production for which the frontline nursing managers are responsible and accountable can safely continue. They are effectively not allowed to manage their own staff numbers even within the boundaries set previously by their senior management.

The evident disempowerment of the Ward Managers is compounded further by the fact as far as any the participants can remember, no request has ever been denied and the process getting permission often takes up time and energy in what one Ward Manager described as "...an undignified procedure to get the inevitable result". Another commented in a post-interview discussion that despite not being in any position of influence or control over virtually any aspect of the use of agency nurses on their ward they felt 'guilty' about the overspend on agency staff further compounding their sense of disempowerment.

At no stage did any of the participants clearly articulate the reasons why they had to seek permission, though the impression was gained that it was something to do with senior management wanting to contain the agency related costs. On the evidence presented, this process does not appear to be working in this way because if the reports are correct the requests are never refused. Instead what is happening is a building of resentment and a perception amongst the Ward Managers that they are in a low trust relationship with senior management. This appears to be in contradiction to the rhetoric discussed earlier in which frontline nurse managers are supposed to be leaders, mentors, change managers and reformers (Edmonstone and Chisnell 1992; Willmot 1998; Bolton 2000; Cook 2001) roles which by definition fall, into the category of high trust relations (Fox 1974; Blyton and Turnball 1994; Thompson and McHugh 2002). The study findings reflect the 'story' of this group of front line nurse managers as sandwiched between sets of competing demands. It also reflects a range of constructs such as role conflict, intrapersonal conflict, alienation and disempowerment reported in the literature discussed above. This study suggests that construct of 'low trust relationships' can be applied in these circumstances and raises issues about how far such relationships impact on managerial effectiveness and efficiency in an organisation that puts more and more emphasis on these as outcomes. Clearly, the question of the nature of the relationships between levels of management provides an opportunity for further study which uses a larger cohort and which addresses participants from both sides of the debate.

REFERENCES

- Alvesson, M. (1987). Consensus, control, and critique: three paradigms of work organization research. Aldershot, Hants, England.
- ANOE (1992). "The role and functions of the hospital nurse manager." Nursing Management 23(9): 36-38.
- Blyton, P. and P. Turnball (1994). The Dynamics of Employee Relations. London, Macmillan.
- Bolton, S. (2000). "Nurses as managers: between a professional rock and an HRM hard place?" Human Resource Development International 3(2): 229-234.
- Burrell, G. and G. Morgan (1979). Sociological paradigms and organisational analysis: elements of the sociology of corporate life. London, Heinemann.
- Clarke, J. and J. Newman (2000). The Managerial State: Power, Politics and Ideology in the Remaking of Social Welfare. London, Sage Publications.
- Cook, M. (2001). "The attributes of effective clinical nurse leaders." Nursing Standard 15(35): 33-36.
- Cooper, L. (1996). "Preparation for management: an exploratory study to ascertain perceptions of F grade nurses and clinical nurse managers." Journal of Nursing Management 4(5): 265-271.
- Cunningham, C. (1997). "Ward Leadership." Nursing Standard 12(4): 20-25.
- Currie, G. (1997). "Contested terrain: the incomplete closure of managerialism in the health service." Health Manpower Management 23(4): 123-132.
- DHSS (1983). The NHS Management Inquiry. London, HMSO.
- DHSS (1987). Promoting Better Health: The Governments Programme For Improving Primary Health Care. London, HMSO.
- DoH (1989). Working for Patients. London, HMSO.
- DoH (1999). Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare. London, The Stationary Office.
- DoH (2001). The NHS Plan: A plan for investment. A plan for reform. London, The Stationary Office.
- Edmonstone, J. and C. Chisnell (1992). "New roles for old." Health Manpower Management 18(4): 34-.
- Fox, A. (1974). Beyond Contract: Work, power and Trust Relations. London, Faber and Faber Ltd.
- Gould, D., D. Kelly, et al. (2001). "The changing needs of clinical nurse managers: exploring issues for continuing professional development." Journal of Advanced Nursing 24(1): 7-17.
- Hunter, D. (2002). A tale of two tribes: the tension between managerial and professional values. Hidden Assets: Values and decision-making in the NHS. B. New and J. Neuberger. London, Kings Fund Publishing.

- McConville, T. and L. Holden (1999). "The filling in the sandwich: HRM and middle managers in the health sector." Personnel Review 28(5/6): 406-427.
- McGibbon, G. (1997). "The ward sister/charge nurse as 'on site' manager." Nursing Standard 11(36): 34-37.
- Oroviogioicoechea, C. (1996). "The clinical nurse manager: a literature review." Journal of Advanced Nursing 24(6): 1273-1280.
- Reedy, P. and M. Learmonth (2000). "Nursing managers, transformed or deformed? - A case study in the ideology of competency." Journal of Management in Medicine 14(3/4): 153-165.
- Thompson, P. and D. McHugh (2002). Work organisations. Basingstoke, Palgrave.
- Williams, A., P. McGee, et al. (2001). "An examination of senior nursing roles: challenges for the NHS." Journal of Clinical Nursing 10(2): 195-203.
- Willmot, M. (1998). "The new ward manager: an evaluation of the changing role of the charge nurse." Journal of Advanced Nursing 28(2): 419-427.

¹ This is a calculation using the number of patients or occupied beds and some nominal figure based on an assessment of each patients 'dependency' the level of care they require.

² A number of the participants indicated that they understood that the establishment figures are being looked at the current time but none of them seemed clear about what this meant.