United Kingdom: report on emerging themes from the interviews

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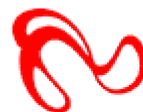

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United Kingdom: University hospital

Introduction

The UK case study organisation is a large teaching hospital in London used for training students from an offsite medical school located at another institution. The status as a University Hospital is in recognition of its education, training and research roles. The 550 bed hospital employs 2,800 staff. It is a long established hospital and some of the buildings date back to the early part of the 20th century. It is said to have the largest Accident and Emergency facility in Europe. It serves a large local population as well as providing specialist services to wider community. Patient services are delivered through four Directorates – Cancer and Clinical Support, Women and Children's Services, Critical Care and Surgery and Specialist and Emergency Medicine.

The fieldwork was undertaken in July-August 2007 at a time when the hospital was undergoing considerable changes with a great deal of uncertainty about the future status of the hospital. This is part of a larger reconfiguration of both London health services and the role and status of District General Hospital in the UK. The hospital has also faced a considerable funding deficit. A campaign against the hospital's possible closure was organised by the trade unions.

There are concentrations of deprivation and poverty in parts of the diverse population served by the hospital. Many people experience health and social inequalities. There are above average proportions of the population who are over 65 years with large numbers also on low incomes. The District falls in the top 50% of unhealthiest districts in England and Wales. A recent report by the District's Director of Public Health (in 2004) highlights some "serious health problems" compared with the rest of London including highest rates of death for babies under one year and poor health in women under the age of 65 years. The hospital is in the catchment area of the 2012 Olympics site and the redevelopment of this part of London will have major implications for population growth and demand for health services.

Organisation of the fieldwork

The interviews were conducted by the UK Quality Research Team, the National Coordinator (Professor Suzan Lewis) and Principal Researcher (Dr David Etherington) with additional assistance provided by Professor Annabelle Mark from the Middlesex University Business School who is Professor of Healthcare Organisation and expert advisor to the team on healthcare organisations. The initial point of contact for

the survey was the Assistant Director of Research and Development at the hospital who was allocated the task of locating staff and organising the interviews. She was unable to fulfil this role because of work pressures and the task was delegated (by the Director of HR) to a Senior Work Life Balance and Benefits Advisor Officer who leads the" Improving Working Lives" Team[1] of the Hospital. This caused delays to the start of the interviews compounded by the fact that interviews were being undertaken during the holiday period. Despite this problem, the response has been encouraging. Twenty one staff have been interviewed, 11 from management and 10 from staff. They included 14 women and 7 men, 9 members of medical staff (including the local BMA (British Medical Association) representative) and 12 non medical. Staff in Management and HR plus key medical staff together with representatives of the Profession Allied to Medicine provided a cross section of the frontline and support workforce. As part of the interview process the Director of HR and 2 trade union representatives were also interviewed with a view to obtaining a comprehensive background and contextual information about the most recent changes and developments within the hospital.

There were some difficulties in recruiting junior doctors for interview but a small number were included. Junior Doctors are an essential element of medical care and have always been a strong political voice within the NHS most recently in relation to the excess working hours In addition a new computer based recruitment process for junior post which was intended to increase efficiency and make the process of selection fair and unbiased, has had implementation problems. This resulted in many doctors not getting employment, recruitment delays and personal details of applicants being able to be located on the recruitment web site. This has become a political issue at the highest level.

Organisational change

The funding arrangement for hospitals in the UK is to establish an internal market on a purchaser provider basis. The private sector has also been included in this scheme. Funding is allocated on estimated average costs in terms of delivering certain medical services. In addition the implementation of a major reframing of the payments to staff and stratification of roles called Agenda for Change has resulted in increased costs especially in relation to certain staff groups e.g. doctors. These nationally agreed changes have not been fully funded at the hospital level. These factors together with some poor management practices are leading to certain hospital trusts overspending on services they provide because of these rising costs, plus changes in demand. This situation is exacerbated by Government attempts to control spending and rising costs in developing the infrastructure (e.g. introduction of computer systems etc and

[1] This is a small team established to advise on flexible working and staff benefits and promote social welfare amongst the staff.

the potentially high costs of public private sector financial arrangements which are now falling out of political favour because of the high costs incurred).

This most recent financial crisis nationally comes after a period of real growth in funding for UK healthcare. It must however be seen also in the context of constant organisational changes as local hospital trusts attempt to meet centrally determined targets, cut costs and rationalise services. The hospital is currently responding to proposals contained in a Government Report on the Reform of the NHS in London which involve creating Polyclinics where doctor's surgeries are merged and these clinics perform services and functions generally undertaken by district hospitals. Thus the general thrust of thinking is to perform more health services 'within the community' which is one reason why there has been considerable uncertainty about the future of the hospital. In addition the hospital is experiencing a high financial deficit which has involved a number of organisational changes under the umbrella change strategy known as "Turnaround." The Government sends external management consultants (from the private sector) into those hospitals experiencing financial deficits, who propose a raft of changes mainly in the form of cut backs. There have been two Turnaround Plans for this hospital in 2006/07 and 2007/08.

Following a period of expansion the financial position of the hospital was £27.3 million in debt at the start of the 2006/07 period. The main changes in the Turnaround process involved vacancy control and freeze in certain areas and expenditure over £250 had to be personally approved at the Director level. The effect on staffing was significant – to lose over 200 staff with most through voluntary redundancies but a few by compulsory redundancies. Within the hospital there have been a series of ward closures/reopening and tight control over the use of Agency Staff for short term cover. After these stringent measures the deficit is now halved.

Emerging themes as challenges and supports for organisational health

The following were the main themes emerging from the interviews:

1. Financial problems of the hospital (and the NHS more widely)

Most respondents expressed anxiety about the financial crisis of the hospital and the subsequent uncertainty was raised many times. Although people had not heard anything concrete from management there were many rumours about the possible closure of the hospital. The loss of so many staff has had an impact upon staff morale which tends to be low although there remains high commitment to the job and patients. As one interviewee commented:

> *NHS Trusts are all in financial dire straights many of them having to pay back huge deficits. We are one of them, we are one of the most financially challenged trusts and we have to pay back a huge deficit to pay back. We are making great bounds on it, but unfortunately, its at the cost to certain things in the Trust mainly with staff. And we have staff lost and made redundant - they're not impressed and generally its up to everybody else to pick up the pieces.* (Woman, HR Manager)

(We work with a) *shoestring budget and no redundancy in the system.* (Man, Doctor)

The uncertainly, or handling of uncertainty also has other consequences such as a decline in good will, organisational commitment and citizenships behaviour. Many members of staff are planning to leave.

In terms of morale one staff commented:

> *Last year was probably the worst year that the Trust had …we had a whole restructuring across the Trust and all the redundancies were made and I think it's obviously a lot of ill feeling for the people made redundant, not all of them because some of them as some were happy to get out and go.* (Man, HR Officer)

The redundancies had a disruptive effect on staff which some considered was not fully taken into consideration by Hospital management.

> *People felt the stress of losing their team and I think that it was something that we found the Trust simply did not appreciate how important working in a team was for staff. Teams had built over a long period of time and the support networks …the informal support networks and the way of working and solving problems.* (Woman, Trade Union Officer)

The redundancy process and the way it was organised with people having to apply for their own jobs had negative impacts on staff.

> *I think the most traumatic thing was having to be interviewed in competition with colleagues. You would be sitting next to people – mates working together, supporting each other – in one case there was a medical secretary who had actually trained her colleagues and they all had to go to the interviews to see who would get the job – or would lose their hours. And this person…a Medical Secretary…who trained all the other up … and she was the one who had to cut her hours and go and work somewhere else.* (Woman, Trade Union Officer)

2. Rising intensity of work and a long hours culture

These two issues are linked in some of the conversations. Workloads have intensified and often cannot be completed in contracted hours so many people work longer to get work done. The hiring of temporary agency staff is not permitted in most contexts so there is no slack in the system, for example, to provide cover for annual leave.

One example is in the Human Resources Department which have lost 12 staff out of a total of 40 – over 25% , yet there is no decline in workload. It is quite common for staff have to work more than their contract hours. Those who resist this by working their normal working hours and do not take work home face great pressures and stress as a result of overwhelming work loads. As one interviewee stated:

> *….I would be in at 7.30, sometimes slightly earlier and often I'd be here 'til after 9'o'clock finishing things off but then obviously as I realised that I'd been forgotten about and I was going to be leaving anyway and I thought "what am I doing?" so then I just started doing 9 to 5 and what didn't get done didn't get done…but.....I stepped up my hours again. I was here 'til 7 yesterday.* (Woman, Senior Manager)

Similarly medical staff talked about the constant sense of pressure, working beyond contract hours .

> *- you rush to get there before 8.30 to get the computer on, but my contract hours don't start until 8.30- you have to rush to meetings, go to …..do a long list, grab my food, rush without a break to (another hospital). It's that sort of atmosphere. I think we all feel pressurised….* (Woman, Doctor)

Working long hours are not new, but the Turnaround process has affected morale and good will in this respect:

> *I should say that a lot of people have always done long hours but I think they felt that they were doing it and they were committed and it was for a good reason. What Turnaround has done is curtailed that good will so people now are no longer happy to do those hours so I think we're our own worst enemies because its "yes I have got to stay another hour, I've got to finish this off" but I felt then that I was appreciated and someone was saying "you know what, thanks X, that's great you've done really well" but that doesn't happen now. So, the goodwill has gone and people are going 'I'm not going to do those long hours anymore, I'm going to do the hours I'm paid for.* (Woman, PA to Manager)

Junior doctors who are no longer allowed to work more than a 48 hour working week because of the European Working Time Directive, are also not supported by any additional staff or fall in workload.

> *It certainly intensifies work within a certain time period. But the workload is disproportionate that is the problem so that you have to work much harder during those hours so the work is more intense and more physically draining and exhausting.* (Man, Doctor)

Moreover, the reduction in working time has resulted in the loss of overtime payments - so doctors are working more intensively and losing pay.

Various other changes have contributed to increased workloads. Changes to patient care management involves more paper work. For example Care Plans [2] have been cited as involving disproportionate time detracting from time for patient care. In addition, workloads can be increased in relation to dealing with

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[2] A Care Plan is information provided about who to contact to get the health services that have been agreed with the patient, a clear explanation of the health condition and likely treatment, and written information about the health care that is to be provided. Also includes advice about the help that can be obtained at home once leaving hospital, and personal involvement in making decisions about long-term care arrangements. .

patient complaints which is seen as a result of the requirement to reduce the length of stay such that patients "feel that we are rushing them." There is a feeling that this increased workload in dealing with complaints is a direct result of reduced staffing levels but also because of the pressure to avoid formal complaints being made to the PCT[3].

The restrictions in recruiting Agency Staff for cover has also contributed to increased workloads and pressures amongst staff who have to organise cover;

> *A staff member phones in sick, we sometimes have to cope with it. For example last night – one of the staff phoned in sick and we couldn't get anyone. Sometimes we are not allowed to get agency and by the time you go through the manager and you try and get this and that – the time has already gone. By the time you are phoning other staff – time is going and in the meantime someone has to be looking after 14 patients.* (Man, Nurse)

The pace and intensity of work are also exacerbated by new targets, for example the need to get people though the casualty department within four hours. One senior woman doctor had mixed feelings about targets, believing that they could be very positive but are undermined by intensified workloads.

> *Some targets have been very good for us. In a way having targets has made us work better, how we have to do things in a certain time.........But one of the problems of targets is they make everything very rushed. They put a lot of pressure on us and staff are exhausted.* (Woman, Doctor)

Some expressed views that in general things are starting to improve perhaps because of significant investments in the NHS and attention to the quality of working life through initiatives like the NHS "Improving Working Lives" policy, although it is generally agreed that without extra staff such initiatives (such as promoting flexible working) can result in people working harder, albeit for shorter hours.

One consequence of the intensification of work is a feeling of constant haste. Haste, as well as general busyness are issues especially for junior doctors.

> *This is the busiest place I have ever worked ....It has the highest level of demands when you are on call. It has the highest intake of patients. And there are fewest junior doctors of anywhere I have ever seen.* (Man, Doctor)

Some participants are concerned that intensification and haste can lead to mistakes. Other consequence of the intensification of work include blockages in work systems because some people have too much work and cannot pass it on as everyone is so stretched. High workloads and tight staffing are also reported to

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[3] The PCT – Primary Care Trust – is the health authority responsible for overall management of the hospital and is the initial body to receive complaints.

be associated with reluctance to work together across disciplines so that working practices become very fragmented, which can undermine efficiency. This gives rise to what is often referred to as the "blame culture" in UK healthcare especially when linked to individual performance targets.
There is some recognition, even among those who are most positive about the changes, that a system where everyone is working at full capacity may ultimately be inefficient. The assumption appears to be that people can take on more and more work - this is almost without expectation.

> *I think its been a huge mistake (*referring to Turnaround and the redundancies) *there's no easy solution to our deficit, but basically, you know, losing the amount of staff you got and good staff, you know it's the kind of staff you can't afford to lose…And what you are left with you know – is an over tired, over worked workforce whose left. Good and bad managers are not able to cope with the amount of work, because we have had to take on more work. And I know in the clinical areas that must be incredibly difficult. Trying to meet government targets, to lower waiting times, plus take on more work, with less staff to do it, it's an absolute nightmare.* (Woman, HR Administrator)

One view is that this may be necessary for smooth running of the trust- but others feel that it cannot be sustained. For example some doctors feel exhausted, physically drained and have little time to think. It is recognised that this is not good for patients' or for doctors' quality of life- (not a healthy organisation).

> *.... generally it (the hospital) provides a decent service, although it provides a decent service at the expense of morale amongst the staff who work in it which is not really sustainable. Morale is low. But there is a recognition of that and senior levels is beginning to recognise that is affecting our ability to do our jobs properly and that people don't see a reason to work any more and are beginning not to want to work here any more.* (Man, Doctor)

External research on stress and burnout in healthcare organisations in the UK confirms this[4]. However this feeling of exhaustion also applies to other medical and managerial staff. One interviewee considered that often stress was taken home and impacted on family relationships and considered that this applied to many staff:

[4] Stress is believed to account for 30 per cent of sickness absence in the NHS, costing the service £300-400 million per year. The Healthcare Commission's 2006 staff survey found that 33 per cent of staff questioned said they had felt unwell because of work-related stress over the past 12 months. The Healthcare Commission is an organization which acts as an NHS 'watch dog.'

*Yes, they do things like go home, have a bite to eat and go straight to bed. Some people come in on the weekends for a couple of hours – yes in our department they do. (*Man, Nurse)

3 Coping with constant change and uncertainty

Much of the change is associated with national initiatives- although local implementation is important. 'Turnaround' and other change decisions are considered as a mixed blessing. To some there are too many changes taking place in too short a time.

You know at the moment there is a lot of very unhappy people about because they've gone through the Turnaround process but they know, a little way down the line, there's going to be another process that's going to happen and they're not sure again, if they are going to be in their jobs, if their jobs are going to be put at risk, so people are still up in the air about what's happening in the organisation. (Woman, Administrator)

To some, there have been improvements such as in communications between departments. To others the pace and regularity of change is a constant pressure and some of the decisions – such as ward closures – are questioned particularly because of the threats to patient care.

It was traumatic and there were some that were handled very badly. The literally a whole raft of middle managers came in and said – we are closing this afternoon. They shipped the patients out and were transferring the patients to different wards and things. The nurses had hardly had time to say goodbye to each other and sort things out. That was very traumatic and we had a lot of complaints about that. What they normally tend to say is that it's a temporary closure so we don't need to consult and then you find that they don't re open the ward. (Woman, Trade Union Official)

Ward closures seem to have had a considerable impact on nursing staff:

You hear through rumours that wards are going to be closed and when we asked we're told exactly which wards are going to be closed. Then I started thinking how am I going to cope and tend to worry because they are not really coming out and telling us in terms of whether our jobs are safe or not. Some wards have been closed, and some nurses have been placed elsewhere and some nurses have been given packages and they have gone and so it's just a cloud hanging over you – not knowing what is going to be happening tomorrow and whether that ward is going to be closed. (Woman, Nurse)

The costs of employing the management consultants for the Turnaround process are resented, considering that many proposals could have been made by hospital management, but the disruption caused by such external change agents allows those left to continue to manage without blame.

But I think that's the thing – the other element about all this thinking and down sizing and cutting back is that apart from the job insecurity for the individuals, it's the awful impact on your service. The people making these decisions don't have a clue about the impact they make and they don't make rational decisions, or decisions that are based on the interest of the service. And the work they are doing is purely financial and that overrides everything else. (Women, Administration Officer)

The situation is unsettling and does not instil a great deal of confidence in people about the future of the hospital. One nurse observed:

> *Yes obviously I am worried whether I would lose my job or not..I've heard all these things on the tele and news about the NHS, it does kind of worry me, but I'm just taking it day by day really …'cos I feel honoured to have the job because I trained with quite a few people who don't have jobs.* (Woman, Nurse)

Uncertainty affects people at all levels. One doctor felt that the subsequent anxiety affected their every day practices, making them reluctant to "rock the boat"

> *The future of the hospital…it's very worrying. Last year has been very stressful for all of us …….'Before we were very independent and could speak our minds, talk freely. We didn't worry about whether our employment would stop….. People used to work until retirement but now we are worried.* (Woman, Doctor)

Changes are not always perceived as efficient – particularly the ward closures: Good will is necessary for the provision of quality service but many feel this has been damaged by the Turnaround process. Even many of those who are not directly affected by the changes and cuts feel uncomfortable about them and the way they have been handled. Two examples were given of cost cutting measures implemented under the Turnaround which were seen as bad decisions. The first relates to mobile phones:

> *They were going to take your Trust mobile phones and funds. Everyone had to give them back, their bleeps and their pagers- and their blackberries too. Take them all back fantastic, brilliant!! I wrote to the guy responsible for this and said I can't work with this.. If I walk from here to somewhere else it is half a mile there and back.* (Man, Trade Union Officer)

The decision to make the in-house painters redundant was also questioned:

> *We lost our painting teams which we thought was a bit stupid. It's stupid because things always need to be painted! And then they (*management*) will pay for it when its needed. Then recently this year, there was a ward found with rotting wood, so they had to evacuate the ward and re-do it. Had to repaint it and apparently the Chief Executive said – she was looking at the costings and someone said we just got rid of our painting team and she said – "well that's a bit stupid isn't it?" They had got the painters in and they were in for two weeks – that must have cost them loads of money. As our guys were going out of the gate these guys* (the painters employed) *had already been here a week.* (Man, Trade Union Officer)

Whether or not the cuts are justified, many participants are critical of the way that change in general is managed and particularly a tendency to be reactive rather than proactive. Furthermore the ideas behind change in relation to Turnaround are seen as coming from the private sector and have been questioned:

> *He (the Turnaround director)was definitely a change agent, there are good change agents and there are bad ones, there are poor change agents. I think he was from the private sector so his version of change is more because he didn't understand the concept and the Governments around health, he came in with this idea that change could happen overnight almost, if you really wanted it to, you could stop something today, implement something new tomorrow and everyone would just fall into line. It's not how the health service works, unfortunately.* (Man, Service Manager)

4. Ageing hospital buildings and inadequacies of resources and infrastructure in some contexts

Many of the buildings are outdated and it is felt that this affects the quality of care and working conditions:

> *This is a difficult site to work in. It is a very old site and needs complete redevelopment.* (Man, Service Manager)

The hospital has had a number of plans to deal with this but whether the whole site will be renewed or replaced is open to question because of a failed Public Finance Initiative bid[5] and the perceived uncertain future for the hospital in relation to the future shape of acute care provision both locally and nationally. Shortages, uncertainties and delays to both resources and infrastructure can create stress for staff. There has been a lot of discussion about the future of the Maternity Unit.

> *The Unit has had a lot of refurbishment done and the labour ward is in bad need of refurbishment. Before Turnaround came in there was a huge plan to rebuild within the delivery suite a new theatre but that all went after Turnaround came in, so if you look at the facilities that the staff and the women had to put up with in the delivery suite, it's not acceptable.* (Man, Senior Nurse)

A doctor felt that resource issues were preventing them from doing what they are actually very good at:

> A doctor felt that resource issues were preventing them from doing what they are actually very good at:

> *We need better buildings, better equipment and to know that (our jobs) are secure so we can get on with it.. We are actually a very good hospital if we can just get on with it.* (Woman, Doctor)

5. Working patterns and rotas

A new rota system has been introduced which is creating difficulties for nursing staff. Staff are required to put forward their desired shift and working hours well in advance – up to 6 weeks - and the rota cycle is for a four week period. The rationale for this is for effective management of staff and to ensure that all areas are covered. Staff find this inflexible and consider that it impinges on their family life (see below) because of the fact that caring whether for elderly people or children is highly unpredictable, and

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[5] The Public Finance Initiative (PFI) is a (controversial) system whereby the government creates a partnership with the private sector to undertake large scale capital projects.

alternatives are too costly to contemplate (even for junior doctors now working under the EU WTD). The main reason for this inflexibility is because the staffing levels are down to the basic minimum and switching shifts and finding cover is difficult. It is felt that this system may be sound but would work better with more staff. The problem is explained by one Member of Staff responsible for organising the rota

> *On a ward I have 37 staff. Out of the 37, I have had three vacancies removed, so that leaves me with 34 staff. Out of the 34 staff, I've got three who are clerical posts, so that leaves me with 31 nursing staff. Out of them 31 nursing staff I've got 5 staff who are pregnant at the moment. And then I have 4 unqualified and the rest are qualified and the pregnant ones are qualified staff. Now 17 out of those 31 staff have got children, they are either single parents, or are parents with a partner. What those staff do is put their requests out and I'm having problems at the moment in relation to planning my rota…There is flexibility within that but there are areas where we can not be flexible as well. ..Out of the 17 staff, 8 may say they want to do an early or I want to do a long day. If I guarantee all the 8 staff their long day I'm going to be short in another shift. If I'm short in another shift I am going to have to book agency cover. Now agency – I'm only allowed if I have got vacancies which I haven't.* (Woman, Senior Nurse)

There are also some concerns about doctors' shift systems

> *The shift system for younger doctors … it's not a proper handover. They need to take responsibility, have ownership. The hospital needs to give you that sense of ownership. People need to feel empowered…. They have taken that away. We need more joined up working.* (Woman, Doctor)

There are instances of some autonomy being given to managerial staff who are able to organise their work within a compressed working week or where extra hours worked are taken as time off in lieu. Among medical staff sometimes hours are changed at short notice which can cause work-family problems

6. Experiences of deprofessionalisation/deskilling

Especially among the medical staff there is a feeling that their professionalism is being challenged by some of the changes [6]. Medical staff are more closely managed and monitored and have less autonomy than in the past. Some feel they are treated "like factory workers". Ironically this is the opposite of the trend in

[6] . While local managerial issues may in part be responsible for this negative perception, it is also a legacy of the negative attitude to the significant power of professions. This started with government intervention under former prime minister, Mrs Thatcher eg the introduction of doctors in management roles in the early 1990s called Clinical Directors. It has further continued as a way of both restricting power and avoiding further scandals notable examples of which in the UK led to patient deaths.

many workplaces to provide more flexibility and autonomy to workers in order to increase personal responsibility. (Lewis and Smithson, 2006)

> *Now we are watched – what time we arrive and what time we go. There's a great sense of* ***demoralisation.*** *We are professionals; you don't clock in and clock out. Sometimes I work late, so if I arrive 10 minutes late, or half an hour because of traffic or because I am held up at (another hospital) or whatever … the mentality is…. there's a change in mentality and philosophy that the consultants are just workers- the professionalism is taken out of it………. We are aware that we are being watched….. A "little boy"* [said disparagingly] *from an accountancy firm came to measure my time use.. It was part of the management consultancy. They were watching how long we take , how many patients we see- never mind if some patents are complex, take a bit longer- its all strictly managed….* (Woman, Senior Doctor)

> *Medicine has been reduced to service provision alone. (*Man, Doctor)

Many feel unappreciated, by the hospital and by the government, because of a lack of recognition of the efforts they are making under difficult circumstances

> *The government thinks we are not doing enough. … I do far more than I ever did.* (Woman, Doctor)

Despite the threats to professional identity, a sense of vocation sustains some doctors though difficult times

> *Its difficult for me to get demoralised because I have worked all my life to be a doctor………this is what I have lived for since 11 years old ....A lot of people do see this as just a job.......* (Man, Doctor)

7. Bullying

Bullying has been reported by many of the participants. One interviewee reported experience of abuse and near physical assault by another member of staff. Many people say they aware of a culture of tolerating bullying in its many forms even if they have not experienced it personally. Personal experiences of bullying are reported by participants at all levels, largely related to gender and/or race and can be associated with considerable distress- What is clear that bullying takes on different forms – some more subtle than others:

> *Ok, I mean obviously I am a junior nurse and I've just started. I think sometimes when some senior manager undermines you or they, in a way act like they are trying to teach you and guide you into something, but they are actually trying to put you down in the process. I think that's one of the challenges I've had.* (Woman, Nurse)

And there are more overt instances of bullying experienced by staff:

> *I find one day I had to stand back and think wow – I'm lucky, I was nearly physically attacked in the corridor by a lady (*member of staff*) waving her hands in my face, she was really aggressive. I was thinking excuse me, she was shouting to my face – she had her right finger in front of my face, she was really aggressive.* (Woman, Administrator)

Nor is bullying restricted to younger or lower status employees as a woman consultant explained, attributing this to gender factors

I have been bullied. Incredibly bullied.. Women are supposed to do as they are wanted to do, not to be forceful. ….. Over the years I've had to change, to become more diplomatic. I had to mellow, be like other women are. Most were quieter….. I was being pushed around. I was bullied by male consultants. I still am. (Woman, Senior Doctor)

Some of the medical staff felt that the introduction of clinical managers, without any management training could, in some circumstances contribute to a bullying culture

What's happened, it comes presumably from the government and DOH, they've introduced people to manage us and nurses and doctors to manage nurses and doctors. I presume they have targets, but there is a forceful atmosphere, in some cases a feeling of being bullied by being pushed…. (Woman, Doctor)

The same doctor felt that bullying was not new, but that general feelings of insecurity made people reluctant to talk about it.

People don't talk about bullying. It's gone on for years. People are put in these positions (managers, clinical directors), ego trips happen. I'm hearing a lot about this. But people are going quiet and keep their heads down- they are very worried about their sessions, their work. (Woman, Doctor)

Despite the fact that there are procedures in place, there is a view that the organisation does not deal with issues of bullying and harassment:

I do know that certain people have been bullied from a racial perspective and the Trust isn't doing enough about it. I know one manager who has had two complaints made against him from two different members of staff, and she is still in her job and nothing has been brought against her at all. (Woman, Communications Manager)

The unions are viewed by some as inadequate and too much part of the wider organisational structures. There is also a view that the unions are important and doing a good job but reluctance to use them and the grievance procedures for fear of being branded as a trouble maker

8. Racism

Forty percent of the hospital workforce is of non UK origin. Racism within the workforce was raised as an issue and there were perceptions that people from BME (black and ethnic minorities) experience fewer opportunities for promotion than others. This is one comment on both women and BME groups:

When you look at the structure – yes, all the directors are male. In terms of senior management the ethnicity in terms of ethnic minorities, there are non in terms of directors, that is really not good when you think that in the actual area how multi cultural we are. But at senior level at that level we have I think 1-2 women directors and the rest Caucasian. When you come down to the level below assistant directors you have a few who are female and black who are actually losing their jobs and I think there is some resentment there. Looking at it from the structure there isn't a big representation from the ethnic minority. (Man, Manager)

There is a definite hint that racism is endemic within the hospital. Although the hospital has sophisticated equality and diversity policies there is a view that in practice they are not effective as they could be:

> *You know as a black woman I don't want it to be turned back on me and that is exactly what happened it was 'so what are we going to do'? and I think as black people we get so fed up of being told 'so this is the problem - so what do you suggest we do about it? ' Yes I can make suggestions but actually you have not got equity here' they are just not interpreting the policies.* (Woman, Manager)

This reflects the recent findings of a report from the RCN (Royal College of Nursing) on this issue in the Health Service more broadly[7]. As also shown above under the discussion on bullying there are instances of racial harassment within the hospital.

One member of management suggested that the former Turnaround Director in particular displayed such behaviours:

> *Certainly when I was working for X who was the former Turnaround Director, there was sexism, I mean, he was sexist, and he was racist, he was a bigot, he was homophobic.* (Woman, Senior Manager)

9. Gender isues

It has been commented that senior management does not reflect the profile of the surrounding community in terms of gender and ethnicity. Also the usual gender segregation exists with women tending to be concentrated in certain areas such as nursing whilst more men are in the medical and especially more senior professional jobs. The CEO is a woman although she is not seen as championing women's causes and there is a perception that some men benefited more from the Turnaround process through wage raises than women did.

In senior jobs it is felt that women tend to keep their heads down and get on with their jobs- in a context of general macho attitudes.

> *A lot of consultants keep their heads down, especially women.. They are worried about their job. There is a macho attitude. The tone of bullying is definitely there……. Some of the women are very worried about their jobs. They keep their heads down.* (Woman, Doctor)

[7] See Royal College of Nursing (2005) Bullying and harassment at work a good practice guide for RCN negotiators and healthcare managers, London: RCN.

While many of these problems exist across the NHS, those who have worked in other hospitals report more of a glass ceiling here than elsewhere. Nevertheless there are also other participants who say that gender is not an issue or not one that they have thought about.

There is a perceived lack of flexibility in working arrangements and because women tend to have the main responsibilities in terms of child care this disproportionately impacts upon women workers within the hospital (see family issues below), although several fathers also discussed difficulties in reconciling work and family. Although child care is a crucial issue (and discussed below) there are subtle areas of indirect discrimination against parents in terms of working hours and the working hours culture:

> *Turnaround, you know, there was a system that you had to be here around 8-8.30 so a lot of times I was struggling with my husband as to bartering who could do that and I would have my son in the evenings and get home at about 6.30 and he would be talking to me on the phone and I'm saying "I know, when I get home I promise I will come and see you, even if you are sleeping".* (Woman, Manager)

There is a flexible medical training scheme, used mainly by women but also some men, but juggling a training programme and childcare and coming back part time is very difficult and participants believed it was probably career limiting. Using this route is reportedly stigmatised by older consultants but not by younger ones, so there may be some change in gender attitudes appearing over time and with the changes in the profile of those being trained to reflect greater diversity. Among the younger men interviewed, some fathers , like mothers, were making carer choices based on family commitments

> *"Doing what I really wanted to do is unfeasible in terms of modernising medical careers and having a family. I was forced into a 9 – 5 speciality- I would have really liked to do intensive care but it was not feasible with young children.* (Man, Doctor).

There is other evidence of pockets of change in gender roles and identities at least among some of the doctors

> *With the implementation of European Working Time Directive as well, we have to be 48 hr compliant by 2009, big, big changes will be necessary which are not necessarily family friendly. Working blocs of 3-4 days and nights. They did try working in 4 blocs of 4 days on call but we managed to block that on the grounds of adversely affecting social and family life... we were supported by a senior consultant who has a family- a man.* (Man, Doctor)

10. Social relations and communication

Accounts of experiences of social relations and communication were mixed. Some of the key changes observed by many staff relate to the fact that the general atmosphere at work is not as friendly as it was prior to the various changes .A staff social club on the hospital site was closed and converted to hospital medical use. Turnaround seems to have led some sort of fragmentation – 'back stabbing' and people suggesting who should be prioritised for redundancy. At the same time however there was still a strong sense of social solidarity and the Save the Hospital campaign brought people together and brought about closer links with the local community.

Others talk about very good social relationships which is one of the main positive aspects of working at the hospital. There are often strong team ties and cohesiveness and some feel that the Improving Working Lives Team plays an important role in the social life of the Hospital. There is much talk of social support, social capital, supportive colleagues and a sense of identity and community. As one newly qualified nurse commented:

> *And I mean since I started working at X I've had a lot of support from my management in the ward and even other colleagues from work as well. Like doctors, physiotherapists, occupational therapists – lots of support.* (Man, Nurse)

Even those who are most critical of the current context say that the social element and particularly the feeling of being involved in something so worthwhile as healthcare compensate for many of their frustrations and keep them in their jobs. Many of the staff live locally- and the hospital is part of the (working class) community

Generally loyalty appears to be to people and healthcare but not the organisation. However there is a tendency to socialise in cliques or tribes. Some accept that this is counterproductive but inevitable in working conditions which make so many demands on time and energy.

> *There is a lot of camaraderie here. People do tend to stick together.... in tribes. It is very tribal. The territory is very distinctive...The doctors stick together because we all work under the same banner so we tend to socialise more with each other ......The nurses moan separately in their own little cliques but you never get together and have a joint moan. No nurses and doctors generally lead very separate lives. – except when they get married to each other and have children .... I think it is a terrible thing. There is no social interaction. No interaction off the ward between nurses and doctors so it is a strictly professional relationship and in general a very good professional relationship but it is quite limited in that respect. It would be nice if there were more social interaction but there isn't.*
> [Interviewer]*Is it a gender issue?*
> *No it is really more a time issue.* (Man, Doctor)

Some feel that this is bad for quality of life and note the benefits of team work when this is possible

> *The quality of work in geriatrics is much better because it is more team oriented. You do not feel alone.......... the quality of life is better as all the time you are working as a team.....We are all supposed to be working in teams but it is not until you work in geriatrics that you see teams working particularly effectively.* (Man, Doctor)

Communications within the hospital can be a problem and there is a widespread view that consultation processes particularly in relation to organisational change do not effectively engage staff. This was articulated in various ways:

> *Management, they really don't pass on the information down to the staff. Some of the staff here, they hear through hear say. Sometimes it is not correct sometimes it is correct.* (Man, Nurse)

> *There has been no engagement with staff….. Its always 'this is what we are going to do and this how we are going to do it' , rather than ask for our suggestions. (*Woman, Doctor)

The lack of information and clear messages about what is happening or going to happen within the hospital is therefore a clear area of concern:

> *I mean as far as I know there have been a few wards shut, you know, and there are rumours going around that the hospital might be closed. And that it's like you don't know whether what people are saying is right, or wrong and we saw all these posters saying 'Save X' and I think there should be an inset day about what's going on with the hospital. What tends to happen is we just hear that this wards been shut - it's sort of rumours going around but no one actually says – this is what's going on in the hospital.* (Man, Nurse)

From a wider trade union perspectives the consultation process has been criticised as not listening to their views

> *Even when they do consultations they do a 30 days consultation where they put out a paper and it goes to the unions and to the staff and there's time for comments. You can write comments or you can ask in meetings etc. They always have a meeting with staff – they say put in your response none of the responses work.* (Woman, Trade Union Officer)

However there are exceptions to this;

> *They were going to close the 4th ward which is the 2nd acute care for the elderly ward and the hospital was on red alert at the time. Red alert means people in Accident and Emergency are waiting for beds. There may be 3 or 4 beds but they are not suitable beds for them. So you have an imbalance basically. It was on red or yellow alert most of the summer which reflects the pressure on the hospital. So the senior staff said don't close it – change its use have it as a balanced ward so if there are too many surgical patients then that ward is more of a surgical overflow ward. If there are too many elderly patients then that ward is an elderly patient overflow ward….they had a board meeting and the campaign…and the public came to the board meeting. They asked questions..so I think the Trust was forced to back down on that.* (Woman, Trade Union Officer)

Criticism about communication is not restricted to non managerial staff but is also strongly reported by people within the management structure:

> *I think communication has improved here for a start but I think decisions are made that have big ramifications for us and ultimately for how its going to be managed and those decisions we are not really consulted on. I think we are just sort of told and I think there are a lot of things like that that go on.* (Woman, Nursing Manager)

Others say that communication is good- e.g. via the Trust website although they acknowledge that when people are very busy they may not have time to look at the website. It is felt that some managers lack interpersonal skills and do not know how to communicate well- especially those who may be appointed without management training.

As mentioned above there are however instances of a people centred approach to management which have had positive impacts on working culture and social relations:

> *My previous team had a very healthy attitude to working relationships and work-life balance. We worked very hard to coin the phrase and we played hard as well. My boss was very good at making sure that there were team*

*nights that we did together as a team where there was no kind of 'I'm top your at the bottom.' Everybody was involved. We had away days when the project was discussed and all levels went including the secretaries. It was everybody involved and we all felt part of one big project. And X was also very good at recognising talents and skills in people and help implement them and promote that or even just if there wasn't like he picked people to get jobs over other people, it was always done in a fair way. (*Woman, Communications Manager)

One impact of the recent changes is for a siege mentality to occur which has created barriers to inter departmental working and communication:

Sometimes you see other people with skills that are fantastic that can work together but it's almost like people have got a fear of inter-working so, there are lots of departments that you feel are separated off. (Woman, Manager)

This can result in resistances to initiatives and innovations (which can improve people's working lives) because:

I had an opportunity come through and what I would need then is..for the ADs (Assistant Directors) to say "how do you think that your department could participate in this? Have you got someone who would be willing to come and talk to me and then I could write up everything and see how we do." But no one is interested because everybody is thinking "it's going to increase my workload, there's just no way, as interesting as it may sound, there's now way I am touching that and if I go back and say that I am remotely interested, I'll end up doing it. (Woman, Manager)

11. Quality of life, stress and well being

When asked what it is like to work here many people talk about stress, related to the nature of the work, lack of resources , the general uncertainty and change, bullying and a string of government initiatives. Exhaustion is common. The workload can be physically and emotionally draining and affects general morale:

If you want to look at morale, they are often related to sickness levels, etc and yes there's genuine sickness but with some, there's exhaustion and I think, you know that does worry me slightly in the sense if we are working really hard and not being recognised for it. (Woman, Manager)

*Before you had a job and you did it well so you could bring in new techniques, be intellectually free to talk. Now that's gone**. It very much a sort of grind**.* (Woman, Doctor)

Turnaround seemed to compound the situation for some:

I mean a lot of people have been off with stress for long periods of time and they come back, they're ok for a little while and then it all hots up and then they're off again and it's also with stress that's developed… and I think is a direct result of Turnaround with the cutting of posts. Obviously people don't like having to change…but having to change when there are less people around to support the work that needs to happen – so yes a lot of people have been off sick and are coming back again and going off again.(Woman, Administrator)

Naturally there is a close link between work intensity, morale and low quality of working life. As one nurse commented:

> *Morale in the particular area I work at the moment is quite low. People are not satisfied, the workload has increased a lot, there hasn't been tangible anything done to try and decrease the workload. With increased workloads you get a lot of stress, there are a lot of mistakes and a lot of things not done.* (Woman, Manager)

There are however some exceptions. For example the intensive care unit is described as being relatively stress free-partly because it is not under resourced, and also due to the way it is organised. It is reported that innovative new initiatives came from the team, who feel consulted and listened to.

There are however positive aspects to the environment - particularly the social and intellectual strengths.

12. Impact on family and free time

"It is difficult to work and look after children" is perhaps a common response by working parents in the hospital. " This comment may be typical:

> *Most of the times I struggle to have a 2 year old son. I need to prioritise my family. My 2 year son really needs me. I haven't got a good life anymore. I say to him 'sorry I cannot play with you because I am so tired.* (Woman, Nurse)

Affordable childcare is an issue for most parents. There is an on site nursery but for three days it costs £400 and this is expensive for in the context of hospital workers' salaries (including those of junior doctors).

> *.. my wife has to rearrange her shifts around mine because we both can't be doing a night at the same time. We can't afford childcare it is just too expensive. (* Man, Doctor)

Rota systems are reported to pose problems – for people with and without children or other family responsibilities. It is a system that makes it difficult to respond to unforeseen occurrences such as school open evenings

Rota systems also make it difficult to juggle work and social life. The long hours work culture can affect social life and family relationships.

> *Most of the time it is hospital, home hospital, home. I have not got any time for a social life any more. Because some times I go home very tired. I haven't got any supper, I can't play with him (her child) because I'm so tired. So sometimes I have two days off and I need to settle my home and cook. I have no social life.* (Woman, Nurse)

Another commented about the effects of the Rota particularly on planning a social life:

> *I know you are guaranteed 4 requests, but the rest of the rota you need to know what you are doing. I think it is very difficult to juggle work and social life.* (Woman, Nurse)

Ability to work flexibly often depends on sympathetic managers and there is much variation in this respect. Family policies were raised as something that needed to be taken seriously (even though there are many policies in place which should cover this) – suggesting and implementation gap between intentions about work flexibility and reality of day to day experiences.

The future challenges

Nearly all interviewees were apprehensive about the future. Work loads and increasing intensity as more effort was expected from fewer members of staff, is a real issue. Too many changes are occurring and it is difficult to plan. Indeed, uncertainty about the future makes it difficult to think ahead. There are numerous national initiatives such as "Fit for the Future" [8] and when asked about the future most could only refer to these. It is possible that the number of such initiatives constrains innovative thinking about the future. Underlying this is also a level of cynicism about constant initiatives or rebadging of old failed initiatives, while staff just try to ensure their primary roles are fulfilled in spite of rather than because of these.

Long term planning and stability are seen as key to the future but seem somewhat illusive given the uncertainties about the future of the hospital as to whether it will close or not. Staffing levels and better pay and working conditions are seen as important for improving quality of working life, although keeping the hospital open is seen as the key challenge. The sustainability of the current situation in terms of workload stress, staff turnover and instability is questioned. There is a need for a stable situation but little confidence that this will occur given the many change initiatives for the NHS.

Some future issues anticipated or discussed include

- Change will continue to be the norm and accepted
- High turnover at least in the short term (fallout from Turnaround and people feeling disgruntled)
- Effectiveness may be compromised by more downsizing- may not be able to sustain a situation with not enough staff and ban on using agency staff. The NHS relies on good will of staff but it is running out- sustainability issues
- There will be more emphasis on keeping people out of hospital.
- Changing expectations: New generation of medical students want to have it all- a medical career and a life outside work
- Population changes- more elderly but also growing young populations (middle ages tending to decline). Increasingly diverse communities- especially now from Eastern Europe

[8] The 'Fit for the Future review' launched by the NHS in 2006 is examining existing health service provision and developing proposals to ensure that health services in future years suit the needs and size of the local population.

- More security issues- perhaps requiring more police on site – less respect
- More competition from the private sector (this may change with new Prime Minister in UK)
- Impact of e.g. very hot weather (climate change) - managing the peaks and troughs- (need for flexibility)
- More infections- like super bugs
- NHS could learn form great examples from overseas e.g. a hospital in Oslo was cited
- Impact of pollution etc and new issues e.g. lots of allergies in babies
- May be intensive care units in people's homes- extending services in the community
- Lack of interest or initiative in relation to Olympics – both the impact on local community of the site development and aftermath as well as actual event.

Healthy organisations

We began buy defining healthy organisations in terms of the dual agenda of workplace effectiveness and employee quality of life. It is widely felt that efficiency has been prioritised over quality of life in the management of change at the hospital, rather than treating the two as interdependent- though there is reported to be some variation across departments. It is clear that some of the changes and cuts in expenditure have consequences that benefit neither staff not the effectiveness of the hospital.

> *This week I have done nothing but work on a ward on my own -no junior doctor – the SHO is on leave because if you do not take leave you do not get paid for it, but we cannot bring in a replacement.* (Man, Doctor)

Interviewees discussed what they considered to be the necessary steps towards a healthy organisation and some of the key points can be summarised as follows.

First of all quality of life, and a healthy organisation are relative concepts and taking more control of organising work is important:

> *If you are so used to not having a good quality of life, then you kind of, it's habitual to stay until 7 then, you know, if you leave at 6 o'clock for 3 days out of 5 you will say "this is a great quality of life because for a change, I've been able to leave at 6, rather than at 7 and so it becomes habit forming so and that's when I mean that sometimes, I think at different levels people are going to take a little more control. X is very good at saying to us things like, you know, "I will not be in", you know, we hate it but she will say "I will not be in tomorrow, can I have tomorrow off? And but in one sense, we look at it and think "well, that's actually quite positive" because if she'd asked someone they would probably have said "no" because I know my workload, I'm not thinking about hers.* (Woman, Manager)

Making the organisation more "family friendly" would make it easier for people (and especially women) with family commitments to reconcile employment and family life. This requires a move beyond policies to a focus on working practices, such as the working of the Rota system.

> *Because people with families- want a rota in a particular way because of childcare needs…how can you plan your life with a 3 month advanced rota?* (Man, Nurse)

The other aspect of moving towards a healthy organisation is:

> *I think having enough resources in terms of staff, and not having the budget constraints. I think if you had enough staff and enough resources you will have staff who would be happy and you know, sickness levels would drop. The workload would be reduced and think it would be a conducive work place.* (Man, Nurse)