

**A study of trust and commitment amongst nursing
staff within NHS organisations**

by

Thomas Joseph McCabe

A thesis submitted to the University of Plymouth for
the fulfillment of a

Doctor of Philosophy

Plymouth Business School

March 2000

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Dedicated

*I would like to dedicate this piece of work to my Mother, my family and friends; Mike
Leat and Jonathan Clark.*

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Abstract

Much academic research supposes that there is a relationship between the level of trust amongst employees and their managers and the extent to which employees are committed, in terms of their attitudes and their behaviour towards the aims and objectives of the organisation and their daily tasks and duties (Kanter, 1972; Eisenstadt and Roniger, 1984; Geller 1988, Guest, 1991; Morgan and Hunt, 1994; Fine and Holyfield, 1996; Brocker, et al, 1997). This study has sought to explore and assess the level and nature of trust and the sources and the conditions which create trust between nursing staff and their managers within two NHS organisations (an acute and a community Trust) and to examine the level of attitudinal and behavioural commitment amongst nursing staff towards the organisation. The purpose of this study was to investigate the relationship between the level of trust amongst nursing staff and their managers with their level of attitudinal and behavioural commitment. Both qualitative and quantitative research methods were used. The research involved a comparative analysis of the findings of the research on trust and commitment amongst nursing staff within the two organisations. The results from this study informed the construction of models depicting and illustrating the nature of trust and commitment amongst nursing staff within the two NHS organisations. These models confirm much of the previous research carried out on employee trust and commitment and they also highlight the significance of organisational context and the professional commitments

of nursing staff and the influence they have upon the level of trust and commitment amongst nursing staff within the two organisations.

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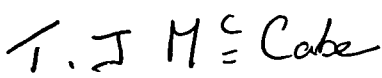
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Authors declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award.

This study was funded with the aid of a bursary and carried out in collaboration with Plymouth Business School. Activities in connection with the program of study consisted of attending conferences, research seminars and undertaking the Pg. Dip in Social Research Skills in collaboration with the Faculty of Human Sciences, University of Plymouth.

Research papers in connection with this study are as follows; 'Employee Trust and Commitment within the NHS', McCabe and Leat, at the Third International Conference on Strategic Issues within the Health Care Sector at the University of St. Andrews, Fife, Scotland - April 2-4 1998 and 'Trust between management and employees within the NHS', McCabe and Leat (currently being prepared for publication).

Signed: 

Date: 19 . 2 . 01 .

Introduction

A considerable amount of research supposes that there is a link between the degree to which employees trust their managers with their level of behavioral and attitudinal commitment, both towards their daily tasks and duties and to the aims and objectives of the organisation (Kanter, 1972; Eisenstadt and Roniger, 1984; Geller 1988, Guest, 1991; Morgan and Hunt, 1994; Fine and Holyfield, 1996; Brocker, et al, 1997). This program of research constitutes an examination of the nature of trust between managers and nursing staff. It has explored the conditions and sources of trust, and the characteristics of 'trustworthy' managers within the context of two NHS Trusts (acute and community sector). The program of research examines the level and the nature of commitment, both in terms of the behaviours and the attitudes of nursing staff, to their daily tasks and duties and towards the aims and objectives of the organisation in which they work. This research also looks at the sources of the attitudinal and behavioural commitment of nursing staff and examines their level of commitment to both their profession and the organisation in which they work. The research undertaken also involved exploring the link, if any, between trust amongst nursing staff and their managers with their level of attitudinal and behavioural commitment. A comparative analysis of the findings of the research of trust and commitment amongst nursing staff within the two organisations was subsequently carried out.

The methodological design used employs both qualitative and quantitative research techniques (see chapter four). The central research method used consisted of in-depth interviews with nursing staff from both organisations. Two questionnaire surveys were used in order to assist in determining the level and the nature of trust

amongst nursing staff and their managers and their level of commitment both towards their tasks and duties and to aims and objectives organisation in which they work. The questionnaire surveys employed two questionnaires, one on trust (Butler, 1991) and one on commitment (Mowday, et al, 1979). The results generated from the administration and the distribution of the questionnaire surveys were subsequently used to back up the findings from the in-depth interviews.

The findings from both the interviews and the questionnaire surveys would suggest that there is a high level of trust amongst nursing staff and their immediate superiors, however they would also suggest that the level of trust between nursing staff and management in general is significantly lower. The results from both the interviews and the questionnaires showed that the level of commitment amongst nursing staff was high, however as will be seen in chapter eight, this can be attributed more to the existing level of commitment amongst nursing staff towards the aims and values of professional nursing as opposed to those of the organisation in which they work. The overall evidence from the findings of this research would suggest that the attitudinal commitment of nursing staff is essentially rooted in the aims and objectives of professional nursing more so than that of the organisation. Research has suggested that when looking at and examining employee commitment one must consider the organisational context of the employee (Coopey and Hartley, 1991). The level of attitudinal commitment amongst nursing staff to the aims and values of professional nursing was therefore reflected in their level of behavioural commitment to their daily tasks and duties. This would suggest that attitudinal and behavioural commitment are linked and that the attitudes of employees can influence the behaviour they exhibit

within the workplace. The results from both the interviews and the questionnaires indicate that the attitudes of nursing staff are linked to their behaviour in terms of their performance within the organisation (Walton, 1985; Mowday et al 1979). While the findings from both the interviews and the questionnaire surveys showed that trust and commitment were related they would also suggest that certain attributes of trustworthy managers are linked to the level of attitudinal and behavioural commitment of nursing staff

Although the findings support the bulk of the research carried out on trust and commitment, they do however highlight the significant role played by the profession of the employee and the organisational context in which they work. The findings and the results generated and analysed through the course of this program of research would suggest that the professional group to which an employee belongs to and the organisation in which they work play a significant role in determining the nature and the level of trust between employee and manager and what the employee will consider to be as characteristics of trustworthy managers. The nature of the professional group to which they employee belongs to and the organisation in which they work is also significant particularly with regard to the creation of dual and competing commitments. As will be witnessed in chapter eight nursing staff have a significantly higher level of commitment towards their profession compared to that of the organisation in which they work. It is their level of attitudinal commitment, towards professional nursing which would ultimately seem to determine their level of behavioural commitment towards their daily tasks and duties.

Structure of thesis

In the first instance a substantial literature review was undertaken which provides the background to NHS organisations in light of the recent history of NHS reform and the impact this has had upon the way NHS organisations are managed (see chapter one). The previous literature on employee trust and commitment was then outlined and described (see chapter two). This was followed by the introduction of a conceptual model and framework for the study of employee trust and commitment which illustrates the inputs and outcomes which can arise from the existence of high levels of trust and commitment within organisations (Morgan and Hunt, 1994). This model was then applied to the context of NHS organisations and the environment in which they operate (see chapter three).

The next stage of this research project looked at the nature and purpose of the research methodology used in fulfilling the aims and objectives of this research. The two traditions of philosophical thought, positivism and interpretism, were explored within this section as the background for the methodological framework and design used. The methodological design employed both qualitative and quantitative research techniques (see chapter four).

The subsequent part of this research project constituted an analysis of the results of the in-depth interviews and the questionnaire surveys (see chapter six and seven).

The final part of this research project involved a discussion of the results of the in-depth interviews and the questionnaire surveys on trust and commitment (see chapter eight). A comparison of the results on trust and commitment within the two organisations were also carried out. The results that arised from this discussion were

explored in the light of contemporary and recent research on trust and commitment and informed the construction of models depicting and highlighting the relationship between trust and commitment amongst nursing staff within the two organisations. Overall this program of research concluded with a discussion of the findings in light of the previous research and models on trust and commitment and the research questions highlighted within the research methodology (chapter four). Again the overall findings would suggest that organisational context and the professional group to which an employee belongs should be brought into account when one is assessing and examining employee trust and commitment.

Chapter One: The NHS; An Introduction

THE NHS ; AN INTRODUCTION

Recent history of the NHS

The NHS was first established in 1948 under a labour administration with the primary goal of providing health care and medical coverage for all the citizens of the UK inclusively. While there were regular changes in governments after this period, little was done in attempting to change the institutions or principles of the NHS as an organisation, these remained intact. It was only through the election of a conservative government in 1979 that the traditional constitution and principles, which had guided the NHS since its inception after 1945, were challenged (Colling, 1997).

The rise of the 'New right' and implications for the Public sector including the NHS

The administration which came to power in 1979 was greatly influenced by 'new right' economists and took a neo liberal view of the state. The advent of this administration was to make a sharp break with the political consensus that had been established between labour and conservative governments regarding affairs of the state since 1945. The new administration perceived organised labour and the maintenance of a large public sector as the main factors contributing to falling standards in British industry and British global competitiveness. The strength of trade union power and the demands they imposed upon British industry were seen as the root causes involved in the decline of British commercial and industrial competitiveness. At the time the new right within the Conservative Party saw trade unions as having a monopolistic stranglehold over the

supply of labour throughout the UK (Bach and Winchester, 1994). Their objective was to remove all obstacles to the development of an enterprise economy wherein the principles of the market would be paramount. Both the existence of trade unions and a substantial public sector were seen as the two main obstacles to the introduction of an enterprise economy based on the principles of the market (Bryson et al, 1996).

The incoming conservative administrations therefore took a minimalist view of the state and undertook a strategy to effectively undermine organised labour in favour of the unitarist principles encompassed in private sector management styles. Purcell and Ahlstrand (1994) describe organisations who follow unitarist principles, as pursuing managerial styles,

‘Based around a single source of (managerial) authority’

(Purcell and Ahlstrand, 1994)

The conservative administrations embarked upon a series of strategies and initiatives aimed at extending the British private sector into those sectors of the economy that had previously been under the control and ownership of the government. This trend was however indicative of a wider perception, amongst other European countries, that the public sector in many countries was becoming too much of a burden on national governments and limiting the scope for economic growth as a result. In their work on trends in employee and industrial relations throughout Europe, Ferner and Hyman (1992), have commented upon the widespread perception that the public sector in Britain as well

as the rest of Europe appeared to be crushing the development of private sector enterprise and was impairing the development and growth of the wealth creating sectors of the economy,

‘The role of the state in the provision of welfare - health, education and social security - has provoked a literature of the ‘overloaded state’, of ‘fiscal crisis’, in which an overextended public sphere was seen as ‘crowding out’ the wealth-generating private sector’ (Ferner and Hyman, 1992, p.52)

In view of this widely held perception the conservative government therefore looked upon the process of ‘rolling back the state’ as its top priority. Public sector expenditure was reduced on the assumption that the private sector was better than the public sector and individualism was superior to collectivism. As a result the profit incentives and financial management of the private sector were introduced into the public sector (Kessler, I. and Purcell, J. 1996). As a result many of the industries previously within the domain of the public sector were transferred to the private sector.

‘Many parts of the public sector have been transferred, by one means or another, to the private sector and the functions left in the public sector have been subject to more exposure to market forces than some had thought possible’

(Bryson, C., Jackson, M. and Leopold, J., p.98, 1996)

The conservative government also embarked upon a program of policies and legislation designed to dramatically curb and reduce the political influence and power of trade unions and organised labour within the UK (Lloyd, 1997). Previously, during the period of post war consensus politics, the government, employers and employees were organised as part of a forum in which negotiations and planning took place on issues concerning the government, employers and employees. The use of tripartite bodies in deciding national economic and fiscal policy is referred to as corporatism. The principles of corporatism therefore informed the style in which the negotiation and the management of employee relations were to be conducted, particularly within the public sector. Under corporatism the government created structures and mechanisms designed to 'enhance the position of industry or national-level institutions' (Hollinshead, G. and Leat, M., 1995, p.74). The government set in place structures and mechanisms designed to institutionalise and contain conflict. This was achieved through the use of tripartite structures whereby the government, employer's organisations and trade unions negotiated and made decisions jointly.

The unitarist principles adopted in the new public sector management introduced by the conservative government were consistent and linked to the wider philosophical bias of the conservative government towards liberal individualism. Those who subscribe to the philosophy of liberal individualism believe in the supremacy of market forces, in terms of efficiency and effectiveness in allocating and providing goods and services, and perceive the government as playing a non interventionist role in regulating the market and its effects upon the wider society in which it operates.

Management practices informed by the unitarist approach uphold the principle that management have the ultimate right to manage and decide (Purcell and Ahlstrand, 1994). This approach sees only one form of authority and foci of employee loyalty, mainly being that of management, there is therefore no scope for any alternative forms of authority or points of view. Unitarist managerial styles are inherently hostile to trade unions and other labour organisations as they are seen as being unnecessary and they also weaken the principle of managerial prerogative.

NHS reform

The initial intentions of conservative government reform within the NHS were signaled by the advent of the Griffiths report (1983). The Griffiths report essentially recommended the introduction of private sector management techniques and styles into the NHS (Winchester and Bach, 1995). Private sector management techniques were perceived as more appropriate and effective than that of traditional public sector management styles (Colling, 1997). The Griffiths report recommended a departure from the joint decision making between NHS professionals and public administrators which had formed the traditional style of NHS management to that of the more unitarist styles of private sector managerialism.

‘One of the most important initiatives during the 1980s was the introduction of a general management role into the NHS’

(Winchester, D. and Bach, S., p.313, 1995)

The report perceived the introduction of private sector management techniques as a way of making the NHS more cost effective and improving the standard of service provided. As a result managers were recruited from the private sector into the public sector during this period,

‘In the early waves of trusts, prominent senior positions were offered to managers with business rather than medical or public administration backgrounds’

(Colling, p.660, 1997)

The introduction of private sector management theory and practices was done so on the basis that the previous system of consensus management was not efficient and provided an ineffective basis for organisational decision making within NHS organisations. The following statement from the Griffiths NHS Management Inquiry, 1983-4, illustrates this point,

‘The idea of general management is founded on the notion that the system of consensus management which has been the norm for at least the past ten years has failed in some way and is not open to improvement’

(Griffiths NHS Management Inquiry, p. XXI, 1983-4)

The Griffiths NHS Management Inquiry also acknowledged the implications which the introduction of general management and private sector management theory and practice would have for NHS clinicians particularly with regard to the professional autonomy and lack of managerial accountability enjoyed by members of the medical profession,

‘Doctors are more rightly concerned about the possible implications of a general manager at unit level. Such a manager, from whatever professional background, would be as close as any manager to the day-to-day issues directly affecting the care of individual patients, and therefore impinge on the way in which individual clinicians worked’

(Griffiths NHS Management Inquiry, p. XXIX, 1983-4)

Despite the introduction of the new managerial practice the NHS continued to suffer crises particularly within hospital services. The problems arose essentially as a result of the ‘incompatibility of finite resources and an infinite demand for health care’ within the NHS (Kendall, Moon, North and Horton, edited by Farnham and Horton, 1996, p.206). In response to this the government launched two reviews, Working for patients and caring for people. These two reviews were to mark the formation of the Community Care Act, 1990. The Community Care Act has been mainly looked upon as having paved the way for the introduction of internal markets within the NHS which took place shortly afterwards (Shaw, 1995). The purpose of the 1990 Community Care Act was to,

‘make further provision about health authorities and other bodies constituted in accordance with the national health service act 1977; to provide for the establishment of National Health Service Trusts’ (Public General Acts and measures of 1990, p.1065, 1990)

The 1990 act created organisational change within the NHS which was designed to facilitate further market reform within the NHS as an institution. This was achieved by breaking the NHS up into two sectors, one providing care and another purchasing care.

Organisational change within the public sector has therefore involved breaking organisations into ‘quasi-autonomous provider units’ that deliver services through ‘contractual relations’ while the centre retains a ‘strategic, coordinating and controlling role through financial systems, performance indicators, targets and output measures’ (Kessler, I. and Purcell, J., 1996, p.208-9).

The introduction of these reforms marked a departure from the old system where health care professionals undertook both the role of deciding the necessity of patient care as well as that of determining what was provided in order to facilitate the treatment of patients within their care. The old system provided little or no quantitative or qualitative control on either the need for or provision of patient care within the NHS. The splitting of the NHS into two sectors, one which provided and one which purchased health care needs was seen by the government as the most effective way of enabling the quantification and qualification of patient needs and provision. The introduction of the Community Care Act of 1990 preceded the creation of NHS trusts (Bryson, C., Jackson, M. and Leopold, J., 1996). Bach, 1998 has referred to the introduction of NHS trusts as follows,

‘Drawing on practice in the private sector, the Conservative government invoked the model of the multi-divisional company with strict head office monitoring of financial performance and service standards by central government accompanied by a proliferation of the number of Trusts acting as separate “business units”

(Bach, p. 566, 1998)

In 1991 the government launched the Citizens Charter. The Citizens Charter established the principle of service quality for patients within the NHS. To some degree it was seen as an initiative to instill a consumer first approach within the public sector. The Citizens Charter aimed to achieve this through maintaining a commitment on behalf of public sector industries to improving standards in service quality and through the adoption of a more customer orientated approach to service delivery.

Managerial change within the NHS

As referred to earlier, the government saw the introduction of private sector management techniques and practices such as performance management as an effective way of addressing the need to cut costs and increase standards within the NHS. The previous conservative governments introduced measures to facilitate the implementation of management's 'right to manage' within the NHS.

Purcell and Ahlstrand 's management style matrix

The type of management style adopted by the NHS has direct implications on how the organisation views its manpower and human resources. The NHS is an organisation where the management and employment of people form the very core of its managerial activities. The type of managerial style adopted will therefore have significant repercussions in all the organisations within and linked to the NHS. In defining and

outlining the importance of managerial style within organisations Purcell and Ahlstrand (1994) have made the following comment,

‘Style implies the existence of a distinctive set of guiding principles, written or otherwise, which set the parameters to and signposts for management action regarding the way employees are treated and how particular events are handled’

(Purcell and Ahlstrand, 1994, p177)

Purcell and Ahlstrand have devised a matrix in which they have outlined a variety of different approaches pursued by companies and organisations in the management of their employees and human resources. The authors have looked at managerial styles in terms of the degree to which they are based upon the two dimensions of individualism and collectivism (Kessler and Purcell, 1996)

Management styles within the NHS

The managerial style that has been traditionally practiced within the NHS, as has been the case within the rest of the public sector, has traditionally fallen into the category of the Bargained Constitutional model (Purcell and Ahlstrand, 1994). As outlined in Purcell and Ahlstrand’s management style matrix (1994) the Bargained Constitutional model mainly indicates that the organisation both recognises and negotiates with trade unions and labour organisations. Within this model there is a heavy emphasis upon the institutionalisation of conflict whereby,

‘Management prerogatives are defended against the encroachment of unions through the use of highly specific collective agreements, and careful attention is paid to their enforcement and administration at the point of production’

(Purcell and Ahlstrand, 1994, p. 197)

As a result of the progressive trend towards privatisation under the conservative administrations it has been alleged that the style of management used throughout the public sector has changed in so far as it is becoming much more guided and informed by private sector ethics and principles. This has implications in the way managers both view and manage their human resources.

Purcell and Ahlstrand (1994) have spoken of the move from the traditional model of bargained constitutional model to what is referred to as the ‘sophisticated consultative model’. The sophisticated consultative model is usually employed in organisations where,

‘Employees, or at least a large part of them, are seen as core elements of a firm’s

(In the case of the NHS) success in the market place. Other employees are more likely to be staff of subcontractors working for example in the canteen or in security’

(Purcell and Ahlstrand, 1994, p. 200)

Over the past decade those industries and organisations within the private sector have witnessed a move away from the bargained constitutional model towards the sophisticated consultative model. The sophisticated consultative model both encourages and accepts employee representation. Those organisations who follow this model have

built in mechanisms into the organisation, that are designed to manage conflict between management and employees. The model prescribes that management are involved in the building and maintenance of consultative relations between them and their employees. While this may sound good in theory from the employees point of view it has been pointed out that given the lack of legislative support such mechanisms are not as effective in protecting the interests of the employee as they may sound. While management may and very often do consult with employee representatives they ultimately retain the right to decide. Purcell and Ahlstrand sum up both the strengths and weaknesses of this model with the following,

‘At their best there will be wide-ranging discussions, with extensive information provided on a whole range of decisions and plans with the aim of gaining consensus while recognising that such bodies are not engaged in joint consultation, in the proper meaning of the term, but in strategic consultation. Management, in the end, will decide’

(Purcell and Ahlstrand, 1994, p. 201)

This model therefore allows management greater maneuver in terms of establishing the areas and issues in which they will consult with their employees while simultaneously giving management the ultimate say in there outcome. Without the legislative infrastructure required from the unions point of view to back up and bolster the position of the unions and other labour organisations they are left with a much weaker hand when dealing with management. While the bargained constitutionalist model tended to be based more on the pluralist perspective (in so far as union negotiations were backed up by

greater legislation resulting in legally enforceable collective agreements) the sophisticated consultative model is essentially based within the unitarist camp as ultimately it upholds the right of management to decide on the outcome of the negotiation process.

‘The sophisticated consultative style is seen as the model type for some companies to aim for from the bargained constitutional box if the strategy includes the continued recognition of trade unions’

(Purcell and Ahlstrand, 1994, p. 201)

In the particular context of management within the NHS, where there is an increasing emphasis on themes such as ‘value for money’, employee flexibility and budget restrictions it is hard to envisage a wholesale transition to the sophisticated consultative model from the bargained constitutional model of employee management. In order for an organisation to comply with the ideal of the sophisticated consultative model management must invest heavily in their manpower and human resources in terms of training and development.

In the circumstances outlined above there is the danger that the model that tends to be adopted is the traditional model. The traditional model is one where labour is seen purely as a commodity that should be purchased and maintained at the cheapest possible price,

‘This style is found in companies which see labour as a cost or a factor of production, along with land and capital, as traditional economics puts it. Here labour costs are all-important and efforts are made to minimise costs, labour security, and the expense associated with recruitment, hiring, and training’
(Purcell and Ahlstrand, 1994, p.194)

Performance management

As mentioned above the conservative administrations which took office from 1979-97 were greatly influenced by the new right economists. The focus was therefore upon efficiency and cutting the costs of financing the public sector. The new administration viewed the introduction of private sector management techniques (as outlined within the Griffiths report on the NHS) into the public sector as the most effective way of fulfilling these objectives. These beliefs would play a significant role when deciding on how the public sector was managed under conservative government.

The government took measures to decentralise public sector organisations from central government under the slogan of ‘rolling back the state’. Managers were given control of decentralised bodies and were given incentives to perform to higher standards through the introduction of performance related pay. Decentralisation was set in motion to operationalise and cultivate managerial autonomy while performance incentives were introduced to encourage greater efficiency and cost effectiveness in how the service was run (Ferner and Hyman, 1992).

Ferner and Hyman (1992) are critical of the introduction of performance related pay within the public sector on the grounds that it is contrary to and conflicts with 'employee perceptions of fairness' (Ferner and Hyman, 1992, p.63) in terms of pay and conditions of employment, it is divisive and in general goes against public sector notions of equity (Sinclair in Kirkpatrick and Lucio (eds.), 1995). The public sector has traditionally operated on the lines of a specified rate or scale of pay for each post. Another reason as to why the introduction of performance management within the public sector has been considered as being inappropriate is due to the fact that work within public sector is hard to measure. Ferner and Hyman have pointed out that it is 'easier to measure volume than quality despite the increasing political emphasis on the latter' (Ferner and Hyman, 1992, p.64). The introduction of performance management techniques would therefore provide an incentive towards the maximisation of volume while at the same time ensuring that there remained no check on the level of quality within their particular service. They also point out that the introduction of the performance ethic introduces commercial values into the public sector, with the subsequent argument from the trade unions that 'if the public sector is to be run like a business then its employees should be paid at the same level as those within the private sector,

'Thus the performance ethic is at odds with and may undermine the public service ethic, and in particular the value of intrinsic, non-monetary motives that have traditionally been important aspects of public sector behaviour (Wise 1993:86)'

(Ferner and Hyman, 1992, p.64)

The authors have commented upon the symbolic potency of the implementation of performance management techniques within the British public sector. They argue that by doing so managers within publicly owned agencies signal to their 'political masters' that they have taken on board notions of financial accountability and responsibility and increasing efficiency. The authors highlight the significance of the implementation of performance management within the British public sector and hint at the political motives behind its introduction in the following statement,

'Such symbolic communication has been especially important in countries such as Britain where the onslaught on traditional management in the public sector had a strong ideological component'

(Ferner and Hyman, 1992, p.64)

Labour costs and flexibility within the NHS

Under the conservative administrations measures were introduced as a means to create greater labour flexibility within the NHS. The objective of creating a more flexible and cost effective workforce was assisted through the introduction of a series of legislative and policy measures designed to reduce the power and relative resistance of organised labour (trade unions and professional associations) as well as strengthening the position of management both within the public sector as well as the private sector within the UK economy. While the power of organised labour was weakened during the 1980s health service trade unions continued to remain strong enough to resist or at least slow down the pace of reform within the NHS,

‘The health service unions undoubtedly had been weakened by defeats in the 1980s. Nevertheless, they remained powerful organisations, instinctively opposed to trust status, and capable of mounting effective resistance across a wide area’
(Bryson, C., Jackson, M. and Leopold, J., p.106)

There was also a marked emphasis on the part of government in favouring local wage bargaining to that of national wage bargaining. This would allow NHS management a greater say regarding the fixing of wage rates for various groups of employees within the NHS (Bach, 1998). Wage rates were therefore intended to reflect local labour market conditions as opposed to a national average for specific categories of employee. The government also embarked upon a program to devolve pay determination and its mechanisms away from national level bargaining towards local level bargaining,

‘Government policies extolled the virtues of a diverse pattern of establishment pay and employment packages that would be more sensitive to local labour market conditions and organisational needs’
(Bach, and Winchester, 1994, p.273)

The process of creating NHS Trusts also played a role in putting pressure on the level of pay of NHS staff. The Review body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, 1995, illustrates this point in the following statement,

‘Trusts are independent units within the NHS, each competing for a share of the funds either allocated directly to NHS purchasers or available from local authorities. This has led to an increasing emphasis on the management of Trust’s costs, of which pay represents some 70% overall’ (The Review body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine; twelfth report on professions allied to medicine, 1995)

When commenting about the introduction of NHS trusts Bryson et al (1996) claims that power was given to NHS managers to determine their own wage determination at local level,

‘The opportunity (introduction of NHS trusts), in part, has been provided by the 1990 Act, which gave Trusts the power to withdraw from national bargaining to determine their own remuneration strategies’

(Bryson, C., Jackson, M. and Leopold, J., p.98, 1996)

The devolution of pay at local level represented a move away from the traditional determination of pay at national level under the Whitley councils. The principles underlying the Whitley councils are described within the following,

‘Whitleyism: the principle that joint agreement between employers and employees should be reached whenever possible, and that the two sides should seek to resolve their differences within an agreed procedure that included arrangements for arbitration’

(Winchester, D. and Bach, S., 1995, 321)

With the introduction of the internal market and NHS 'trusts' the governments aim was to,

'move the 1 million employees away from the national Whitley system of collective bargaining and pay review bodies, with their central role for the 36 trade unions and professional associations, to a system of pay determination at trust level with or without union involvement'

(Lloyd, C., 1997, p.430)

This did not however go as smoothly as anticipated. Many researchers claim that the determination of pay at local level, in line with local labour market rates was fraught with difficulties not least because health service managers were poorly equipped to deal with local pay bargaining but also because, as Bach (1998) has pointed out, of the, 'distinctive organisational, occupational and political characteristics of the public services' (Bach, 1998, p.566) which he claimed constrained the development of pay bargaining at local level. He also claims that the development of local pay bargaining and more flexible labour practices was to some degree undermined by government intervention,

'despite important changes in working practices, the possibilities for a more strategic approach towards the management of staff in the NHS remains heavily constrained by

national policies and central government intervention which inhibits autonomy at Trust level'

(Bach, 1998, p.565)

The problem with devolving pay from national level e.g. through the Whitley councils, to local level lay essentially in the fact that management at local level would then have to bargain with a very large number of professional and occupational groups each with their own separate terms and conditions of employment (Bryson et al, 1996). Another factor that made the movement of pay determination from national to local level so difficult was the fact that many of the personnel systems in the newly established trusts lacked the expertise and the resources to negotiate pay at local level effectively (Bach and Winchester, 1994). It was for these reasons that the,

'creation of a decentralised system of pay determination, responsive to the needs of managerial efficiency, labour-market and employee performance, has proved to be a difficult enterprise'

(Winchester, D. and Bach, S., 1995, p.318)

As a result of their inability to negotiate pay at local level many health sector managers embarked on a cost cutting strategy,

'Instead of negotiating local pay and conditions packages, managers have sought short-term reductions in their overall payroll by imposing changes in work organisation and

labour utilisation...Managers have sought to reduce payroll costs through the reorganisation and intensification of work rather than through the development of local bargaining on pay and conditions'

(Bach, S. and Winchester, D. 1994, p.265-79)

Through the introduction of competitive tendering practices (whereby a range of in-house services within the NHS could be contracted out to private companies) NHS management were allowed greater scope in cutting labour costs.

Sheaff, 1988, has commented upon measures introduced by the government which were designed to achieve greater labour flexibility and also allowed management greater scope in cutting the cost of labour. The primary outcome of the introduction of these measures was a significant increase in the level of managerial control over their employees.

'a tightening of managerial control over employment has been one of the most significant consequences of the policy, together with a shift towards greater local bargaining'

(Sheaff, 1988, pp. 93-4)

Kelliher (1995) has suggested that the trend of introducing outside contractors to undertake previously run in-house services has not been as widespread as was previously thought. The evidence from the study strongly suggests that there was a widespread initiative on the part of NHS management in reorganising working schedules as a means of reducing labour costs. The perceived threat of outside competition and the pressures on

labour cost reduction arising from central government were highlighted as the two main factors contributing towards this trend.

Alteration of employee skills mix

Despite the efforts to enhance the extent of local pay bargaining the great majority of NHS employees remained covered by the terms and conditions determined through national Whitley committee arrangements. In order to overcome this perceived barrier to cutting labour costs NHS management started to alter the skill mix of their employees (Colling, 1997, Bach and Winchester, 1994). The recent addition of health care assistant (HCA) to the number of employee groups within the NHS is indicative of this trend. This enabled NHS managers to take greater strides in reducing labour costs within their organisations. The creation of the HCA is intended to create a cheaper and more cost effective grade of employee who will undertake the more repetitive and less technical tasks previously undertaken by NHS nursing staff. The new position of HCA is not covered by national machinery (Whitley pay structure) and is therefore in a much weaker position than that of other professions when negotiating and bargaining with NHS Trust managers over the terms and conditions of employment,

‘New hybrid grades, incorporating a broad range of tasks and responsibilities from across occupational groupings, have also been introduced. NHS trusts have developed a new grade of nursing staff (referred to as a ‘health care assistant’) not covered by any of the existing grading structures’

(Colling., 1997, p.667)

The HCA undertakes the more basic tasks that had previously been undertaken by NHS nursing staff i.e. washing patients, cleaning etc. This new grade of employee has been introduced so that management can get the most out of their nursing staff for the money and conditions that they receive under the Whitley pay structure. NHS management can achieve this by encouraging professional nursing staff to concentrate on the more important tasks outlined under their job descriptions whilst delegating their more basic tasks to the newly created HCA.

‘Throughout the health service, managers have sought cost savings through ‘re-profiling’ or grade-mix exercises, frequently a euphemism for skill dilution. This was encouraged by the creation of a new grade of ‘health care assistant’ and the symbolically important insistence of the NHS Management Executive that pay and conditions of the new grade should be excluded from any of the pay arrangements and be determined at local level’

(Bach, S. and Winchester, D., 1994, 276)

This is a strategy which management have devised in an effort to reduce labour costs. Once again this initiative was government lead,

“The Conservative government regards self governing trusts (SGTs) as mould breakers and a number of trust managers are set to embark on widespread changes affecting union recognition, pay determination machinery, pay rates, skill mix and pay and benefit

systems. In so doing, they are unlikely to meet effective resistance from the staff organisations'

(Corby, 1991, p.179)

Divisions between staff organisations within the NHS

Corby's study (1991) of management initiatives regarding trade union recognition and payment systems within the NHS has highlighted the inadequacies of staff organisations within the NHS in pursuing the interests of their members. This has been mainly seen as a result of the large number of trade unions and professional associations within the NHS. As a result of the level of competition between the unions there has been no tradition of solidarity among staff organisations in the NHS and the competition for members amongst the unions enables management to divide and rule, if it so chooses (Corby, 1991; Lloyd, 1997). The fragmented nature of organised labour within the NHS left it vulnerable to government and managerial initiatives which appear to have been calculated to further the fragmented nature of the labour movement within the NHS and hence maintain its weakness and subservience to management. In Beaumont and Elliot's study (1992) regarding employee choice among trade unions within the NHS, the authors discovered one factor which contributed to the growth of the RCN in the 1980s had resulted from the exclusive managerial sponsorship and support of the RCN at the expense of other labour organisations. Historically the RCN has operated more as a staff association than a trade union. The RCN represents the interests of the British nursing profession as a collective. Unlike the two other main nursing trade unions, NUPE and COHSE, (who have now merged to form UNISON) the RCN had a non-industrial action

clause built into its constitution. The RCN was therefore perceived as less threatening to NHS management than either NUPE or the COHSE,

‘Moreover, the logical implication of our central argument is that the growth success of the RCN in the 1980s has been due to some combination of...a switch to greater management sponsorship of the RCN (paralleling the view of the government)’

(Beaumont and Elliot, 1992, p.142)

Market reform: the role of government and the traditional public sector ethos of the NHS

Government regulation of the NHS

Corby (1991) argues that while central government allowed NHS management greater discretion and initiative in the area of personnel matters and human resource planning this has not however been the case with regard to financial matters (Kessler and Purcell, 1996; Bach, 1998; Bach and Winchester, 1994). Management discretion is limited by restrictions in NHS funding, which is essentially under the control of central government. Sheaff, 1988, has also commented on government restrictions on large scale investment within the NHS as a means to pressurise NHS management into contracting out in house services to outside competitors. Both authors acknowledge the apparently political motives behind the process of market reform within the NHS.

Despite the governments objective of 'rolling back the state' and exposing the public sector to the dynamic of the market economy, government reforms have not resulted in a more minimal role for the state within the NHS. The introduction of market lead reform within the NHS has been achieved only through the creation of further government regulations and bureaucracy to ensure that the new reforms were implemented,

'paradoxically, the new structure has also facilitated centralisation and the NHS is now more politically directed and controlled than at any time in its history. The internal

market conceals a highly bureaucratised organisation, albeit one controlled by managers and finance-driven', (Farnham and Giles, Farnham and Horton (ed.s), 1996, p.125)

Oswick and Grant (1996) comment on the role played by the government in their study of contemporary personnel management and practice within the public sector. According to the findings of their research the authors claim that government policy and legislation in changing how the NHS and the public sector operate, have been the most important and decisive factors in introducing change and the process of market reform within the NHS and the rest of the public sector,

'Government policy and legislation relating to the public sector have been instrumental in reshaping all the public services. The pervasive repercussions of government intervention have meant that it has been identified as the singularly most important area contributing to role change within public sector personnel management. The tightening of public spending and restrictive legislation (incorporating measures such as rate capping, compulsory competitive tendering and opting out for schools and hospitals) has forced public sector bodies to commercialise through the introduction of cost cutting exercises' (Oswick and Grant, 1996, p.7)

Stewart and Walsh (1992) have sought to examine how the pace of change in public sector management reflects wider developments taking place throughout the rest of the economy, with particular reference to the pervasive influence of private sector management techniques and practice during the 1980s and 1990s. The authors look upon

the wholesale introduction of private sector management practice and techniques as mainly the result of the ideological and political tenets of 'new right' thinking within the British political body. The motives for NHS reform would therefore appear to have been derived more so from ideological conviction, with regard to the superiority of market forces and private sector managerialism, than that arising through a thorough analysis of the nature, purpose and function of the NHS as an organisation,

'One of the dangers of the emerging patterns of public management is that approaches that have value in particular situations are assumed to have universal application. Public organisations carry out a wide range of activities subject to very different conditions. If in the past there were dangers in the universal assumption of direct provision of services in organisations structured by hierarchical control, there may, equally, be danger in the assumptions that are replacing it, if universally applied'

(Stewart and Walsh, 1992, p. 512)

While the previous conservative administrations, looked upon the introduction of market reform within the NHS as an effective way of making the service provided more efficient and responsive to its users, the introduction of market reform may act to undermine the public service ethos of the traditional NHS. Walsh (1995) underlines the role of the state in the allocation of specific goods and services while also warning of the possible erosion of the traditional public sector ethos only to be replaced with the language and culture of enterprise capitalism,

‘The redesign of the public service along market lines will also involve a fundamental change in incentives, and , in particular, a move away from traditional notions of the public service ethic toward more commercial orientations. It may well be that these different motivations will clash one with the other, leading to ethical dilemmas, and clashes between differently motivated groups of staff.’ (Walsh, 1995, p. 49)

The previous conservative administrations’ engaged in the process of redefining the role of government and acted to change the nature of the governments relationship with the public sector. This was essentially achieved through a process of systematically hiving off large parts of the British public sector onto the private sector. The conservative administrations embarked upon a process of marketisation throughout the British public sector in general.

‘The changes in public sector management in the 1980s and 1990s have been characterised in large part by the government attempting to reduce its responsibility for the direct provision of service and to move towards what has come to be called an ‘enabling’ role. Market-based systems of management are proposed to replace traditional bureaucracy’ (Walsh, 1995, p. 12)

The values of private sector commercialism introduced by the conservative administrations (1979-97) are seen to be threatening and undermining the traditional culture of the NHS. Indeed if the progress of market reform means the erosion of the traditional public sector ethos of the NHS the results arising from such a development

could have both adverse and negative repercussions on the operation of the NHS and for those who avail of its services. Stewart and Walsh (1992) have commented on how the structure and organisation of the NHS has changed as a result of the formation of the internal market. Once again it has been pointed out that the structure and constitution of the NHS has been altered by the government to facilitate the implementation of market-based principles,

‘Delegation of financial control is implicit in the development of the internal market, but there has also been an explicit experiment with devolved finance, the Resource Management Initiative. The National Health Service is changing from being an integrated, hierarchical bureaucracy to becoming a dispersed network of organisations interacting on increasingly market-based principles’ (Stewart and Walsh, 1992, p.502)

Walsh (1995) has commented on the difficulty of creating trust-based relationships (the ability of one partner to confidently work with another whose behaviour is not under their control), within the current organisational environment and structure of the newly reformed NHS. Walsh looks at trust in the context of inter-organisational relationships within the NHS and the level to which NHS organisations have built up a sufficient level of trust upon which good working relationships can be established. Walsh claims that there is a low level of trust between NHS organisations, which he attributes to the fragmented nature of the newly reformed system in terms of both its structure and organisation. Prior to the process of market reform the NHS functioned as one single organisation, since the creation of the internal market the NHS has tended to operate as a

network of organisations. The building up of trust based relationships between organisations is harder to achieve in the newly reformed NHS.

‘The process of trust development in a network will therefore be different from that within an organisation. It will be necessary to develop systems for signaling and recognising trustworthiness in ways that do not rely upon personal contact (Spence, 1972). Trust will be more difficult to develop at a distance than it is when there is direct personal contact’ (Walsh, 1995, p. 51)

The research conducted so far does not show any strong indication that the introduction of private sector management reforms within the health service will result in the proposed benefits of efficiency and quality of service as intended by the previous government.

Culture clash: NHS Managerialism Vs Professionalism

This section will look at how the alleged introduction of private sector management culture and practice and market reform may act in undermining and eroding the traditional public service ethos which has underpinned the operation of the NHS since its creation in 1948.

When we consider culture we must also consider that there are many definitions as to what culture actually is. When looking at organisational culture the context in which the organisation, being studied is set, and the nature and purpose of its business must be

taken into account as these are factors which can and do influence culture. In his work on culture Ogbonna, has defined culture as being,

‘the interweaving of the individual into a community and the collective programming of the mind that distinguishes members of a social unit or group. It is the values, norms, beliefs and customs that an individual holds in common with members of a social unit or group’ (Ogbonna, 1995, p. 113)

The grafting of private sector management techniques within the NHS and the structural changes which were introduced to facilitate this process appear to be altering the organisational culture and outlook of the NHS itself.

Colling (1997) has made the following observations on how the policies and practices of the private sector are seeping into the NHS and the rest of the public sector and replacing the traditional principles and values of the public sector,

‘Individualised performance-related pay overturns the principles of equity and consistency within occupational groups which have been paramount in the past. Teamworking and changed grading structures are blurring established professional boundaries. Broad notions of public service, with their attendant processes based on consistency of treatment and formal accountability, are arguably being replaced as the defining features of state sector employment relationships. Individual contributions to ‘customer service’ and the achievement of measured organisational targets are now

central, a reflection of the market-driven environment in which many public sector employees now work’

(Colling, 1997, 668)

The employment of people within the NHS currently accounts for 70% of the NHS’s financial resources. If it is indeed the case that the introduction of private sector style management practices is having adverse and negative effects upon the commitment traditionally exhibited by NHS employees to the work they carry out within the NHS, the costs of such a move could considerably outweigh any of the proposed benefits. Pratchett and Wingfield (1995) claim that the public service was founded upon accountability, impartiality and commitment to communitarian values. This they claim was deliberately fostered within the traditional public service industries and acted as a primary motivating factor for public sector employees (Pratchett and Wingfield, 1995).

The NHS has traditionally operated upon the lines of a professionally driven culture one which has shaped the institution itself. In outlining the attributes of a professional culture, particularly the professional culture within the NHS Anthony (1990) has said the following,

‘It must be acknowledged that there is much to be said about the politics and power of professionalisation which suggests that it is rather more of a dutiful concern and moral rectitude... In the NHS...the internal values...are shared by the inhabitants, who influence the culture of their organisations because they regard its institutions as instrumental to their practices and to their concern with internal values’

(Anthony, 1990, p. 6)

The concept of professional duty and concern for the patient remains a strong theme within the professional culture of the NHS. Many of those professionals who work within the NHS are motivated by a concern for and a belief that their work is bringing positive benefits for the society at large. While commenting on the governments plans to devolve pay arrangements throughout the public sector Kessler and Purcell (1996) also highlight the significance of professional groups within the public sector in preserving and maintaining traditional public service ethos and values and the tensions that have arisen between professional and managerial values.

‘the presence of professional groups, reinforced institutionally through their associations has not only affected the determination of terms and conditions but equally significantly helped preserve a set of values and principles potentially in tension with the newer managerial approaches’

(Kessler, I. and Purcell, J., p. 217, 1996)

It has therefore been suggested that the culture and language of the market and private sector managerial styles and practice are to a greater extent alien to the traditions of the NHS. Stewart (1996) has highlighted the difficulties which professional doctors have in conceptualising those who use the NHS as customers when traditionally they have always considered them as patients,

‘Some clinicians, whether nurses or doctors, dislike the idea of patients as customers which they see as alien to their view of professional service. This is understandable. It is a view that can come from the best motives of service and of responsibility to the individual, where the analogy of treating the patient like a relative is seen as more appropriate’

(Stewart, 1996,p. 40)

The clash between the traditional professional culture and the new management within the NHS has already arisen over the issue of quality and the implementation of quality initiatives within the newly reformed NHS. The struggle between NHS management and professionalism reflects differences in outlook between the two occupations that have arisen largely as a result of the training and educational background of the two groups. The differences in the opinion and outlook which have formed the basis of this conflict with regard to the definition of quality within the NHS, have been highlighted in the work of Kirkpatrick and Lucio (1995),

“We thus have different vocational specialities developing different paradigms of quality: medical profession verses planner or manager”

(Morgan and Potter, edited by Kirkpatrick and Lucio, 1995,p.185)

Currie (1996) also illustrates the existence of conflict between NHS professionals and NHS management. Again the manifestation of conflict appears to be arising as a result of differences in the training, education, and the process of socialisation each group

undergoes when pursuing their vocation. The result is that NHS management and professionals tend to have diverging principles and values which provide the basis for conflict and recriminations within the organisation.

‘Potential for conflict between managers and professionals may manifest itself in the distinction between the occupational and the administrative principles’

(Currie, 1996, p. 10)

It would appear that the holistic view of patient care which has underpinned the traditional philosophy of professional nursing within the NHS is currently under threat by managerial initiatives aimed at fragmenting the workforce under the goal of ensuring cost effectiveness. One of the ways this is being achieved, as already mentioned, is through the use of HCAs and ancillary staff who are not as highly paid as professional nurses. Professional nurses on the other hand are being used to do more and higher level duties, duties which have previously been undertaken by NHS doctors. This has been highlighted by Stewart (1996),

“There are the changes in nurse education resulting from project 2000 and in the skill mix of nurses. Nurses have been developing their clinical base so that they can undertake work that was previously done by doctors” (Stewart, 1996, p.32)

The traditional professional boundaries within the NHS are becoming much more blurred as a result of managerial attempts aimed at creating a more flexible and cost effective

labour force. In outlining changes taking place throughout the British public sector Oswick and Grant (1996), have commented upon the new organic orientation and the “de-bureaucratisation” process occurring throughout public sector organisations in general. As a result of the findings gathered from this research it is believed that public sector employees are undergoing a series of role changes,

‘The enactment of this organistic orientation has involved the loosening of role definitions, the flattening of hierarchies and less formalised systems of management and communication’

(Oswick and Grant, 1996, p.8)

The changes that have occurred within the organisational structure of the NHS appear to represent an attempt to change the NHS from that of being a professionally driven and run organisation to one which is becoming much more accountable to NHS management. The result and the outcome of this structural and cultural change in the short term is marked by managerial and professional conflict over what was and has been considered up until now the domain of the professionals, that of devising and administering health care policy and practice. Currie (1996), highlights the basis of this conflict as part and parcel of the wider changes occurring within the structures and culture of the NHS,

‘The application of business management approaches into spheres such as health care has been seen as not so much an empirical issue about how such activities may be organised but as the transformation of such an organisation into a managerial organisation.

The management of employee relations within the NHS:

Employee trust and commitment within the newly reformed NHS

Most current research proposes that employee trust of management is an essential prerequisite to the formation and development of employee commitment to the aims, objectives and values of the organisation in which they work. Another linked assumption is that human resource efficiency and effectiveness are positively influenced by high levels of employee commitment. An implication of these two assumptions is that where NHS management use their HRM departments to implement policies that are designed to disseminate and perpetuate managerial aims, objectives, and values these HRM plans may not be as effective as they could be if NHS management fail to win over the trust and subsequently the commitment of their employees. This means that managers maybe failing to maximise the optimum level of effort and output available to them from their human resources. The subsequent aim of this research paper will be to outline and establish the nature and scope of employee commitment and values regarding their work within the NHS.

This program of research will be conducted in the context of:

- organisational change, resulting from market reform and its impact on the management of employee relations within the NHS
- The impact of the alleged introduction of private sector managerial styles on the work practices of NHS employees

organisational resources when making clinical decisions. As mentioned above this is mainly attributed to the professional character and outlook of the NHS. The NHS is a domain within the public sector where its employees uphold the task of attending to the needs of those requiring medical attention as their number one priority. Anthony (1990) highlights the professionally driven nature and value system of the NHS which makes it different from that of other institutions. Anthony (1990) illustrates the differences between the cultures of professional organisations like the NHS with that of managerial driven organisations such as private sector companies and corporations and claims that there is a high level of incompatibility between the two cultures in terms of their priorities and commitments. Clinical practice within the NHS is perceived as having a higher priority than that of the other organisational concerns e.g. budget restrictions. Within private sector companies however, the organisation takes much greater precedence than that of the activities of particular individual employees,

‘In the National Health Service and the universities the internal values of health or education are shared by the inhabitants, who influence the culture of their organisations because they regard its institutions as instrumental to their practices and to their concern with internal values. In these instances, culture is based upon identifiable values widely shared; they are not imposed by the institution although they may be reinforced by it. Historically, the institution is secondary to the practice. In managed organisations the opposite is true: the institution comes first in time and any culture that follows is likely to have been imposed, often coercively, by a leader or founder, who may have charismatic qualities attributed to him or her. The values communicated and reinforced by the leader

will have to be incorporated into the individual meanings of subordinate members who, if they do not find these meanings acceptable, will not be permitted to join or may soon be asked to leave. And the values and culture are, of course, likely to be changed or obliterated with a change in the leadership; in the professions, culture is more likely to abide'

(Anthony, 1990, p.6)

From these comments it is easy to see why the values of private sector managerialism may conflict with the values of public sector professionalism. What is more apparent however is that the professional culture of the NHS is very deeply rooted and indeed has acted to shape and forge the outlook of the institution itself. The task set aside for NHS management, that of making the NHS much more financially driven and management lead, appears to be a formidable one, given the durability and pervasiveness of the existing professional culture.

Anthony (1990) has commented upon other industries and institutions which having lacked a strong 'professional' culture were much more susceptible to the importation of private sector management techniques and culture as a result.

'Strong cultures have been destroyed in sectors without professional characteristics. In occupational communities like railways, coal mining, steel production, the internal cohesion and commitment to the task has been deliberately weakened by management's pursuit of alternative values' (Anthony, 1990, p. 6)

In order to attain dominance and control through out the wider organisational entity management must aim at destroying the culture that stands in its way. The task for NHS management appears to be all the more daunting given the diversity and range of what have been referred to as organisational sub-cultures. As has been mentioned previously the NHS employs a considerable range of occupational and employee groups (Bach, 1998; Bach and Winchester, 1994). In attempting to subordinate the existing professional culture of the NHS to managerial prerogatives, management within the NHS would appear to be confronting a number of different cultures and professional categories.

Newton and Hunt (1997) have illustrated the inherent resistance within NHS professionalism towards managerial control and accountability. Given the high level of autonomy and the explicit sense of purpose traditionally enjoyed by most NHS professionals, they may see restrictions on their clinical freedom and sense of purpose negatively and view such initiatives with distrust and suspicion. As has been suggested by Freidson (1973), professions are organised around ‘‘the occupational principle’’. This leads them to assert vigorously their autonomy and to a greater extent ensures their resistance to managerial or administrative/bureaucratic strategies of control.

Through the introduction of market reform within the NHS the previous government designed and implemented an organisational structure which would ultimately strengthen the hands of NHS management vis a vis that of NHS professionals. The government achieved this through the introduction of organisational structural reform with the explicit intent of subordinating the health care service to the ethos of the market,

‘Many of the changes sought by the government can be seen as attempts to change the cultures of the public services, dominated as they have been by the traditions of administration, hierarchy and professionalism...The changes in the management of the health services introduced by the Griffiths report emphasised the patient as customer, and the appointment of the general manager challenges the dominant professional culture. The impact of compulsory competitive tendering on local authorities has been to stimulate a commercial culture. Change in culture is slower than change in mechanisms, but institutional theory would suggest that fundamental changes in the rules will have strong effect, though not necessarily that predicted’
(Stewart and Walsh, 1992, p. 508)

While it is clear that the NHS is currently undergoing change in organisation, culture and outlook, the final outcome of the reform process is not yet clear. The extent to which the NHS reforms introduced by the previous government will succeed in changing how the NHS is run may largely depend on the durability of the existing professional cultures within it and their willingness to become involved within this process.

Impact upon employee commitment, trust and morale

As a result of the funding restrictions on the operation of the health service, as outlined above, the practice and implementation of personnel management throughout the public sector is to some extent being viewed in an increasingly negative light. This has arisen mainly as the result of the unpopularity of the policies which are being implemented through the personnel function as a consequence of funding restrictions and the increase

in competitive pressures arising from the process of market reform (Winchester, D. and Bach, S., 1995; Oswick and Grant, 1996; Edwards et al, 1998). Oswick and Grant (1996) have commented on the increase of this trend throughout the public sector in general as well as within the NHS,

‘Perceptions of personnel management in the public sector have changed in recent years. There is an increased association with negative activity. The recession, privatisation and diminishing funds have all conspired to put pressure on public sector organisations to reduce labour costs. This has resulted in a number of unpopular measures being introduced’ (Oswick and Grant, 1996, p.11)

The authors also conducted research into how the ‘unpopular policies’ mentioned above affected employees throughout the public sector. The findings gathered from this study explain why the personnel function was becoming increasingly associated with negative activity from the perspective of the employee. The results were as follows,

‘Our participants talked of; voluntary and compulsory redundancy; enforced early retirement; withdrawal of unsociable hours payments; relocation and redeployment; general downsizing; the introduction of more flexible working practices; the removal and reduction of perks and fringe benefits; and moratoriums on the filling of vacant posts. personnel practitioners are normally at the forefront of implementing and policing the aforementioned measures’ (Oswick and Grant, 1996, p.11)

The present working environment and conditions of employment within public sector organisations such as the NHS has been associated with a steep decline in employee morale. This has been mainly attributed to financial cuts in the operation of the NHS and also due to measures been pursued by NHS management, mentioned above, in reducing labour costs. Winchester and Bach (1995) have also commented upon the changes that have taken place within the NHS and there ultimate impact on employee job security in the following,

‘In the 1990s the NHS has evolved from an integrated, professionally dominated bureaucracy into a plethora of separate organisations, where managers hold the purse-strings and make decisions using increasingly financial criteria. These reforms have undermined employees’ job security and challenged traditional employment practices’

(Winchester, D. and Bach, S., p. 314, 1995)

The findings taken from the Review Body for Nursing Staff, Midwives, health Visitors and Professions Allied to Medicine, 1999, claimed that the failure of the government and NHS Trusts to implement previously agreed wage rate increases also had the effect of demoralising NHS nursing staff and other professional categories,

‘Staging has an effect on the morale of staff in our remit group, and can also impact on recruitment, retention and motivation’

(Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine, p.3, 1999)

While NHS staff may appear to exhibit a high level of commitment to their work, the research conducted so far would however indicate that the level of commitment, trust and morale amongst employees within the service remains very low. This has been observed by Edwards et al (1998) as is illustrated in the following comment,

‘Studies suggest that change has not generally led to the creation of a high level of trust in management or commitment to organisational goals’

(Edwards et al, 1998, p.41)

This has been mainly attributed to the measures encouraged by the government and introduced by management in cutting the funding of the service. Unfortunately this has had negative implications for NHS staff regarding their salaries and the terms and conditions of employment under which they work.

‘The future prospects for many public service employees are also uncertain; surveys of employee attitudes and exit interviews have revealed widespread stress and demoralisation arising from work intensification, job insecurity and deteriorating career prospects’

(Winchester, D. and Bach, S., 331, 1995)

The cutting of government expenditure has also had wider implications regarding the availability of equipment and resources needed in order for many NHS professional staff

to carry out their jobs in the delivery of patient care. Opposition to these measures has prompted industrial action by nurses unions, who have pressed for support in their 'right to deliver care'. In the context of the present situation, nurses feel that their ability to deliver the care traditionally provided by the NHS has been undermined. Cuts in government expenditure on the NHS has been cited as the main reason why this is the case. Despite the fact that NHS staff appear to illustrate the commitment and loyalty necessary to ensure that the NHS continues to operate, the morale of NHS staff continues to remain low as a direct result of their present circumstances. NHS management may indeed continue to enjoy the full commitment of their staff, however this could be eventually eroded with the introduction of new reforms. The introduction of market reform and the culture of the enterprise economy that has been introduced by the previous conservative governments and implemented by management within the NHS may indeed act to undermine the traditional public service ethos which has instilled such a high level staff dedication and commitment to the work they do within the NHS. Whether or not such practices will continue under the current labour administration remains to be seen. Whitston and Edwards (1990) have highlighted this concern in their study regarding the factors contributing to high levels of absence within the NHS;

"Management has so far been able to depend implicitly on traditional forms of loyalty. As the contradictions between these and commercialism are heightened, this loyalty may begin to erode"(Whitson and Edwards, 1990, 296)

Although pressure on labour costs and resources have taken their strain on health care staff the Review Body for Nursing Staff, Midwives, health Visitors and Professions Allied to Medicine, 1999, claimed that the motivation of NHS staff and their concern for patient care remained relatively high as the following statement illustrates,

‘Evidence from the Departments of Health said that they recognised that there were problems with NHS staff morale, but that this was not surprising ‘’given the long running problems of service organisation which promoted competition rather than professional care, tight funding and emphasis on efficiency measures which were clinically inappropriate, a stressful working environment with a patchy record on staff management and personnel support systems’’. Despite all the difficulties staff faced, however, individual motivation and concern for patients remained high’

(Review Body for Nursing Staff, Midwives, health Visitors and Professions Allied to Medicine, p.20, 1999)

Kelliher (1995) has also commented on the recent deterioration of employee morale and job satisfaction within the NHS. Kelliher’s study aims to examine the introduction of private competition in carrying out NHS services which had previously been undertaken in-house e.g. cleaning, catering etc. While there is some evidence which suggests an increased ‘customer’ satisfaction (as a result of market testing) and better work performance, the author provides evidence which strongly suggests that employee satisfaction and morale have deteriorated. The study would therefore indicate an emerging paradox between that of apparent increases in the level of employee

productivity and performance while simultaneously illustrating decreasing levels of employee commitment ,loyalty and morale,

‘61% reported that staff attitudes to work had been affected by the experiences of competitive tendering, more than half of these indicated that staff morale had suffered. Equally, loyalty and job satisfaction were reported as having deteriorated. On the other hand, both work effort and customer orientation were described as having improved...this evidence demonstrated that there have been costs to employee relations, particularly in the areas of workforce morale and employee loyalty.’(Kelliher, 1995, p313)

Although NHS management has succeeded in reducing labour costs and appears to have also secured higher productivity and behavioural commitment (measured by labour turnover, absenteeism, and performance) from their employees the evidence would however indicate that this has only being achieved at the expense of the employee in terms of morale, trust and attitudinal commitment. The study conducted by Kelliher (1995) does illustrate the existence of a high level of behavioural commitment on the part of NHS employees regarding their daily tasks and duties, the author does however indicate the existence of a decreasing trend in employee attitudinal commitment,

‘indications of deterioration’s in morale, employee loyalty and job satisfaction suggest a longer term effect and an altered orientation of NHS catering workers to their jobs’ (Kelliher, 1995, 316)

Walsh (1995) has commented on the wider implications of market reform within the NHS on the trust and loyalty of NHS employees. As the pace of market reform accelerates the traditional culture and organisational structure which provided a basis upon which trust, loyalty and commitment could be both established and maintained may be replaced with a system that is not as effective in cultivating the optimum level of employee trust, loyalty and commitment,

‘The danger is that the more commercial, market-based approaches to service management can undermine the traditional bases of trust, dependent as they are on service-based commitments and professional organisational cultures.’ (Walsh, 1995, p 51)

‘New Labour’

With the recent election of a new labour government, in May (1997) the government is now more informed by the ideals outlined under liberal collectivism. Like those who follow the liberal individualist perspective liberal collectivism accepts the main themes and beliefs underlying the free market. However the liberal collectivist perspective views and accepts society and organisations as being made up of competing and alternative factions and groups. When looking at an organisational context liberal collectivists adhere to the principles of pluralism whereby the existence of competing interests is recognised and conflict is managed through collective bargaining and negotiation. Pluralism is a system where,

‘differing goals are reconciled by negotiation’

(Purcell and Ahlstrand, 1994)

The ‘New labour’ administration (elected in may 1997) has indicated that there will be no new major reform process within the NHS and has instead stated that it is ‘committed to building on what has worked, but discarding what has failed’ (The New NHS, Modern Dependable, p.10, 1998). The new labour government therefore proposed a ‘third way’ in which successful innovations and reforms introduced by the previous conservative administrations would be retained and unsuccessful aspects of conservative policies would be discarded. The new labour government decided (The New NHS, Modern Dependable, 1998) that the ethos of competition, introduced into the NHS through the creation of the internal market, has proved itself to be expensive and inefficient. This will not however involve scrapping of the internal market. The purchaser/provider split will remain. ‘New Labour’ envisages a return to co-operation, collaboration and partnership within the NHS.

‘Fragmentation in decision-making has lost the NHS the cost advantages that collaboration can bring. Co-operation and efficiency go hand in glove’

(The New NHS, Modern Dependable, p.8, 1998)

Bach (1998) is however cynical about the extent of the changes taking place under the new labour government particularly with regard to any major changes to the internal market and the level of government expenditure on the NHS,

‘Behind the rhetorical support for the abolition of the internal market, it is evident that its most important feature, the separation of purchasers from providers, will be maintained and Trusts will survive intact with a renewed emphasis on decentralised operational control (The New NHS, Modern Dependable, 1998). Alongside a commitment to tight public expenditure limits and reducing NHS management costs, this policy framework suggests that the pressure on managers to bear down on labour costs, including their own, will continue unabated’

(Bach, S., 1998, p.575)

The commitment on behalf of the ‘New labour’ government to containing and constraining the cost of NHS services has also been highlighted in the 1998 white paper, The New NHS, Modern Dependable, when it states that,

‘Doctors, nurses and other senior professions will be much more closely involved in designing service agreements with commissioners, and in aligning NHS Trusts financial priorities with clinical priorities’ (The New NHS, Modern Dependable, p.45, 1998)

The government has also recognised the contribution and value of NHS staff and the role they play in ensuring that the NHS continues to operate and function for the benefit of those who use it. The following comment not only recognises this but also outlines the need for greater involvement of NHS staff in the running of NHS organisations as a way of ensuring their long term commitment to the health service,

‘To succeed in the NHS of the future, NHS Trusts will need to develop and involve their staff. In the past this has not been a high priority. In the new NHS it is - for one simple reason, the health service relies on the commitment and motivation of its staff - that is why there will be a new approach to better valuing staff and NHS Trusts will spearhead it’

(The New NHS, Modern Dependable, p.45, 1998)

Chapter Two: Employee Trust and Commitment

Employee trust and commitment

The main body of literature on employee trust and commitment implies that in order for employees to feel committed to the aims and goals of the organisation in which they work they must first trust their management. Research carried out on trust and commitment would indicate that the two concepts are both related and that the relationship may be positive (Kanter, 1972; Eisenstadt and Roniger 1984:6; Gellner 1988; Fine and Holyfield, 1996). If one assumes that there is indeed a positive relationship between trust and commitment, it subsequently follows that managers should take initiatives towards gaining the trust of their workforce if they wish to obtain and achieve the commitment of their employees and thereby maximise the potential from their human resources. Brocker et al (1997), have highlighted the link between trust and commitment within the following statement,

‘Studies have shown that trust in organisational authorities influences a variety of subordinates’ work attitudes and behaviors. In general, employees are more supportive of or committed to authorities, and the institutions that the authorities represent, when trust is relatively high...People who feel supportive of organisational authorities are likely to be: (a) satisfied with their relationship with the authorities, (b) committed to the organisation, and (c) willing to behave in ways that help to further the authorities’ goals and, by extension, the goals of the organisation’

(Brockner, et al 1997, p.559)

Employee trust defined

Kramer (1999), is critical of the definitions used to describe trust on the basis that they are very often not compatible and tend to reflect the context and area in which the subject of trust is brought up.

Hosemer (1995), has argued that while most research on trust goes far to outline its importance there has been little in the way of producing a universally accepted definition of trust,

‘There appears to be widespread agreement on the importance of trust in human conduct, but unfortunately there also appears to be equally widespread lack of agreement on a suitable definition of the concept’

(Hosemer, p.380, 1995)

The problem with defining trust, as argued by Hosemer, is indicative of the numerous approaches that can be applied to the concept of trust and the various contexts in which it can take place. Having conducted research on both the intellectual traditions of normative philosophy and organisational theory Hosemer has been able to construct a more universal definition of trust as,

‘the expectation by one person, group, or firm of ethically justifiable behavior - that is, morally correct decisions and actions based upon ethical principles of analysis - on the part of the other person, group, or firm in a joint endeavor or economic exchange’

(Hosemer, 1995,p.399)

Most research carried out to date on trust does however agree that the concept involves an element of vulnerability (Mayer, et al 1995; Zand, 1972; Lindsfold, S. 1978; Govier, 1993; Brockner, et al 1997). When defining trust many researchers refer to the definition used by Zand (1972) who defines trust as being essentially,

‘one’s willingness to “increase one’s vulnerability to another whose behavior is not under one’s control”’ (Zand, 1972, p. 231)

It would seem that in order for trust to be established between managers and their employees the latter must be willing to increase their vulnerability to the other (the participation and willingness of both employees and management alike is therefore required). While Managers can develop and demonstrate behavior to encourage the trust of their employees (and subsequently their commitment to managerial objectives) their employees must also be receptive to managerial overtures and reciprocate by making themselves vulnerable within the process of creating and facilitating trust. Despite the fact that managers may attempt to do everything in their power as a way of gaining the trust of their employees the development and cultivation of trust between the two groups will not be possible if the employee has decided at the outset that (as a result of previous

experience) for some reason or another not to trust management and as a result will be unwilling to act in any way which they feel makes them vulnerable. In this sense the process of trust is reciprocal in nature, in the words of Robinson (1996), 'trust begets trust'. This is also supported by other research and is referred to as reciprocity (Kramer, 1999; Brocker et al, 1997). Both Coopey (1995) and Stiles et al (1997), underline the importance and centrality of the role of the manager in building up and establishing trust between themselves and with those they manage. In describing the processes and the journey through which an individual goes before they are committed to an organisation Coopey (1995), highlights the importance of those who he refers to as 'significant others' in consolidating each stage of the process through which the employee goes.

In this case 'significant others' is a reference to the employees' superiors i.e. managers or supervisors, whose comments and interactions with the employee tend to influence how the employee feels about the work they do and the organisation in which they work (Butler, 1991).

The process outlined by Coopey is composed of three phases, starting with that of 'rational choice', followed by 'affective bonding' and finally 'normative conformity'. Coopey has elaborated on these three phases and outlines the relationship between each stage of the process with that of 'significant others',

'These are implicated when someone becomes committed to an organisation, that is, motivated to join; willing, once a member, to deploy personal resources and to participate in collective endeavors; and prepared to remain a member (Knoke, 1990). Crucially, each process will be dependent for its effects - in changing behavior, beliefs, attitudes and

values- on interpersonal relationships between the target person and significant others (Schein, 1979)' (Coopey, 1995, p 58).

This would therefore highlight the importance of interpersonal relationships between manager and employee within a process whereby the employee becomes committed to the goals and objectives of the organisation in which they work.

When attempting to understand and assess employee trust and commitment it is necessary to examine how the employee perceives and relates to their superiors within the organisation. The relationship between managers and their employees must therefore be examined in order to assess the level to which employees trust their superiors and are subsequently committed to the goals and the mission of the organisation itself. As seen in Kramer (1999), Hardin (1992) claims that it is useful to,

'conceptualise trust as a three-part relation involving properties of a truster, attributes of a trustee, and a specific context or domain over which trust is conferred' (Kramer, 1999, p.574)

One of the problems with creating trust is that certain individuals are more trusting than others (Kramer, 1999; Hardin, 1992; Robinson, 1996). In his study on the level of gullibility between high and low trusters, Rotter (1980), discovered that certain individuals were more trusting than others (high and low trusters).

‘The high truster says to himself or herself, I will trust the person until I have clear evidence that he or she can’t be trusted. The low truster says, it will not trust the person until there is clear evidence that he or she can be trusted’ (Rotter, 1980, p. 6)

Kramer (1999), has described suspicion as being central to distrust. Suspicion and distrust are psychological states whereby the perceiver ‘actively entertains multiple, possible rival, hypotheses about the motives or genuineness of a person’s behavior (Fein and Hilton, 1994, p.168)’

Attributes of trust and characteristics of trustworthy managers

Butler, 1991, has reviewed the literature to date in order to distill a base from which a definition of trust could be constructed. He has done so in order to design a questionnaire which seeks to measure the level of trust amongst employees of particular managers e.g. immediate superiors.

‘In short the literature on trust has converged on the beliefs that (a) trust is an important aspect of interpersonal relationships, (b) trust is essential to the development of managerial careers, (c) trust in a specific person is more relevant in terms of predicting outcomes than is the global attitude of trust in generalised others, and (d) a useful approach to studying trust consists of defining and investigating a number of conditions (determinants) of trust’ (Butler, 1991, p. 647)

From this assessment it may be reasonable to assume that trust is a significant factor in inter-personal relationships, it is conducive and supportive in the development of individual careers within an organisation and what is also apparent is that trust in specific individuals within an organisation e.g. supervisor, manager, employee etc., is of greater importance in determining its outcome than that of a more general kind of trust i.e. whether or not an employee trusts the organisation in which they work or whether or not a manager trusts their employees (in the general sense). This is also supported by the work of Orbell, et al (1994), whose study on the perceived level and actual level of trustworthiness between genders showed little difference. While they highlighted the fact that some people had opinions about the level of likely cooperation of certain categories of people e.g. women were perceived as been more cooperative than men, they were however more inclined to trust people on an individual basis regardless of which category they belonged to,

‘The point is, of course, reminiscent of La Pierre’s (1934) classic finding that peoples’ generalised dispositions with respect to groups predict only poorly their actual choices with respect to individuals’ (Orbell, J., Dawes, R. and Schwartz-Shea P. 1994, p.114).

In his work on trust within an organisational context, Barnes (1981), has shown that the development and emergence of trust takes place over a period of time and that it is to some extent related to participant honesty and willingness to share information regardless of an individuals particular position and duties within an organisation.

Govier (1993) and Lindsfold (1978) both suggest that certain behavioural and personality characteristics can promote and encourage the development of trust.

‘If we want to be worthy of trust, we must indicate in our actions, statements and body language that we are honest, sincere, reliable, dependable, competent persons, persons genuinely concerned for the welfare of others. To deserve trust, we must be, and seem to be persons of integrity’

(Govier, 1993, p.173)

Mayer, et al (1995) have outlined three main factors (from the literature on trust) which they claim represent the characteristics of trustworthy individuals. Those in whom individuals are more likely to place their trust tend to have ability (competence) to do what one is trusting them to do, they are benevolent and they have integrity.

Butler and Cantell (1984) also claim that trust involves competence and integrity and as opposed to benevolence they have put loyalty. Unlike Mayer, et al (1995) they have also added consistency and openness (Brann, and Foddy, 1988, p.384). Mayer et al (1995) have suggested that while there appear to be certain attributes and related concepts of trust such as cooperation, confidence and predictability they do however maintain that trust is essentially different from these concepts because it involves being prepared to take risks. This would therefore be consistent with the view held by Butler (1991) that trust involves making oneself vulnerable.

Benefits of trust

Kramer (1999), has outlined three main elements when considering the benefits associated with trust. He argues that those who trust each other tend to give one another the 'benefit of the doubt', this he claims can reduce the costs of transactions within organisations. This is achieved by managers and employees making more efficient use of their time and not spending it checking up on one another (Bromily and Cummings 1992; Mayer, et al 1995; Brann, and Foddy, 1988; Kramer, 1999; Sitkin, S.B., 1995). Secondly Kramer argues that trust increases the level of 'spontaneous sociability among organisational members'. This leads to greater levels of cooperation amongst managers and employees which can ensure restraint when using organisational resources and ensure the fulfillment of collective and organisational goals. The third benefit is that of appropriate forms of deference to organisational authorities. This ensures that management do not continually have to justify their actions and ensures that individuals are more willing to cooperate with the rules and regulations of the organisation which provides a more appropriate setting for creative conflict to occur.

Mayer, et al (1995) have argued that a lack of trust e.g. distrust and suspicion, can lead to a,

'greater amount of surveillance or monitoring of work in progress'

(Mayer, R.C., Davis, J.H. and Schoorman, F.D., 1995, p.728)

Brann and Foddy (1988) claim that introducing mechanisms and structures designed to increase the monitoring and surveillance of workforce and employee performance can have the undesired effect of reducing the level of innovation and cooperation amongst employees. They claim that such mechanisms and structures designed to monitor employees can reduce employee motivation and can act to undermine the relationship between managers and employees. Kramer (1999), also speaks of monitoring and surveillance systems and how they can act to inhibit and stunt the development of employee trust and motivation,

‘there is evidence that when people think their behavior is under the control of extrinsic motivators, intrinsic motivation may be reduced (Enzle and Anderson 1993). Thus, surveillance may undermine an individuals’ motivation to engage in the very behavior such monitoring is intended to ensure’ (Kramer, 1999, p.591)

Sitkin, 1995 argues that the process of legalisation e.g. mechanisms introduced to create the desired behavior, should support and not act as a substitute for trust.

Research carried out to date suggests that trust is linked to cooperation either as an input (a necessary precondition required in order for trust to take place) or as an outcome of trust based relations (Deutsch, 1960; Parks, and Hulbert 1995; Mayer, et al 1995; Sitkin, 1995; Fine and Holyfield, 1996). Whether or not cooperation is an outcome or an input of trust does however seem to be something of a debatable issue amongst researchers on trust. Gambetta, 1988, has claimed that that,

‘trust can be seen as a result rather than a precondition of cooperation’

(Gambetta, 1988, p.213)

Walsh (1995) has outlined the role played by trust between British and German troops within the trenches in the first world war, who although sworn enemies, maintained an implicit form of co-operation to reduce the level of death and injury to troops on both sides.

‘Trust need not require personal liking or close relationships...The great benefit of trust is that it is efficient ; the more there is trust the less necessary it will be to engage in detailed and expensive monitoring of performance’

(Walsh, 1995, p. 50)

Fine, and Holyfield, (1996) have also linked trust with support which they claim acts to create cohesion between people within groups,

‘Trust, which is connected directly to mutual support, contributes to cohesion’

(Fine, and Holyfield, 1996, p.29)

As quoted in Morgan and Hunt (1995), Rotter (1967), argues that trust between individuals within organisations can bring about benefits which can determine the future existence and survival of the organisation itself,

‘One of the most salient factors in the effectiveness of our present complex social organisation is the willingness of one or more individuals in a social unit to trust others. The efficiency, adjustment, and even survival of any social group depends upon the presence or absence of such trust’

(Morgan and Hunt, 1994, p. 20)

Sato, 1988 (as seen in Kramer, 1999, p.585) used a simulated social dilemma which showed that the effects of trust weaken as group size increases. Sato, 1988, claimed that this could be attributed to,

‘diminished perceptions of the impact of one’s own actions on others, as well as diminished expectations about others’ cooperativeness, reduce the perceived efficacy of trust as a collective becomes larger’

(Kramer, 1999, p.585)

It should therefore be kept in mind that trust may be easier to establish in smaller groups than it is in larger ones and that trust may become harder to sustain as the size of the group increases.

Employee commitment defined

While one would suppose that there is a link between employee commitment and organisational performance the bulk of the research that has been carried out on employee commitment to date has not yet provided clear cut evidence of such a link. (Armstrong, 1991). Despite this many leading academics and researchers claim that high levels of employee commitment can have benefits for the organisation in which they work and can enhance its long term performance,

‘It should come as no surprise that eliciting worker commitment - and providing the environment in which it can flourish - pays tangible dividends for the individuals and for the company’

(Walton, 1985, p.77)

Although there are many different definitions of the concept of employee commitment, most literature to date (Armstrong, 1991) has however referred to the definition outlined in the work carried out by Mowday, Steers and Porter (1979) who describe employee commitment as being,

‘the relative strength of an individual’s identification with, and involvement in a particular organisation, It can be characterised by at least three related factors: a strong belief in and acceptance of the organisation’s goals and values; a willingness to exert

considerable effort on behalf of the organisation; and a strong desire to maintain membership in the organisation' (Mowday, Steers and Porter, 1979, p. 226)

According to this definition employee commitment has three dimensions. The first dimension is classified as attitudinal, this is where the employee accepts and identifies with the 'goals and values' of the organisation.

The second dimension of employee commitment is referred to as behavioural commitment. Behavioral commitment is mainly concerned with the extent to which an employee is willing to exert 'effort' in the fulfillment of an organisations goals in carrying out the tasks and duties encompassed within their job title

Salancik (1977) has defined behavioural commitment in the following statement,

'The degree of commitment derives from the extent to which a person's behaviors are binding. Four behavioural acts make them binding, and hence determine the extent of commitment; explicitness; revocability; violation; and publicity'

(Salancik, 1977, p. 4)

The third dimension is that of exchange commitment, this is mainly concerned with the level of attachment an employee has to the organisation in which they work expressed through the employees 'desire to maintain membership' in their place of work. Under exchange commitment employees will remain and work within an organisation according to the level of benefits they receive in exchange for their labour. This type of commitment also relates to what the employee may perceive as 'sunk costs' within the organisation i.e.

twenty years of work, or the trouble they may encounter in looking for another job.

Hrebiniak and Altutto, (1972) have stated that exchange commitment arises as,

‘a result of individual-organisational transactions and alterations in side bets or investments over time. The more favorable the exchange from the participants’ point of view, the greater the commitment to the system’

(Hrebiniak and Altutto, 1972, p.556)

Exchange commitment relates to the degree to which an employee remains committed to an organisation in terms of perks and status they receive from the organisation in exchange for their labour. This form of commitment is cultivated through the existence of reward based incentives.

The research carried out to date appears to be mainly concerned with two dimensions of employee commitment, that of attitudinal and behavioural. It is widely assumed by researchers of employee commitment that a relationship exists between the behaviour and attitudes of employees within the workplace. It is also assumed that attitudes can influence behaviour and behaviour can influence attitudes; it is therefore believed that the relationship between attitudinal and behavioural commitment is reciprocal. Guest (1989) highlights the relationship between employee behavioural and attitudinal commitment by stating that it is,

‘concerned with the goals of binding employees to the organisation and obtaining behavioral commitment to high performance’. (Guest, 1989, p. 49)

This definition of employee commitment illustrates how employee attitudes and behaviour overlap in situations where attitudes can influence behaviour and ones behavior can influence their attitudes.

In the research conducted by Coopey and Hartley (1991) on organisational commitment the authors have stressed the need to look at the relationship between the organisation and that of employee attitudinal commitment. They warn against treating commitment as separate and argue that employee commitment can only be fully understood within its organisational context. An understanding of the nature and purpose of the organisation is therefore an essential precondition to establishing the goals and values which employees are committed to. Coopey and Hartley have stated that,

‘When we consider organisation commitment, we have to ask committed to what ? the organisation, of course. But what is the organisation? Many writers seem to treat this concept unproblematically, seeing commitment in terms of the organisation’s goals and values’.

(Coopey and Hartley p. 20)

Employee commitment within the NHS

As mentioned previously the NHS is a very large and well established institution which employs a considerable diversity and range of employees and professionals from a variety of backgrounds and disciplines. When we examine employee attitudinal and behavioral commitment it should therefore be anticipated that there may be a variety of values and goals which NHS employees may feel committed towards. The study of employee attitudinal and behavioral commitment within the NHS will therefore undoubtedly be a challenge not only for this reason alone but also in light of recent organisational reform.

The purpose and goals of the traditional NHS tended to be much more explicit and certain than that of the recently reformed NHS. The traditional NHS operated as a professionally driven organisation with the primary goal of serving the health requirements of the nation. Health care was delivered primarily on the basis of need, the cost of the service received by the recipient was not highly prioritised. The reforms which started with the election of the conservative government in 1979 have altered the philosophy and goals of the NHS, it is now much more financially controlled and managerially driven than ever before. The NHS is also allegedly much more market driven, this can be observed in the existence of internal markets, the introduction of performance management techniques and measures aimed to reduce costs and the customer orientation adopted through the creation of a Citizens Charter, 1991. Therefore when examining employee attitudinal and behavioral commitment it should be accepted that the objects of employee commitment may vary and there could even be the existence of competing commitments i.e. patient

care versus financial considerations, management verses professional or staff organisation, free patient care verses marketing and profit making initiatives etc.

Dual commitments

In their study regarding the factors contributing to high levels of absence within the NHS, Whitston and Edwards (1990) have highlighted the potential for the values and goals which formed the basis of traditional employee commitment to clash and compete with the goals and policies of the newly reformed NHS. The authors describe the influence of the traditional public sector ethos on ensuring the present commitment of NHS employees. This remains the central source of employee commitment despite the implementation of management policies and goals which employees neither empathise with nor feel committed towards.

Hayward and Fee's (1992) study of the British nurses' strike of 1988 also illustrate the tensions brought about by the introduction of reforms geared to create a more market driven and more cost efficient NHS with that of traditional public sector professionalism. The authors offer this as a good example of the competing commitments within the NHS and the present ambiguity which surrounds the commitment of employees within the NHS.

'Many nurses are torn between the ideals of professionalism and the realities of their workplace'(Hayward and Fee, 1992, p. 397)

It must therefore be kept in mind that the range of employee commitments may vary or indeed may conflict when studying employee attitudinal and behavioral commitment within the NHS. This variation of commitments may also be influenced by the present reforms within the NHS.

It is also possible for employees to have dual commitments to the organisation in which they work with that of the trade union or staff association of which they are a member. There are a large number of staff associations and trade unions within the NHS, indeed very often membership to either one is a compulsory part of being a recognised professional. Dual commitments between NHS Trusts with that of an employee organisation could therefore be a common feature amongst NHS employees and they may conflict and impose stress and anxiety etc. on employees.

Obstacles to employee commitment

Coopey's (1995) study on managerial culture and employee commitment has illustrated concerns regarding current management culture and practice within the British private sector which could be acting to inhibit optimum levels of employee commitment. As it is also the aim of this research proposal to examine the effects market reform are having on employee relations within the NHS an examination of the relationship between private sector managerial practice with that of employee commitment within the British private sector could be of value to this study in determining future developments within the NHS (especially if the pace of market reform is to increase). The research conducted to date would strongly suggest that the introduction of private sector models of performance management backed up and supported by a greater emphasis on managerial prerogative

has had a significant effect upon the trust and commitment of NHS employees. Coopey (1995) illustrates the significance of the present nature of private sector management culture on the public sector when he says,

‘public sector organisations’...management have been under considerable pressure of late to import private sector values, beliefs and practices (Ranson and Stewart, 1994)’
(Coopey, 1995, p 73)

Measuring commitment

Guest (1992) and Coopey and Hartley (1991) in their research regarding the level to which an individual is committed to an organisation mention the use of the ‘Organisational Commitment Questionnaire’(OCQ). The Questionnaire incorporates 15 items which are designed to measure employee commitment. Porter and colleagues (1974) have operationalised their approach to employee commitment within this questionnaire by incorporating the three definitions of exchange, attitudinal and behavioural commitment. These have been described as,

1. ‘A strong desire to remain a member of the organisation.
2. A strong belief in, and acceptance of, the values and the goals of the organisation.
3. A readiness to exert considerable effort on behalf of the organisation’

(Porter et al, 1974)

As can be seen in the above the first factor relates to exchange commitment (or normative), the second to attitudinal commitment and the final factor relates to behavioural commitment

While this questionnaire is recognised as an effective tool in measuring employee attitudinal and behavioral commitment it is by no means above criticism. The questionnaire outlined above has been criticised on the grounds that it does not cover the entire range of commitments which employees could be committed to. As a result of this oversight the questionnaire may not take into account the full range of commitments an employee may have i.e. patient care, public sector values, value for money etc.

At present a number of research tools for the measurement of employee attitudinal commitment are being considered. As can be seen from the OCQ the effectiveness of the research techniques used in measuring employee commitment will depend on how well the potential range of employee attitudinal commitment have being established at the outset. This must take place prior to the design of a research technique which will attempt to measure them.

The precise mix of the research techniques used in measuring the attitudinal and behavioral commitment of employees within the NHS will essentially be derived from the established sources of employee commitment within the NHS at present. This will be achieved through preliminary and structured discussions with management and employees within NHS trusts. It is intended that the feedback resulting from such discussions will assist greatly in establishing the range of employee attitudinal commitments.

Measuring employee behavioral commitment

It has been pointed out that there are three main variables through which employee behavioral commitment can be measured. Kelliher (1995) has pointed out that behavioral commitment can be measured in terms of labour turnover, employee absenteeism and employee performance. In measuring employee behavioral commitment a range of qualitative techniques (which could include questionnaires, structured interviews, surveys etc.) and quantitative techniques could therefore be considered.

An assessment of the levels of employee attitudinal and behavioral commitment of NHS employees would take place after an examination of the level to which managers and employees trusted one another within their organisational context. The findings which arise from the proposed studies would form the basis upon which a model illustrating the relationship between employee trust with employee commitment (attitudinal and behavioral) within the NHS could then be constructed.

Compliance versus Commitment

In the past organisations have often tended to rely upon securing employee compliance rather than commitment as the driving force behind the management and control of their human and manpower resources. Keenoy (1992) defines compliance and the role of management within the process of compliance when he says,

‘managers, in attempting to persuade, cajole or coerce employees to do as they are told, are responsible for constructing, operating and maintaining a bewildering array of control

mechanisms designed to ensure each individual actually performs their designated work’
(Keenoy, 1992, p.92)

Under the traditional system of work practices individuals were held accountable for the work that they did through the use of mechanisms and systems which were designed to monitor and measure their performance (Walton, 1985). Sitkin (1995) has referred to the work of Strickland (1958) and Fox (1974) and claims that such legalistic methods in order to ensure and enforce employee compliance were counterproductive in gaining the trust of ones employees,

‘Strickland’s(1958) findings highlight is that to the extent that legalisation requires strict levels of monitoring and formal accountability it is likely to induce distrust regardless of the behavior of those being observed. This contention is supported by Fox (1974), who describes how employee trust in superiors (and supervisor trust in subordinates) can degenerate as close performance monitoring and precise evaluative criteria are enacted’
(Sitkin, 1995 p. 204)

An alternative perspective was provided by the work of Maslow (and others) who identified human needs and wants that could be used by management to motivate employees and thereby achieve compliance. Keenoy (1992) has however outlined the potential for conflict between the motivational dimension of employee management with management’s need for control,

‘On one side is the need to ensure the active involvement and positive participation of the workforce in the pursuit of business objectives - something which may be critical where the quality of the product or service is directly dependent on employee performance. This implies treating employees with respect, rewarding them fairly or even generously and, perhaps, seeking to elicit responsibility and trust’

(Keenoy, 1992, p. 96)

Keenoy (1992) suggests that managers need to motivate, empower and involve employees so they become part of the process within the organisation and not simply used as a tool in the process of production. However there is also the need to ensure that employees act in accordance with managerial aims and objectives. While management may encourage their employees to become more motivated to the tasks and duties they carry out within the organisation they also require an element of compliance on the employees behalf,

‘On the other side is the need to control work-behavior in the light of the economic realities of competition and the profit motive. These imply treating the employee as an economic resource to be made as economically efficient as possible: in practice this may require extracting additional productivity for no additional cost, minimising wages and rewards and declaring redundancies. As Hyman (1987) observes of this contradiction, ‘employers require workers to be both dependable and disposable’ (Keenoy, 1992, p. 96) Brockner, et al (1997), highlight the importance of trust within the context of modern day organisations. They describe the role trust between managers and employees within the

workplace and claim that traditional methods designed to ensure employee compliance are no longer valid,

‘As organisations have become flatter and more team-based, organisational authorities’ surveillance of their subordinates has given way to less dictatorial modes of interpersonal influence. Perhaps now more than ever, managers’ effectiveness depends on their ability to gain the trust of their subordinates’

(Brocker, et al, 1997, p.558)

It would appear that those managers who desire to encourage and facilitate employee motivation and commitment through greater employee involvement and empowerment are to a greater extent undermined by the realities of the modern market in which managers are called upon to make hard decisions. While it is acknowledged that employees may work better if they feel that they are valued and involved within the processes of organisational planning and decision making, the desire for control on the part of management to ensure the compliance of the workforce, contradicts and undermines those initiatives aimed to ensure that the organisations employees feel valued.

Walton (1985) has highlighted those strategies that were designed to elicit employee control and compliance and those designed to gain employee commitment. Implicit in the commitment model/strategy is the belief that ‘eliciting employee commitment will lead to enhanced performance’ (Walton, 1985, p.80). Walton criticises the compliance/control

model on the basis that it is ineffective and ill suited in taking into account the needs of organisations operating in competitive and volatile markets,

‘Under the commitment strategy, performance expectations are high and serve not to define minimum standards but to provide “stretch objectives”, emphasize continuous improvement, and reflect the requirements of the market place”

(Walton, 1985, p.79)

Within the process of ensuring employee compliance managers must adhere to an array of bureaucratic mechanisms that are required in order to measure employee output as part of the terms and conditions offered to employees in exchange for their labour. Guest (1991) criticises the use of compliance based models of employee management on the grounds that they represent an inefficient use of organisational resources. If an organisation does decide to change from a system based upon employee compliance to one based on employee commitment, Guest, has suggested that managerial assumptions about the nature of their workforce would need to be reassessed accordingly,

‘These represent both inefficiencies (Bureaucratic controls under compliance models of employee management), in that top management, if they believed that they had a trustworthy and competent workforce, could dispense with many of the controls, and inbuilt inflexibilities’ (Guest, 1991, p. 114)

Guest (1991) highlights the unstable nature of the current economic environment as another major reason for organisations to transfer from systems based on compliance to models which are more oriented towards facilitating employee commitment. It is believed that organisations that use systems modeled on compliance are not as flexible to the changing nature of local and global markets,

‘To meet...demands swiftly and effectively, organisations require a workforce which is more than merely compliant. It requires their active help and the use of considerable local initiative’ (Guest, 1991, p. 114)

Walton also makes this claim but posits his argument on the fact that within the west labour costs are higher and therefore in order to gain competitive advantage organisations must maximise the performance and capability of their human resources,

‘in a high-wage country like the United States, market success depends on a superior level of performance, a level that, in turn, requires the deep commitment, not merely the obedience- if you could obtain it - of workers’

(Walton, 1985, p.78)

Wood also speaks of the current switch in emphasis away from the compliance model of people management towards one based on employee commitment,

‘Though in the past a minimal level of co-operation and commitment was required, management’s are being characterised as having traditionally been more concerned with achieving compliance and conformity to their regulations and standard operating procedures’ (Wood, 1995, p.216)

Compliance, Commitment and HRM

If the relationship between positive attitudinal and behavioral commitment with that of positive organisational performance outcomes is accepted, mechanisms and processes designed to cultivate employee commitment could therefore be used in organisations to optimise the level of output from their employees. Traditional UK managerial and personnel practice has used compliance as the driving force behind maximising the efforts of their workforce. As mentioned above the use of policies to ensure employee compliance in attempting to maximise the efforts of organisational human resources has been criticised on the grounds that it requires numerous time consuming and expensive external mechanisms in attaining the surplus value of an organisations human resources.

The antecedents of employee commitment tend to be found within soft HRM theories and practice. Soft HRM theory and practice seeks to outline the importance of facilitating the development of employee commitment as one of a number of components within an effective HRM strategy. Employee commitment is very often operationalised within the workplace as one component element within an integrated HRM strategy. Guest (1991) illustrates the compatibility of employee commitment with other HRM objectives in the following statement,

‘Indeed, commitment is just one of four key human resource policy goals, the others being flexibility, quality, and strategic integration’

(Guest, 1991, p. 129)

While research to date recognises the potential benefits which employee commitment can bring to an organisation in terms of output and performance, Guest (1989) does however point out that employee commitment should also be linked to other human resource policy goals if the totality of these benefits are to be fully realised. It is therefore important to point out at this stage that commitment should be linked to both quality and flexibility within the workplace (with regard to employee management) in order to fully realise the benefits associated with employee commitment.

Walton (1985) has outlined the work practices encompassed within the ‘new’ commitment-based approach towards employees as follows;

‘jobs are designed to be broader than before, to combine planning and implementation, and to include efforts to up grade operations, not just maintain them. Individual responsibilities are expected to change as conditions change, and teams, not individuals, often are the organisational units accountable for performance’

(Walton, 1985, p.79)

Wood, (1995) has carried out research on the extent to which high commitment management practice is occurring on the shop floor within the UK. When identifying

high commitment management practices Wood has outlined high commitment work practices as involving,

- ‘the development of career ladders and emphasis on trainability and commitment as highly valued characteristics of employees at all levels of the organisation
- a high level of functional flexibility with the abandonment of potentially rigid job descriptions
- the reduction of hierarchies and the ending of status differentials at least between white-collar and manual or blue-collar workers, if not between managers and workers
- a heavy reliance on the team structure for disseminating information (team briefing), structuring work (team working) and problem solving (quality circles)’

(Wood, 1995, p.216-217)

Black, 1999 also talks of employee involvement, and ways of achieving it e.g. team working/briefings, quality circles etc., job flexibility and good relations between management and employees as part of modern high commitment practices. In addition to this Black also highlights job security, opportunities for advancement and recruitment practices as additional high commitment work practices.

Coopey (1995) underlines the centrality of organisational commitment within HRM strategies and also refers to Guest’s (1992) view of a HRM strategy being related to policies and outcomes,

‘There is a two step process: first, the actions of management in implementing a range of HR policies will produce certain HR outcomes that include strategic integration of human resources and organisational commitment. Secondly, these HR outcomes lead, in turn, to overall outcomes such as high job performance, problem-solving capacity and cost effectiveness. ‘Leadership’, ‘culture’ and ‘strategy’ act to moderate the relationship between policies and HRM outcomes, and the HRM and organisational outcomes’

(Coopey, 1995, p 56)

Much of the current HRM literature perceives employee commitment as being more effective than that of the compliance mechanisms used under traditional personnel management and practice. Wood (1995) also highlights the centrality of employee commitment in contemporary human resource management theory,

‘High commitment work systems have been a key element in the increasingly salient discussions of human resource management’

(Wood, 1995, p.216)

The argument over compliance and commitment can also be seen as part of a wider debate concerning traditional theory and practice of personnel management with that of the newly established HRM. Guest and Walton (1990) highlight the relationships between these practices and theories when they state that,

‘Personnel management is closely associated with compliance-based systems of control while HRM is typically allied to commitment...compared with personnel management, HRM is a more central, senior-management-driven activity’

(Guest, 1990, p 152)

From this statement it can be seen that the functions of personnel and HRM practice both focus on the relationship between the organisation and the employee within the workplace. It has also been claimed that the nature of HRM is essentially different from that of traditional personnel management. This is attributed to the fact that within many organisations HRM is much more strategically orientated and also now the concern of senior as well as line management.

The table below (Fig 1.1) outlines and summarises the main features and attributes of compliance and commitment. Compliance mechanisms have been traditionally associated with personnel management and practice where systems of employee commitment have been largely associated with contemporary HRM practice.

Aspects of policy	Compliance	Commitment
Psychological contract	Fair day's work for a fair days pay	Reciprocal commitment
Locus of control	External	Internal
Employee relations	Pluralist Collective Low trust	Unitarians Individual High trust
Organising principles	Mechanistic Formal/defined roles Top-down Centralised	Organic Flexible roles Bottom-up Decentralised
Policy goals	Administrative efficiency Standard performance Cost minimisation	Adaptive work-force Improving performance Maximum utilisation

Fig. 1.1 Alternative assumptions and beliefs underlying Human Resource Management

(Guest, 1991, p 152)

As can be seen employee commitment is associated with HRM and also with schemes designed to increase employee involvement within organisations (Marchington, et al, 1992). Initiatives which are geared to increase greater employee involvement within the

organisation are not a recent phenomena. The latest and most recent development of employee involvement initiatives started in the early 1980s. Marchington et al (1992) outline the nature of employee involvement and its relationship to employee commitment in the following,

‘The most recent manifestation of employee involvement is individualistic (as opposed to collective and conducted via representatives), it is championed by management’s often without any great pressure from employees or trade unions (as opposed to previous incarnations where employee or union pressure was influential), and it is directed at securing greater employee commitment to and identification with the organisation and its success’

(Marchington, et al, 1992, p.6)

From the above it can be seen that employee involvement is not only designed to enhance employee commitment, it would also appear that it is linked with models associated with contemporary HRM. As with that of HRM employee involvement has its basis within the organisation where the aim is to ensure employee commitment to the goals and values of the organisation in which they work. Similar to that of the philosophy underpinning much of contemporary HRM models, employee involvement has an individualistic orientation. In outlining their four paradigms of employee participation Marchington, et al (1992) have described what they refer to as the second paradigm,

‘where involvement (employee) is reckoned to lead to an increase in employee commitment to the organisation, and this is central to much of HRM literature’

(Marchington, et al, 1992, p. 9)

This would therefore illustrate the link between employee involvement, HRM and employee commitment.

Background to the emergence of the new HRM model

Guest (1991) has outlined the decline of industrial relations and personnel management departments in both institutions of higher learning and in industry. He is of the opinion that the traditional Donovan framework where the focus of debates and issues surrounding industrial relations and personnel management centered on pluralism, tripartism and the power of trade unions is at an end. Wood (1996) has carried out research on high commitment management in unionised manufacturing plants. While his research proved that the rate at which high commitment management is implemented is to some extent ‘dragged’ or slowed within unionised organisations Wood claims that,

‘unionism does not seem incompatible with the relatively high use of high commitment, as Guest implies’

(Wood, 1996 p.52)

While Guest (1991), and other researchers argue that HRM theories and practices have arrived to replace traditional personnel management theory and practice there is little

evidence however to suggest that the transition from one form of people management to another has gone as smoothly as anticipated. Indeed the research conducted so far would indicate that there has been a considerable level of resistance to the transition from one form of employee management to another. The successful implementation of a new system of employee management, that of Human Resource management, will influence the extent and effectiveness to which theories of employee commitment and practice will be introduced within the workplace. This is particularly true if the new system of employee management is based upon soft HRM approach as employee trust and commitment are closely associated with soft HRM theory and practice.

In his study on HRM practice across three American electronic companies (operating within the Irish republic), Geary (1992) conducted an assessment on the successful introduction of new policies, within the HRM departments of the three companies, designed to improve and reward employee commitment, motivation and performance through the manipulation of pay systems. The author perceives traditional personnel management and the previous status quo regarding the management of employee and industrial relations as being the main obstacles to the implementation of the new policies,

‘This return to the previous practice of paying ‘a rate for the job’ also supports Brown’s (1989) contention that people tend to accept as fair that which is conventional, or that which they have grown accustomed. Change in the method of remuneration can upset such accepted notions of fairness. Management at TEC, therefore, thought the benefits of sticking by convention outweighed those perceived advantages of a wage system which created new anomalies’ (Geary, 1992, p 47).

The problems with replacing an old system of employee management with a commitment based system mainly concern that of worker dissatisfaction with the system introduced or the style in which the system was implemented. This point has been highlighted by Stiles, Gratton and Truss (1997) within their study of three large organisations undergoing large scale change. The authors sought to examine how the organisations under study used performance management as a tool to guide the process of organisational change. The organisations studied sought to use performance management as a way to support the move away from the traditional status quo of the working environment, away from the job security and clear career paths of the past. As opposed to improving employee commitment, the authors discovered that, as a result of the changes which took place, the organisations studied showed a significant deterioration in the level of employee commitment, trust and morale (The findings from this study are also consistent with the findings taken from the studies conducted by Oswick and Grant, 1996, Whitson and Edwards, 1990 and Kelliher 1995 on their work regarding employee commitment, trust and morale within the NHS). The authors outlined two main reasons as to why the changes had such negative consequences. The level of employee trust and commitment in the three organisations studied was measured with the use of the 'organisational commitment' questionnaire, (Mowday et al, 1978). Firstly it was pointed out that the employees had resisted changes to the old employment contract as it had 'produced certainty and consistency' within the employment relationship. The second reason outlined by the authors concerned the way in which the changes were implemented. Given the apparent lack of employee input and consultation in which the proposed

changes were introduced, the employees felt 'disenfranchised' from the change process itself,

'The general picture seems to be one of low levels of commitment and, in companies B and C, low levels of trust, in the wake of restructuring and downsizing and following changes in the value system and the management of performance.'

It was also discovered by the authors that,

'in the case of company A, the relatively reasonable showing on the trust indicator was considered to be a residual, with the organisation perceived to be trading on the continuing loyalty of its employees. The level is expected to gradually reduce, according to directors, line managers and operating core alike'

(Stiles et al, 1997, p. 64)

The findings and discoveries of the research conducted by Stiles et al (1997) can also be compared with other research conducted in the public sector and the NHS. Performance management techniques have also been implemented within the NHS as well as throughout the rest of the public sector as a result of political pressures brought about by the previous conservative administrations (see Purcell and Ahlstrand, 1992). As has been mentioned previously the introduction of practices designed to reduce the costs of labour and increase the flexibility of employees has been highlighted as the main cause of a significant deterioration in the levels of employee trust, morale and loyalty within the NHS (see Kelliher, 1995, Oswick and Grant, 1996, and Whitson and Edwards, 1990).

As with that of the research conducted by Stiles et al (1997); Kelliher (1995) and Whitson and Edwards (1990) there is the impression that management are tending to rely on the previously high level of commitment and loyalty of their employees while simultaneously introducing measures and practices which in the long term are seen as detrimental to employee trust, morale and loyalty. All the authors mentioned above agree that the commitment of employees within the organisations studied will be eventually undermined as a result of the changes introduced by their managers and the way in which they were introduced.

Guest (1991) has also commented on the difficulties regarding the implementation of new policies within the field of HRM. As the introduction of new HRM strategies and policies are based on different assumptions and ideas than those of the past they are often met with resistance. The level of resistance to changes in employee management encountered is usually more intense when attempting to introduce new policies in established plants and organisations. Guest uses the introduction of initiatives designed to facilitate greater employee involvement to illustrate this point when he states,

‘It has proved much more difficult for companies to introduce significant changes towards employee involvement in established plants. The constraints of technology, worker attitudes, management attitudes and lack of financial resources have proved insurmountable...Both workers and management may be suspicious of attempts to change established patterns...In particular, they can cause anxiety and resistance among managers

if they become attempts to move away from the old system of compliance based control without satisfactorily replacing it with a new commitment based system'

(Guest, 1991, p 130)

The problems encountered from moving from one system of employee management to another can also be the result of managerial resistance as well as that of opposition from employees within the organisation. Greater employee involvement within an organisation has been seen as an effective way of achieving a higher level of employee commitment to the aims and objectives of the organisation in which they work. In defining employee involvement O'Creevy and Nicholson state,

'Employee involvement' is taken to refer to managerially initiated processes at the level of the workplace designed to increase employee information about, and commitment to, the organisation'

(O'Creevy and Nicholson, 1994, p. 6-7)

From this definition it is apparent that management involvement is instrumental to the implementation of initiatives designed to ensure employee involvement within the organisation. It has however also been pointed out that very often managers (particularly middle management) tend to resist initiatives aimed to ensure employee involvement throughout the organisation. In highlighting the reasons behind managerial resistance to employee involvement, O'Creevy and Nicholson (1994) have identified the three following factors,

- '1. Protection of self interest
 - 2. Lack of competence to facilitate EI (employee involvement)
 - 3 Mixed signals from top management and the organisation'
- (O'Creevy and Nicholson, 1994, p.14)

The first reason highlights managerial fear and insecurity at the prospect of loosing their own power and control as a result of employee involvement. The second reason highlights managerial perceptions concerning the adoption of new styles of management and the development of new skills while rendering their existing style of management and skills base redundant or inappropriate. The final reason concerns that of managerial perceptions of employee involvement initiatives within the organisation as suffering from a lack of institutional support from the top (top management level) or from the bottom of the organisation (employees).

Marchington, et al (1992) have also commented upon the role of middle management in obstructing the effective implementation of employee involvement initiatives and hence employee commitment to organisational objectives. The authors are critical of what they see as a of lack of managerial foresight in acquiring greater employee commitment to the aims and the goals of the organisation in which they work through the use of initiatives designed to increase the level of employee involvement,

'managers themselves are often the major barrier to high levels of commitment on the part of staff...If only management could find ways to release and tap employees'

creativity, for example via employee involvement, then their commitment to organisational goals would follow'

(Marchington, et al, 1992, p.9)

Management may also perceive the introduction of employee involvement as just another passing fad within the organisation and may therefore not take it seriously. One recommendation that has been offered by O'Creevy and Nicholson (1994) in overcoming managerial resistance to employee involvement initiatives has been to use middle management as 'guinea pigs' prior to the wider application of employee involvement initiatives throughout the organisation,

'A number of reviewed studies also emphasise the importance of making middle managers and supervisors the targets as well as the agents of EI (employee involvement) initiatives. Unsurprisingly perhaps, managers who experience the benefits of EI first hand and see their own influence in the organisation and control over their work increasing, are more ready to foster such developments among their own subordinates' (O'Creevy and Nicholson, 1994, p. 19)

Employee commitment and Private sector enterprise

Coopey (1995) has approached the subject of employee commitment by examining the underlying assumptions of private sector management culture and tradition. The author seeks to examine the dominant themes and assumptions underlining management culture

and tradition within the private sector with a view to assess whether or not it offers a favourable environment for the cultivation and development of employee commitment.

As mentioned previously the relationship an employee has with his/her manager is instrumental in the development of trust and commitment. If this is the case then managers must act consistently with the behavior and attitudes they expect from their subordinates. Given the high level of influence management have on the behaviour of their subordinates it is therefore crucial to their credibility and the extent to which they can be trusted that they practice what they preach as well as utilising and promoting initiatives to encourage commitment,

‘It is proposed that managers, directly, or through others who already identify with them, must be able to act in ways that both exemplify commitment as defined by Porter et al (1974) and to build up relationships as significant others with non-committed employees if the latter are to be ‘converted’. Otherwise the management’s view of organisational reality will continue to be different from, even in conflict with, that of other employees who reject the models offered and with whom positive personal relationships cannot be developed’ (Coopey, 1995, p 59)

If management desire their employees to become more committed to the values and goals of the organisation they must act positively in setting an example in both word and action. Consistency in terms of managerial behaviour in both action and word should be illustrated at all levels within the organisation from the top down.

The author perceives the main obstacles preventing the development of employee attitudinal and behavioural commitment as being largely associated with the culture of private sector managerialism. A culture which from the authors point of view values self interest over other stated concerns and values its workers only in so far as they are 'affecting business strategy' (Coopey, 1995, p 59). In illustrating the basis for this approach refer back to Guest's model of the HRM perspective where the policy goals of HRM are stated as being 'improving performance' and ensuring the 'maximum utilisation' of human resources. In outlining and backing up his hypothesis Coopey refers to the work of Kelly et al (1991) who have outlined the conditions under which employee attitudes and behaviors can be changed through interacting and socialising with their managers,

'Kelly et al (1991) propose that, for attitudinal and behavioral change to be achieved via relationships, both parties should have:

- influence on the establishment of superordinate goals which are equally satisfying for both parties and on the setting up of schemes of participation to achieve those goals;
- choice as to whether to participate in such schemes;
- a mutually acceptable status relationship as measured by such factors as earnings, job security and influence;
- institutional support for the initiatives taken and the relationships forged through participation in them (Coopey, 1995, p 68).'

Having outlined the criteria under which the behavioral and attitudinal commitment of employees can be cultivated Coopey then outlines the reality as to why the preconditions outlined under this criteria cannot be fulfilled. The author outlines the realities of the current nature of private sector management culture as well as taking into account the social, political and economic forces which have allowed this culture to develop unchecked right up to the present day,

‘In building relationships that encourage greater commitment, company directors are constrained by perceived pressures to meet shareholders’ short-term profit expectations and the need to serve their own interests...The possibility of UK employee involvement in goal setting through union representatives, never high, has dwindled even further as union channels of communication have been by-passed or eliminated...If, as Kelly et al (1991) claim, marked status differentials are an impediment to positive relations, it is easy to understand why a culture that enshrines control through hierarchical and differentiated relationships breeds problems...Managerial contradictions also undermine institutional support for initiatives designed to achieve greater commitment.

(Coopey, 1995, p.70)

Coopey (1995) perceives the introduction of HRM techniques and practice in particular as being anathema to the traditions and culture of private sector managerialism. While certain aspects of HRM practice are introduced into mainstream management they are done so in a fashion which does not threaten managerial prerogative and dominance within the workplace.

‘First, private enterprise managerial culture is inimical to the introduction of aspects of HRM which, even though they might increase employee commitment, threaten to erode managerial prerogatives. This would account for the lack of HR approaches in most workplaces (Millward, 1994) and, in turn, have a large influence on the survey report of low commitment by Gallie et al (1993). Second, even where HRM is introduced into a company, the managerial culture tends to provide an inadequate basis for trust-building leadership and management-worker relationships on which commitment depends’

(Coopey, 1995, p 59)

Coopey has therefore not only examined the feasibility of introducing mechanisms for the fostering of employee commitment within the context of the private sector but has also touched on the issue of effectively introducing HRM into mainstream managerial practice. This also remains a recurrent theme throughout the literature and has also a significant bearing on the introduction of techniques and practices associated with employee commitment within the workplace.

In looking at employee commitment from a more conventional perspective, Stiles et al (1997) have also commented that the relationship between employees and management can affect the level of employee commitment. As mentioned previously the organisations under study sought to use performance management techniques in moving the system of employee relations away from the traditions and practices of the past to making work schedules relate more to performance. The authors discovered that one reason which had led to failure in improving employee commitment to the levels anticipated was that

concerning the employees perception of fairness and accuracy. Managerial prerogative, in particular that of middle management was perceived to have been the major obstacle to ensuring adequate employee participation in the setting up of and the creation of the newly introduced system. The lack of employee involvement and feedback in the change process as well as their perception that the new system was ineffective and poorly administered would confirm this,

‘In terms of fairness and accuracy of the performance management systems, the evidence suggests that employees are largely disenchanted. Lack of negotiation in objective setting, question-marks over the achievability of targets, variability and inconsistency in appraisal, lack of opportunities for development, in particular career development, and a large degree of mystification over the workings of the appraisal-pay linkage, were indicative of this concern’ (Stiles et al, 1997, p 65)

The authors also highlight the way the organisation operates as a system, they outline the role of middle management as acting as buffers in preventing a smooth flow of feedback from the employee to top management and vice versa with regard to the reform process. Both the structure of the organisation and the role of middle management present barriers to the setting up of effective mechanisms to ensure that employee commitment is both fostered and encouraged within the organisations under study (also see O’Creevy and Nicholson, 1994).

‘In all cases, changes were being driven in a top-down systematic manner and the lack of consultation has brought cynicism and a lack of trust among employees...Further, as the new strategies and visions in these firms were rolled out through a cascade process, it was often the case that managers would act as buffers between top management and employees, filtering the messages to avoid communicating harsh news in order to preserve morale and to ensure no dip in productivity (and so continue to hit targets). This confirms the claim by Butler et al (1991) that politics can be used to thwart changes in the performance management system as a whole’ (Stiles et al, 1997, p.65)

In view of the nature of the changes being introduced and given the fashion in which these changes were implemented Stiles et al (1997) feel that the previous high levels of commitment enjoyed by the organisations under study may be in decline,

‘such is the extent of the violation of the old contract, it is unlikely that trust and commitment will be easily recovered’

(Stiles et al, 1997, p 65)

It is easy to see why employee morale and commitment continued to decline in the face of such barriers. The existing belief systems and the organisation of the companies under study would appear to have built-in barriers which are inhibiting the introduction of HRM and techniques designed to maximise employee trust and commitment. It may therefore be necessary to focus on the nature of the culture, tradition, and assumptions within the organisation under study prior to the measurement of employee trust and commitment.

The measurement of employee trust and commitment within an organisation can also indicate the extent to which it has adopted a more HRM orientated approach to the management of its employees as opposed to a personnel management based approach which uses mechanisms designed to ensure employee compliance. The significance of employee commitment and mechanisms designed to cultivate it to maximum levels would therefore appear to be twofold in so far as the organisation has effectively implemented a more HRM oriented strategy regarding the management of its employees and the degree to which employee commitment forms a part of the strategy.

Employee commitment and organisational culture

Within the context of contemporary management theory and practice Anthony (1990) has outlined the role and significance of organisational culture in the following statement,

‘The control of organisational culture is the latest and most extreme attempt to achieve the whole-hearted commitment of the organisation’s members to the pursuit of its objectives...it purports to define the meanings of people’s lives so that they become concomitant with the organisation’s view of itself’

(Anthony, P.D., 1990, p 4)

Willmott (1993) suggests that organisational culture strongly influences the attitudes and behaviours of employees towards the aims and objectives of the organisation in which they work. Indeed it is suggested that organisational culture can be used to capture the

commitment of employees in terms of their attitudes and behaviour. Willmott (1993), has described the purpose of organisational culture as being,

‘to win the ‘hearts and minds’ of employees: to define their purposes by managing what they think and feel, and not just how they behave. The strengthening of corporate cultures, it is claimed, provides the key to securing ‘unusual effort on the part of apparently ordinary employees (Peters and Waterman, 1982)’ (Willmot, 1993, p.516)

The ability to create, mould and implement organisational culture in order to cultivate the commitment of employees is at present a significant preoccupation of HRM theories and practices. As with most organisations however and especially with that of the NHS organisational culture already exists. As organisational culture tends to be the result of an organisation’s history and represents to a greater extent its *raison d’être* it is therefore extremely difficult to mould or create as it tends to be deeply rooted within the organisation. As mentioned previously this is especially the case in professionally driven organisations where the organisation has been shaped by a professional culture. The NHS is an organisation which encompasses many different professional groupings, the control of culture within an organisation such as the NHS would therefore appear to be a very challenging and difficult task for NHS management.

Currie (1996) has examined the existence of conflict between management and professionals within the NHS. She has looked at this conflict through the conduct of a case study assessing the effectiveness of a management development program within an NHS trust. Within this study she looks at how management have introduced new values

and ideals through the existing culture of the NHS as a way of creating desired behavioral outcomes from NHS employees. The following is an example illustrating how management envelop their objectives in the existing cultural tapestry of the NHS as a way of gaining acceptance within the wider organisation for their initiatives,

‘A clinical services manager in health care for the elderly commented: “I think we are dealing with public money and we have to be efficient”. Here we see efficiency promoted in the name of the public interest; that is, being rooted in cultural anchorage...organisations produce discourse which converges with other wider discourses, thus invoking the concept of “intertextuality”, and interpretation of discourses being embedded in one another’ (Currie, 1996, p. 11)

Currie goes further to illustrate how NHS management have attempted to bind the motivation and commitment of employees towards managerial objectives by illustrating the practical attributes of desired managerial changes for employees and also through the manipulation of particular groups and individuals within the organisation who desire organisational change,

‘It is also suggested that reality anchorage facilitates belief change. In line with this...some clinical services managers initially showed a utilitarian involvement and this led to a more persistent form of commitment in the light of new work experiences in changed circumstances: “I took a job because I thought I need a job but I’ve grown into it now” (clinical services manager, adult intensive therapy). Finally within this theme,

one clinical services manager (mental health) when asked how managers felt about their new roles, suggested: ‘‘Many were people who just wanted change from the old ways. They didn’t know which way but they just wanted change’’; thus invoking the concept of motivational anchorage as facilitating belief change’
(Currie, 1996, p. 11)

Management also deployed the use of cultural symbolism as a route and rite of passage from that of the ancien regime to that of the new more managerially driven NHS.

As with any discussion on organisational culture, cultural symbolism is used as a potent force for the transformation of existing culture in the introduction of a new one.

Currie mentions the use of symbolism as a method of gaining and acquiring employee commitment towards managerial goals. In this case it was felt that training events had symbolic meaning in fulfilling this end. In other words the author felt that the management development programme was used as a bench mark to signal a period of transition in the organisational culture of the NHS.

‘It is suggested that training events are company-sponsored attempts to generate commitment to organisational ideology. Training events have been described as a rite of passage. There is a separation phase, that is, letting go of the previous role; a middle transition phase which predominates; and the incorporation of trainees into new roles, a phase which is often skipped over. In the stage of separation scientific trappings of extended testing symbolise the rationality that is valued in managerial circles in general’
(Currie, 1996, p. 14)

While it has been shown that certain employees did adopt the new roles and techniques desired by management, in most cases however this involved a degree of conflict which was evident even on a personal level. Currie outlined the personal conflict between professional and managerial roles which were apparent in the ambivalence of personal identity and the newly appointed role in the delivery of health care. Currie's research indicates a personal identity conflict within those individuals who undertook managerial roles and tasks i.e. dual commitments (see Whitson and Edwards, 1990; Hay and Fee, 1988). Those employees which broke with the totally professional role experienced divisions of loyalty and conflict about how they perceive themselves and their role within the NHS,

'It would appear... that there are many "reluctant managers" in the health service... The change in roles causes those involved considerable discomfort, for instance in terms of their organisation and self-identities as discussed earlier. The discomfort was reflective of the competing ideologies inherent in identities, the former encompassing managerial ideology and the latter professional ideology' (Currie, 1996, p.12-14)

One issue which appeared to determine the extent to which employees were receptive to their newly appointed roles regarded that of the age of the employee and the amount of time they had spent working within the NHS.

‘there are significant differences in opinions and involvement of two clinical services managers in accident and emergency directorates in different trusts. It is suggested that this is due to age’ (Currie, 1996, p.12-13)

Currie also suggests that cultural difference exists among staff whose outlook and attitude differs according to their age and the amount of time that they have spent working within the NHS. This has been illustrated amongst nursing staff where age and experience appears to bear a relationship with the individuals responsiveness to the changing culture of the NHS,

‘When analysing the management development programme in the case study it is seen that the “different ideas” that younger nurses bring in are linked to wider societal change; for example, discourse around consumerism was embedded in the managerial discourse’ (Currie, 1996, p. 13)

Having had no preconceptions or history of work within the NHS it is easy to understand how younger employees and professionals could adopt their newly changed roles with much greater ease and less discomfort than those already familiar with the public service ethos of the traditional NHS. Another significant discovery concerned the ease with which younger and less experienced members of staff find themselves with the discourse and culture of the new management within the Trust. As outlined above the author points towards wider cultural change throughout society in terms of consumerisation and the dominance of market culture in explaining this phenomena.

NHS cultural fragmentation

Currie (1996) describes the existence of what is referred to as cultural fragmentation within the NHS. In the case study the existence of cultural differences between different trusts was discovered hence rendering any unitary meaning regarding the overall way of doing things as ineffective. Current NHS managerial practice and theory (which is rooted within the unitarist principles of private sector management practice, as encapsulated in the belief in management's right to manage) would appear to be wholly inappropriate given the particular circumstances of the NHS. The differentiation of culture within the NHS was summed up by the view of the clinical director at the outset of Currie's research,

'In an interview with a clinical director (accident and emergency directorate) the study was summarised as "So you are interested in the different tribes of the health service"'

(Currie, 1996, p.12)

Sabel (1993) has explored the potential for the development of trust-based relations to take place within the context of a market economy. He speaks of the problems involved in developing trust-based relations between individuals and groups of people from different cultures who inevitable look at the world and their own particular set of circumstances in a particular way as this caption illustrates,

‘What needs to be explained here is how...mistrust arises. One way would be as the result of disputes that begin as disagreements over the interpretation of common norms, and end as the articulation of irreconcilable views of the world. Another would be as the result of the clashes of different cultural worlds which were, so to speak, irreconcilable from the first’

(Sabel, 1993, p.1139)

Sable suggests that the most effective way around the problem of mistrust and the development of more trust-based relations can be found in an effort to rearticulate and redefine ‘community interests’ (Sabel, 1993, p.1159) which he claims would act to blur differences between groups and would establish a more appropriate climate for cooperative relations to develop.

Currie has gone on to criticise the design and delivery of the management development programme for its assumption of a unitarist perspective amongst employees within the NHS. Instead she recommends an analysis of the various professional sub-cultures within the NHS as forming the basis of a much more appropriate programme design,

‘This reinforces the researchers’ perception that differentiation or fragmentation perspectives are more useful in the design and delivery of management development than one which assumes unitarism in terms of objectives’ (Currie, 1996, p.18)

This would square with criticisms outlined previously of the carte blanche importation of private sector notions of unitarist management styles without any regard for the peculiar and specific requirements and needs of the NHS and indeed of particular groups within it. This particular case study would appear to illustrate that the unitarist managerial styles found within the private sector are hard to instill in an organisation with a multi-cultural identity. Currie goes on to reinforce this criticism when outlining recommendations as to how these misgivings can be addressed,

‘Comments have been made that ‘British managers’ comparative lack of education may, in fact, have resulted in this one disabling weakness, not so much an incapacity to think but to debate, to see different perspectives, different conceptions of truth and right’...Whilst recognising that every organisation is unique, the history and professional elaboration of groups in the health service make a hospital environment particularly unique’

(Currie, 1996, p. 19-20)

Summary

This chapter has explored the various definitions and measurements (i.e. Butler, 1991; Mowday et al, 1979) of employee trust and commitment to date. It also has attempted to explore the background to the emergence of these concepts in light of industrial relations and contemporary HRM theory and practice. As shown HRM tends to involve the use of mechanisms to cultivate and foster employee trust and commitment whereas employee compliance tends to be associated with traditional industrial relations theory and practice.

The role played by organisational culture in either facilitating or inhibiting the development of employee trust and commitment has also been examined, particularly with regard to private sector and NHS organisations. This will therefore inform the next chapter which seeks to devise a model depicting the nature of employee trust and commitment within the context of NHS organisations.

Chapter Three: A Model of Employee Trust and Commitment within the NHS

A model of

Employee trust and commitment within the NHS

In order to provide a conceptual framework which illustrates the various internal and external factors influencing the development of employee trust (of management) and employee commitment to managerial aims and objectives two conceptual models have been devised. The first model, as devised by Morgan, and Hunt (1994), looks at the various inputs which assist the cultivation and development of employee trust and commitment within organisations. This model also outlines the various outcomes which may arise as a result of positive levels of trust and commitment within an organisational context.

The second model illustrates the various factors, internal and external, which affect the management of employee relations within the NHS with particular reference to employee trust and commitment. This model was derived from the NHS literature (and other related literature) reviewed to date. The two models outlined and described below offer a conceptual framework which will assist in the study and analysis of employee trust and employee commitment within the NHS.

Trust and commitment model

In outlining a model upon which the relationship between trust and commitment can be clearly seen and understood, Morgan, and Hunt (1994), have illustrated the factors involved in the cultivation and development of both trust and commitment within an organisational context. It should be said however that this model was designed for the study of relationship marketing and co-operation between organisations in highly

dynamic and competitive environments. It is argued by the authors that successful relationship marketing is to a considerable degree dependent upon relationship commitment and trust. The antecedents and the basis for the construction of this model come mainly from the body of research and literature carried out within the domain of organisational behaviour theory and social science. The authors do imply the transferability of their model to other organisational contexts and settings when they state that,

‘relationship marketing requires a definition that accommodates all forms of relational exchanges’

(Morgan and Hunt, 1994, p. 21)

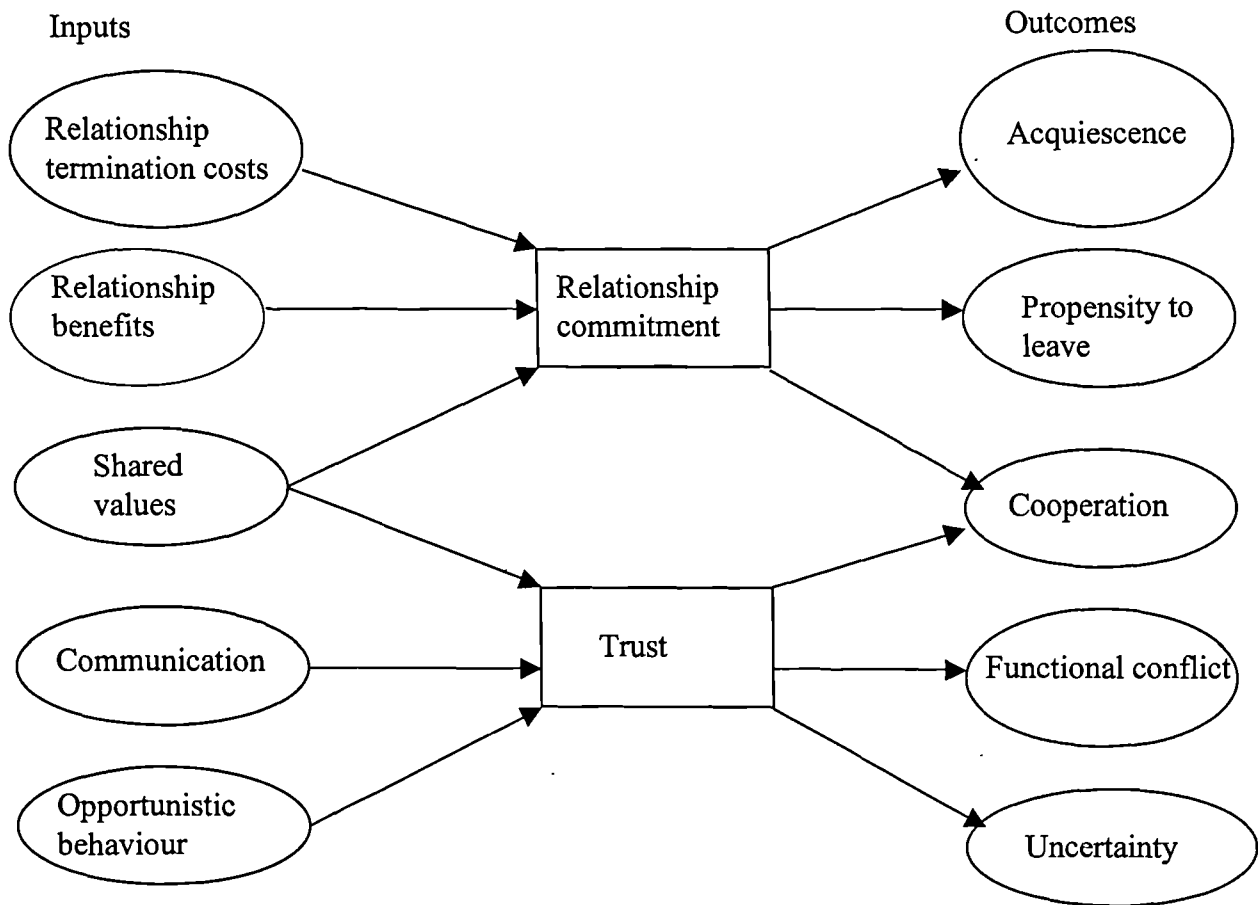
The model described below is based on a synthesis, carried out by Morgan and Hunt, of the literature and research carried out on employee trust and commitment to date. The model describes the specific preconditions and requirements for the development and cultivation of trust and commitment within an organisational context. These preconditions and requirements are identified and listed on the left hand side of the model. On the right hand side of the model the authors have outlined particular ‘qualitative’ outcomes which can be derived from the existence of trust and commitment within organisational relationships (see fig.1. 2)

As can be seen from the model below the authors have outlined specific prerequisites which they perceive necessary in creating and developing organisational trust and commitment which are linked to particular ‘qualitative’ outcomes associated with the development of optimal levels of employee trust and commitment. The following is

an explanation of the specific variables required for the development of trust and commitment and the qualitative outcomes that can arise from the existence of trust and commitment within the organisation.

First of all however it is necessary to describe what the authors mean by relationship commitment and trust.

Fig. 1.2 Organisational trust and commitment



(Morgan and Hunt, 1994, p.21)

Relationship commitment

Relationship commitment relates to the extent to which individuals within a relationship view it as long term and are willing to invest within the particular relationship accordingly. The authors state that relationship commitment occurs when a,

‘committed party believes the relationship is worth working on to ensure that it endures indefinitely’

(Morgan and Hunt, 1994, p. 23)

This would imply that in order for relationship commitment to manifest itself within a working environment the participants must adopt a long term view towards the employment relationship and endeavour to invest within the relationship in order to reflect this view.

Trust

The authors refer to the work of Mooreman, Deshpande and Zaltman (1993) who have defined trust,

‘as a willingness to rely on an exchange partner in whom one has confidence

(Mooreman, Deshpande and Zaltman, 1993, p. 82)’

(Morgan and Hunt, 1994, p. 23)

The authors have outlined the role of confidence as that arising,

‘from the firm belief that the trustworthy party is reliable and has high integrity, which are associated with qualities such as consistent, competent, honest, fair, responsible, helpful, and benevolent’

(Morgan and Hunt, 1994, p. 23)

The authors argue that relationship commitment and trust are linked to each other. It is argued that individuals will only truly commit themselves to those relationships where they feel that they can trust the participants. They will therefore be more willing to invest in such relationships where trust is present,

‘because commitment entails vulnerability, parties will seek only trustworthy partners’

(Morgan and Hunt, 1994, p. 24)

The following represent the five major precursors to the establishment of relationship commitment and trust. These five factors are outlined in the model above.

Relationship termination costs:

This implies the loss of investment, in terms of effort, time, financial expenses etc. which can arise as a result of the termination of a relationship. The participant will weigh up these costs when judging as to whether or not they should switch to another alternative and end the existing relationship in favour of the alternative.

‘Termination costs are, therefore, all expected losses from termination and result from the perceived lack of comparable potential alternative partners, relationship dissolution expenses, and/or substantial switching costs. These expected termination costs lead to an ongoing relationship being viewed as important, thus generating commitment to the relationship’

(Morgan and Hunt, 1994, p. 24)

Relationship benefits:

This outcome refers to the perceived potential benefits which the participants could enjoy arising from their involvement with their exchange partners. Relationship

benefits is recognised as a two way process whereby benefits exchanged between both partners within the relationship are mutually beneficial and satisfactory.

Shared values:

The authors highlight the sharing of values as a means of strengthening commitment towards a relationship and trust in its participants. The authors refer to the work of Kelman (1961) who has described the way in which the attitudes and behaviours of people are created.

‘people’s attitudes and behaviours result from (1) rewards or punishments, or “compliance”; (2) the desire to be associated with another person or group, or “identification”; or (3) having the same values as another person or group or “internalisation”

(Morgan and Hunt, 1994, p. 25)

Communication:

The authors refer to the work of Anderson and Weitz (1989) who have highlighted the positive relationship which communication has with trust. The authors point out that past communication leads to trust and trust in turn leads to better communication. Communication leads to the resolution of disputes, prevents misunderstandings and can cement and foster positive relationships between participants.

Opportunistic behaviour:

Opportunistic behaviour is defined by Williamson (1975, p. 6) as

“self-interest seeking with guile”

(Morgan and Hunt, 1994, p.25)

Those who demonstrate opportunistic behaviour traits tend to have a high degree of self interest. This it is claimed can have an adverse effect on trust and inhibits the manifestation of trust within relationships,

‘such behaviour results in decreased relationship commitment because partners believe they can no longer trust their partners’

(Morgan and Hunt, 1994, p.25)

Outcomes arising from trust and commitment

Morgan and Hunt outline five ‘qualitative’ outcomes which can arise as a result of the successful development and cultivation of trust and commitment in organisational relationships. These outcomes are illustrated in the model above and are subsequently described below.

Acquiescence and propensity to leave;

The authors define acquiescence and outline its link to relationship commitment as follows,

‘we define acquiescence as the degree to which a partner accepts or adheres to another’s specific requests or policies, and we posit that relationship commitment positively influences acquiescence’

(Morgan and Hunt, 1994, p.26)

The authors argue that trust can only influence acquiescence through relationship commitment. In the context of the NHS acquiescence implies employee compliance with the aims and goals of the employing organisation. Propensity to leave highlights the willingness of the employee to leave the organisation. The authors suggest that employee commitment bears a negative relationship with the propensity of the employee to leave the organisation. In other words the greater the level of commitment an employee has to an organisation the less likely they are to leave and seek out an alternative source of employment. Since high employee turnover is expensive and can prove time consuming stability of employment is desirable and is positively linked to commitment.

Co-operation:

The authors look upon co-operation as an outcome which is ‘influenced directly by both trust and commitment’. Co-operation refers to the existence of situations whereby parties engage in activities and actions in the fulfilment and achievement of mutually desired goals.

Functional conflict:

The existence of functional conflict within organisations can,

‘prevent stagnation, stimulate interest and curiosity and provide a “medium through which problems can be aired and solutions arrived at (Deutsch, 1969, p. 19)”

(Morgan and Hunt, 1994, p.26)

The authors argue that for organisational conflict to have positive benefits for the organisation at large trust must exist between the parties. Trust between the parties involved will ensure that conflict is functional and will prove beneficial both to the organisation and the various parties involved.

Decision-making uncertainty:

The authors have referred to the work of Achrol and Stern, 1988, when describing this qualitative outcome.

‘Uncertainty in decision making refers to the extent to which a partner (1) has enough information to make key decisions, (2) can predict the consequences of those decisions, and (3) has confidence in those decisions (Achrol and Stern, 1988)’

(Morgan and Hunt, 1994, p. 26)

The authors argue that decision-making uncertainty is minimised and lowered by the existence of trust between the various parties. Decision-making uncertainty has a negative relationship with trust. Decision-making uncertainty is limited and minimised if the trusting partner is confident that the other party can be trusted and relied upon.

The NHS and its environment

The following is a model derived from the literature reviewed to date which outlines the various factors which influence and effect the current organisational culture within the NHS and its environment. The subsequent part of the model illustrates how external and internal factors within the NHS affect the development and cultivation of employee trust, of NHS management, and subsequently the level of commitment of NHS employees towards the aims and objectives of the NHS organisation in which they work. The model illustrated below, Fig. 1.3, will also assist in outlining the supposed relationship between employee trust and commitment within the context of NHS organisations.

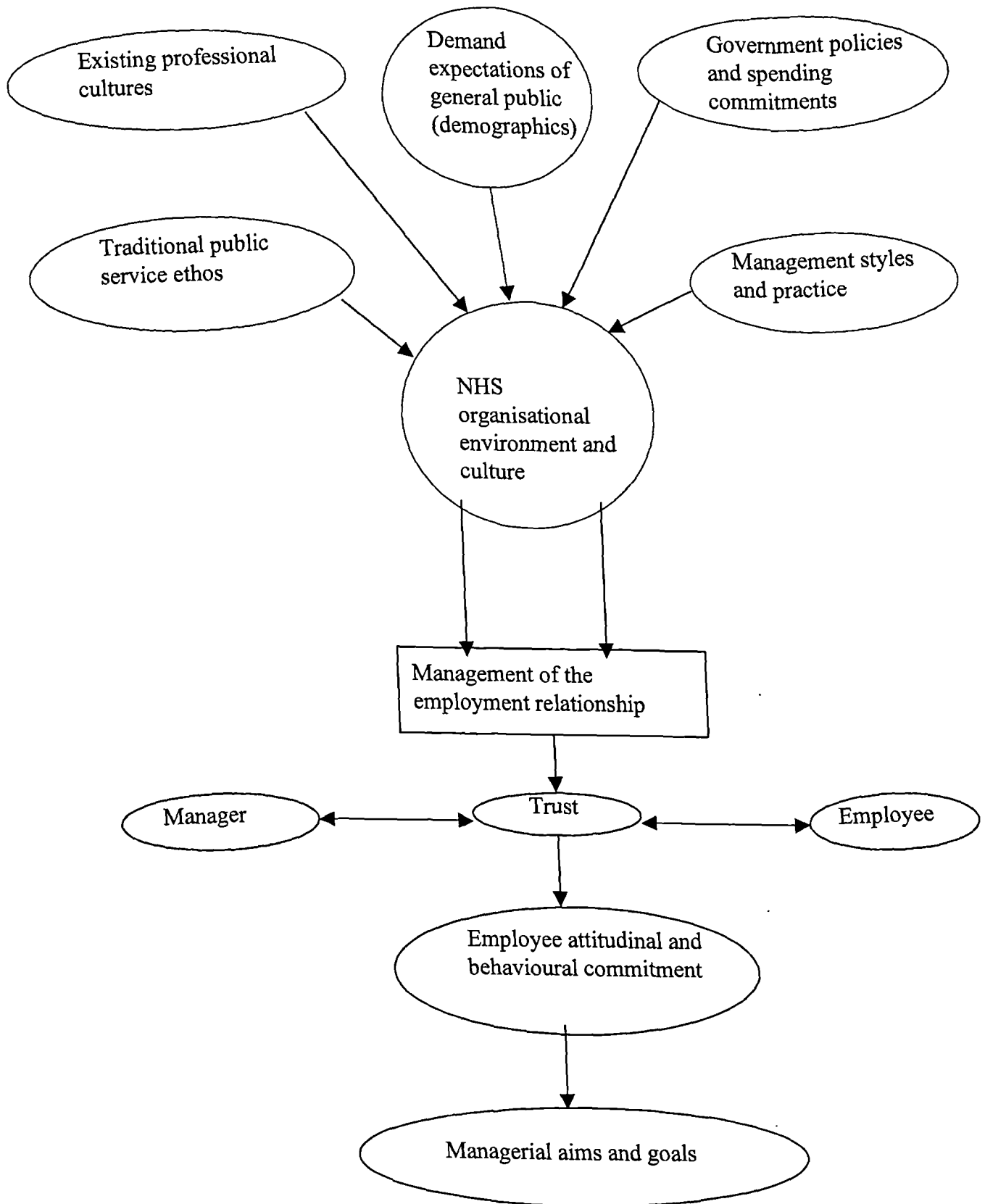
The context in which the modern NHS is set will be taken into account and referred to when studying the development and maintenance of employee trust and commitment within the NHS. The model constructed below depicts the various factors and forces which have played a pivotal role in shaping the organisational environment of the modern NHS. (See fig. 1.3)

The development of trust between managers and employees will be looked at within the context outlined below. As has been mentioned earlier current research supposes that employee trust of management is a precondition to employee attitudinal and behavioural commitment towards managerial aims and goals. The model set out below illustrates the relationship between the management of employees within the NHS and its environment. The factors outlined above are both internal and external to the NHS.

The external factors include government policy and spending restrictions on NHS funding and public expectations of NHS services. Internal factors constitute NHS management styles and practice, professional sub-cultures and the public service which has traditionally underpinned the operationalisation and day to day business of the NHS. As has been illustrated earlier government policy and spending allocations can influence and determine the way in which NHS organisations are managed. The style in which NHS organisations are managed and the priorities outlined and subscribed by NHS management can very often conflict with the existing professional cultures within the NHS and can indeed clash with the public service ethos traditionally upheld by NHS employees whilst carrying out and executing their daily tasks and duties.

Having surveyed the literature to date it can be observed that the factors which have shaped the modern NHS tend to be in conflict with one another. The five factors highlighted below (fig. 1.3) have been divided into two groups. Government policy and spending restrictions, public expectations of services provided and managerial styles have been listed on the right while professional cultures and public service ethos have been listed on the left. The factors listed on the right and the left regularly and indeed frequently clash and struggle with each for the heart and soul of the NHS. The organisational environment of the NHS could therefore be classified as one which is in constant flux and tension, arising mainly as a result of power struggles between government and managerial priorities with professional prerogatives and traditional public service ethics and ethos.

Fig. 1.3 Environmental factors influencing the development of trust and employee commitment



Chapter Four: Research Methodology

Research Methodology

Research aims

The aims of this research proposal were as follows,

- To examine and assess the level and the nature of trust between nursing staff and their managers within two NHS organisations (From the acute and the community sectors).
- To examine and establish the scope and the degree of commitment (attitudinal and behavioural) amongst nursing staff within the two organisations.
- To examine the relationship between trust (between nursing staff and their immediate superiors/management) and the level of commitment of nursing staff within the two organisations.
- To compare the results and findings from the two organisations in order to make judgements about the level and the nature of trust and commitment amongst nursing staff within the two organisations.

The examination of the level of trust and commitment amongst nursing staff was carried out within the following contexts,

- The impact of organisational change, resulting from market reform, on the management of employee relations within the NHS.

- The impact of the alleged introduction of private sector managerial styles on the work practices of NHS employees.
- The impact of potential organisational culture change as a result of market reform, upon the working practices and ethos of NHS employees.
- The new proposals from New Labour regarding co-operation and partnership.

Background of study

The study of employee trust and commitment took place against a background of recent organisational change within the NHS. It was suspected, although not assumed, that the process of organisational change may have had some impact on altering the level and the nature of the commitment and the traditional values held by NHS management and employees. The process of NHS reform was designed to facilitate the adoption of a much more market led approach to the delivery and allocation of health care to NHS users. The NHS has therefore undergone a considerable degree of change in terms of its structure and management.

Current research would suggest an increasing trend towards the introduction of private sector management styles within the NHS as well as other public sector organisations. Employee trust and commitment were therefore explored and measured within the context of the alleged introduction of private sector management styles within the NHS.

As a result of the organisational change and through the recent alleged introduction of private sector management styles and practices the NHS may be undergoing a culture change. As mentioned earlier the NHS has traditionally been dominated by a culture of professionalism with a strong ethos of public service. NHS employees like that of other groups of employees within the public sector have traditionally carried out their work under a strong public service ethos. An investigation into the level of employee trust and commitment of NHS employees was therefore carried out within the context of an organisation that has possibly undergone a profound transformation in its organisational culture as a result of recent organisational and managerial change.

Recently the 'New Labour' government has spoken of further organisational change within the NHS. The current government has highlighted the destructive competition introduced by the internal market as the main failure of the process of NHS reform. The proposals outlined within the new government white paper on the NHS propose a change in the emphasis from that of competition to one of co-operation and partnership between NHS organisations, (The New NHS, Modern Dependable, 1998). The implications these changes may have on the management of employee relations within the NHS will be examined when assessing the trust and commitment of NHS employees.

Purpose of methodology

The methodological design outlined within this section, in the fulfilment of the research aims outlined above, proposed to assist in the exploration, evaluation and the understanding of employee trust (of management) and commitment within the NHS.

The research techniques used within the proposed methodological design were essentially derived from their effectiveness in fulfilling the stated aims and objectives of this research project.

‘The selection of method implies some view of the situation being studied, for any decision on how to study a phenomenon carries with it certain assumptions, or explicit answers to the question “what is being studied” (Morgan, 1983 p. 19)’

(Gill and Johnson, 1991, p. 125)

From the above comment it is clear that when outlining a proposed program of research, researchers are advised to consider the nature of the subject and the context in which the research will take place. When considering the methodological construct and design used to carry out the aims and objectives outlined within this proposal, the nature of the subject, employee trust of management and employee commitment to managerial aims and objectives, all had to be brought into consideration when deciding upon the most appropriate methodological design to adopt.

Bryman (1984) comments upon the merits of allowing the nature of the subject under investigation to guide decisions concerning the choice of research techniques and methodologies used within the research process. When deciding on the most appropriate research techniques used in conducting research Bryman, has stated that,

‘A solution to many of the discussions seem to lie in Trow’s apparently sound advice that ‘the problem under investigation properly dictates the methods of investigation’

(Bryman, 1984, p. 76)

The following section entails a discussion of the main positions and approaches taken in carrying out contemporary social research. The outcome of this discussion leads onto the ontological, epistemological and the theoretical frameworks which have established the parameters in which the conduct of this research investigation took place.

Traditions of thought/Philosophical debate

The choice of methodological design used in carrying out social research is usually indicative of an individual's assumptions about the world around them and what they consider as being relevant and important in defining their reality. Bryman (1984) succinctly sums up the issue of how one's perception of the world relates to the choices they made in deciding on the most appropriate and effective way to carry out social research,

'Philosophical issues relate to questions of epistemology i.e. the appropriate foundation for the study of society and its manifestations'

(Bryman, 1984, p. 75)

The philosophical bias of an individual would therefore influence their choice of techniques and methodologies when fulfilling the aims and objectives of their research proposal. As researchers we therefore carry assumptions about the world around us, these assumptions can unwittingly determine the direction of what is studied and

therefore affect the outcomes and findings during the course of the research process itself. The body of knowledge one carries to any situation involving the conduct of research is referred to as an epistemology. The nature of an individual's epistemology is derived from the philosophical outlook held by the individual. The philosophies and subsequent epistemologies of social research vary on a sort of pendulum. To most contemporary social researchers the methodologies and epistemologies form a spectrum involving two sets of philosophies where it very often seems that 'never the twain shall meet'. On one side there is the tradition of positivism and at the other side of the spectrum lies the tradition of interpretism. A contemporary example which can help to illustrate the different positions of the two philosophical outlooks can be seen in the Canadian T.V. series *The X files*. On one side is the cold, unemotional and clinical Scully who looks for rationality and uses scientific techniques while conducting her investigations. Scully would therefore personify a modern day positivist, one who uses rational scientific techniques to explain cause and effect relationships. At the other side of the spectrum is the intuitive, unassuming and inquiring Mulder who digs beneath the surface and reads between the lines, one who is unbridled by the knowledge of science and rationality when researching and conducting his investigations. Mulder represents the interpretist approach, and adopts an approach which seeks to explain, explore and understand particular events and unexplained phenomena. While the two characters look at the world from two opposing angles it is hoped that somewhere along the way they meet in the middle and eventually 'uncover the truth'.

Positivist and interpretist philosophies are therefore based on two different sets of assumptions on how the world should be perceived and how reality should be defined.

As Positivist and interpretist philosophies define reality in different ways they therefore derive and construct different ontological, epistemological and theoretical frameworks in exploring and researching phenomena,

‘All philosophical positions and their attendant methodologies hold a view, implicitly or explicitly about social reality...this determines what can be regarded as legitimate knowledge...therefore the ontological shapes the epistemological’
(Williams and May, 1996, p.69)

The following is an attempt to outline and define the positions of the two philosophical view points and their subsequent methodological frameworks and how they relate to the research that was carried out.

Positivism

The philosophical tenets of positivism underpin the ontological, epistemological and theoretical foundations of modern science. The tradition of positivism acknowledges the existence of what it refers to as the ‘natural world’, one that is governed by laws, facts and certain outcomes. As such positivistic epistemology seeks to uncover and identify ‘facts’ and uses quantitative (or scientific) research techniques to establish cause and effect relationships through the quantification, standardisation, and measurement of specific variables. These variables are established at the outset of the research process and are aimed at the generation, explanation, reproduction and prediction of particular outcomes and findings. Bryman, (1984) sums up the positivist tradition in the following,

‘The paraphernalia of positivism are characterised typically in the methodological literature as exhibiting a preoccupation with operational definitions, objectivity, replicability, causality, and the like’

(Bryman, 1984, p. 77)

The positivist philosophy subscribes to an epistemology where theories must be scientifically proven, or in many cases disproved, before being officially accepted; positivism therefore perceives human subjectivity and intuition as having little or no relevance within this process as the following statement suggests,

‘The result of the positivist’s concern to emulate natural science methodology thus necessitates a denial of the importance of human subjectivity, a denial usually supported by further methodological criteria’ (Gill and Johnson, 1991, p. 126)

According to the positivist tradition the natural world can be broken down into variables which can be identified, measured and controlled to disprove or prove laws and theories. Positivism would therefore explain human behaviour in ‘terms of cause and effect’ (May, 1993, p.5)

One of the central tenets of positivist philosophy is that the observer remains detached and isolated from what is being observed, hence upholding the principle of objectivity. As the researcher maintains a sense of detachment from their subject the

findings of the research are not therefore contaminated by the subjectivity of the researcher,

‘Objectivity is defined by positivism as being the same as that of natural science and social life may be explained in the same way as natural phenomena. We can characterise this tradition in the same terms as the aims of natural science; the prediction of the behaviour of the phenomena; explanation of the behaviour of phenomena and the pursuit of objectivity, which is defined as the researcher’s ‘detachment’ from the phenomena under investigation’ (May, 1993, p. 5)

Interpretism

The interpretist approach disputes and contests the objectivity of the researcher by claiming that the researcher cannot be separated from the external world indeed the researcher is inextricable intertwined and involved with the external world. The researcher can not look at what the positivist tradition refers to as the ‘real world’ but can only explain and interpret what they themselves observe. The interpretist approach acknowledges what it perceives as the existence of multiple realities, the world is made up of what individual people perceive it to be. Interpretism places greater emphasis on subjectivity as opposed to clinical objectivity. Although the interpretist approach can be seen as an alternative philosophy to the positivist tradition it can also be seen as a reaction towards positivism in so far as it attempts to address what it perceives as the shortcomings of positivism. The interpretist tradition does this through adopting an approach which emphasises exploration, interpretation and understanding,

‘In the past , much attention has been given to describing, coding and counting events, often at the expense of understanding why things are happening. This has led to a predominance of quantitative research methods which are geared, for example, to finding out how many people hold particular views, or variations in measures of corporate performance. By contrast, qualitative methods might concentrate on exploring in much greater depth the nature and the origins of people’s viewpoints, or the reasons for, and consequences of, the choice of corporate performance criteria’

(Easterby-Smith et al, 1991, P. 1)

The interpretist perspective therefore seeks to examine how people interpret, explain and give meaning to the world as they see it. Gummesson (1991) has referred to the work of Taylor and Bogdan when he sums up the role of the interpretist (in this case referred to as the phenomenologist).

‘the ’phenomenologist is committed to understanding social phenomena from the actor’s own perspective. He or she examines how the world is experienced. The important reality is what people perceive it to be’ (Gummesson, 1991, p. 150)

As can be seen there is a significant variation and shift in emphasis between the two philosophies in terms of what each one regards as important in the process and conduct of contemporary research.

Choosing the method

While quantitative techniques, as used by the epistemologies of the positivist tradition, have their contextual merits, they were not however viewed as effective devices in the measurement and understanding of employee beliefs, feelings and perceptions. The methodological design was therefore developed according to the nature of the subject being investigated,

“As Morgan and Smircich (1980) observe, the appropriateness of a research investigation ‘derives from the nature of the social phenomena to be explored’ (p. 149)”

(Easterby-Smith et al, 1991, p. 41,)

As mentioned at the beginning of this section, one of the aims of this research proposal was to examine and assess the level of trust between managers and employees within the NHS. Another aim of this proposal was to examine and establish the scope and degree of employee attitudinal and behavioural commitment to managerial aims and objectives. To date very little research has been conducted on employee trust and commitment within the NHS. The nature of the proposed research investigation was to explore, explain and understand employee trust and commitment within the context of NHS organisations in the late 1990s. The methodological design therefore needed to be flexible enough to adapt in pursuing significant areas of inquiry and interest which could be of value to the aims of the research proposal. Qualitative research techniques would facilitate an appropriate level of flexibility to enable adjustments in the focus of this research investigation. This allowed the researcher to explore other points of significance and value during the course of the research.

‘Qualitative research is deemed to be much more fluid and flexible than quantitative research in that it emphasises discovering novel or unanticipated findings and the possibility of altering research plans in response to such serendipitous occurrences. This is contrasted sharply with the quantitative methodologist’s research design with its emphasis upon fixed measurements, hypothesis (or hunch) testing, and a much less protracted form of fieldwork involvement’

(Bryman, 1984, p.78)

As mentioned earlier the decisions involved in choosing the methodological design in conducting one’s research should essentially be derived from a careful analysis of the nature of the subject being investigated. As it was essentially the nature of this research investigation to define, explain and outline the scope of employee trust (of NHS management) and the attitudinal and behavioural commitment of NHS employees, the use of qualitative research techniques taken from the interpretist tradition were believed to be the most appropriate. The research techniques chosen within the proposed methodology were selected on the basis of their effectiveness in gathering and measuring qualitative data. The research methodology used in carrying out the aims of this research proposal were therefore mainly from the interpretist tradition.

Case study research

In light of the philosophical issues discussed earlier and given the nature of the particular subject being investigated case study analysis was considered to be the best possible way of effectively conducting and carrying out the research investigation.

As mentioned in greater detail above this program of research proposed to examine, assess and explore employee trust (of management) and attitudinal and behavioural commitment within the NHS. This program of research was therefore conducted and carried out within organisations which have allegedly undergone considerable change in terms of their structure and management and possibly their culture as a result of market reform.

A case study investigation is an ethnographic form of research, where in the words of Robson (1993) the researcher adopts an approach which,

‘seeks to provide a written description of the implicit rules and traditions of a group. An ethnographer, through involvement with the group, tries to work out these rules. The intention is to provide a rich, or ‘thick’ description which interprets the experiences of people in the group from their own perspective’ (Robson, 1993, p. 148)

In order to establish the level of trust between managers and employees it was necessary for the researcher to adopt a ‘mode of engagement’ which approaches the research topic from the perspective of the subjects involved (management and employees within the NHS). Given the apparent lack of research on employee trust and commitment within the NHS it was believed that this ‘mode of engagement’ could be a more effective approach than one which involved the imposition of an externally simulated criteria with the purpose of measuring specific variables. The research tools used within the proposed case study were selected for their effectiveness in collecting and gathering data on the subjectivity of NHS managers

and employees, particularly on the meanings that NHS employees attribute to their environment and context in which they work,

‘To concentrate on subjectivity we focus on the meanings that people give to their environment, not the environment itself.’ (May, 1993, p.8)

As mentioned earlier qualitative research methodologies informed by the interpretist tradition tend to be more flexible in altering the focus of the investigation throughout the course of the research process. The construction of a qualitative research methodology offers the researcher an element of flexibility in exploring and pursuing areas of value in order to address the aims and objectives outlined within the research proposal. Quantitative research techniques were however used as a way of triangulating the data gathered through qualitative research methods. This was used in order to verify the results gathered through the course of carrying out the interviews and hence give greater credibility to the overall findings. The use of qualitative research methodologies are appropriate where the research objectives consist of exploring assessing and understanding social phenomena. Bryman (1984) has commented upon the merits of qualitative research techniques in terms of their ability to allow the researcher greater flexibility in the exploration of social phenomena,

‘Its fundamental point is that because of the unstructured nature of most qualitative research with its associated lack of hypotheses, except in a very loose sense, qualitative research is inherently exploratory. As a result of this emphasis, the qualitative researcher embarks on a voyage of discovery rather than one of

verification, so that his or her research is likely to stimulate new leads and avenues of research that the quantitative researcher is unlikely to hit upon, but which may be used as a basis for further research'

(Bryman, 1984, p.84)

Bryman outlines the role of the 'quantitative researcher' as being more effective and relevant in testing theories and data on social phenomena after qualitative research has taken place. It is for this reason that quantitative research methods were used after the use of qualitative research methods.

The use of a qualitative research techniques in carrying out case study research allowed the researcher greater scope and flexibility in exploring the antecedents of trust between management and employees and the extent to which employees were committed to managerial aims and objectives. By employing a 'mode of engagement' which was designed to explore, assess and understand trust from the employee's perspective, that employee trust and commitment could be more effectively assessed and understood.

Robson (1993) has outlined the benefits and advantages of conducting case study research as being more effective than that of other techniques in 'bringing out' and illuminating the issues and questions under the research proposal,

'Viewing any prospective study initially in case study terms has the advantage of bringing the research questions to the fore and of emphasising and making explicit the relationship between these questions and the conceptual structure of your study'

(Robson, 1993, p.166)

As mentioned previously the choice of research techniques were derived essentially from the nature of the subject being explored, that of employee trust and commitment. Case study research allows the researcher greater flexibility in choosing research techniques based on their ability to effectively address the central issues and questions outlined within the research proposal,

‘As with other questions, case study permits you to approach this in a variety of ways, ranging from loose and unstructured to tight and heavily pre-structured. There are no absolute answers. Though individual researchers will have their own personal preferences and prejudices, the basic rule is that the nature of the data collection should depend on the kind of study that you are doing. The conceptual framework, research questions and sampling criteria you have adopted largely determine the approach to data collection’ (Robson, 1993, p.157).

Case study research - a soft option?

As can be seen from the above case study research has many advantages and offers an effective and appropriate framework in conducting and carrying out exploratory research. Despite all the advantages outlined previously, case study research should not however be perceived as providing the researcher with a soft option. Robson, 1993, has hinted at the potential pitfalls of such attitudes, with particular reference to the design stage of case study investigations,

‘In case study the design process is in one sense more forgiving; there is the opportunity to modify and change focus. In other senses it is more arduous as the design is a continuing issue during the course of the study’(Robson, 1993, p. 150)

Unlike other more structured approaches to research design and methodology there are limits on the extent to which findings derived from case study research can be extrapolated in order to make wider generalisations. The type of investigation outlined within this proposal involved a cross-sectoral case study investigation between two NHS organisations. The research proposal therefore involved exploring, assessing and ultimately understanding employee trust and commitment within two NHS organisations. Other research investigations which use quantitative research methodologies look at particular and specific variables which can be measured across a larger number of organisations/samples and can therefore make wider generalisations and judgements on the findings from their research endeavours. This would therefore highlight the trade off between the depth of the investigation been conducted with that of a broader type of investigation, arising usually from a research program involving the use of a more positivist based methodology. It has been said that a broader scope of study, which in this case would have involved studying a larger number of NHS organisations, would have been more effective in generating findings and conclusions upon which wider generalisations could have been made. The disadvantage of such an approach is that the researcher must clearly identify what it is they were looking for at the outset of the research process. By outlining specific variables, at the outset of the research process the researcher runs the risk of overlooking significant phenomena and other factors which may not have been

accounted for at the outset of the research project. By using a more quantitative research methodology it is therefore more difficult to alter the direction of ones inquiry in order to explore other significant factors and phenomena which arise during the course of the investigation.

‘Because ethnographers produce large amounts of qualitative data in an inductive fashion it is perhaps the most likely of all strategies to identify and include all the relevant variables in any subsequent theoretical analysis. In contrast, the experimental and survey approaches entail the formulation of theory prior to data collection through operationalization and instrumentation. At each stage of this process the deductive researcher is, in effect, excluding variables from consideration and limiting the extent and form that data takes in a priori fashion. To put it crudely, the researcher is throwing information away!’ (Gill and Johnson, 1991, p. 124)

Given the apparent lack of qualitative research on both employee trust and commitment, within the NHS, the use of techniques requiring the creation of theory in order to construct experimental and survey design approaches (prior to the research process) would, to put it crudely, have been a case of putting the ‘cart before the horse’. Despite the limited scope for wider generalisations arising from case study research it does however offer an effective route to explore, assess and understand the nature of employee trust and commitment. Not only was this consistent with the aims and objectives of this particular research proposal it also offers potential for the creation of theories upon which further experimental and survey approaches could then be operationalised and carried out. Bryman (1984) has commented upon the

belief that positivist and interpretist methodologies are indeed compatible but differ only in terms of their place within the research process and cycle. The use of interpretist research methodologies are effective in exploring and understanding the nature of the research subject. On the other hand however positivist research methodologies are used in identifying particular variables within the research data, in order to prove particular theories and relationships between specific variables. When commenting upon the supposed relationship between interpretist and positivist research methodologies within the research cycle, Bryman (1984) has made the following link,

‘Quantitative studies serve primarily to firm up and modify knowledge first gained in a fundamentally qualitative fashion’ (Bryman, 1984, p.85)

This would suggest that positivist research methodologies are more appropriately used after the conduct of a more qualitative research investigation.

One of the strengths of ethnographic forms of research such as that incorporated within case study research design is the natural way in which the subject/s under investigation are researched. While positivist research techniques display many advantages in terms of internal validity (the extent to which the research techniques used can measure variables in order to determine ‘cause’ and ‘effect’) and reliability (the extent to which the same research process can be recreated to produce the same results by another researcher) they are not as effective in providing a ‘natural’ setting in carrying out social research. The use of positivist techniques involve the use of highly artificial and pre-programmed research designs which have been known to

affect both the setting and the subjects under study. In their evaluation of positivist and ethnographic research techniques, Gill and Johnson (1991) have stated,

‘It is often considered that ethnography has inherent advantages over positivistic research methodologies (e.g. laboratory experiments and surveys) that suffer from deficiencies in ecological validity (Brunswick, 1956; Bracht and Glass, 1968). That is, ethnographic research (unlike other research strategies) takes place in the natural setting of the everyday activities of the subjects under investigation. This and the research procedures used, reduce contamination of the subject’s behaviour by the researchers themselves and the methods they use for collecting data’

(Gill and Johnson, 1991, p. 124)

Outline of research

The proposed case studies were conducted across two sectors within the NHS; Acute and Community sectors. Access to the main acute sector organisation within the south west of England and the largest community sector organisation within Plymouth was negotiated for the purposes of this program of research. A series of preliminary interviews and discussions took place between the Personnel Manager from the acute sector and a Personnel Officer from the community sector organisation within the Plymouth area. The interviewees were asked questions about the recent history of their organisations, both in terms of recent organisational change and restructuring, and employee relations amongst the various groups of staff. These preliminary interviews formed the context and the basis upon which a sufficient level of rapport and trust was established. The nature of the proposed program of research was

explained to both the Personnel Manager from Derriford Hospital and the Personnel Officer from Mount Gould. Access to both organisations for the purposes of carrying out the proposed research was requested. Once access to the two organisations mentioned above was acquired, the basis for the proposed cross sectoral case study analysis had been established.

Research methods

Preliminary interviews

The purpose of these interviews was to gain an informed insight into the recent background of the two organisations and to inform the basis for an approach in carrying out the proposed program of research (these interviews will be discussed in-depth within the next section).

The preliminary interviews helped to establish a degree of context in which the research was carried out. The two respondents spoke of their current organisational environments and outlined the aims and objectives of their organisations and the nature of the care they provided and the type of patients they looked after i.e. long term care, short term care. They also spoke of the various groups of employees working within their organisations. Having discussed the research aims and objectives with the two interviewees it was decided that the most feasible and appropriate group of employees to investigate was going to be NHS nursing staff within the acute and community sector. It was felt that there were sufficient numbers of nurses within both organisations and that they would be more accommodating and receptive to cooperation than that of other occupational groups i.e. consultants. Unlike other employee groups nursing staff tended to remain longer within their organisations as opposed to doctors who were continually being rotated from hospital to hospital and from department to department. Nursing staff were therefore in a more favourable position to talk about issues of trust and commitment within the particular context of the organisation in which they worked. The aims and objectives of the management of the two organisations were discussed with the personnel manager (from the acute sector organisation) and the personnel officer (from the community sector

organisation) in relation to their employees. They did this by providing an insight into the aims and objectives of Trust management and those of nursing staff (which was later collected through the in-depth interviews and the questionnaire surveys). The data collected helped to inform the research questions and also guided the focus of the research investigation itself.

In-depth interviews

The purpose of carrying out these interviews was firstly to examine and assess the level of trust between nursing staff and their managers and secondly to establish the nature of and the level of the organisational commitment (attitudinal and behavioural) of nursing staff within an acute and a community sector organisation. The interview schedule was flexible enough to allow the interviewees to talk about other issues which they felt were relevant to levels of trust and commitment amongst nursing staff. Twenty nurses were interviewed within Derriford hospital and another twenty nurses were interviewed within Mount Gould (altogether forty nurses were interviewed). The interviewees were selected at random from all the various directorates/departments within both organisations i.e. A and E, maternity, rehabilitation, renal etc. While the structure of the interviews were linked to the models discussed previously (Morgan and Hunt, 1994) it was clear from the responses that the clear cut distinctions between the various elements constituting trust and commitment described and outlined within the models were not made by the respondents.

Questionnaire survey

Two questionnaires were used for the purposes of this study. One questionnaire was designed to measure employee trust and the other was designed to measure employee commitment. As mentioned previously the two questionnaires used for the purposes of this research were independently tested and verified as legitimate tools in measuring the level of employee trust and commitment. It was considered that the results from the questionnaire survey could therefore be relied upon. Additional questions were however added to the survey. The purpose of the questions was to reflect the particular culture and context in which the respondents were set i.e. patient care, the nursing profession and to find out as to whether or not their managers or their immediate superiors had any nursing training or experience etc. These issues would not have been addressed by the two original questionnaires on trust and commitment so it was therefore necessary to include them within the questionnaire survey.

Derriford hospital

On the advice of the personnel manager 350 questionnaires were to sent to all nurses working within the trauma and surgical directorates within Derriford hospital.

The personnel manager claimed that the trauma and surgical directorates were representative of nursing staff throughout the hospital as a whole. They were therefore chosen so that generalisations could be made about nursing staff throughout the entire organisation. The questionnaires were distributed through the hospitals internal mailing system with enclosed self addressed envelopes. 87 of the 350 questionnaires were returned there was therefore a 24.9% response rate.

Mount Gould community hospital

Eight four questionnaires with enclosed self addressed envelopes were sent to Mount Gould for distribution in November 1998. Again they were distributed through the hospitals internal mailing system. The sample covered the majority of qualified nursing staff within Mount Gould Community hospital within the hospitals rehabilitation units. Unlike Derriford however only one questionnaire was used (employee commitment questionnaire). The nursing staff manager, did not permit the use of the questionnaire on trust. Given the recent changes within the organisation and the current climate within the organisation, at the time of the research, the nursing staff manager felt that the use of the questionnaire on trust was not politically feasible and felt that it would be too controversial. Thirty-nine questionnaires were returned the response rate was therefore 46.42%.

Chapter Five: Preliminary Interviews within the NHS

Preliminary interviews with NHS Trust Management

The following is an analysis of preliminary interviews and discussions which were carried out with a personnel manager from an acute sector organisation (Derriford hospital) and a personnel officer from a community sector organisation (Mount Gould community hospital). The findings from these interviews were as follows;

Acute sector organisation

The interviewee from the acute sector organisation proceeded to outline and clarify the structure of the HRM department within his organisation.

The HRM team within the acute sector organisation is small. A small senior team deals with policy and procedures and another small senior team deals with the process of recruitment. The HRM department consists of two personnel officers, two personnel managers, one medical staffing manager and one director. The personnel officers each head a team of seven people to deal with areas such as recruitment, administration, annual leave etc. There are two secretaries within the personnel department who provide back up service and support to the director and the two personnel managers. The interviewee said that the role of the medical staffing manager was to provide personnel service to the medical and clinician staff. As the personnel and career needs of clinicians and medical staff were unique compared with that of other groups of employees within the hospital they are treated as a separate category to that of other employee categories. The job of the medical staffing manager deals with the recruitment, interviewing, selection and other personnel issues

involving the medical and clinician staff within the hospital. The position is two years old and the medical staffing manager heads a team of three people.

The acute sector organisation is structured as follows;

The chief executive is at the top of the hierarchy who oversees all the clinical directorates. Each clinical directorate consists of a clinical director and a business manager. The role of the HRM function within this context is to 'iron out' and tie up any loose ends and problems which may arise when implementing the plans and activities outlined between the directorates and the chief executive. The directorates make up the plans for their own particular directorate, these plans are subsequently submitted to the chief executive for his approval. The function of the personnel/HRM department is to ensure the smooth implementation of the approved plans by removing any potential obstacles or barriers to their implementation. The purpose of the HRM function is to therefore 'moderate' and 'smooth out' any opposition to change and to ensure that the employees are sufficiently prepared and equipped for the implementation of the proposed plans. In this respect the HRM department adopts a trouble shooting function in terms of its role in alleviating any adverse effects which organisational planning may have on the management and employee relations within the Trust. The role of the HRM department is to ensure that the skills mix of the Trust's employees match the requirements set out in the plans issued by the directorate. The HRM department ensures that employees are sufficiently flexible, in terms of their skills mix, in order to achieve this objective. The role of the HR manager consists of matching employee profiles with the aims and objectives drawn up by the directorate and overseen by the chief executive.

In outlining how the NHS functioned under the previous conservative administrations and how it would operate under the 'New Labour' the interviewee made the following comments.

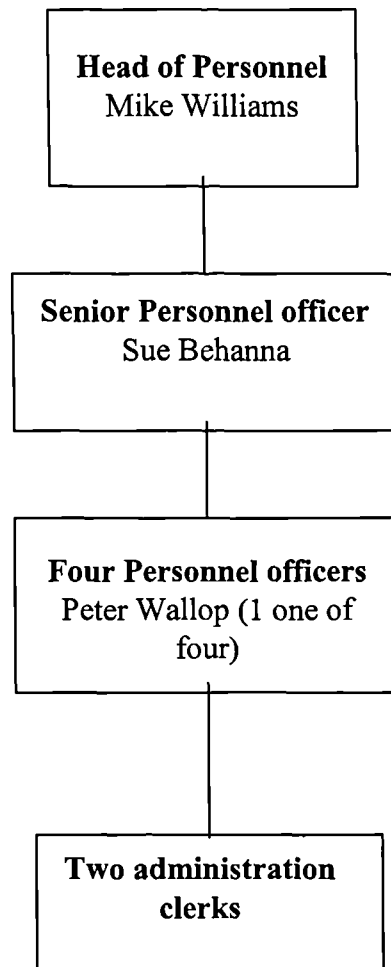
Currently there was much greater emphasis on collaboration, partnerships and co-operation between the organisations of the NHS. The new government recognised what it referred to as the existence of destructive competition, whereby the creation of the internal market had pitted doctors and NHS Trusts' against each other in the name of market reform. Under the new government there was to be a much greater pooling of resources. The interviewee indicated that the new government perceived the present state of the NHS and the internal market as in much need of reform. While he recognised the merits of the new initiatives, he did however cast an element of doubt regarding the extent to which the new government would be able to fulfil its goals for the NHS (given the tight spending restrictions it had inherited from the previous conservative government).

The goals of the Trust were to provide the best health care possible with the limited resources available to the Trust. The new Chief Executive within Derriford had set up a strategic group whose purpose would be to plan the Trust's strategy over the next five years. The interviewee claimed that the group would receive input from all the staff within the hospital. The chief executive was currently in the process of developing a new strategy for the Trust which would be completed within a year.

Community sector organisation

The figure below is a plan illustrating the composition of the HRM department within the community sector organisation.

Fig. 1.4 Personnel department at Mount Gould Hospital.



The interviewee said that up until now the role of the personnel department within the Trust had been purely administrative. The organisation lacked a operationalised HRM strategy (the introduction of a HRM strategy in any period within the future would therefore be unprecedented). With the introduction of the new chief executive the interviewee suggested that the Trust was now considering taking moves towards the development of a HRM strategy. The interviewee looked upon the appointment of the new chief executive as marking the beginning of a turnaround strategy for the organisation. Since the new chief executive has taken office only two out of the seven directors of Mount Gould remain, this is the finance director and the medical director. The other five have either been dismissed or have taken up other appointments outside the organisation. The organisation has been streamlined and made more functional, the board of directors now consists of five people, previously up to 18 people had to report to the chief executive. The new chief executive felt that this figure was too high and decided to streamline the board to make it more functional and manageable. There is also one non-executive director on the board.

The interviewee perceived the appointment of the new chief executive within the Trust as marking a break with careerist thinking among the Trust's employees in favour of a more Trust centred approach to health care delivery. The interviewee claimed that the Trust also sought the guidance of management consultants when initiating the process of organisational restructuring. A new HR directorate was created which amongst other units also incorporates the old personnel department and other associated functions. As a result of the creation of a new HR directorate the interviewee was more confident about that the role and significance of HRM. The interviewee also felt that the influence and importance of personnel management

would expand and grow within the organisation. Training within the Trust, especially for clinicians who are attempting to adopt a more managerial role within the organisation, was criticised by the interviewee who claimed that it was in need of serious attention. Many clinicians who have undertaken more managerial tasks under their job title receive little or no back up training. The interviewee said that the problem of inadequate training of employees within the Trust was currently being addressed.

The interviewee discussed the relationship between the managerial and clinical roles of the community Trust's employees. He stated that the dual role of employees in undertaking the work and tasks of clinician and that of manager were 'negatively correlated'. He believed that the two roles were incompatible, as employees either tended to be good in one particular role but never in both. Having said that the interviewee claimed that the role of manager and clinician should remain separate, the interviewee proposed that personnel could eventually develop the capacity to bridge the gap between the two by working in conjunction between manager and clinician. In doing so the personnel department would branch out and undertake the managerial functions which up until now had been undertaken, albeit very poorly and with little real understanding, by clinicians. This in the interviewee's opinion would ensure that managerial tasks were fulfilled by those trained as professional managers while simultaneously freeing clinicians to pursue their practice uninterrupted by managerial tasks and duties. The personnel function would also act as a moderating influence between the two roles which would also ensure the smooth running of the organisation. While the interviewee showed enthusiasm for this idea he was also

sceptical about the possible implementation of his suggested proposal in the near future. The proposal could possibly be implemented in ten years time, in the mean time the possibilities of implementing such a plan were remote.

On the question regarding the use of the term NHS the interviewee replied that the NHS currently existed in name only and that the difference between a hospital such as Mount Gould and Derriford was now similar to the differences between Sainsbury's and Tesco's.

The term NHS could now only be used as a banner signifying a sort of loose corporate identity that covered acute, community and ambulance units. This had come about largely as the result of organisational change and restructuring as a result of government reform.

Organisational change

The manager within the acute sector organisation emphasised the new realism and 'brave new world' of the newly reformed NHS.

The emphasis had indeed shifted towards concepts and slogans such as 'value for money' and lower taxes. The political climate under the 'new right' was seen as having shaped the current environment of the NHS. The interviewee went on to justify the grounds for this new realism in the following commentary. This provided the basis for the new approach in managing the NHS.

At present the population of the UK is getting older, a dramatic demographic downturn looms on the horizon. The health care needs of a much larger aged population will be much harder to cater for than that of a much younger population

The dramatic increase in the demand for hip replacements was used to illustrate this point. To this end the interviewee perceived the NHS as becoming a 'victim of its own success'. The ability of the NHS to successfully replace the hips of an elderly population provided the impetus and infrastructure for a market where there is much demand and where demand is predicted to increase. The interviewee used the following example in backing up his point of view.

Recently an anaesthetic has been developed where a patient could attend surgery for one afternoon and then return home later that day. This meant that the NHS could now treat more and more patients while simultaneously freeing up hospital beds for other patients. Once again the interviewee looked upon this as the NHS becoming 'a victim of its own success', through the process of establishing infrastructure to facilitate increasing demands, the organisation indirectly created more demand for its services.

Technology was another factor contributing to the new approach within the NHS. The introduction of new technology enabled discoveries such as hip replacements and more sophisticated forms of anaesthesia. While the introduction of new technology helped the NHS to keep up with demand it also imposed greater costs upon the service for at least two reasons. New technology was needed in order to fulfil demands for particular services i.e. such as hip replacements and as a way of providing solutions for new ailments or ailments which up until now could not be treated. The introduction of new technology was therefore seen as something of a double edged sword. While it provided the infrastructure required to cater more effectively for the health care needs of the local population it also encouraged greater demand for the trusts services, it did this though its ability to treat illnesses which up until now could not be treated.

The interviewee said that the NHS had now got a much better 'handle on the costs of its services'. This was essentially attributed to the new style of management and the new realism in the way the service operated. The interviewee contrasted the new approach with the laid back attitude of the previous system by saying that the trust was becoming more effective in servicing the health care requirements of service users.

Employee management

The interviewee from the acute sector organisation was asked to start off with a background account of what was happening within the Trust in terms of HRM strategy and people management. The interviewee stated that the chief executive articulates the principles and values of the organisation. The principles and values espoused by the chief executive are linked to and are compatible with the traditions within the organisation. The 'vision' and direction of the organisation both emanate from the chief executive. The 'vision' outlined by the chief executive and the aims and objectives subsequently being implemented as a way of 'realising' the vision are consistent and compatible with the policies and plans of the new government. This in the view of the interviewee could be seen in the language and emphasis given to particular slogans currently being used in the new white paper on government proposals regarding the running of the NHS.

The interviewee compared the employee groups within the Trust with that of a caste or class system, a sort of labour aristocracy e.g. some employee groups had more power and influence than others (see Currie, 1996). The interviewee spoke of the

professional tunnel vision of the different employee groups. He spoke of how hard it was to manage employee groups who had outside interests other than their work within Derriford.

The interviewee said that professional doctors had competing interests outside their own work within the Trust, such as their involvement in the major medical universities throughout the UK, their involvement in the medical systems of other countries and their involvement in various medical bodies, both national and international. This made the job of managing the trust much more difficult as outside interests could conflict with the employees commitments to their work within the Trust. Professional medical considerations tended to be more global and external, while management, on the other hand were primarily concerned with the Trust and its ability to service the health care needs of the surrounding population. This essentially provided the basis for conflict of interest within the NHS.

The interviewee suggested that while many managerial decisions regarding employees where indeed widely unpopular amongst the employees he did however feel that the aims and objectives of Trust management were in part facilitated by the commitment of the employees to their work within the NHS. The manager spoke briefly of the 'warm glow' and positive feelings the employee 'may experience' in carrying out a service which has positive repercussions for the community at large. To this extent the employees commitment to task could be relied upon when considering policies and plans which would be undoubtedly unpopular. The commitment of employees towards the care of people within the community they serviced was of little real concern or interest to the manager. Its significance was acknowledged only in so far as

it was the aim of the organisation to maximise the efforts of the organisations manpower and get the most for the least from its employees. To this end the persistence of a 'public service ethos' enabled management to achieve this goal as it ensured to some degree the compliance of the workforce and kept the organisations workforce more passive when introducing organisational change and introducing unpopular policies. The management of the Trust were to some degree reliant on the good will of the employees and on their commitment to the tasks and duties they carried out on a daily basis. Trust management were therefore able to introduce unpopular measures because the employees had a unique commitment to the work they did within the Trust.

Research conducted into NHS and private sector organisations strongly suggests that management were able to implement unpopular plans, despite employee opposition, because of existing high levels of attitudinal and behavioural commitment amongst their employees. The research suggests that the level of employee trust, morale and loyalty would eventually decline as a result of the steps taken by management in implementing changes top down within the organisation (Stiles et al, 1997, Kelliher, 1995, Whitson and Edwards, 1990).

The interviewee mentioned the issue of employee flexibility and employee skills mix, while explicitly linking these issues with the notion of receiving 'value for money'. The interviewee justified this approach as it upheld the interests of service users and ultimately brought into account the requirements of the patient (The theme of employee flexibility and 'value for money' is consistent with the objective of 'flexible

roles' and 'maximum utilisation' of employees as outlined under Guest's, 1991, model of HRM. Guest has identified 'flexible roles' and 'maximum utilisation' as themes underlying the emerging models of HRM).

The interviewee described the outlook of management within the Trust as being local in focus. Management are concerned with the health requirements of their particular region. This is in contrast to the professional outlook which is much more global in orientation (as mentioned previously). He claimed that management are much more Trust centred than the professional clinicians who it is their responsibility to manage.

This apparent conflict of interest between Trust management with that of the existing professional culture can be seen as part of the wider issue concerning the clash between the unitarist principles of private sector managerialism with that of the traditional and existing professional culture within the NHS. Currie, 1996, has argued against the use of unitarist management styles within the NHS on the basis that such approaches are not appropriate in managing an organisation with a multi-cultural identity.

The interviewee spoke of the increase in patient expectations within the NHS and linked it to the emergence of consumerism and its dominance throughout the wider society. Patients tend to question NHS professionals much more now than they ever did in the past. The infallibility of the professional doctor/ nurse is no longer seen as sacrosanct by service users. Patients are now much more willing to question the appropriateness and the effectiveness of prescriptions and the remedies suggested to them by medical staff. The interviewee suggested that this is mainly due to the fact

that patients know more about what is available on the market and are increasingly becoming much more informed about recent developments and breakthroughs. Patient awareness has been facilitated as a result of the growth in mass media. The interviewee cites Richard and Judy, Goodmorning T.V., and various other talk shows as examples of media that have undermined the myth of the infallibility of the professional medical practitioner. In previous years patients tended to be much more complacent and docile. They are now much more assertive and articulate.

When questioned on strategy the interviewee mentioned the use of what he referred to as 'building blocks' as his own approach to HRM strategy. In order to introduce change the interviewee felt that he had to follow an incremental step by step process in establishing foundations and removing obstacles as a way of implementing the desired change. The 'removing of obstacles' was linked directly to employee opposition to the proposed changes. The interviewee spoke of conflict when changes were being introduced. This can be seen as an indication of the top down approach used by the Trust's management towards organisational change. The research conducted so far indicates that top down approaches towards the introduction of changes which affect employees as being detrimental to employee trust, commitment and loyalty (see Stiles, et al, 1997 and Coopey, 1995). The following is an anecdote offered by the interviewee, to illustrate and describe what he has referred to as the 'building blocks' approach to organisational change. This anecdote illustrates the manifestation of conflict between management and employee, typically associated with the introduction of managerial plans and policies within the Trust.

During the winter period the NHS tends to be much more busy than at any other time of year, the interviewee said that there was a much greater demand for bed space

throughout this period. The winter period was typically associated with a substantial increase in hospital admissions. The interviewee claimed that many people were however been admitted unnecessarily and were taking up badly needed bed space as a result. The Trust would therefore experience a bed shortage. In order to provide a solution to this problem, the management of the Trust decided to create a 'medical assessment unit'. The purpose of this unit was to operate as a 'pit stop' for incoming patients as a way of screening their suitability for admission to the hospital. The medical assessment unit would run a series of tests on incoming patients which were carried out by a team of senior medical personnel. The purpose of the medical assessment unit would be to determine the patients suitability for further medical treatment.

They would either admit the screened patients (If that was indeed deemed necessary) or they would suggest alternative methods of treatment (based on the particular needs of the patient). By creating the medical assessment unit the trust discovered that 20% of those admitted to the hospital did not actually require hospital treatment. The interviewee suggested that because many elderly people got ill over the winter period many GPs were being over cautious by sending them directly to the hospital without adequately assessing their needs before doing so. The introduction of the medical assessment unit enabled the hospital to economise on bed space, hence freeing up beds to treat more patients. The creation of the medical assessment unit also prevented the Trust from spending funds unnecessarily on patients who did not actually require the Trust's services.

In creating the medical assessment unit the hospital management closed down two hospital wards in order to generate the financial capital required. Ultimately this

involved changing the working patterns and schedules of existing staff within the two wards marked for closure. 106 nursing staff were to be reallocated as a result of the proposal to close the two wards.

The process of reallocation started off with a consultation process whereby the manager consulted with the 106 members of staff on the changes to their work patterns and schedules. Eventually the interviewee managed to accommodate all of the nursing staff except 21 nurses to whom the interviewee referred as the remaining 'hard core'. These employees up until now had worked on the night shift only and were unwilling to be flexible on any changes which would alter their working practices. They were therefore opposed to the changes that management were introducing. The employees position on this issue was firmly backed by the trade unions. As a result of intransigence on both sides and an inability to subsequently alter their positions the outcome resulted in an industrial and public relations crisis for the hospital management. The problem received considerable local media attention and backing. The local media used the case of one of the 21 nurses who had three children and an elderly mother to support. The woman had worked in the trust for 20 years and was been forced to leave if she did not accept the new working arrangements set out by the management of the Trust. The management of the hospital offered the discontented nurses an ultimatum, they could either accept their new working arrangements or they could leave. The case went to an Employment Tribunal.

Eventually the Trust management succeeded in implementing their proposals. As can be seen from this particular case the nature of the changes and the style in which they were implemented were opposed by a significant minority of the Trust's employees who were given the backing of their trade union. The process of implementing

management proposals had not gone through as smoothly as they had anticipated. Employees were consulted with the new arrangements only after the Trust's management had decided what the plans should be. Stile's et al, 1997 and Coopey, 1995, warn against the implementation of organisational plans and policies in top down fashion. This particular method of implementation and the ensuing conflict which followed the implementation of the new plans could precipitate a future decrease in the level of employee trust, commitment and loyalty within the Trust.

The interviewee contested the idea that the organisation was firmly under the control of the Trust's management. He seemed to think that in some way management were becoming convenient scape goats for present difficulties within the NHS and attempted to dispel the myth that the NHS had been taken over by an influx of men in grey suits. The title of hospital managers signified a change in emphasis, this just entailed a change in title of existing clinical staff to manager i.e. Sister changed to nurse manager. According to the interviewee the managers within the Devon/Cornwall region constitute some of the lowest paid managers within the whole country.

The interviewee within the community sector Trust stressed the profound effects that recent organisational change were having upon Trust staff in terms of morale, motivation and commitment. The process of organisational change was seen as having very negative effects on the staff throughout the entire organisation. At present approximately 80% of the organisations staff were currently in the process of seeking alternative sources of employment (the percentage given above was an educated guess

offered by the interviewee). To some degree this can be interpreted as an indication of the level of employee behavioural commitment within the Trust.

The interviewee highlighted the process of recruitment and selection as being inadequate and requiring serious attention. The selection and recruitment of new employees within the organisation had up until now been conducted mainly through the use of panel interviews. The interviewee raised question marks over the legitimacy of this process and also doubted its effectiveness as an appropriate method for the selection and recruitment of employees within the organisation.

The interviewee stressed that the Trust had very positive relations with the trade unions and showed a positive attitude towards organised labour in general.

On the question regarding the use and implementation of a strategic plan within the trust the interviewee said that none existed. There appeared to be a three year time lapse of communication from the top of the organisation to filter down throughout the rest of the organisation. The interviewee more or less stated that communication to the 'people on the ground' (Trust employees) was poor. Management's task was not helped by the fact that in most cases their employees had a higher standard education than they themselves had. The interviewee said that due to the fact that most employees within the organisation could see through managerial slogans, aims and objectives they were much harder to control. The strategy for organisational change currently being implemented by the new chief executive was (in the words of the interviewee) being introduced in a 'top down fashion'. The interviewee felt that this was the best way forward for organisational change in this particular Trust. The style used to implement organisational change within the community sector organisation would appear to be similar to that used by the management within the acute sector

organisation. As commented earlier other research indicates that change introduced in a top down fashion with minimal consultation with employees does little to encourage employee trust and commitment (see Barnes, 1981 and Stiles et al, 1997).

Up until the appointment of the new chief executive, the community Trust operated along the lines of a highly unitarist style of management culture. The emphasis was on management's unilateral right to manage. This culture was now being challenged as a result of a change in leadership. Although the interviewee emphasised that a hard core of die hards would resist the change in culture he was never the less quite confident that the process of organisational change and restructuring would eventually bear fruition in the near future.

The interviewee said that in future management within the organisation would no longer be able to sack employees 'at the drop of a hat'. There was now a much greater emphasis shifting towards equal opportunities and new employee legislation which would ultimately promote the creation of a much more caring and softer management culture. The environment would eventually become more participative and consensual in terms of managerial styles and attitudes.

The interviewee emphasised the need for 'new blood' within the organisation. At the moment the recruitment of managers had come from within the organisation itself. Recruitment from outside the NHS had resulted in either great success stories or unmitigated disasters. At the minute the overwhelming number of managers within the NHS were clinicians. This was more to do with the change in emphasis on their job titles (many head doctors and nurses had just assumed the title manager under their job title), therefore dispelling the myth that 'men in grey suits' had arrived and had taken over the Trust.

The interviewee spoke of the apparent lack of an effective reward structure for the Trusts employees, which would outline specific employee skills and tasks for which the employees would be given a specific level of pay. The absence of an effective reward structure made the process of evaluating and analysing jobs tasks and requirements difficult. From the interviewee's point of view this was something which would occupy the attention of the HRM department within the near future.

Employee commitment and the current situation within the Trust

On the issue of commitment the interviewee from the acute sector organisation spoke of the consensual approach adopted by the Trust's management in their dealings with the trade unions. The interviewee did however say that HRM policy creation and planning lay purely within the domain of the Trust's management and as such trade unions were excluded from this process. The interviewee said that employee commitment was likely to arise as a result of an outcome from synergies between Trust management and its dealings with trade unions and other labour organisations. The interviewee was not himself familiar with the concept of employee commitment. On the theme of employee commitment the interviewee claimed that the trust recognised its importance and pointed to the fact that all the various employee, management and patient interests were represented on the board of directors as evidence of this recognition. The board consisted of two equal sets of directors, non-executive and executive. Non-executive directors came from the local community, these consisted of business and local leaders from a variety of different settings. Executive directors came from each of the separate directorates within the Trust i.e. nursing director.

The new director of HRM within the acute sector Trust had only been in his post for two weeks. At the minute the Trust has no HRM strategy to speak of other than that of the concept of 'Building blocks', as outlined and described by the interviewee earlier. On the issue of HRM strategy within the Trust the interviewee has said that an explicit HRM strategy was to be formulated by Easter 1998.

The interviewee from the community sector Trust stated that Trust management would have to make tough financial decisions over the next few years. At the time of the interviews the interviewee was in the process of compiling a data bank which listed reasons as to why employees were leaving the organisation. The interviewee had designed questionnaires for this purpose (the data bank would then be updated annually).

Research questions

The following are a number of research questions which have been derived from the current literature reviewed, they are listed as follows;

R1 Is the current organisational climate within the NHS effective in facilitating the development of trust between managers and NHS nursing staff?

R2 Assess the level of trust between nursing staff and their management ?

R3 To what extent does trust between management and nursing staff need to be reciprocated in order to exist ?

R4 To what extent do nursing staff share information with their work colleagues and their immediate superiors ?

R5 What are the characteristics of trustworthy managers/ what are the conditions required for the development of trust between nursing staff and their managers ?

R6 To what extent does the presence of trust assist nursing staff to carry out their daily tasks and duties ?

R7 What effects could a lack of trust have on the work carried out by nursing staff ?

R8 What benefits are there to having a trust based relationship with ones immediate superior/manager ?

R9 To what extent do NHS nursing staff demonstrate a high level of attitudinal commitment to the aims and objectives of Trust management ?

R10 To what extent do NHS nursing staff exhibit a high level of behavioral commitment towards managerial aims, objectives and values ?

R11 Describe and outline the motives/needs of NHS nursing staff ?

R12 To what extent are the aims and values of nursing staff being fulfilled within their current working environment ?

R13 What are the professional commitments of nursing staff ?

R14 Is there a disparity between the aims and objectives of management with the aims, objectives and aspirations of NHS nursing staff ?

R15 Does the level of attitudinal/behavioral commitment amongst nursing staff have a relationship with the extent to which they trust their immediate superiors ?

R16 Is there a disparity between the level of trust and commitment amongst nursing staff within the acute and the community sector organisations involved within this investigation ?

Both primary and secondary sources of data were used in the collection process in order to address the research questions. Qualitative and quantitative techniques were also used in the collection and analysis of primary data. Qualitative research techniques were used in the form of in-depth interviews and postal questionnaires etc. while quantitative research techniques were used in employing a range of statistical techniques in order to analyse the data collected from the questionnaires.

The conclusions deriving from this research were then used to devise a model depicting the nature of trust and commitment amongst nursing staff within the two NHS Trusts which may be applicable to other organisational situations and contexts (Both public and private).

Chapter Six: Analysis of interview data on trust and commitment

Analysis of interview data on trust and commitment

The following represent the summaries and highlights of the main points and issues raised during the course of the forty in-depth interviews amongst nursing staff within Derriford and Mount Gould community hospital. The purpose of conducting these interviews was two fold. Firstly to examine and assess the level of trust between nursing staff and their managers, and secondly to establish the nature and the level of commitment amongst nursing staff working within the two organisations.

Interviews on trust between nursing staff and their managers within Derriford hospital

1.1 General level of trust within the organisation

- Thirteen interviewees claimed that there was a high level of trust within the organisation. Four claimed that there was a medium level of trust within the organisation and three interviewees claimed that there was a low level of trust within the organisation.

1.2 Trust in management

- Three interviewees claimed that they had a high degree of trust in their managers.

This they attributed to the following reason;

1. The interviewees claimed that there was a high level of trust between themselves and their managers because the environment in which they worked was small, this made trust easier to establish and maintain.
- Nine interviewees claimed that they had a limited degree of trust in their managers. This they attributed to the following reasons;
 1. There were certain issues and areas in which the interviewees claimed that they could not trust their managers i.e. differences in managerial and nursing aims and objectives regarding organisational resources.
 2. They claimed that those employees lower down the organisational hierarchy (or the less skilled employees were) were less likely to trust management.
 - Eight interviewees claimed that they did not trust management at all. This was attributed to the following reasons;
 1. Previously management had misinformed them on important issues involving nursing staff.
 2. They felt that management lacked communication and interpersonal skills.
 3. They did not feel supported by management.
 4. They felt that management were working towards a different agenda that was contrary to their own interests i.e. patient care verses resource restrictions.
 5. They looked upon management and nursing staff as a classic case of 'them and us' whereby nursing staff always received a 'raw deal' from management and lacked control over their own terms and conditions of employment.

1.3 Management trust in nursing staff

- Twelve interviewees were under the impression that management had a high level of trust in nursing staff because of their reliance upon the professional judgments of nursing staff.
- Six interviewees claimed that management did not have a high level of trust in nursing staff as they claimed that management did not know them well enough.
- Two interviewees claimed that they did not know whether or not management trusted them because the level of communication coming from management was very poor.

1.4 Sharing information with people at work

- Seventeen interviewees claimed that they did share information with the people they worked with. Three out of this number claimed that they would not include management and three claimed that they would.
- Three interviewees claimed that they would not share personal information with their work associates indicating that they liked to keep their work and personal lives separate.

1.5 Sharing information with ones immediate superior

- Thirteen interviewees claimed that they would share personal information with their immediate superior and would feel comfortable in doing so.

- Seven interviewees claimed that they would not feel comfortable in sharing information of a personal nature with their immediate superior. Their main concern was that it could be used against them.

1.6 Characteristics of trustworthy managers and the conditions necessary in order for trust to develop

- Seventeen interviewees claimed that they trusted their immediate superiors and three claimed that they did not.
- The interviewees described and outlined the characteristics of trustworthy managers and the conditions necessary in order for trust to develop within the following table.

Conditions	Number of respondents
Competence	14
Consistency/predictability	10
Openness and support	9
Honesty and respect	8
Confidence (ability to confide in them)	8
Communication	8
Commitment	6
Accessibility	5
Understanding	4
Reciprocity	4
Time (time taken to get to know them)	3
Objectivity and fairness	3
Integrity	2

1.7 The benefits of trust Vs the costs of mistrust

- Sixteen interviewees claimed that trust in other individuals had helped them fulfill their career aims and aspirations and four claimed that it had not.
- Of those who claimed that trust had helped them fulfill their career aims and objectives their responses were grouped within the following.

Factors associated with trust and career aims and objectives	Number of respondents
Support in career training and development	7
Trust in ones manager/ role models	5
Teamwork	2

The interviewees claimed that the support they received from others helped them within their training and development. They claimed that trustworthy managers acted as role models and teamwork helped them to build up their confidence and carry out their work to the best of their ability.

1.8 Trust and daily tasks and duties

- All twenty nurses interviewed claimed that trust in other individuals helped them carry out their daily tasks and duties. The table below illustrates why they felt that this was the case.

Issues	Number of respondents
Supervision/ reliability/ standards	12
Support and backup	5
Openness and honesty	4
Confidentiality	2
Learning	1

The interviewees claimed that they did not have to check up on their colleagues and their immediate superiors to see if they were carrying out their work properly. They could therefore rely on them to maintain good standards. They also claimed that they could rely on those they trusted for support and back up, to be open and honest and to keep confidences. One interviewee claimed that an environment based on trust offered a better place in which to learn.

1.9 The effects a lack of trust would have on the work of nursing staff

- All twenty interviewees claimed that a lack of trust within their working environment would have adverse repercussions upon nursing staff and the work they did. They outlined the following as reasons why they felt this would be the case.

Issues	Number of respondents
Decrease in morale and communication	9
Stress	7
Break down in the level of teamwork	5
Self confidence/ self esteem	3
Lack of commitment	2
Development and learning	1

1.10 Benefits of trusting ones immediate superior/manager

- All twenty interviewees claimed that there were benefits to having a trust based relationship with their immediate superior. These benefits were highlighted as follows.

Issue	Number of respondents
Open lines of communication	6
Continuity in aims and objectives	4
Support	3
Confidentiality	3
Self confidence/ self esteem	3
Team work	3

Summary

The general level of trust amongst the respondents was high. Slightly over half those interviewed claimed that they had a medium to high level of trust in their managers. Slightly over half those interviewed claimed that they felt that their managers trusted nursing staff. The majority of those interviewed claimed that they did share information of a personal nature with those they worked with and over half claimed that they shared information of a personal nature with their immediate superiors and that they trusted their immediate superiors.

The majority of interviewees claimed that trust in other individuals had helped them to carry out their daily tasks and duties, that a lack of trust would have adverse repercussions upon nursing staff and their environment and that there were benefits to having a trust based relationship with ones immediate superior.

Interviews on trust between nursing staff and their managers within Mount Gould community hospital

2.1 General level of trust within the organisation

- Eight interviewees claimed that there was a high level of trust within the organisation.
Six claimed that there was a medium level of trust and another six interviewees claimed that there was a low level of trust within the organisation.

2.2 Trust in management

- Four interviewees claimed that they had a high degree of trust in their managers. This they attributed to the following reason;
 1. The interviewees claimed that the level of trust between themselves and their managers proved easier to establish and maintain because they saw and had regular contact with them. They also claimed that trust was harder to establish with managers higher up the organisational hierarchy as they did not get the opportunity to meet or talk to higher level management on a regular basis.
- Sixteen interviewees claimed that they did not trust management at all. This was attributed to the following reasons;
 1. Traditional mistrust of management amongst nursing staff i.e. history of mistrust due to previous dealings with management.

2. Managerial financial and budgetary objectives clashed with the priorities and goals of nursing staff.
3. They claimed that nursing staff were more inclined to trust managers who were closer to them (within the context of the Trust's organisational hierarchy) as opposed to higher level management i.e. middle and senior level. The interviewees claimed that higher level management had aims and objectives contrary to their own.
4. Management failed to inform and consult nursing staff over intended organisational changes and had frequently broken their promises.
5. Management had altered the employment contract of employees and had made (unfavourable and undesirable) changes to their terms and conditions of employment.

2.3 Management trust of nursing staff

- Seventeen interviewees were under the impression that management had a high level of trust in nursing staff,
1. While they felt that management trusted them the interviewees did however complain about certain managerial rules and regulations which they felt were unnecessary i.e. car parking fees.
 2. They believed that management trusted them because they (nursing staff) received a low number of complaints from those who used the service.
 3. The interviewees claimed that it was harder to know if they were trusted by higher level management as they rarely seen or conversed with them.

4. The interviewees claimed that management were heavily reliant upon the professional judgments of nursing staff and were therefore obliged to trust nursing staff to get on with their work and to do it competently.
- Three interviewees claimed that management did not have a high level of trust in nursing staff.
1. The interviewees claimed that management were not supportive of them, that they did not converse with them and they claimed that management did not know them well enough as people.

2.4 Sharing information with people at work

- Fourteen interviewees claimed that they did share information of a personal nature with those they worked with. Six out of this number claimed that they would not include management when doing so.
- Six interviewees claimed that they would not share personal information with their work associates, as they liked to keep their work and their personal lives separate.

2.5 Sharing information with ones immediate superior

- Nine interviewees claimed that they would share information of a personal nature with their immediate superior and would not be concerned when doing so.
- Four interviewees claimed that they would share information of a personal nature with their immediate superiors but would reserve the right to be selective about what they told them.

- Seven interviewees claimed that they would not feel comfortable in sharing information of a personal nature with their immediate superior.

2.6 Characteristics of trustworthy managers and the conditions necessary in order for trust to develop

- Fifteen interviewees claimed that they did trust their immediate superiors. Five interviewees claimed that they did not.

The interviewees described and outlined the characteristics of trustworthy managers and the conditions necessary in order for trust to develop within the following;

Conditions	Number of respondents
Confide/discreet	10
Professional competence/reliability	6
Communication/openness	5
Sharing information i.e. about personal life	4
Respect and value	4
Reciprocity/quid pro quo	4
Time and consistency	4
Support	3
Fairness/equity	3
Accessibility/greater involvement	3
Compatibility of aims and objectives	3

2.7 The benefits of trust Vs the costs of mistrust

- Seventeen interviewees claimed that trust in other individuals had helped them to fulfill their career aims and aspirations. Three interviewees claimed that it hadn't.

- Of those who claimed that trust had helped them fulfill their career aims and objectives their responses were as follows;

Factors associated with trust in assisting the realisation of personal career aims and objectives	Number of respondents
Support in career training and development	11
Teamwork	5
Self confidence	4
Learning/ role models	2

2.8 Trust and daily tasks and duties

- Nineteen interviewees claimed that trust in other individuals helped them carry out their daily tasks and duties. One interviewee claimed that it had not. They outlined the following reasons as to why they felt that this was the case;

Issues	Number of respondents
Supervision/ reliability/ standards	10
Teamwork	8
Support and morale	3
Confidentiality	2

The interviewees claimed that the existence of trust meant that they did not have to check up on their colleagues to ensure that they were doing their work properly. Trust also ensured higher levels of teamwork, support and morale. Its existence also meant that there was a high level of confidentiality upon the wards.

2.9 The effects a lack of trust would have on the work of nursing staff

- All twenty interviewees claimed that a lack of trust would have adverse repercussions upon nursing staff and the work they carried out within the organisation. They outlined the following as reasons as to why they felt that this would be the case;

Decrease in delegation and teamwork	9
Stress/ anxiety/ insecurity	7
Decrease in morale/ motivation	5
Lower standards of patient care	3
Higher levels of absenteeism/ labour turnover	2

2.10 Benefits of trusting ones immediate superior/manager

- All twenty interviewees claimed that there were benefits to having a trust based relationship with their immediate superior. These benefits are described and outlined within the following table;

Happiness/ patient care	8
Support	7
Openness/ honesty/ confidence	7

Summary

The interviewees claimed that the level of trust was generally high. The majority of those interviewed claimed that they did not trust management at all. The overwhelming number of those interviewed claimed that their managers trusted them. The majority of the interviewees claimed that their managers trusted nursing staff and that they did share

information of a personal nature with those they worked with. Slightly under half of those interviewed claimed that they would share information of a personal nature with their immediate superior. The majority of those interviewed claimed that they did trust their immediate superior. The overwhelming number of those interviewed claimed that trust helped them to fulfill their career aims and aspirations and to carry out their daily tasks and duties. All twenty nurses interviewed claimed that a lack of trust would have adverse repercussions upon nursing staff and the work they did and claimed that there were benefits with trusting ones immediate superior.

Analysis of the interviews on commitment amongst nursing staff within Derriford hospital

The following is a summary of the interviews on the level and nature of the commitment amongst nursing staff, attitudinal and behavioural, within Derriford and Mount Gould community hospital (see appendix one for full analysis).

3.1 Level of commitment

- Eighteen interviewees claimed that most nurses were committed to the work they carried out within the organisation. The reasons as to why they felt that this was the case were as follows;
 1. The poor terms and conditions of employment under which nursing staff worked were considered as evidence of their level of commitment to the work they carried out.
 2. The high level of teamwork and support nursing staff received from their colleagues acted to reinforce the commitment of nursing staff.

- Two interviewees indicated that there was a medium level of commitment this was attributed to the following reasons;
 1. The increase in the workload of nursing staff, which they claimed, inhibited the motivation and morale of nursing staff.
 2. Shortages of qualified nursing staff and the use of health care assistants as a way of reducing the cost of labour was undermining the commitment of nursing staff.

3.2 Behavioural commitment

- Fifteen interviewees claimed that their attitudes towards managerial aims and objectives did not influence the level of effort they put into their work, this was attributed to;
 1. The existing high level of commitment amongst nursing staff towards patient care.

- Five interviewees claimed that their attitudes towards managerial aims and objectives did influence the level of effort they put into their work, this they attributed to;
 1. The career prospects available to nursing staff. Better career prospects ensured higher levels of commitment.
 2. The level of morale and motivation of nursing staff influenced the level of effort they put into their work.

- Twenty interviewees claimed that they could not undertake their role as nurses if they were not committed to the work they did. This was attributed to the following reasons;
 1. The demanding nature of the work nursing staff did and the poor conditions of employment for which many nurses worked.
 2. They claimed that they could not carry out their work unless they were committed to patient care.

3.3 Attitudinal commitment

- Thirteen interviewees claimed that their own aims and values were the same as those of the organisation on the following issues;
 1. Patient care.
 2. Patient throughput (amount of patients being pushed through the hospital system) and quality care.
 3. Career aspirations of nursing staff.

- Three interviewees claimed that their own aims and values were, to some extent, the same as those of the organisation and the management of the organisation in which they worked.

- Four interviewees claimed that their own aims and values were not the same as those of the organisation in which they worked. They highlighted the following as reasons as to why this was the case;
 1. Resource restrictions.
 2. Staff shortages.
 3. Quality of care Vs business culture of hospital management.

3.4 Sources of attitudinal commitment of nursing staff

The interviewees were asked what made nursing staff committed to the work they carried out within the organisation. The following is a summary of their responses.

Source of commitment	Number of respondents
Patient care/ vocational commitment	8
Team work and training	7
Career progression	3

- Twelve interviewees responded positively when asked about the extent to which their own personal aims and values were currently being fulfilled within their working environment. Their responses were as follows;
 1. They felt that they were supported.
 2. Some claimed that they had quasi-managerial roles.
 3. Some claimed that they had adequate resources in order to administer high quality patient care.
- Seven interviewees claimed that their own aims and objectives were only partially fulfilled within their current working environment and one interviewee said that her own aims and values were not being fulfilled at all. Their reasons were as follows;
 1. Resource restrictions/workload pressures.
 2. Lack of promotion prospects.
 3. Feeling dispirited and general lack of morale.

3.5 Motives/needs of nursing staff

- When asked what motivated nursing staff in the work that they carried out within the organisation the interviewees gave the following responses;

Motivation	Number of respondents
Patients	15
Team work/colleagues	10
Money	4
Education and learning	4
Status	3

3.6 Professional commitments Vs organisational commitments

- When asked to describe the main aims, objectives and values of professional nursing the interviewees gave the following responses;

Aims, objectives and values of professional nursing	Number of respondents
Patient care	20
Research based/ centered care	8
Positive attitude towards caring	4
Informing patients	2
Supporting fellow nurses	1
Adherence to occupational standards	1
Professional accountability	1

- Seventeen interviewees claimed that their professional commitments came into conflict with the aims and objectives of the organisation in which they worked. They attributed this to the following;

1. Lack of resources Vs quality of care.

2. Lack of training and education.
 3. Inability to carry out holistic patient care effectively.
 4. Dislike for the notion of conveyor 'belt care'.
 5. Current organisational policies i.e. 'budget restrictions'.
- Three interviewees claimed that their professional commitments did not come into conflict with the aims and objectives of the organisation in which they worked. They attributed this to the following;
6. They claimed that hospital management (like nursing staff) were concerned about ensuring quality patient care.

Summary

The overwhelming number of interviewees claimed that they were committed in terms of their attitudes and their behaviours. All of those interviewed claimed that they could not do their jobs as nurses if they were not committed to the work they carried out within the organisation. Over half those interviewed claimed that their own aims and values were the same as those of the organisation in which they worked. The interviewees highlighted patient care, teamwork, training, and career progression as the main sources of attitudinal commitment amongst nursing staff in the organisation in which they worked. Slightly over half those interviewed claimed that their own aims and values were the same as those of the organisation in which they worked. The interviewees outlined their patients, team work, money, education and status as the main motivations for many nurses. The majority of those interviewed claimed that their professional and organisational commitments did come into conflict.

Analysis of the interviews on commitment amongst nursing staff within Mount Gould hospital

4.1 Level of commitment

- Thirteen interviewees indicated that most nurses were committed to the work they carried out within the organisation, evidence for this was attributed to the following;
 1. Vocational commitment of nursing staff towards patient care.
 2. The poor terms and conditions of employment (highlighted as a reason why they had to be committed in order to do their work as nurses).

- Three interviewees indicated that there was a medium level of commitment amongst nursing staff and that the level of commitment was not as high as it should be. They attributed this to;
 1. Career mobility (which was too restrictive).
 2. Recruitment and training practices (which were too academic and were judged as unsuitable preparation for 'hands on care').

- Four interviewees indicated that there was a low level of commitment amongst nursing staff within the organisation, they attributed this to the following;
 1. Absence of vocational commitment amongst some nurses.
 2. The level of 'burn-out' amongst older nurses.

4.2 Behavioural commitment

- Thirteen interviewees claimed that their attitudes towards managerial aims and objectives did influence the level of effort they put into their work, this was attributed to;
 1. Training and development (the more they received they harder they claimed they worked).
 2. Staff shortages (made them work harder, hence more effort).
 3. Employee involvement (greater involvement within the organisation would give them more motivation to work harder).
 4. Support (from management and immediate superiors).

- Seven interviewees claimed that their attitudes towards managerial aims and objectives did influence the level of effort they put into their work, this was attributed to the following;
 1. Patient care/vocational commitment of nursing staff would remain the same regardless of managerial aims and objectives.
 2. They claimed that their commitment would remain the same and criticised managerial aims and objectives on the basis that they were 'unrealistic' and were very often 'empty gestures'.

- Sixteen interviewees claimed that they could not undertake their role as nurses if they were not committed to the work they did. They attributed this to the following;

1. The demanding nature of the work nurses did and the poor conditions of employment they received for doing it.
 2. In order to nurse one needed to be committed to patient care.
 3. The interviews claimed that commitment was necessary in order for the team work philosophy to work.
- Four interviewees claimed that it was possible for nursing staff to carry out their roles even if they were not committed. This was attributed to the following reasons;
 1. They could provide 'basic care' for patients and nothing more.
 2. They could still carry out their work whilst suffering 'Burn out' (period of time spent nursing).

4.3 Attitudinal commitment

- Eleven interviewees claimed that their own aims and values were the same as those of the organisation and the management of the organisation in which they worked. They claimed that managerial aims and values were similar to their own within the following areas;
 1. Patient care.
 2. Staff involvement.
 3. Some interviewees claimed that the aims and values of management and nursing staff were generally compatible however they did complain about a shortage of qualified nursing staff within the organisation.
 4. Career structure and prospects for nursing staff.

- Seven interviewees claimed that their own aims and values were, to some extent, the same as those of the organisation and the management of the organisation in which they worked. Two interviewees claimed that their own aims and values were not the same as their management and the organisation in which they worked. The reasons for this was attributed as follows;

1. Resource restrictions
2. Administration (the time nursing staff spent on hospital administration)

4.4 Sources of attitudinal commitment of nursing staff

- On the question regarding what it was that made nursing staff committed to the work they carried out within the organisation, the interviewees offered the following responses;

Source of commitment	Number of respondents
Valued, respected and encouraged	6
People centered	5
Teamwork	3
NHS principles	2
Resources/ empowerment	1

- Thirteen interviewees responded positively when asked about the extent to which their own personal aims and values were being fulfilled within their current working

environment. They claimed that their own aims and values were been fulfilled within the following areas;

1. Training and education

2. Job satisfaction/patient care

- Six interviewees claimed that their aims and objectives were only been partially fulfilled within their working environment, one interviewee said that her aims and values were not being fulfilled at all (Seven interviewees in total). Their reasons were as follows;

1. Financial restrictions/budget limitations.

2. Pressures to specialise in a particular area.

3. Need for greater involvement amongst nursing staff.

4.5 Motives/needs of nursing staff

- When asked what it was that motivated nursing staff within their work the interviewees gave the following responses;

Motive	Number of respondents
Patient care	7
Team work/ colleagues	7
Money	6
Feeling valued	2

4.6 Professional commitments Vs organisational commitments

When asked to describe the main aims, objectives and values of professional nursing the interviewees gave the following responses.

Aims, objectives and values of professional nursing	Number of respondents
Patient care	20
• Quality of patients life	4
• Research based care	2
• Efficient patient care	1
Support	2
Team work	1

- Eleven interviewees claimed that their professional commitments came into conflict with the aims and objectives of the organisation in which they worked. They attributed this to the following reasons;
 1. Lack of resources versus quality of care.
 2. Management policies (e.g. resuscitating terminally ill patients).
- Nine interviewees claimed that their professional commitments did not come into conflict with the aims and objectives of the organisation in which they worked.
 1. Some interviewees claimed that they were compatible but nursing staff were generally pressurised by managerial expectations combined with the restricted level of resources they were been given.

Summary

Over half those interviewed claimed that most nurses were committed to the work they did within the organisation. Over half those interviewed claimed that their attitudes influenced their behaviour within the workplace. The majority of those interviewed claimed that they could not do their work as nurses if they were not committed. Slightly over half those interviewed claimed that their own aims and values were the same as those of the organisation in which they worked and of their managers. The interviewees highlighted being valued, people centered, teamwork, NHS principles and resources as factors which made them committed to their work. The interviewees also highlighted patient care, teamwork, money and feeling valued as the things that motivated them the most in the work that they did. Slightly less than half those interviewed claimed that their professional commitments came into conflict with the aims and objectives of the organisation in which they worked.

Chapter Seven: Descriptive statistics for Derriford and Mount Gould Community hospital

Descriptive statistics for Derriford hospital

Method

The purpose of these two questionnaires was to assess and gauge the level of organisational commitment amongst nursing staff and assess the extent to which they trusted their immediate superiors and managers in general (see appendix two). The findings from this survey were then compared with the findings from the interviews.

On the advice of the personnel manager 350 questionnaires were sent to all nurses working within the trauma and surgical directorates within Derriford hospital. These were dispatched to the various departments via the hospital's internal mailing system. The respondents then posted the questionnaires back for analysis..

The personnel manager claimed that the trauma and surgical directorates were representative of nursing staff throughout the hospital as a whole. They were therefore chosen so that generalisations could be made about nursing staff throughout the entire organisation as a whole.

The use of more sophisticated statistical techniques were considered however given the fact that the sample sizes were comparatively small, the use of such techniques was deemed as inappropriate.

Sample Characteristics

The following are the results taken from five questions which sought to establish and outline the profile of those who responded to the questionnaires on trust and commitment.

The purpose of these questions was to get the respondents to state their age, the period of time they spent working within the organisation, their gender, their current position and grade. The information gathered was then subsequently used to test for possible relationships and associations between the personal details of the respondents and their level of commitment and the degree to which they trusted their immediate superiors and their managers in general. 87 of the 350 questionnaires were returned, there was therefore a 24.9% response rate.

		Frequency	Percent
Age	21-25	4	4.6
	26-30	8	9.2
	31-35	17	19.5
	36-40	17	19.5
	41-50	33	37.9
	51-60	7	8
	60+	1	1.1
Period of employment	Less than 1 yr	6	6.9
	1-3 yrs	12	13.8
	4-10 yrs	22	25.3
	11-20 yrs	30	34.5
	21-30 yrs	16	18.4
	31-40 yrs	1	1.1
Gender	Male	6	6.9
	Female	81	93.1
Grade	Valid	1	1.1
	D	30	34.5
	E	28	32.2
	F	12	13.8
	G	11	12.6
	H	4	4.6
	I	1	1.1

Table 1. Sample characteristics

Job type	Frequency	Percentage
Valid	3	3.4
Enrolled nurse	1	1.1
Clinical nurse	3	3.4
Departmental nurse manager	1	1.1
District nurse	1	1.1
Ed nurse	1	1.1
En nurse	7	8.0
Jn sister	1	1.1
Matron/manager	1	1.1
Nu	1	1.1
Nurse	3	3.4
RGN	7	8.0
SEN	1	1.1
Sis	1	1.1
Sister	4	4.6
Sn Sis	1	1.1
Sn Sister	1	1.1
Sn st nurse	2	2.3
Sp nurse	2	2.3
Spec nurse	2	2.3
St nurse	34	39.1
St nurse su	1	1.1
Su Nurse	1	1.1
Ward manager	5	5.7
Wd manager	1	1.1
Ward sister	1	1.1

Table 2. Nursing grade/Position

Organisational commitment questionnaire

The questionnaire itself was originally designed to measure the level of employee commitment to the organisation in which they worked and towards their daily tasks and duties. The questionnaire was designed and created by Mowday, et al (1979), and contained fifteen items (see appendix two).

In order to reflect the particular context and setting in which this research was carried out five additional questions were inserted into the questionnaire which sought to capture data on the level of the professional commitment of nursing staff and the extent to which they cared about their managers and identified with their aims and values. The following depicts the various components of the questionnaire on commitment (with additional parts) and shows what the questions were trying to measure.

Part A: Commitment

1. **Organisational commitment;** This incorporates questions 1-15 in the questionnaire.

Organisational commitment is the original questionnaire designed by Mowday, et al (1979), which seeks to measure the level of employee commitment, attitudinal and behavioural, to the aims and objectives of the organisation in which they work and to their daily tasks and duties.

2. **Professional commitment;** Professional commitment incorporates questions 16-18.

These are additional questions which sought to assess the degree to which the interviewees felt committed towards their profession.

3. **Organisational values;** This incorporates questions 19 and 20. These questions were designed to find out the extent to which the interviewees cared about their managers and the degree to which they felt that their own values were shared by management (extent to which they identified with the values of Trust management).

Employee trust questionnaire

The following illustrates and explains how the questionnaire on trust is broken up into its various items and components. The original questionnaire on trust, designed by Butler (1991), seeks to measure the level of trust amongst nursing staff with their immediate superiors. In order to achieve this the respondents were asked questions about their immediate superiors relating to a variety of different subsets of trust. Other questions have however been added to the questionnaire which seek to examine and establish whether or not nursing staff believe that their managers trust them, whether or not they feel that their immediate superiors are committed towards nursing staff and their patients, whether or not their immediate superiors have nursing training and experience and whether they trust their management as a group/collective i.e. the management of the organisation in general. The purpose of these questions was to find out whether or not trust had to be reciprocated in order to exist and to assess whether or not nursing staff trusted their managers generally.

Part B: Trust

1. **Trust;** This involves all the questions in the original questionnaire on trust by Butler, (1991); questions 21-64. The following are the individual items that the original

questionnaire was designed to measure, each item has four associated questions one of which is a reversed score question. These items and their questions are as follows,

- **Availability** (extent to which ones immediate superior is available when needed); 21-24
 - **Competence**; 25-28
 - **Consistency**; 29-32
 - **Discreteness** (extent to which ones immediate superior can be relayed upon to be discreet); 33-36
 - **Fairness**; 37-40
 - **Integrity**; 41-44
 - **Loyalty**; 45-48
 - **Openness**; 49-52
 - **Overall trust**; 53-56
 - **Promise fulfillment**; 57-60
 - **Receptivity**; 61-64
2. **Management trust**; This incorporates two questions, and looks at the degree to which nursing staff perceive their managers acting in ways that suggest that they trust and value nursing staff; 65-68
3. **Management commitment**; This incorporates two questions and looks at the degree to which nursing staff perceive their managers being committed towards nurses and the patients within their care; 66-67

4. **Management experience;** This involves one question which asks the respondent if their immediate superior/manager has had previous nursing training and experience;

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5. **Trust in management;** This incorporates four questions and looks at the extent to which nursing staff trust their managers in general/ as a group; 70-73

Organisational commitment statistics

The following table illustrates the results from the questionnaire on commitment and highlights the mean response given to each particular question by the respondents. Means and standard deviations have been calculated to two decimal places (the responses to the questions were measured on a five point Likert scale).

Question	Frequencies (percent)					Mean	Standard deviation
	sd	d	n	a	sa		
1. Effort	3.4	13.8	29.9	35.6	17.2	3.49	1.04
2. Positive	12.6	34.5	31.0	19.5	2.3	2.64	1.01
3. Loyalty (-)	21.8	19.5	35.6	20.7	2.3	3.38	1.11
4. Acceptance	42.5	31.0	21.8	2.3	2.3	1.90	0.97
5. Values	17.2	28.7	29.9	19.5	4.6	2.66	1.12
6. Proud	11.5	17.2	39.1	21.8	10.3	3.02	1.13
7. Similar (-)	8.0	11.5	24.1	36.8	19.5	2.52	1.17
8. Performance	17.2	36.8	28.7	14.9	2.3	2.48	1.02
9. Change (-)	13.8	20.7	28.7	23.0	13.8	2.98	1.25
10. Glad	5.7	20.7	54.0	13.8	5.7	2.93	0.90
11. Sticking(-)	4.6	20.7	31.0	31.0	12.6	2.74	1.07
12. Policies (-)	1.1	11.5	26.4	40.2	20.7	2.32	0.97
13. Fate	5.7	8.0	28.7	39.1	18.4	3.56	1.06
14. Possible	20.7	29.9	35.6	10.3	3.4	2.4	1.04
15. Mistake (-)	24.1	20.7	41.4	10.3	3.4	3.52	1.08

Table 3. Organisational commitment.

(-) indicates negatively worded question.

The majority of respondents, 52.8%, were prepared to put in a greater level of effort, beyond that normally expected in order to help the organisation succeed. Most of those who responded did not however speak of their organisation positively as a ‘great organisation’ to work for (47.1% either disagreed or strongly disagreed with this statement). A significantly large minority of people felt loyal towards the organisation in which they worked (41.3% either disagreed or strongly disagreed with the following statement; ‘I feel very little loyalty to this organisation’). 4.6% of those interviewed either agreed or strongly agreed with the statement, ‘I would accept almost any type of job assignment in order to keep working for this organisation’. The overwhelming majority of the respondents, 73.6%, either disagreed or strongly disagreed with this statement hence indicating that their focus of commitment was not the organisation in which they

worked but could lie in the nature of the work they did within the organisation. 45.9% either disagreed or strongly disagreed with the following statement; 'I find that my values and the organisation's values are similar' which would suggest that their values were not the same as those of the organisation in which they worked. On the issue of pride in their organisation the sample was split down the middle. 56.3% of the sample agreed/strongly agreed with the statement that they would just as happily be working within another organisation 'as long as the type of work was similar'. This would suggest that either the level of loyalty to this particular organisation remains low or that the majority of the interviewees have a higher level of commitment towards the work they carry out as opposed to a commitment towards the organisation. 54% disagreed/strongly disagreed with the statement that 'this organisation really inspires the very best in me in the way of job performance' which would suggest that if the interviewees are being inspired to work hard and to perform well they must be getting their inspiration from another source i.e. their patients, their work as nurses or their colleagues.

When asked whether or not they agreed with the statement 'it would take very little change in my present circumstances to cause me to leave this organisation' the sample was evenly divided. This would indicate a medium level of commitment, as the mean for this answer was 3.02. When asked whether or not they agreed with the statement, 'I am extremely glad that I chose this organisation to work for over others I was considering at the time I joined' there was only a slight leaning towards disagreement with this statement as the mean of 2.93 would indicate. 43.6% of those agreed/strongly agreed with the statement that 'there is not much to be gained by sticking within this organisational indefinitely' indicating that many of those within the organisation have no incentive to

feel committed to this organisation in the long term. 60.9% agreed/strongly agreed with the statement that ‘Often I find it difficult to agree with this organisation’s policies on important matters relating to its employees’. It is clear from this response that some level of discord and disharmony exists amongst the respondents with regard to policies towards employee issues and relations. 57.5% of those interviewed agreed/strongly agreed with the statement, ‘I really care about the fate of this organisation’, which would suggest that they were committed to maintaining the operation and functioning of the organisation in which they worked. 50.6% of the respondents disagreed/strongly disagreed with the statement that the organisation in which they currently worked ‘was the best of all organisations for which to work’. Only 13.7% agreed/strongly agreed with the statement that ‘Deciding to work for this organisation was a definite mistake on my part’.

Additional questions relating to organisational context

Question	Frequencies (percent)					Mean	Standard deviation
	sd	d	n	a	sa		
16. Care	2.3	0	0	12.6	85.1	4.78	0.67
17. Nurses	2.3	0	4.6	20.7	72.4	4.16	0.78
18. Aims	2.3	1.1	3.4	26.4	66.7	4.54	0.82

Table 4. Professional commitment

97.7% agreed/strongly agreed with the statement ‘I care for the patients I look after within the organisation’ indicating that the respondents were strongly committed to patient care. 93.1% of the sample also agreed/strongly agreed with the statement ‘I care about the other nurses I work with within this organisation’ this would therefore strongly

suggest that the respondents had an even bigger commitment towards their colleagues. 93.1% of the respondents agreed/strongly agreed with the statement, 'I care about the aims and objectives of the nursing profession'. The responses given to the three questions above would suggest that the overwhelming majority of respondents care about their colleagues, the aims and objectives of professional nursing and the patients within their care.

55.2% respondents agreed/strongly agreed with the statement 'I care about the management of this organisation and their aims and objectives'. This would suggest that the respondents are less committed to their managers and the aims and objectives of the organisation than they were to their patients, their colleagues and the aims and objectives of professional nursing. 49.4% disagreed/strongly disagreed with the statement 'I think that the management of this organisation also shares my own values'. This would highlight possible differences in the value systems of the respondents and those whose responsibility it was to manage them.

Question	Frequencies (percent)					Mean Standard deviation	
	sd	d	n	a	sa		
19. Management	2.3	13.8	28.7	27.6	27.6	3.64	1.10
20. Shared	20.7	28.7	34.5	13.8	2.3	2.48	1.04

Table 5. *Organisational values*

Intercorrelations

Scale	Prof. Com.	Org. Val.	Mean	SD
Organisational com.	0.03	0.61***	2.84	0.63
Professional com.	_____	0.31**	4.49	0.68
Organisational values	_____	_____	3.06	0.86

Table 6. Intercorrelations (*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$)

As can be seen from the above there is a high correlation between organisational commitment (attitudinal and behavioural commitment of nursing staff) and organisational values ($p < 0.001$). This would suggest that those respondents who showed to have a high level of organisational commitment also tend to care more about Trust management and organisational values and are under the impression that their managers share their values. One explanation for this could lie in the possibility that in this particular case the immediate superiors of the respondents may themselves be a nurse or a member of the medical profession. Those respondents who showed a high level of commitment, in their attitudes and behaviours may therefore perceive their immediate superiors i.e. their 'managers', as embodying their own aims and values and therefore enhancing their commitment towards the organisation.

The results from the survey also showed a moderate correlation between professional commitment with the degree to which they respondents cared about their managers and the extent to which they identified with managerial and organisational aims and values i.e. organisational values. This would suggest that those with a high level of professional commitment also cared about their managers and identified with their values. Again as mentioned earlier it could be that their managers i.e. immediate superiors, in the case

where their level of professional commitment was high, were more professional in terms of their outlook and background as opposed to been managerial.

Employee commitment and trust descriptive statistics

The following table (Table 7) illustrates the results from the original questionnaire on trust (which shows the means for the various subsets of trust) and shows the intercorrelations between all the various factors and variables measured by the two questionnaires on commitment and trust. N.B. For each subset on trust there were four questions. The means within the table is the average means from the four questions under each subset. These questions were answered on a five point Likert scale (1 = Strongly agree - 5= Strongly disagree);

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	M	sd
1. Organisational commitment	1.0	.03	.61*	.36*	.20	.13	.25*	.32*	.30*	.38**	.38**	.20	.32**	.34**	.29**	.40**	.25*	-.09	.36**	2.84	0.63
2. Professional commitment		1.0	**	*	.14	.25*	.03	.09	.11	.06	.06	.25*	.07	.20	.15	.28**	.14	.03	.15	4.64	0.68
3. Organisational values			*	.34*	.14	.19	.17	.21	.27*	.28**	.31**	.38*	.27*	.37**	.34**	.39**	.23*	-.13	.37**	3.06	0.86
4. Trust				1.0	.68*	.78*	.84*	.77*	.90*	.87**	.86**	.73*	.91**	.90**	.82**	.82**	.80**	.28**	.31**	3.55	0.76
5. Availability					1.0	.58*	.48*	.38*	.59*	.52**	.49**	.46*	.60**	.53**	.48**	.55**	.56**	.26*	.20	3.72	0.88
6. Competence						1.0	.61*	.54*	.68*	.63**	.63**	.57*	.65**	.64**	.56**	.74**	.64**	.31**	.24*	4.00	0.83
7. Consistency							1.0	.64*	.75*	.77**	.66**	.58*	.73**	.72**	.68**	.62**	.68**	.20	.27*	3.48	0.88
8. Discreteness								1.0	.64*	.74**	.61**	.46*	.71**	.67**	.62**	.64**	.68**	.28**	.16	3.7	0.94
9. Fairness									1.0	.77**	.80**	.63*	.80**	.80**	.72**	.74**	.73**	.30**	.29**	3.65	1.02
10. Integrity										1.0	.72**	.52*	.73**	.79**	.67**	.71**	.70**	.25*	.29**	3.50	0.95
11. Loyalty											1.0	.59*	.80**	.80**	.69**	.72**	.69**	.16	.27*	3.43	0.95
12. Openess												1.0	.64**	.64**	.60**	.61**	.54**	.26*	.22*	3.13	0.96
13. Overall trust													1.0	.83**	.74**	.72**	.71**	.26*	.27*	3.54	1.02
14. Promise fulfilment														1.0	.76**	.75**	.73**	.17	.26*	3.48	0.86
15. Receptivity															1.0	.67**	.68**	.23*	.24*	3.52	0.82
16. Management trust																1.0	.76**	.25*	.33**	3.64	0.95
17. Management commitment																	1.0	.23*	.16	3.50	1.00
18. Management experience																		1.0	.32**	4.50	0.87
19. Trust in Mgt																			1.0	3.52	0.65

Table 7. Intercorrelations

As can be seen from Table 7 most of those who responded to the questionnaire agreed with most of the statements. The results show that the respondents considered their immediate superiors were competent, which received the highest score. However the respondents also agreed with statements that suggested their immediate superiors were not as open as they could or should be. The respondents tended to agree with statements suggesting that their immediate superiors were discrete, available/accessible when needed, they were fair, generally trust worthy, receptive, possessed integrity, were consistent, were able to fulfill their promises and were loyal to them individually. Given the fact that the respondents sided towards agreeing with the various statements on trust one would therefore conclude that in general the respondents tend to trust their immediate superiors.

Intercorrelations between commitment and trust

The following looks at the various correlations between the various variables and factors measured by the questionnaires on commitment and trust, and the additional questions (highlighted in Table 7).

Organisational commitment

As can be seen from Table 7 organisational commitment correlates highly with the perception that the respondent's immediate superior is loyal (11) to their staff, they trust (16) their staff and they value (16) their staff. Organisational commitment is therefore associated with the degree to which one feels their immediate superior is loyal to them and whether or not they feel that they are trusted and valued by their immediate superiors.

Organisational commitment showed a moderate correlation with the extent to which one trusted their immediate superior (4), the degree to which one perceived their immediate superior as being discreet (8), fair (9), the extent to which they fulfilled their promises (14), their level of overall trust in their immediate superior (13), the extent to which they were receptive (15) to them individually and the degree to which the interviewees trusted their management generally (19).

Organisational commitment also showed a mild correlation with the extent to which one perceived their immediate superior as behaving consistently (7) and the level to which they perceived their immediate superiors as acting in ways that suggested that they were committed towards nursing staff and their patients (17).

Professional commitment

Professional commitment correlated with organisational values. Throughout the interviews it was suggested that there was an underlying conflict of interest between the professional commitments of nursing staff with their organisational commitments. The results from the statistics would imply that the level of one's commitment towards their profession (2) is correlated with the extent to which they care about their managers and the degree to which they share their values (3). Professional commitment also correlated with the degree to which the respondents perceived their immediate superiors as acting in ways which suggested that they both trusted and valuing nursing staff (16). There was also a mild correlation between professional commitment and the extent to which one perceived their immediate superior as being open (12).

Organisational values

Organisational values (the degree to which respondents cared about their managers and felt that the both they and their managers shared the same values) showed to have a high correlation with the level to which they respondents perceived their immediate superior as being open (12), able to fulfill their promises (14), the degree to which their immediate superiors trusted and valued nursing staff (16) and the extent to which the respondents trusted management in general (19).

Organisational values also showed a medium correlation with the level of trust in their immediate superior (4), the extent to which they perceived them as having integrity (10), loyalty (11) and the degree to which they perceived them as been receptive to nursing staff(15).

Organisational values also showed a mild correlated with their level of overall trust (13) in their immediate superior, the extent to which they perceived them as being fair (9) and the degree to which they perceived them as being committed to both nursing staff and their patients (17).

Trust

Trust correlated highly with the perceived level of integrity (10), loyalty (11), openness (12), overall trust (13), promise fulfillment (14) and the receptivity of their immediate superiors (15). The level of trust in ones immediate superior was highly correlated with the extent to which the respondents felt that their immediate superiors both trusted and

valued (16) them and the degree to which they perceive their managers being committed (17) towards nursing staff and the patients within the hospital.

Trust proved to have a medium correlation with the extent to which they considered their immediate superiors as being competent (6), available (5) when needed, consistent (7) and fair (9).

Availability

As can be seen in Table 7 availability, the extent to which one perceived their immediate superiors as being available when needed correlated highly with the degree to which they perceived their immediate superior as having integrity (10), loyalty (11), openness (12), overall trust (13), capable of fulfilling their promises (14) and their level of receptivity (15). Availability also correlated with the extent to which the respondents perceived their managers acting in ways which suggested that they trusted and valuing nursing staff (16) and the degree to which they perceived their managers as being committed to both nursing staff and their patients (17).

Availability also showed a mild correlation with the degree to which one perceived their immediate superior as being competent (6), consistent (7), discreet (8), fair (9), and the degree to which they perceived them as having had previous nursing training and experience (18).

Competence

As can be seen in Table 7 the extent to which one perceived their immediate superior as being competent, correlated highly with the degree one perceived them as being consistent (7), discreet (8), fair (9), having integrity (10), loyalty (11), being open (12), overall trust (13), the ability to fulfill their promises (14) and the extent to which they were receptive (15). It would seem that competence is highly correlated to other attributes associated with trust. Competence is also proved to have a high correlation with the level to which the interviewees perceived their immediate superiors trusting and valuing nursing staff (16) and being committed to nursing staff and patients (17).

Competence proved to have a medium level of correlation with the extent to which ones immediate superior had previous nursing training and experience (18). This would suggest that the respondents perception of competence of their immediate superiors was related to the extent to which they perceived them as having previous nursing training and experience. Competence showed a mild correlation with the degree to which the respondents trusted their managers in general (19).

Competence also featured strongly in the interviews on trust.

Consistency

As can be seen in Table 7 consistency, the degree one perceived their immediate superior as being consistent, correlated highly with the extent to which they perceived them as being discreet (8), fair (9), having integrity (10), loyalty (11), being open (12), overall trust (13), the ability to fulfill their promises (14) and the extent to which they were

receptive (15) to nursing staff. Consistency also proved to have a high correlation with the degree to which the respondents perceived their immediate superiors acting in ways which suggested that they valued and trusted nursing staff (16) and were committed to nursing staff and their patients (17).

There was also a mild correlation between consistency (7) and the extent to which the respondents trusted their management in general (19).

Discreteness

As can be seen in Table 7 discreteness, the perception that ones immediate superior was discreet correlated highly with being fair (9), having integrity (10), loyalty (11), being open (12), overall trust (13), being able to fulfill their promises (14) and being receptive (15). It also correlated with the perception amongst the respondents that their immediate superior both valued and trusted nursing staff (16) and were committed towards nursing staff and their patients (17). Discreteness proved to have a medium correlation with the extent to which the respondents perceived their immediate superior as having nursing training and experience (18).

Integrity

As could be seen in Table 7 the extent to which one perceived their immediate superior as having integrity proved to have a high correlation with loyalty (11), openness (12), overall trust (13), promise fulfillment (14), receptivity (15), and the extent to which the respondents perceived their managers acting in ways that suggested they both trusted and

valued nursing staff (16) and were committed to nursing staff and their patients (17). The extent to which one perceived their immediate superior as having integrity also proved to have a medium correlation with the extent to which the respondents trusted their managers in general (19).

Loyalty

The degree to which one perceived their immediate superior as been loyal proved to have a high correlation with the degree to which they perceived them as been open (12), their level of overall trust one had in the person concerned (13), their ability to fulfill their promises (14), the extent to which they were receptive (15), and the extent to which one perceived them in acting in ways that suggested that they both trusted and valued nursing staff (16) and were committed to nursing staff and their patients (17). Loyalty also proved to have a mild correlation with ones general level of trust in management (19).

Openness

As can be seen in Table 7 the extent to which one perceived their immediate superior as been open, proved to have a high correlation with their level of overall trust (13) they had in the person in question, the extent to which they fulfilled their promises (14), the degree to which they were receptive (15), and the extent to which one perceived their immediate superiors as acting in ways which suggested that the trusted and valued nursing staff (16) and were committed to them and their patients (17). Openness also proved to have a mild correlation with the extent to which ones immediate superior had nursing training and experience (18) and their level of trust in management in general (19).

Overall trust

The general level of trust in ones immediate superior showed to have a high correlation with the extent to which they could fulfill their promises (14), the extent to which they were receptive (15), the extent to which one perceived their immediate superiors as acting in ways which suggested that the trusted and valued nursing staff (16) and were committed to them and their patients (17). Overall trust also showed to have a mild correlation with the extent to which ones manager had nursing training and experience (18) and their level of trust in management in general (19).

Promise fulfillment

Promise fulfillment showed a high correlation with the degree to which one perceived their immediate superior as been receptive (15), the extent to which they believed their immediate superiors trusted and valued nursing staff (16) and were committed to them and their patients (17).

Promise fulfillment also showed a mild correlation with the level to which the respondents trusted their management in general (19).

Receptivity

The extent to which one perceives their immediate superior as been receptive showed to have a high correlation with the extent to which they believed their immediate superiors trusted and valued nursing staff (16) and were committed to them and their patients (17).

Receptivity also proved to have a mild correlation with the extent to which ones'

immediate superior had nursing training and experience (18) and the degree to which they trusted management in general (19).

Management trust

As can be seen in table 7 the extent to which one perceived their managers both trusting and valuing nursing staff was linked to the to which they perceived them as being committed towards nursing staff and the patients within their care (17). This would confirm or at least suggest that trust and commitment are linked.

Management commitment

The extent to which the respondents perceived their immediate superior as being committed towards nursing staff and their patients showed a mild correlation with the extent to which ones immediate superior possessed nursing training and experience (18).

Management experience

There was a high correlation between those who trusted management in general and who perceived their immediate superiors as having had previous nursing training and experience (18). This would correspond to the findings within the interviews which suggested that in order for the interviewees to trust their management their managers would need to be able to see things from their point of view and would need to be able to understand what it is to be a nurse.

Summary

Overall the results from the survey showed that there was a medium level of organisational commitment (2.84) amongst the respondents and a slightly higher level of trust in their immediate superiors (3.55).

The extent to which the respondents were committed to the organisation correlated with the various subsets of trust. The extent to which the level of organisational commitment correlated with the different subsets of trust tended to vary from one subset to another. The level of professional commitment amongst the respondents proved to have a moderate correlation with the extent to which they identified with the values of the organisation in which they worked.

Descriptive statistics for Mount Gould

Method

Eighty four questionnaires were sent to Mount Gould for distribution in November 1998. Access was negotiated with the nursing staff manager who distributed the questionnaires to all qualified nursing staff within the organisation. Thirty nine questionnaires were returned, the response rate was therefore 46.42%.

The use of more sophisticated statistical techniques were considered. Given the fact that the sample sizes were comparatively small, the use of such techniques was deemed as inappropriate.

Coverage

The sample covered the majority of qualified nursing staff within Mount Gould Community hospital within the hospitals rehabilitation units. Unlike Derriford only one questionnaire was used (employee commitment questionnaire). As mentioned previously the use of the questionnaire on trust was not permitted by the nursing staff manager (see Chapter Four: Research Methodology).

The following are the results taken from five questions seeking to outline the profile of those who responded to the questionnaire on commitment. The purpose of these questions was to get the respondents to state their age, the period of time they spent working within the organisation, their gender, their current position and grade.

Sample Characteristics

		Frequency	Percent
Age	21-25	2	5.1
	26-30	5	12.8
	31-35	8	20.5
	36-40	8	20.5
	41-50	11	28.2
	51-60	5	12.8
Period of employment	Less than 1 yr	3	7.7
	1-3 yrs	8	20.5
	4-10 yrs	11	28.2
	11-20 yrs	14	35.9
	21-30 yrs	2	5.1
	31-40 yrs	1	2.6
Gender	Male	1	2.6
	Female	38	97.4
Grade	D	16	41.0
	E	18	46.2
	F	3	7.7
	G	2	5.1

Table 2.1. Sample characteristics

Job type	Frequency	Percent
Valid	3	7.7
Associate nurse	3	7.7
Enrolled	2	5.1
Enrolled nurse	3	7.7
HCE	1	2.6
Primary nurse	1	2.6
RGN	2	5.1
RN1	1	2.6
SEN	1	2.6
Senior sister	1	2.6
Staff nurse	18	46.2
Unit sister	1	2.6
Ward manager	2	5.1

Table 2.2. Position

Organisational commitment questionnaire

The nursing staff manager again objected to the wording of some of the questions. Unfortunately the wording of some of these questions had to be changed slightly. The changes however were kept to a minimum and the overall meanings of the items within the questionnaire were retained.

The questionnaire itself was originally designed to measure the level of commitment of an employee (Mowday, Steers and Porter, 1979), in this case nursing staff, to the aims and objectives of the organisation in which they worked and towards their daily tasks and duties. There were originally fifteen questions in this questionnaire.

Five additional questions were added to the questionnaire in order to reflect the particular context and setting in which this research was to be carried out. The purpose of questions sixteen to eighteen was to assess the level of professional commitment of the respondents. Questions nineteen and twenty sought to assess the extent to which the interviewees cared about their managers and the degree to which they identified with the values of their managers (additional questions are 16-20).

N.B. The table has a five point Likert scale. Means and standard deviations have been calculated to two decimal places.

	Frequencies (percent)						
Question	sd	d	n	a	sa	Mean	Standard deviation
1. Effort	5.1	12.8	56.4	23.1	2.6	3.05	0.83
2. Positive	17.9	35.9	33.3	12.8	0	2.41	0.94
3. Loyalty (-)	7.7	25.6	38.5	10.3	17.9	2.95	1.19
4. Acceptance	46.2	35.9	15.4	0	2.6	1.77	0.90
5. Values	17.9	30.8	43.6	7.7	0	2.41	0.88
6. Proud	7.7	38.5	25.6	25.6	2.6	2.77	1.01
7. Similar (-)	2.6	12.8	23.1	46.2	15.4	2.41	1.00
8. Performance	17.9	43.6	25.6	7.7	5.1	2.38	1.04
9. Change (-)	12.8	25.6	25.6	20.5	15.4	3.00	1.28
10. Glad	5.1	15.4	53.8	17.9	7.7	3.08	0.93
11. Sticking (-)	7.7	28.2	30.8	23.1	10.3	3.00	1.12
12. Policies (-)	5.1	12.8	23.1	35.9	23.1	2.41	1.14
13. Fate	2.6	15.4	41.0	23.1	17.9	3.38	1.04
14. Possible	15.4	28.2	46.2	5.1	5.1	2.56	1.00
15. Mistake (-)	33.3	20.5	30.8	15.4	0	3.72	1.10

Table 2.3 Organisational commitment.

(-) signifies a negatively worded question

	Frequencies						
Question	sd	d	n	a	sa	Mean	Standard deviation
16. Care	0	5.1	0	7.7	87.2	4.77	0.71
17. Nurses	0	5.1	0	12.8	82.1	4.72	0.72
18. Aims	0	2.6	7.7	10.3	79.5	4.67	0.74

Table 2.4 Professional commitment

	Frequencies						
Question	sd	d	n	a	sa	Mean	Standard deviation
19. Management	5.1	20.5	30.8	30.8	12.8	3.26	1.09
20. Shared	15.4	30.8	41.0	10.3	2.6	2.54	0.97

Table 2.5 Organisational values

Scale	Prof. Com.	Org. Val.	Mean	SD
Organisational com.	0.01	0.25	2.75	0.65
Professional com.		0.66***	4.72	0.69
Organisational values			2.64	0.52

Table 2.6 Intercorrelations (*** $p < 0.001$; ** $p < 0.01$; * $p < 0.05$)

Comparison of the results between Mount Gould compared and Derriford

Organisational commitment

The respondents within the Mount Gould sample were evenly split when asked whether or not they agreed with the statement ‘I am willing to put a great deal of effort beyond that normally expected in order to help this organisation to be successful’. The respondents within the Derriford sample on the whole tended to agree with this statement which would indicate that the level of commitment tends to be higher within Derriford and less so within Mount Gould.

Within the Mount Gould sample 53.8% disagreed/strongly disagreed with the statement ‘I talk positively about this organisation to my friends as a great organisation to work for’ this would indicate that the respondents generally feel demoralised in the organisation in which they work.

33% of the respondents disagreed/strongly disagreed with the statement that they felt ‘very little loyalty’ to the organisation in which they worked. This can be compared to 41.3% within Derriford. The respondents from the Derriford sample would appear to feel a greater depth of loyalty to their organisation than their counterparts within Mount Gould.

Within the Mount Gould sample only 2.6% strongly agreed with the statement , ‘I would accept almost any type of job assignment in order to keep working for this organisation’. This would suggest that the level of organisational commitment amongst the Mount Gould respondents was low. Within the Derriford sample 4.6% of the respondents agreed/strongly agreed with the same statement. This would suggest that the level of organisational commitment is lower amongst the respondents within the Mount Gould sample than it is compared with their counterparts within the Derriford sample. Within the Mount Gould sample 48.7% of the respondents disagreed/strongly disagreed with the statement, ‘I find that my values and the organisation’s are very similar’. Within the Derriford sample, a slightly lower percentage 46%, disagreed/strongly disagreed with the same statement.

46.2% of the Mount Gould sample disagreed/strongly disagreed with the statement ‘I am proud to tell others that I am part of this organisation’. This would suggest that a considerable size of the sample does not feel proud of where they work. Within Derriford only 28.7% disagreed/strongly disagreed with the same statement. This would indicate that the respondents from the Derriford sample took greater pride in working within their organisation than did their counterparts within Mount Gould.

61.6% within the Mount Gould survey agreed/strongly agreed with the statement ‘I could just as well be working for a different organisation as long as the type of work was similar’. This compares with 56.3% within the Derriford sample. Again when comparing the responses to this question it would seem that the level of commitment amongst the respondents within Mount Gould is lower than their counterparts within the Derriford survey.

61.5% of the respondents from the Mount Gould survey disagreed/strongly disagreed with the statement 'This organisation really inspires the very best in me in the way of job performance'. This would suggest that the respondents from the Mount Gould survey felt little or no commitment/motivation towards the organisation in which they are currently working. 54% of the respondents within the Derriford sample disagreed/strongly disagreed with the same statement once again suggesting that their level of commitment is higher than their counterparts within Mount Gould.

The respondents from the Mount Gould sample appeared to have been evenly split on the following two statements;

'It would take very little change in my present circumstances to cause me to leave this organisation' and 'I am extremely glad that I chose this organisation to work for over other I was considering at the time I joined'. This was also the case for the same two questions amongst the respondents within the Derriford sample.

33. 4% of the Mount Gould respondents strongly agreed/strongly agreed with the statement 'There is not too much to be gained by sticking with this organisation indefinitely'. 43.6% of the Derriford respondents agreed/strongly agreed with the same statement. This would appear to contradict the previous trends and would suggest that the respondents from the Derriford sample had a lower level of commitment than their counterparts within Mount Gould. One why this could be explained might be that the respondents from the Derriford sample may have a lower level of long term organisational commitment than their counterparts within Mount Gould. It could also mean that the respondents within the Derriford sample are more mobile and proactive in pursuing their career options and more prepared to move to other organisations in order to fulfill their career goals and aspirations.

59% of the Mount Gould sample strongly agreed with the statement ‘Often, I find it difficult to agree with this organisation’s policies on important matters relating to its employees’ this was more or less the same for the respondents from the Derriford sample where 60.9% disagreed/strongly disagreed with the same statement.

41% of the Mount Gould sample agreed/strongly agreed with the statement, ‘I strongly care about the fate of this organisation’. This would indicate that a significant minority care about the fate of the organisation, the rest of the sample were however either neutral on this statement or they did not care. When asked the same statement 57.5% of the respondents within the Derriford sample agreed/strongly agreed that they did care about the ‘fate’ of their organisation.

43.6% of Mount Gould respondents disagreed/strongly disagreed with the statement ‘For me this is the best of all possible organisations for which to work’ compared to 50.6% within the Derriford sample. This would suggest that the respondents within Derriford were generally slightly less happy with their lot compared with their counterparts from Mount Gould.

15.4% of the Mount Gould respondents agreed with the statement ‘Deciding to work for this organisation was a definite mistake on my part’, slightly less respondents agreed/strongly agreed with the same statement within Derriford, 13.7%, which suggests, once again, that they are more satisfied than their counterparts in Mount Gould.

Professional commitment

94.9% of the Mount Gould respondents agreed/strongly agreed with the statement ‘I care for the patients I look after within the organisation’. This would indicate clearly

that the patients within this organisation are the real source of commitment for nursing staff. 97.7% of the Derriford respondents agreed/strongly agreed with the same statement. This would suggest that patients are slightly more important to the respondents within the Derriford sample.

94.9% of the Mount Gould respondents agreed/strongly agreed with the statement 'I care about the other nurses I work with within this organisation'. This would suggest that the respondents are equally committed to their colleagues as well as to their patients. 93.1% of the respondents agreed/strongly agreed with the same statement within Derriford which is more or less the same result of their respondents from the Mount Gould sample.

89.8% of the Mount Gould respondents agreed/strongly agreed with the statement, 'I care about the aims and objectives of the nursing profession' once again indicating that the respondents feel committed to professional nursing. 93.1%, a slightly higher percentage, agreed/strongly agreed with the same statement within the Derriford sample.

The respondents from both the Mount Gould and Derriford samples would seem to have a very high level of commitment towards their patients, their colleagues and to the nursing profession itself.

Organisational values

43.6% of the Mount Gould respondents agreed/strongly agreed with the statement, 'I care about the management of this organisation and their aims and objectives'. The responses to this question would indicate that the aims and objectives of management take a much lower place on the list of priorities of the respondents within Mount

Gould. 55.2% of the respondents within the Derriford sample agreed/strongly agreed with the same statement suggesting that the respondents from the Derriford sample have a higher level of commitment towards managerial aims and objectives.

12.9% of the Mount Gould sample disagreed/strongly disagreed with the statement, 'I think that my own values are also shared by the management of this organisation' indicating a possible lack of empathy and acceptance of managerial aims and objectives amongst the respondents within the Mount Gould sample. 16.1% of the respondents within Derriford disagreed/strongly disagreed with the same statement indicating that they were just slightly more predisposed towards the values of the management of their organisation.

Professional commitment and organisational values

Within the Mount Gould sample professional commitment correlated at $p < 0.001$ with organisational values which would strongly suggest the existence of a relationship between professional commitment and organisational values amongst the respondents within the Mount Gould. Professional commitment correlated slightly less within Derriford at $p < 0.01$. Generally it was indicated throughout the interviews that nursing staff were committed to their profession but lacked a similar commitment towards the organisation. The results from the two surveys would suggest that those with a strong professional commitment can also have a strong commitment towards the values of the organisation in which they work. The only way that this could be explained is that the extent to which one is committed towards their profession may also reflect the level to which they care about the management of the organisation in which they work and identify with their values. This is possible if either the aims and

objectives of Trust management are highly similar and are compatible with those of the respondents or that the management within the two Trusts i.e. immediate superior, tend to embody professional values and aspirations and not those modeled on generic private sector style management practices and beliefs.

Unlike their counterparts within Derriford the respondents from the Mount Gould sample showed no signs of their level of organisational commitment correlating with the extent to which they cared about their managers or identified with their values i.e. organisational values. Organisational commitment correlated at $p < 0.001$ with organisational values amongst the respondents within the Derriford sample (see Table 7). This may suggest that the extent to which the respondents within the Mount Gould sample feel committed towards their organisation may have little or no relation to the extent to which they care about their managers or empathise with their values.

Summary

As can be seen earlier, in Chapter Four: Research Methodology, the questionnaire on trust was absent in the Mount Gould survey. The results from the organisational commitment questionnaire showed, like that of their counterparts at Derriford, that there was a slightly less than medium level of commitment amongst the respondents (2.75). The mean score for the level of organisational commitment proved to be slightly lower than that of the respondents counterparts within Derriford.

The respondents level of professional commitment showed to have a high correlation with the extent to which they identified with the values of the organisation in which they worked. Unlike the results from the survey conducted amongst the nursing staff within Derriford there was no correlation between the level of organisational

commitment amongst the respondents with the extent to which they identified with the values of the organisation in which they worked.

Chapter Eight: Discussion and Conclusions

Discussion and conclusions

General commentary on findings

The findings would suggest that when studying employee trust and commitment within organisations one must consider the organisation itself and the nature of its purpose. This would resonate with the research carried out by Coopey and Hartley, (1991) who suggest that when considering organisational commitment one must ask 'committed to what?'. The findings above would also suggest that when studying employee trust and commitment one must also take into consideration the relationship between the employee and the organisation in which they work in terms of the role played by the employee themselves. In this case the employee belonged to a particular professional category within the two organisations studied. The study of employee trust and commitment within this particular context therefore had to take into account the nature of the profession of the employee and the nature of the organisation in which they worked. Through the course of analysing the interviews and the questionnaires it was discovered that the employees had a high level of commitment towards professional nursing, this was not however reflected in their level of commitment towards the organisation. The results from the questionnaires did however illustrate a link between the level of professional commitment with the extent to which they cared about and identified with the values of the management of their organisation. The level of professional commitment proved to be significantly higher than their level of organisational commitment and the extent to which the respondents/interviewees cared about their managers and identified with their values.

The definitions and theories surrounding the development and establishment of trust in the literature reviewed have generally been confirmed through the analysis of the interviews and the questionnaires used within this study. The data generated through the interviews does however highlight organisational context as a significant factor which needs to be taken into account when looking at employee trust and commitment. The idea that trust entails a degree of vulnerability and that commitment involves choosing trustworthy partners (Morgan and Hunt, 1994) would seem to be consistent with the comments given by the interviewees. The idea also that in order for trust and commitment to be established they must be reciprocated amongst the participants would also appear to have been confirmed i.e. managers must demonstrate behavior which suggests that they trust nursing staff and that they are committed to the same goals under the guise of shared values. Concepts relating to both trust and commitment within the two organisations studied relate specifically to nursing staff within NHS organisations (acute and community sector organisations). The way in which trust, its attributes and benefits, were described by the participants would indicate that the concept of trust and commitment does to some extent bear the trade mark of and reflects the organisation in which it is being studied and the profession of the employee. It is for this reason that research on trust and commitment should take into account and make reference to the organisational context and setting of the employee under study.

Trust and commitment amongst nursing staff within Derriford hospital and Mount Gould Community hospital

The following is a discussion of the level of trust between nursing staff and their managers and the level of commitment amongst nursing staff within Derriford (an acute sector organisation) and Mount Gould Community hospital (a community sector organisation). This discussion also seeks to address the research questions outlined in chapter four by drawing upon the findings gathered and generated through the in-depth interviews and questionnaire surveys carried out on trust and commitment.

R1 Is the current organisational climate within the NHS effective in facilitating the development of trust between managers and NHS nursing staff ?:

The overall evidence from both the interviews and the questionnaires would suggest that the general level of trust within the working environment of nursing staff is higher within Derriford than it is within Mount Gould.

The results from the interviews and the questionnaires would however suggest that the overwhelming number of nurses trusted their immediate superiors, but did not generally trust 'management' to the same extent (although a significant minority claimed that they did) i.e. senior and board level. The literature reviewed also suggests that the establishment of trust based relations usually arises through interaction with specific individuals as opposed to general groups or categories of people (Butler, 1991; Coopey 1995). Those interviewees who claimed that they did trust their managers said that it was

primarily due to the fact that they came into contact with them regularly and that the environment i.e. unit, ward etc, they worked in was comparatively small. The interviewees claimed that they found it harder to trust managers further up within the organisational hierarchy. The interviewees within the Mount Gould sample were under the impression that managers who were closer to the top of the organisational hierarchy pursued aims and objectives contrary to their own (see Sable 1993). The interviewees claimed that nursing staff and other employees lower down the organisational hierarchy (or those who were less skilled) were much less inclined to trust their managers. The results from the questionnaires also showed a strong correlation between availability and overall trust. Research carried out on trust suggests that trust is easier to establish and maintain in small groups and gets harder to sustain as group size increases (Kramer, 1999). The results from the interviews suggest that flatter organisational structures might be more conducive to the development of trust based relationships between nursing staff and their managers. This would ensure greater scope for interaction between nursing staff and their managers. The interviewees responses would also suggest that if their managers managed nursing staff in smaller units, with greater scope for personal and face to face contact they would provide a more effective mechanism in developing and cultivating trust based relations.

R2 Assess the level of trust between nursing staff and their management

The interviewees within Derriford and Mount Gould who claimed that they did not trust management attributed this to having being previously misinformed by management and felt that management did not support them or their goals. They claimed that management had altered the employment contract of nursing staff and had changed the terms and conditions under which they worked for the worse. The role played by suspicion in creating mistrust and the importance of knowing that the person you trust has concern for the welfare of others has also been highlighted in the research on trust (Kramer, 1999; Govier 1993; Lindsold 1978). Because of management's preoccupation with organisational budgets the interviewees were under the impression that their managers had aims and objectives contrary to their own (Lindsold, 1978; Govier, 1993; Sable, 1993). As mentioned in Morgan and Hunt (1994), Kelman (1961), outlines the role played by shared values in helping to establish and gain employee trust and commitment. The literature reviewed on trust and commitment also highlighted differences in individual training and educational backgrounds as a factor that can contribute towards feelings of mistrust between employees and their managers (Morgan and Potter, Kirkpatrick and Lucio (Eds.), 1995; Stewart, 1996). Research carried out on trust also highlights the importance of personality characteristics such as honesty, reliability, competence and integrity as characteristics of trustworthy individuals (Govier, 1993; Lindsold, 1978; Barnes, 1981; Fine and Holyfield, 1996, Sable, 1993).

The results from the questionnaires also showed that overall trust in ones immediate superior was linked to the extent to which their immediate superiors were able to fulfill their promises, their level of receptivity towards nursing staff, their level of availability

and commitment to both nursing staff and the patients within their care. The results from the questionnaires also showed that the level of trust in management in general was high, that the respondents generally believed that their managers trusted and valued nursing staff, were committed towards nursing staff/patients and that they had previous nurse training and experience. The role played by reciprocity within the development of trust based relations has also been highlighted in the research carried out on trust (see Robinson, 1996; Kramer, 1999; Brocker et al, 1997).

The results from the questionnaires and the interviews showed that that in order for trust to take place and develop that there should be a higher degree of communication between nursing staff and their managers and that their managers should fulfill their promises or they should at least not make promises which they cannot keep. Evidence gathered from both groups of interviewees would suggest that a lack of information/misinformation about impending organisational change and the belief that the aims and objectives of management are contrary and are not compatible with those of nursing staff can create mistrust (Lindskold, 1978; Sable, 1993; Govier, 1993, Barnes, 1981). The literature on trust also suggests that communication acts as both an input and an outcome of trust based relations (Barnes, 1981; Morgan and Hunt, 1994) and also suggests that the existence of shared values can act to strengthen the level of trust amongst the participants within a relationship and their commitment towards it (Morgan and Hunt, 1994).

R3 To what extent does trust between management and nursing staff need to be reciprocated in order to exist ?

A significantly higher number of interviewees within Mount Gould as opposed to Derriford claimed that their managers did indeed trust nursing staff.

Those who felt that their managers had a high level of trust in nursing staff claimed that their managers were heavily reliant upon the professional opinions and judgments of nursing staff and were also professionally responsible to replace them if they felt that they could not be trusted. Research on trust suggests that competence and reliability are characteristics of trustworthy individuals (Govier, 1993, Lindsfold, 1978).

Those nurses within Derriford and Mount Gould who either felt uncertain about or believed that their managers did not trust them at all claimed that the level of communication from management to nursing staff was poor. As a result of this lack of communication they felt that their managers did not know them well enough in order to trust them (Barnes, 1981; Morgan and Hunt, 1994).

The majority of the interviewees within Derriford and Mount Gould who claimed that their managers did not trust them also claimed that nursing staff did not trust their managers. The results from the questionnaires also showed that there was a high correlation between the level of trust in the respondents immediate superior with the degree to which the respondents felt that their immediate superior was receptive towards nursing staff and trusted and valued them. The results from the questionnaires on trust carried out within Derriford would therefore suggest that trust is reciprocal. This is also supported by the previous research carried out on trust (Robinson, 1996; Kramer, 1999; Broucker et al, 1997).

The responses to the two questions relating both to the extent to which nurses trusted their managers and the extent to which they felt that their managers trusted them would indicate that trust between individuals within the organisation is reciprocal in nature. This is also supported by the literature on trust (see Robinson, 1996; Kramer, 1999; Bocker et al, 1997).

The majority of the interviewees within Derriford and Mount Gould who claimed that nursing staff did not trust management also claimed that they would not make themselves vulnerable by sharing information of a personal nature with their immediate superior and said that to do so would concern them personally. Research carried out on trust suggests that trust involves vulnerability and a willingness to undertake risks (Mayer, et al, 1995; Lindsfold, 1978; Govier, 1993; Bocker, et al, 1997; Butler, 1991; Zand, 1972).

R4 To what extent do nursing staff share information with their work colleagues and their immediate superiors ?

The majority of those interviewed within Derriford were prepared to share information of a personal nature both with their colleagues and their immediate superiors even if it meant placing themselves in a vulnerable position with the superiors concerned. A greater number of interviewees within the Derriford sample were prepared to share information of a personal nature with their colleagues. The majority of those within the Mount Gould sample who were willing to share personal information with their immediate superior also claimed that they did share personal information with their colleagues. The literature on trust also suggests that communication is both an indicator of trust and a requirement needed in order for trust to develop (Barnes, 1981; Morgan and Hunt, 1994).

The results from the interviews would suggest that there is a high degree of trust and openness both amongst the interviewees themselves and their immediate superiors. Openness, communication and sharing information are seen as both an outcome and an input required for the development of trust based relations (Barnes, 1981). The results from the questionnaire survey also highlighted the existence of a high correlation between the degree of trust in ones immediate superior with the extent to they perceived their immediate superiors as being open, discreet, receptive and loyal.

Those interviewees within Derriford and Mount Gould who claimed that they would not feel comfortable sharing information of a personal nature with their immediate superior claimed that they were afraid that such information could be used against them.

The results showed that a higher number of interviewees within Mount Gould as opposed to Derriford were more reluctant and less comfortable to share information of a personal nature with their immediate superiors. The evidence would therefore suggest that the interviewees within Mount Gould are generally less trusting of their immediate superiors than their counterparts within Derriford. Research on trust shows that certain individuals are more predisposed to trust than that of some others and has suggested that an unwillingness to trust others may be due to a previous experience whereby an individual has been let down as a result of trusting other people (Kramer, 1999; Hardin, 1992; Robinson, 1996).

R5 What are the characteristics of trustworthy managers ?/ what are the conditions required for the development of trust between nursing staff and their managers ?

On the issue of characteristics of trustworthy managers the results from the Derriford and the Mount Gould samples proved to be similar, the main difference between the responses given by the two groups of interviewees would concern the degree of emphasis given to certain qualities and factors over that of others. This would explain why the list of characteristics and factors within both organisations are not ranked in the same order. The results from the interviews and the questionnaires would however suggest that the majority of the respondents and the interviewees within both organisations did trust their immediate superiors.

Those interviewed within Derriford mentioned more characteristics and factors and mentioned them more frequently. They also showed a higher degree of consistency amongst their peers when responding to this question and tended to give much more articulated and detailed responses. Professional competence was looked upon as the most important condition required for the development of trust within Derriford. The results from the questionnaires also showed that the majority of the respondents perceived their immediate superiors as being competent and also showed a high correlation between trust in ones immediate superior with the extent to which they perceived them as being open, discreet, loyal, receptive and having integrity. These results are consistent with the findings on the research that has been carried out on trust (Govier, 1993; Lindsfold, 1978; Butler and Cantell, 1984). As seen in Morgan and Hunt (1994), Mooreman, Deshpande and Zaltman, (1993) define trust as 'a willingness to rely on an exchange partner in whom one has confidence' (Morgan and Hunt, 1994, p.23).

In Mount Gould professional competence was mentioned by a considerably lower number of interviewees. The most frequently mentioned characteristic of a trustworthy manager/ colleague within Mount Gould was the ability to confide in the person they trusted. Support was mentioned within both organisations. The interviewees within the Derriford sample described support in terms of their immediate manager supporting them in practical ways i.e. career training and development etc. Those interviewed within Mount Gould however also described support but did so mainly in terms of emotional support with little or no reference to support in terms of their career development and training needs. The literature on trust is consistent with the results taken from the interviews, that individuals engage in trust based relations do so in the 'firm belief that the trustworthy party is both reliable and has integrity. These are associated with qualities such as consistency, competence, honesty, fairness, and being responsible, helpful and benevolent' (Morgan and Hunt, 1994, p.23). Other research on trust would also support this (Lindsfold, 1978; Govier, 1993; Butler and Cantell, 1984). The literature on trust suggests that when studying trust one should look at a number of conditions and characteristics (Butler, 1991). Communication and openness and the role played by time were also mentioned by both groups of interviewees (see Barnes, 1981).

Although both groups of interviewees outlined the characteristics of trustworthy managers and the conditions required for the development of trust in different orders. It is however uncertain as to whether this would reflect any differences in what both groups consider to be most important within the context of trust based relationships. On the other hand it could be supposed that the reasons for the differences in emphasis on some factors over that of others (amongst both groups of interviewees) could be attributed to

differences in the nature and culture of the two organisations studied. Both organisations provide different types of services to different types of patients. This could therefore influence the outlook and the approaches of the nurses working within the two organisations i.e. professional competence may be of greater importance within Derriford because it is a busier and more pressurised environment in which to work.

Interviewees within both organisations claimed that in order for trust to develop and occur it had to be reciprocated by both parties on a quid pro quo basis. This would suggest that trust is something which is created interdependently amongst the individuals involved.

The issues which arose during the course of the in-depth interviews but were not however accounted for within the questionnaires were mainly an understanding by ones immediate superior of the nature of the work nursing staff did. The interviewees also indicated that in order to trust someone they would need to have known them over a certain period of time and that they would also need to know that they were both committed to nursing staff and patient care and had some understanding of the nature of the work that nurses did.

The research findings have enabled the development of the following model (fig. 1.4) depicting the various conditions required for the development of trust and the characteristics of trustworthy managers.

Conditions for the development of trust

Characteristics of trust worthy managers

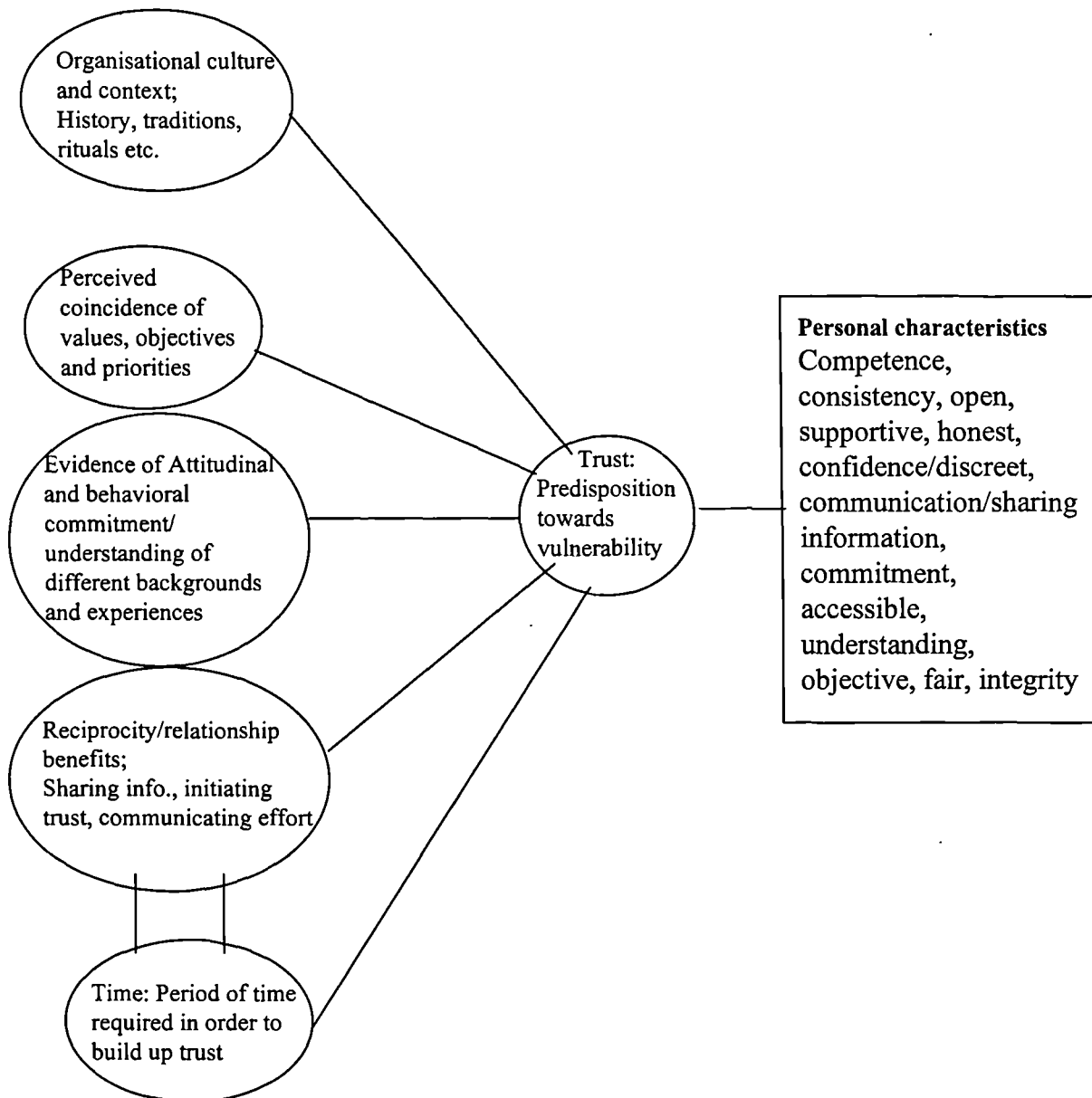


Fig 1.5 Conditions required for the development of trust and characteristics of trustworthy managers

Benefits to be derived from trust based relationships: Organisational and individual

R6 To what extent does the presence of trust assist nursing staff to carry out their daily tasks and duties ?

The overwhelming majority of interviewees within both organisations claimed that trust had helped them achieve and acquire their career aims and objectives (see Butler, 1991) and had also helped them carry out their daily tasks and duties.

The interviewees claimed that trust amongst themselves and their managers usually meant that they had the support of those they trusted in pursuing their career development and training which ensured higher levels of teamwork, greater self confidence and assistance/encouragement in helping them establish good relationships with potential role models. The interviewees claimed that when trusting the other members of staff that they could rely on them to carry out their tasks properly in the knowledge that their immediate superiors and colleagues were committed (attitudinally and behaviorally) to the same things as they themselves were i.e. patient care. This would suggest that trust and commitment within this context are both linked and make for a more efficient working environment (see Brocker, et al, 1997; Kanter, 1972; Eisenstadt and Roniger, 1984; Gellner, 1988; Fine and Holyfield, 1996).

The literature on trust highlights greater employee commitment, higher levels of co-operation, organisational cohesiveness, the existence of functional conflict and a reduction in decision making uncertainty as potential benefits which can arise from the

existence of trust based relations (Gambetta, 1988; Morgan and Hunt, 1994; Walsh, 1995; Fine and Holyfield, 1996). The role trust played in helping the interviewees establish cooperative relations with someone they could learn and take example from was highlighted by both groups of interviewees. The most frequently mentioned benefit within both organisations concerned the need for less supervision and checking up on nursing staff to ensure they were doing their jobs properly. This was mentioned by a significantly large number of interviewees within both organisations. The literature on trust would confirm that one benefit of trust is a reduction in the need for supervision which has the additional benefit of ensuring a higher degree of efficiency amongst the participants (Morgan and Hunt, 1994; Walsh, 1995). The literature on trust would also confirm that co-operation is an outcome that arises out of trust based relationships within organisations (Morgan and Hunt, 1994). The interviewees also highlighted team work and support/back up from their fellow colleagues as a benefit of trust based relations. Working in an open and honest environment (see Govier, 1993; Lindsfold, 1978; Morgan and Hunt, 1994) was highlighted as a benefit by those interviewed within Derriford but was not however mentioned by any interviewees within Mount Gould. Confidentiality was mentioned in equal measures by the interviewees within both organisations. While the interviewees within Mount Gould mentioned trust and the role it played in enhancing the level of teamwork upon the wards the Derriford sample also mentioned support/backup and confidentiality. Support/backup, openness, honesty, learning and confidentiality were all cited as benefits that can arise from the existence of trust based relations amongst the interviewees within Derriford. While they have been highlighted as outcomes they can also act as the conditions necessary in order for trust between

individuals to take place. The inputs required in order for trust based relationships to occur and develop can also constitute the benefits which can arise from the existence of trust based relationships. The presence of trust therefore ensures that these benefits/inputs remain and strengthen the level of trust amongst the participants. The literature on trust also describes the benefits of trust based relations as both the inputs and outcomes of trust (Govier, 1993; Lindskold, 1978; Morgan and Hunt, 1994).

R7 What effects could a lack of trust have on the work carried out by nursing staff ?

All forty nurses interviewed within Derriford and Mount Gould claimed that a lack of trust between themselves and their managers/immediate superiors would have adverse repercussions upon both nursing staff and the work they did within the organisation. Both groups of interviewees claimed that the level of communication and teamwork upon the wards would break down and that the level of self confidence, morale, self esteem and commitment amongst nursing staff would decrease. This they claimed would result in a decrease in the quality of patient care and an increase in the level of absenteeism and labour turnover. The results from the questionnaire showed that the level of commitment amongst nursing staff correlated with the extent to which they perceived their managers acting in ways which suggested that they both trusted and valued nursing staff. Interviewees from both organisations claimed that their level of attitudinal and behavioural commitment would decrease and claimed that that the level of work related stress, work force absenteeism and labour turnover would increase in circumstances where there was a low level of trust (see Whitson and Edwards, 1990). While the interviewees may still remain committed towards professional nursing they would not

necessarily remain committed to the organisation in which they work. The literature on trust suggests that there is a positive relationship between trust and commitment and that commitment influences the willingness of an individual to remain with an organisation and adhere to its specific requests and policies (Brockner, et al, 1997, Coopey, 1995; Morgan and Hunt, 1994).

As noted in Morgan and Hunt (1994), Anderson and Weitz (1989), describe communication as both an input and an output arising from trust based relationships. The absence of trust would therefore imply a breakdown and weakening in the level and the quality of the communication upon the wards. The literature on trust also highlights commitment, co-operation, functional conflict, a reduction in decision making uncertainty as outcomes of trust based relations (Barnes, 1981; Walsh, 1995; Morgan and Hunt, 1994). The results from the interviews would suggest that the absence of trust would mean that the outcomes listed above would not be present within the working environment of nursing staff. This is also indirectly confirmed by the literature on trust (Morgan and Hunt, 1994).

R8 What benefits are there to having a trust based relationship with ones immediate superior/manager ?

All forty nurses interviewed within both organisations claimed that there were benefits associated with having a trust based relationship with their immediate superiors'. As can be seen earlier the scope and the range of benefits associated with trusting ones immediate superior tended to be much more wide ranging amongst those interviewed within Derriford compared to their counterparts within Mount Gould. The respondents

within Derriford gave more detailed answers to questions relating to the benefits of trust based relations and outlined a wider range of benefits associated with trust in ones immediate superior (This is in contrast to those interviewed within Mount Gould who gave a more limited number of benefits but mentioned them in greater numbers).

The most mentioned benefit was found in Mount Gould, which was that of ensuring the general well being and happiness of nursing staff and NHS employees which they claimed helped to ensure the swift recovery of their patients and the quality of life they enjoyed whilst being within their care. This they claimed would also increase work force stability and ensure a high standard of nursing care and practice for their patients. The literature (Brocker, et al, 1997; Morgan and Hunt, 1994) also suggests that commitment, through trust, can reduce the likelihood of employees leaving the organisation and can ensure that they adhere to organisational requests and policies.

Openness, communication and self confidence were looked upon as benefits associated with trusting ones immediate superior in both Derriford and Mount Gould (the level and number who mentioned them as benefits varied within both organisations). This has also been confirmed in the literature on trust (Barnes, 1981; Butler and Cantell, 1984; Morgan and Hunt, 1994). Those interviewed within Derriford highlighted team work, confidentiality and greater continuity in fulfilling the aims and objectives of the organisation as benefits of trusting ones immediate superior. The literature on trust suggests that co-operation and functional conflict are benefits that can arise through the existence of trust based relationships (Morgan and Hunt, 1994).

The research findings have enabled the development of the following model (fig 1.5) of organisational and individual benefits that may be derived from the existence of trust

based relationships between nurses and their colleagues and immediate superiors.

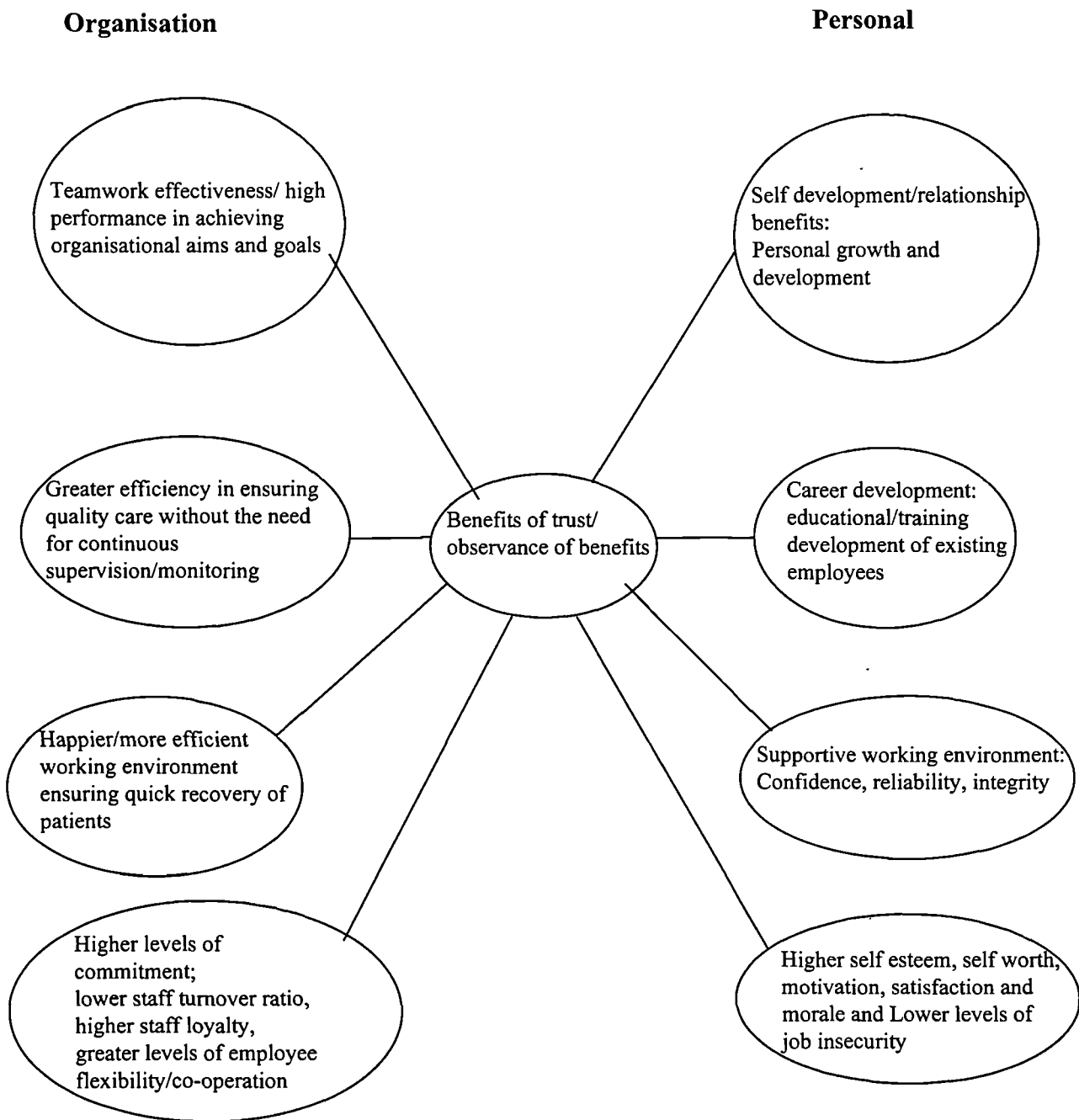


Fig. 1.6 Benefits of trusting ones superiors and colleagues within the two organisations

Level of commitment

R9 To what extent do NHS nursing staff demonstrate a high level of attitudinal commitment to the aims and objectives of Trust management ? :

The results from both the interviews and the questionnaires would suggest that nursing staff have a high level of attitudinal commitment towards the aims and objectives of their managers only in so far as they perceive them as being directly relevant to patient care and to the aims and objectives of professional nursing. The interviewees who claimed that they had a high level of attitudinal commitment towards the aims and objectives of the Trust in which they worked did so on the basis that they perceived their own aims and objectives as being compatible with those of their management, that of ensuring a high standard and a high quality of patient care. Thirteen interviewees within Derriford and eleven within Mount Gould claimed that their own aims and values were the same as those of their management and the organisation in which they worked. They claimed that nursing staff and hospital management both had the common aim of ensuring that their patients received high quality care (Anthony, 1990; Sable, 1993; Currie, 1996) and that nursing staff received optimum levels of training and career development. The interviewees within Mount Gould also spoke of employee involvement in the implementation of new systems.

Those who responded to the organisational commitment questionnaire showed a significantly higher level of commitment towards the aims and objectives of professional nursing compared to their level of commitment towards the organisation in which they worked. The results from the questionnaire surveys carried out within both organisations

would however also suggest that there is a level of compatibility between the professional commitments and organisational values of nursing staff e.g. the level of professional commitment within both organisations correlated with organisational values. The results from the interviews and the questionnaire surveys would therefore suggest that the majority of those interviewed carry out their tasks and duties with a belief in and acceptance of the organisation's goals and values (Mowday, Steers and Porter, 1979; Armstrong, 1991).

The results from the questionnaires showed that the respondents within both organisations could at best feel a medium/neutral level of commitment towards the organisation in which they worked. If as suggested within the interviews and the questionnaires, that nursing staff are indeed highly committed, in terms of their attitudes and behaviours, the evidence would also suggest that this can be mainly attributed to the high level of professional commitment amongst nursing staff within both organisations which proved to be significantly higher than their level of organisational commitment. The results from both the interviews and the questionnaires within both organisations would suggest that the level and the nature of the attitudinal commitment of nursing staff appears to have been shaped by the nature of the profession to which they belong to and not the organisation in which they work. What did however appear to be striking within both sets of questionnaires on commitment was the existence of a correlation between the level of professional commitment with the degree to which the interviewees cared about their managers and identified with their values. This would suggest that the respondents with a high level of professional commitment also cared about their managers and identified with their values because their managers were more inclined to having

professional values than managerial values i.e. Within Derriford the overall mean for the question which asked the respondents if their immediate superior had nursing training or experience was 4.50. This would suggest that the immediate superiors of the respondents are themselves clinicians or nurses which in turn could explain why nursing staff identify and care about the aims and values of their managers.

More nurses interviewed within Derriford than Mount Gould claimed that nursing staff were committed both to the organisation in which they worked and towards their daily tasks and duties. The interviewees highlighted the poor terms and conditions they received from hospital management as both a potential threat to their existing level of commitment and as evidence of their existing high level of vocational commitment towards patient care. They described the existence of high levels of team work and comradeship which they claimed enhanced the level of commitment amongst nursing staff towards their colleagues and their patients.

More interviewees within Mount Gould than Derriford claimed that there was a low level of commitment amongst nursing staff. Seven interviewees within Derriford and nine within Mount Gould claimed that their own aims and values were to some extent compatible or were not compatible at all with those of their management. The basis for limited and non compatibility between the aims and values of the interviewees with the aims and objectives of the organisation in which they worked mainly concerned the current financial and resource restrictions on the activities of nursing staff, staff shortages, increasing workloads, poor recruitment of vocationally committed nurses and the level of burn out experienced by senior and older nurses and the perception amongst nursing staff that management were introducing private sector business culture and

practice into the organisation (see Anthony, 1990; Stewart and Walsh, 1992). They claimed that such measures undermined their ability to deliver high quality patient care. The results from the interviews would suggest that staff shortages and increasing workloads do little to increase or maintain the level of commitment of nursing staff. This is also supported by the literature on employee relations within the NHS (Kelliher, 1995). The results from the questionnaires within both organisations showed that there was a medium level of commitment and a comparatively higher level of professional commitment amongst nursing staff within both organisations (see Anthony, 1990).

R10 To what extent do NHS nursing staff exhibit a high level of behavioral commitment towards managerial aims, objectives and values ?:

All twenty nurses interviewed within Derriford and sixteen interviewed within Mount Gould claimed that they could not carry out their work if they were not committed i.e. patient care, colleagues' etc. The interviewees spoke of the poor terms and conditions of employment, which they currently received as a reason why they could not do their work as nurses without being committed. They said that an essential part of being a professional nurse involved a commitment towards patient care. The responses to this question would also indicate that all the nurses interviewed within this organisation were themselves committed otherwise they would not have made this claim. This would suggest the existence of a link between the attitudinal commitment of nursing staff towards professional nursing and the resulting behavioural commitment towards their daily tasks and duties. The comments given by the interviewees above would suggest that there is a link between their level of attitudinal and behavioral commitment (Guest, 1989; Walton, 1985; Mowday, et al, 1979; Brocker, et al, 1997).

Fifteen interviewees within Derriford and seven within Mount Gould claimed that their attitudes towards managerial aims and objectives did not influence the level of effort they put into their work, again they attributed this to the strength of the commitment of nursing staff towards patient care. A significantly higher number of interviewees within Derriford therefore claimed that the level of effort they put into their work i.e. behavioral commitment, was not influenced by their attitudes towards managerial aims and objectives. The fact that the majority of those interviewed within both organisations claimed that they could not do their work without being committed i.e. looking after and

caring for the sick, would suggest that attitudinal commitment initiates the process and development of behavioral commitment and that behavioral commitment cannot take place until attitudinal commitment has occurred (see Guest, 1989; Mowday, et al, 1979; Walton, 1985; Brocker, et al, 1997). Again as mentioned previously the results from both the interviews and the two questionnaire surveys would suggest that the respondents level of behavioural commitment is derived as an outcome from their level of attitudinal commitment towards professional nursing and not to the organisation in which they work. Four interviewees within Mount Gould claimed that it was possible for nursing staff to do their work without being committed. They claimed that those who were not committed were those nurses who treated nursing just like 'any other job', by providing the basic level of care or they were existing nurses (who due to their length of service) had suffered burn out as they tended to do the minimum and failed to take any pleasure from the work they carried out within the organisation. The literature on commitment would also support the belief that attitudinal and behavioural commitment are linked and can maximise workforce performance (Walton, 1985; Brocker, et al, 1997; Mowday et al, 1978).

Thirteen interviewees within Mount Gould and five within Derriford claimed that the level of effort they put into their work could be influenced by their attitudes towards the aims and values of their managers, and the majority claimed that the aims and values of their managers could have a positive influence upon their level of behavioural commitment and as a result could make their efforts more fruitful and productive. The positive relationship between attitudinal and behavioural commitment is highlighted in the literature on employee commitment. The role played by employee involvement in

cultivating employee commitment is also supported by the literature reviewed (see O'creevy and Nicholson; Marchington, et al, 1992) which also suggests that employee commitment is linked to organisational performance (Walton, 1985; Mowday, et al, 1979; Brocker, et al, 1997) and that there is a link between employee attitudinal and behavioural commitment (see Guest, 1989). Those interviewees within Derriford who claimed that their attitudes towards organisational aims and objectives would influence their level of effort also claimed that if their career prospects and training requirements were not being addressed they would be inclined to put less effort into their work and maybe look for an alternative source of employment. They also claimed that if they perceived managerial aims and objectives in a negative way they would experience a decrease in their level of morale and motivation (see Winchester and Bach, 1995; Kelliher 1995).

The interviewees within Derriford highlighted career mobility as a factor which could positively influence their level of attitudinal commitment and subsequently determine their level of behavioral commitment. They also indicated that if the level of morale and motivation of other nurses was low it would affect their attitudes and how they behaved as nurses (see Wood, 1995; Black, 1999). The interviewees claimed that their level of behavioral commitment and workplace performance would decrease if managerial aims and objectives were perceived to be contrary to their own or were limiting their career prospects. It would seem therefore that the level of behavioral commitment amongst a significant minority of those interviewed is linked to their level of attitudinal commitment towards managerial aims and objectives. The results from the questionnaires would support these findings as they showed a high correlation between organisational

commitment and organisational values. This would suggest that, in the case of some nurses at least, the level of ones commitment to the organisation is related to the extent to which they identify and subscribe to the aims and values of the organisation itself.

The claims made by the interviewees would confirm the results from the questionnaire on organisational commitment which suggested that the commitment of the interviewees towards their profession was significantly greater than their commitment towards the organisation and its policies. As mentioned previously the interviewees highlighted the poor terms and conditions of employment for which they worked as evidence of their high level of commitment. In view of the fact that their terms and conditions of employment are an outcome of managerial policies, it would prove to some extent that nursing staff are indeed uninfluenced by managerial aims and objectives and the policies which follow on from them. The responses in general would indicate that the behavioral commitment of the interviewees is generally high and appears to remain independent from managerial aims and objectives. The fact that there was no correlation between organisational and professional commitment would also suggest that the two can exist separately. The level to which the interviewees cared about their managers and the extent to which they believed that their own values were shared with those of their managers correlated with their degree of professional commitment. This would suggest that professional commitment is linked with the degree to which the respondents cared about and identified with the values of their management. Professional commitment did not however show any correlation with the level of organisational commitment in either organisation.

R11 Describe and outline the motives/needs of NHS nursing staff:

The interviewees within Derriford and Mount Gould highlighted patient care, teamwork/colleagues and money (see Kelliher, 1995; Winchester and Bach, 1995) as the three top motives/ needs of nursing staff. As before patient care constituted the major source of motivation for many nurses, once again emphasising the interviewees high level of professional commitment (see Colling, 1997, Pratchett and Wingfield, 1995). Team work and professional camaraderie amongst nursing staff in pulling together to fulfill common goals came second. Those interviewed within Derriford spoke of having a vocational commitment towards nursing, patient care, team work, training and career progression. Within Mount Gould the interviewees spoke of being valued, respected, encouraged, having altruist values, teamwork, the NHS/public sector principles and empowerment through greater employee involvement as the main sources of attitudinal commitment. In terms of the motives of nursing staff those interviewed within Derriford outlined education, learning and status as motivations these were not however mentioned by those interviewed within Mount Gould.

Those interviewed within Derriford offered a more limited range of commitments but tended to mention them more frequently. The responses within Derriford appeared to be more precise and consistent with each other in contrast to the responses given by the interviewees within the Mount Gould sample which tended to be more varied. Unlike those interviewed within Derriford the interviewees within the Mount Gould sample spoke of the need of feeling valued. Feeling valued was also the most frequently mentioned factor in the previous question relating to the sources of attitudinal

commitment. The fact that this was not mentioned by the interviews within Derriford would suggest that either there is a greater need to feel valued amongst the interviewees within Mount Gould i.e. because of the nature of the patients they have to deal with, or that they don't feel that they are being valued enough for the work they are currently doing.

As mentioned above the nature of the motives of nursing staff within the two organisations seem to reflect the nature of the organisations in which they work and the professional group to which they belong (see Coopey and Hartley, 1991; Hayward and Fee, 1992). As mentioned earlier the results of the questionnaires highlight the dominance of professional commitments in the working lives of nursing staff. As can be seen the nature of employee commitment is unique within both NHS organisations. When we consider organisational commitment it has been suggested that the nature of the organisation in which the employees work should be considered and taken into account (Sable, 1993; Currie, 1996; Anthony, 1990; Coopey and Hartley, 1991). NHS organisations employ a wide range of employee groups and have traditionally operated along the lines of a public service ethos (see Walsh, 1995; Colling, 1997). While it is important to consider the NHS organisation under study it is also important to bring into account the nature of the profession of the employee, as they may experience dual and competing commitments between the profession to which they belonged to and the organisation in which they work (Hayward and Fee, 1992).

The responses offered by the interviewees showed a high level of consistency and overlap amongst the questions relating to employee attitudinal and behavioural commitment and the motives/needs of nursing staff. This would suggest that all three are linked.

R12 To what extent are the aims and values of nursing staff being fulfilled within their current working environment ?:

Twelve interviewees within Derriford and thirteen within Mount Gould responded positively when asked about the extent to which their own personal aims and values were currently being fulfilled within their working environment.

They claimed that they were receiving the right amount of education, training and development which was helping them to fulfil their career prospects (see Wood, 1995; Black, 1999). They also claimed that their level of job satisfaction was high because they were able to deliver high quality patient care and had the resources to do so (see Wood, 1995; Black, 1999) and that in some cases they had been given quasi managerial/nursing roles and felt a greater level of involvement as a result (O'Creevy and Nicholson, 1994; Marchington, et al, 1992). The nature of the responses to this question are consistent with the findings on the level of attitudinal commitment. This would suggest that there is a link between the extent to which the interviewees identify with the aims and objectives of the organisation in which they work with their level of behavioural commitment (Mowday, Steers and Porter, 1979).

Eight interviewees within Derriford and seven within Mount Gould claimed that their own aims and objectives were only partially fulfilled within their current working environment or were not being fulfilled at all. The interviewees claimed that this was due to resource restrictions, lack of promotion prospects and lack of involvement within their organisations decision making processes.

Throughout the course of these interviews resource restrictions were repeatedly highlighted as a major bone of contention amongst nursing staff. The interviewees also

highlighted the importance of career development/mobility and training as something which fulfills them if it is present or demotivates them if it is absent. As mentioned previously the results from the questionnaires within both organisations showed a disproportionately higher level of commitment towards professional nursing as opposed to that of the organisation. The literature reviewed also highlights the depth and the purpose of the traditional public service of many public sector employees and its importance within the workplace and the different cultures and groups of workers within the health service (Colling, 1997; Currie, 1996; Anthony, 1990)

R13 What are the professional commitments of nursing staff ?:

All forty nurses interviewed within Derriford and Mount Gould described patient care as the main aim of professional nursing and described different aspects and sub components of patient care which supported and reinforced the development of high standards of nursing care and practice. Given the central role of the patient within the psyche of professional nursing it is easy to see how anything which is perceived as threatening to the ability of nursing staff to administer high quality patient care would be met with a hostile response i.e. resource cuts (see Anthony, 1990; Newton and Hunt, 1997).

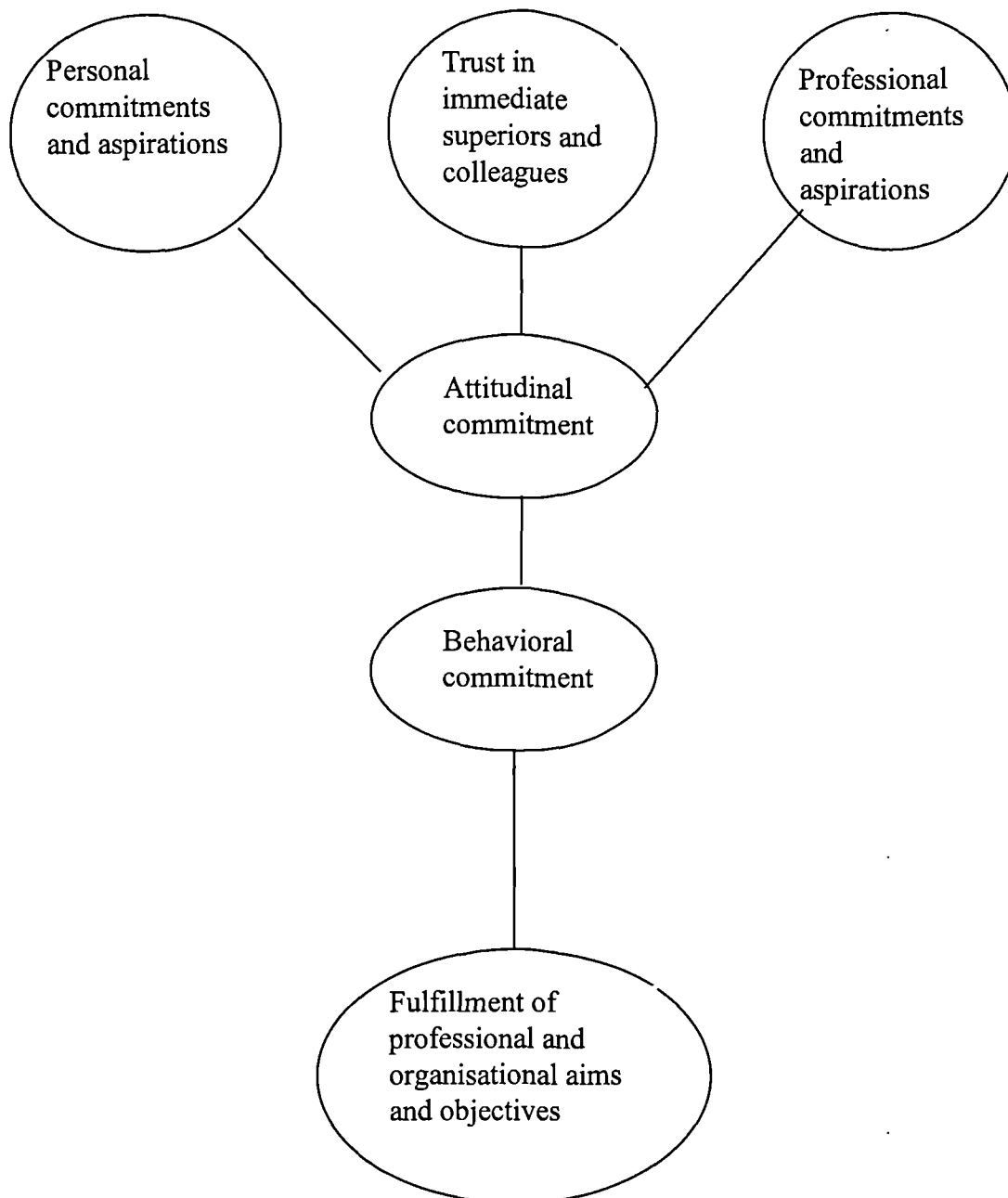
Within Derriford the interviewees mentioned research based care, a positive attitude towards caring and informing patients. Despite the differences in emphasis upon similar themes (which may reflect the different nature of the treatments offered by the two organisations) it would however seem that these are all practices designed to support the implementation and realisation of high quality patient care. Both groups of interviewees made an explicit reference to research centered care. The interviewees within Mount Gould spoke of ensuring and maintaining the quality of the patient's life, this was not mentioned by those interviewed within Derriford. This response could reflect differences in the nature of the patients and illnesses dealt with by the two organisations (Coopey and Hartley, 1991). As mentioned previously Mount Gould caters for those with chronic and long term illnesses which could be incurable and terminal i.e. dementia, this could explain why the focus would shift towards the quality of the patients life.

The interviewees within Derriford also mentioned support for ones fellow nurses/ colleagues, professional accountability and adherence to occupational standards.

While the interviewees within Mount Gould also mentioned support for their patients and their family and teamwork.

The following model (fig. 1.7) illustrates the various inputs and the factors which can influence the attitudinal commitment of nursing staff within the two organisations studied. The model also illustrates how attitudinal commitment is linked to behavioural commitment and how the behavioural commitment of nursing staff acts to ensure the fulfillment of the aims and objectives of the organisation itself.

Fig. 1.7 Trust and attitudinal and behavioural commitment



R14 Is there a disparity between the aims and objectives of management with the aims, objectives and aspirations of NHS nursing staff ?:

As mentioned previously the evidence from both the interviews and the questionnaires carried out within Derriford and Mount Gould would clearly show that patient care, teamwork and professional competence featured highly as factors contributing to the development of trust, as characteristics of trustworthy managers, sources of attitudinal commitment and motives of nursing staff. All forty nurses outlined patient care as the central aim of the nursing profession. When asked if they ever experienced conflict between their professional commitments and those of the organisation in which they worked seventeen interviewees within Derriford and eleven within Mount Gould claimed that they did. Those interviewed within both organisations spoke of the lack of resources i.e. staff shortages, lack of specialist equipment etc which they claimed curtailed their ability to deliver quality patient care. They also claimed that the lack of resources meant that they were constantly being overstretched and as a result were being prevented from pursuing their own personal training and education. This they claimed restricted their ability to administer holistic patient care. The interviewees criticised what they perceived as the current objective being pursued by hospital management of administering 'conveyer belt' care with the primary objective of reducing hospital waiting lists. As a result the interviewees they claimed that the policies currently being pursued by their managers were not in the best interests of the patients within their care (see Anthony, 1990; Stewart and Walsh, 1992; Walsh, 1995).

The interviewees highlighted resource restrictions and the introduction of 'private sector' management practices and styles into the service as the basis for the conflict between the

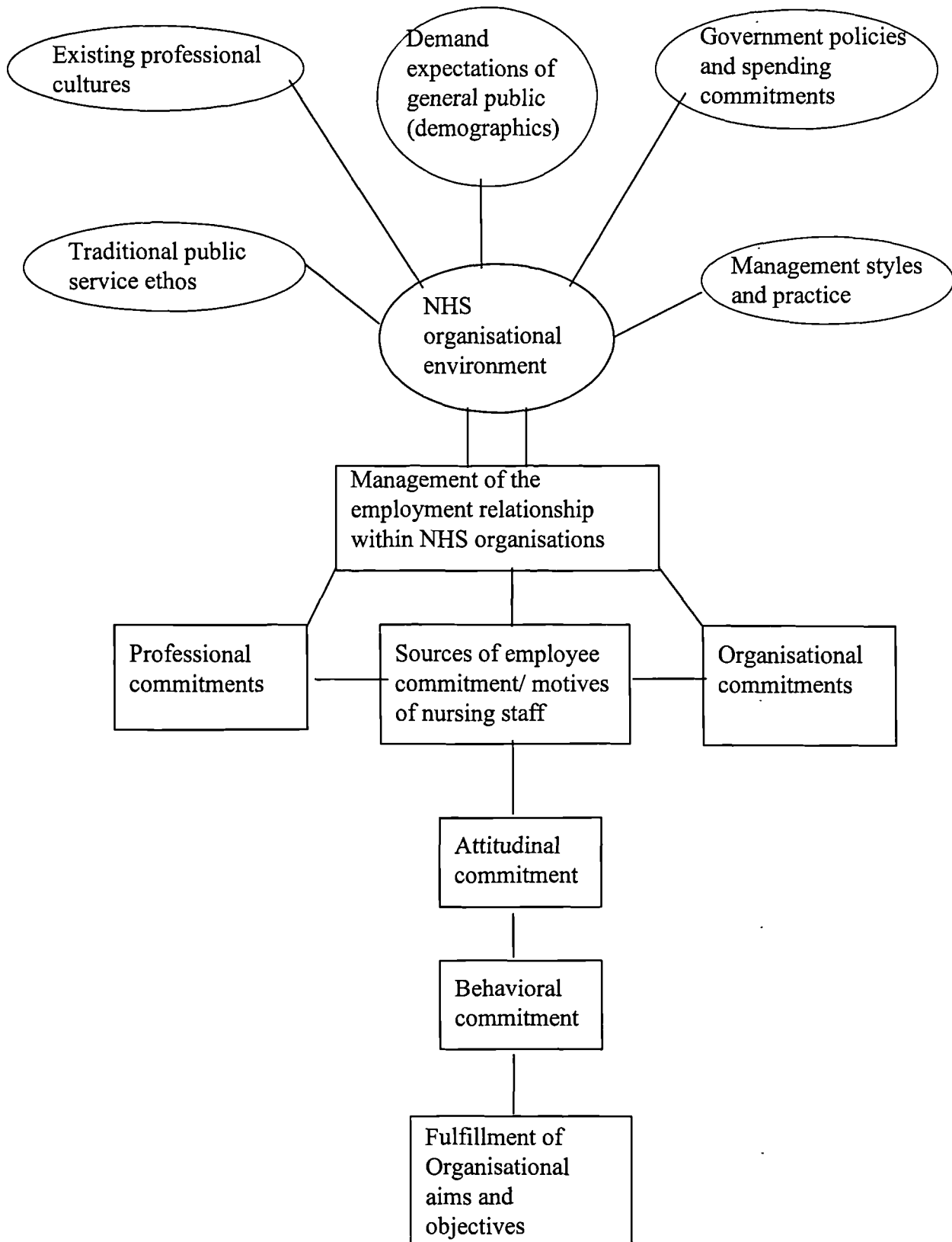
professional and organisational commitments of nursing staff. The results from the interviews would therefore show that a significant majority (more so within Derriford) of interviewees within both organisations, experienced a conflict between their organisational and their professional commitments. As mentioned above the results from the questionnaires showed that the level of professional commitment amongst the respondents was significantly higher than their level of commitment towards the organisation in which they worked.

Three interviewees within Derriford and nine within Mount Gould claimed that their professional commitments did not conflict with those of the organisation in which they worked and that the aims and objectives of the organisation in which they worked were compatible with their own, mainly that of delivering high quality patient care. Within Mount Gould five out of the nine interviewees who claimed that their professional commitments did not conflict with those of the organisation did however concede that the aims and objectives of the organisation very often made their professional commitments harder to fulfill i.e. training and development, implementing high standards of nursing care etc. The results from the questionnaires suggested that the respondents within Mount Gould experienced a slightly higher level of professional commitment than their counterparts within Derriford.

This would therefore suggest the existence of a clash between the professional and organisational commitments of nursing staff within both organisations. The depth of this clash would appear to be much greater within Derriford than it is Mount Gould. The literature on employee commitment does suggest the possibility of competing/dual commitments amongst nursing staff (see Hayward and Fee, 1992).

The following is a model depicting the nature of the attitudinal and behavioral commitment within the context of the two NHS organisations studied (see fig. 1.8). The model highlights the various influences upon the organisational environment of the NHS i.e. existing professional cultures, government policies and spending commitments etc. The organisational environment of the NHS is in turn is linked to the management of the employment relationship within NHS organisations. The sources and motives of nursing staff are in turn influenced by how they are managed and their professional and organisational commitments. These in turn (in varying degrees) influence the nature and the level of attitudinal commitment which determines their level of behavioural commitment either to their profession, their patients, the organisation and indeed a combination of all three. The level and the nature of the behavioural commitment of nursing staff in turn determines the extent to which the aims and goals of the organisation are fulfilled (Brockner, et al, 1997; Mowday, et al, 1978).

Fig.1.8 Environmental factors influencing the development of employee attitudinal and behavioural commitment



R15 Does the level of attitudinal/behavioral commitment amongst nursing staff have a relationship with the extent to which they trust their immediate superiors ?:

The analysis of the interviews carried out within Derriford would suggest that the level of commitment amongst nursing staff was more or less the same as the extent to which they trusted their immediate superiors but proved to be higher than the degree to which they trusted their managers in general (Butler, 1991). The results taken from the interviews carried out within Mount Gould would suggest that the level of trust amongst nursing staff in their immediate superiors was slightly higher than their level of organisational commitment. The interviewees within Derriford and Mount Gould who claimed that either there was a high level of trust within their organisation or that nursing staff had a high level of trust in their immediate superiors also claimed that nursing staff were highly committed both to the organisation and towards their daily tasks and duties. Of the fifteen interviewees who said that they did trust their immediate superior eleven claimed that they had a high/medium level of commitment to both the organisation and the work they carried out within it.

Again this would suggest that trust and commitment are linked (Guest, 1989; Brockner, et al, 1997). Given the absence of a questionnaire on trust within the Mount Gould survey the level of trust and commitment amongst nursing staff could not be compared in the same way as it was within Derriford. The research carried out within both organisations would indicate that high trust relations amongst nursing staff and their immediate superiors can strengthen the level of attitudinal commitment and low trust relations can weaken the level of attitudinal commitment amongst nursing staff. In a situation where there is a low degree of trust the results from the interviews would suggest that the level

of staff turnover, absenteeism and stress upon the wards would increase. The results from the questionnaires, on trust and commitment, within Derriford, showed a correlation between the level of commitment with the degree to which the respondents trusted their immediate superiors. The degree to which the respondents trusted their immediate superiors also showed a high correlation, with the extent to which they perceived their immediate superiors as acting in ways which indicated and suggested that they both valued and trusted nursing staff and were committed towards nursing staff and patients. Organisational commitment also proved to have a high correlation with the extent to which the respondents were committed to the organisation in which they worked with the degree to which they cared about their managers and shared their values. The evidence would not only highlight the relationship trust has with commitment but it would also highlight the reciprocal nature of both trust and commitment amongst nursing staff and their managers. Sable (1993) and Morgan and Hunt (1994) highlight shared values as a contributing factor to the development of trust based relations.

The majority of the interviewees within both organisations claimed that they trusted their immediate superiors but were not however prepared to trust hospital/Trust management (in general) to the same extent. This would confirm Butler (1991) and Orbell, et al's (1994) analysis that trust in specific individuals is of greater importance in determining its outcome as opposed to that of trusting groups or categories of people.

The analysis of the data taken from the questionnaire survey carried out within Derriford revealed a high correlation between the level of trust amongst the respondents with the extent to which they perceived their immediate superior to be committed towards nursing staff and patient care. The level of commitment amongst the respondents correlated with

the extent to which they cared about and shared their managers aims and values, the extent to which they perceived their immediate superiors as having integrity, loyalty and the degree to which they both trusted and valued nursing staff. Out of all the subsets within the original questionnaire on trust (subsets from the original questionnaire on trust, designed by Butler, 1991), integrity and loyalty showed to have the highest correlation with the level of commitment of the respondents. Again this would illustrate the reciprocal nature of both employee commitment and high trust relations (Robinson, 1996; Kramer 1999; Brockner et al, 1997).

R16 Is there a disparity between the level of trust and commitment amongst nursing staff within the acute and the community sector organisations involved within this investigation ?:

While the level of trust amongst nursing staff and their immediate superiors proved to be similar within both organisations, the evidence from both the interviews and the questionnaires would however suggest that the general level of trust within the working environment of nursing staff was higher within Derriford than it was within Mount Gould.

A higher number of interviewees within the Derriford sample were prepared to share information of a personal nature with their colleagues and their immediate superiors. This would suggest that the interviewees within the Mount Gould were generally less trusting of their immediate superiors than their counterparts within Derriford. Ironically however a significantly higher number of interviewees within Mount Gould as opposed to Derriford felt that their managers did indeed trust nursing staff. As mentioned previously

the literature on trust suggests that in order for trust based relations to take place it must be reciprocated between the individuals involved (Robinson, 1996; Kramer, 1999; Brockner et al, 1997). It is therefore unusual that the interviewees within Mount Gould were less willing to trust their managers but felt that their managers trusted them.

On the issue of characteristics of trustworthy managers the results from the Derriford and the Mount Gould samples proved to be similar, the main difference between the responses given by the two groups of interviewees would concern the degree of emphasis given to certain qualities and factors over that of others. Both groups of interviewees outlined similar characteristics of trustworthy managers and conditions required for the development of trust in different orders.

The scope and the range of benefits associated with trusting ones immediate superior tended to be much more wide ranging amongst those interviewed within Derriford compared to their counterparts within Mount Gould. The respondents within Derriford gave more detailed answers to questions relating to the benefits of trust based relations and outlined a wider range of benefits associated with trust in ones immediate superior (This is in contrast to those interviewed within Mount Gould who gave a more limited number of benefits but mentioned them in greater numbers).

More nurses interviewed within Derriford than Mount Gould claimed that nursing staff were committed both to the organisation in which they worked and towards their daily tasks and duties. A significantly higher number of interviewees within Derriford also claimed that the level of effort they put into their work i.e. behavioral commitment, was not influenced by their attitudes towards managerial aims and objectives. This was attributed to the strength of the commitment of nursing staff towards patient care. The

results from both the interviews and the questionnaire surveys would suggest that the level of commitment, both behavioural and attitudinal, is higher within Derriford than it was within Mount Gould.

When describing the sources of attitudinal commitment and the motives and needs of nursing staff those interviewed within Derriford offered a more limited range of commitments but tended to mention them more frequently. In comparison with the responses given by the interviewees within the Mount Gould the responses offered by the interviewees within Derriford appeared to be more precise and consistent. The interviewees within Mount Gould spoke of ensuring and maintaining the quality of the patient's life, this was not however mentioned by those interviewed within Derriford. As mentioned previously the differences in the responses given by the interviewees and the respondents to the questionnaires within the two organisations could be attributed to the nature of the organisation in which the respondents and the interviewees work and the particular type of patients which the two organisations cater for. The literature on commitment would also highlight the importance of organisational context when examining employee commitment (Coopey and Hartley, 1991).

In general the level of trust and commitment seemed to be higher within Derriford than it was within Mount Gould. While carrying out the research within Mount Gould the organisation was undergoing a considerable level of change i.e. ward closures, organisational restructuring etc. The fact also that the second questionnaire, Butler's questionnaire on trust, 1991, had to be omitted from the survey at the request of the nursing staff manager would indicate that trust between nursing staff and their management/immediate superiors was a sensitive issue at the time could also explain the

comparatively lower level of trust shared amongst the interviewees within Mount Gould in comparison with their counterparts within Derriford.

Limitations

This project looked at two organisations, one an acute sector Trust and the other a community sector Trust, within the NHS. The findings of this research are limited to them and cannot be extrapolated to make judgments on the nature and the level of trust and commitment amongst nursing staff within NHS organisations throughout the rest of the UK. In order to fulfill the aims and objectives of this research project both qualitative and quantitative research methods were used.

Both questionnaires used, on trust and commitment, have been tested and recognised as sound investigative tools in assessing the level of employee trust and commitment. Additional questions were inserted into the questionnaire on commitment which sought to measure the level of commitment of nursing staff towards their profession. Additional questions were also inserted into the questionnaire on trust in order to assess the degree to which the interviewees perceived their managers valuing and trusting nursing staff and degree to which they perceived their managers as being committed towards nursing staff and the patients within their care (research carried out on trust and commitment would suggest that in order for trust and commitment to be established they must be reciprocated by the individuals involved, Morgan and Hunt, 1994). The research on trust and commitment has suggested that individuals will only commit themselves to relationships where they perceive the other person as being trustworthy (Morgan and Hunt, 1994). The respondents were also asked whether or not their managers had previous nursing training and experience (in order to assess if they trusted those managers with nursing training and experience more so than those who did not), they were also asked whether or not they trusted managers in general (as opposed to the original

questionnaire which sought to establish whether or not they trusted their immediate superior).

The intention of these additional questions was to address issues which would have not been addressed had the respondents just been given the two original questionnaires. The additional questions may therefore reflect the peculiarities of the organisations studied, the professional group that would have received them and the nature of the work they carried out within the organisation. Unlike the two original questionnaires on trust and commitment these additional questions have not been thoroughly tested or vetted by independent sources prior to their dispatch. It should therefore be kept in mind that they represent an attempt to address issues related to the particular organisational setting and occupation of the respondents which would not have been taken into account by the two original questionnaires.

As can be seen earlier (within the methodology chapter) the nursing staff manager within Mount Gould community Trust did not grant permission for the use of the questionnaire on trust, as she felt that, at the particular point in time when the research was being carried out, it would have proved 'too sensitive'. I was therefore unable to triangulate data from the interviews on trust with the data on the questionnaires on trust between the two organisations. The data collected on trust within Mount Gould is therefore solely reliant on the interviews.

Another limitation of the questionnaire survey concerned that of the sample sizes and the rate of responses from the two organisations involved. Although the use of more sophisticated statistical techniques were considered, given the fact that the sample sizes were considerably small, the use of such techniques was deemed inappropriate.

The methods used for the purposes of fulfilling the aims and objectives of this research project have their drawbacks and limitations however the use of multi-method research was considered as the most effective way of building upon the strengths and the merits of particular research methods while simultaneously canceling out or at least reducing their weaknesses (see methodology chapter). The main purpose of carrying out the interviews was to explore and assess the level and the sources of trust and commitment amongst nursing staff within Derriford and Mount Gould. The purpose of the questionnaires on trust and commitment was to measure and assess the level of trust and commitment amongst a larger body of nursing staff within the two organisations (by measuring a number preset factors and variables of trust and commitment).

Another potential limitation of this research could be the extent to which the Morgan and Hunt (1994) model has been referred to and used as a conceptual framework when looking at trust and commitment. Originally used for relationship marketing between organisations and their customers the antecedents and the basis of this model does borrow heavily from concepts from the social and behavioral sciences. It was therefore felt that given the nature of this research i.e. values between managers and nursing staff, that it was an appropriate point, amongst others (i.e. Butler, 1991; Zand, 1972; Barnes 1991, Broucker, et al, 1997; Kramer, 1999), of comparison with the level of trust and commitment of nursing staff within NHS organisations.

One other possible limitation of this research concerns that of looking at who the managers of nursing staff within the NHS are. This issue was addressed within the questionnaire on trust however it was discovered during the course of the research that the immediate superiors of nursing staff very often tend to be nurses themselves. Those

managers higher up the organisational hierarchy do however tend to be managers in the traditional sense. It was for this reason that other questions were encompassed within the questionnaire on trust i.e. whether nursing staff trust 'management' in the general sense, such as those clearly identified as management in the traditional/private sector mould i.e. 'men in gray suits'.

Scope for further research

This study explored trust and commitment amongst nursing staff and their immediate superiors and their managers. It also explored the nature and the level of attitudinal and behavioural commitment amongst nursing staff.

As a way of making the study more comprehensive NHS managers and the superiors of nursing staff could also have been included i.e. whether or not managers trusted nursing staff. Thus a future study could explore the characteristics and the conditions necessary in order for trust to develop, from the point of view of NHS managers and supervisors, with NHS nursing staff. Similar research methods and techniques, used within this study, could be used to explore how NHS managers, and the immediate superiors of nursing staff, both defined trust and the benefits of trust based relations between themselves and nursing staff. Further research could also explore the nature of the attitudinal and behavioural commitments of NHS managers and the immediate superiors of nursing staff i.e. career progression, fulfillment of performance targets etc. The outcomes of such research could then be compared with the findings within this study which would help to establish the importance of trust amongst NHS managers and the immediate superiors of nursing staff and whether or not they defined and conceptualised the benefits of trust in

the way as that other professional groups within the NHS. The scope of such a study would also establish whether or not nursing staff and NHS managers (both lay managers and NHS clinicians) felt committed towards the same ideals and values. Such a study would help further the level of understanding between the nature and the level of trust and commitment between nursing staff and their managers. The study could also involve additional research in attempting to establish the basis for best practice in establishing high trust based relations between managerial and professional groups within NHS organisations. This could be achieved by conducting focus groups between nursing staff and NHS managers with the objective of outlining the basis upon which high trust based relations could be established within a hospital/community based Trust environment. The findings from the focus groups would then be used to inform a set of measures and guidelines for NHS managers, which would then be implemented i.e. weekly meetings between NHS managers and nursing staff. A participant observation exercise could then be used to assess the effectiveness of such measures in helping establish trust-based relations between managers and nursing staff. The outcomes of such research could then be used to provide and offer an example of best practice for other NHS organisations within the U.K.

Another area for further research could involve exploring and highlighting similarities and differences between middle/senior management within NHS and private health care organisations. Although explored within the literature in the guise of public sector management and current management practices within the NHS a more in-depth comparative study could be carried out between managers and directors within NHS and

private sector health care organisations. This would act as a much more focused study into the main similarities and approaches of current managerial practices within the NHS with their counterparts within the private sector. An appropriate suggestion could be to carry out research in a contemporary NHS acute sector organisation such as Derriford hospital with a modern private sector health care organisation i.e. BUPA organisation, whereby the focus of the study would look into the nature of the managerial styles and practices used within both organisations. The investigative tools used in this research could consist of in-depth/semi-structured interviews and the use of questionnaire surveys amongst middle and senior level management within private and public health care organisations. The second prong of the research project could involve looking at the nature of employee trust and commitment by carrying out research on the nature of trust and commitment amongst employees within both organisations in order to search for any differences and similarities. The outcome of the findings could then be related to the various management styles used within the two organisations which would highlight growing trends within NHS organisations which could suggest, as has been alleged within this research, of a move towards a much more private sector style and orientation of management within NHS organisations.

Another potential area for further research could involve looking at professionalism and the culture of professionalism amongst nurses, doctors and other medical staff within these public and private health care organisations and examine them in terms of their level of professional verses organisational commitment. The aim would be to examine the effects of the progressive marketisation of health care organisations upon the occupational and professional groups working within them and to examine whether or not

professional aims and objectives can be reconciled with those of the growing trend (as has being alleged) towards private sector management styles and practice. It would also be interesting to look at any synergy's that can occur between the two within the context of trust based relations between managers and employees/professional groups and their commitment towards organisational aims and objectives as well as those of the profession to which they belong.

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Appendices

Appendix One

EMPLOYEE COMMITMENT & TRUST SURVEY

PART A: COMMITMENT

The purpose of the first part of the survey is designed to measure the level to which an employee feels committed to the organisation in which they work.

Please circle the appropriate number (where 1 = strongly disagree through to 5 = strongly agree) to describe your level of commitment.

	Strongly Disagree	Neither Agree/Nor Disagree	Strongly Agree		
1 I am willing to put in a great deal of effort beyond that normally expected in order to help this organisation to be successful	1	2	3	4	5
2 I talk positively about this organisation to my friends as a great organisation to work for	1	2	3	4	5
3 I feel very little loyalty to this organisation ®	1	2	3	4	5
4 I would accept almost any type of job assignment in order to keep working for this organisation	1	2	3	4	5
5 I find that my values and the organisation's values are very similar	1	2	3	4	5
6 I am proud to tell others that I am part of this organisation	1	2	3	4	5
7 I could just as well be working for a different organisation as long as the type of work was similar ®	1	2	3	4	5
8 This organisation really inspires the very best in me in the way of job performance	1	2	3	4	5
9 It would take very little change in my present circumstances to cause me to leave this organisation ®	1	2	3	4	5

	<i>Strongly Disagree</i>	<i>Neither Agree/Nor Disagree</i>	<i>Strongly Agree</i>		
10 I am extremely glad that I chose this organisation to work for over others I was considering at the time I joined	1	2	3	4	5
11 There is not too much to be gained by sticking with this organisation indefinitely ®	1	2	3	4	5
12 Often, I find it difficult to agree with this organisation's policies on important matters relating to its employees ®	1	2	3	4	5
13 I really care about the fate of this organisation	1	2	3	4	5
14 For me this is the best of all possible organisations for which to work	1	2	3	4	5
15 Deciding to work for this organisation was a definite mistake on my part ®	1	2	3	4	5
16 I care for the patients I look after within the organisation	1	2	3	4	5
17 I care about the other nurses I work with within this organisation	1	2	3	4	5
18 I care about the aims and objectives of the nursing profession	1	2	3	4	5
19 I care about the management of this organisation and their aims and objectives	1	2	3	4	5
20 I think that my own values are also shared by the management of this organisation	1	2	3	4	5

PART B: TRUST

Here are some statements that describe how you might feel about your **immediate superior** i.e. ward manager, directorate manager etc. Keep this person in mind as you respond to the following questions as your answers should refer to the same person. Please circle the appropriate number (where **1** = strongly disagree through to **5** = strongly agree) to describe your level of trust.

	<i>Strongly Disagree</i>	<i>Neither Agree/Nor Disagree</i>	<i>Strongly Agree</i>		
AVAILABILITY					
21 He/she is usually around when I need him/her	1	2	3	4	5
22 I can find him/her when I want to talk with him/her	1	2	3	4	5
23 It's usually hard for me to get in touch with him/her	1	2	3	4	5
24 He/she is available when I need him/her	1	2	3	4	5
COMPETENCE					
25 He/she does things competently	1	2	3	4	5
26 Unfortunately, he/she does things poorly	1	2	3	4	5
27 He/she performs his/her tasks with skill	1	2	3	4	5
28 He/she does things in a capable manner	1	2	3	4	5
CONSISTENCY					
29 He/she does things consistently from one time to the next	1	2	3	4	5
30 He/she does the same thing every time the situation is the same	1	2	3	4	5

	<i>Strongly Disagree</i>		<i>Neither Agree/Nor Disagree</i>		<i>Strongly Agree</i>
31 He/she behaves in a consistent manner	1	2	3	4	5
32 I seldom know what he/she will do next	1	2	3	4	5

DISCRETNESS

33 He/she keeps secrets that I tell him/her	1	2	3	4	5
34 He/she talks too much about sensitive information that I give him/her	1	2	3	4	5
35 If I give him/her confidential information, he/she keeps it confidential	1	2	3	4	5
36 He/she does not tell others about things if I ask that they be kept secret	1	2	3	4	5

FAIRNESS

37 He/she treats me fairly	1	2	3	4	5
38 He/she treats others better than he/she treats me	1	2	3	4	5
39 He/she always gives me a fair deal	1	2	3	4	5
40 He/she treats me on an equal basis with others	1	2	3	4	5

INTEGRITY

41 He/she always tells me the truth	1	2	3	4	5
42 He/she would not lie to me	1	2	3	4	5
43 He/she deals honestly with me	1	2	3	4	5
44 Sometimes he/she does dishonest things	1	2	3	4	5

	<i>Strongly Disagree</i>	<i>Neither Agree/Nor Disagree</i>	<i>Strongly Agree</i>		
LOYALTY					
45 He/she would not do anything to make me look bad	1	2	3	4	5
46 He/she is likely to take advantage of me	1	2	3	4	5
47 If I make a mistake, he/she will not use it against me	1	2	3	4	5
48 I can discuss problems with him/her without having the information used against me	1	2	3	4	5
OPENESS					
49 He/she tells me what he/she is thinking	1	2	3	4	5
50 He/she tells me what's on his/her mind	1	2	3	4	5
51 He/she shares his/her thoughts with me	1	2	3	4	5
52 He/she keeps information from me	1	2	3	4	5
OVERALL TRUST					
53 Sometimes I can not trust him/her	1	2	3	4	5
54 I can count on him/her to be trustworthy	1	2	3	4	5
55 I feel that he/she can be trusted	1	2	3	4	5
56 I trust him/her	1	2	3	4	5
PROMISE FULFILMENT					
57 He/she follows through on promises made to me	1	2	3	4	5

58	Keeping promises is a problem for him/her	1	2	3	4	5
59	If he/she promises something to me, he/she will stick to it	1	2	3	4	5
60	He/she does things that he/she promises to do for me	1	2	3	4	5

RECEPTIVITY

61	He/she readily takes in my ideas	1	2	3	4	5
62	He/she really listens to me	1	2	3	4	5
63	He/she often fails to listen to what I say	1	2	3	4	5
64	He/she makes an effort to understand what I have to say	1	2	3	4	5
65	I feel that he/she trusts us as a group	1	2	3	4	5
66	He/she is more concerned with organisational budgets and finances than they are about staff	1	2	3	4	5
67	He/she is very committed to the patients we serve	1	2	3	4	5
68	He/she values nursing staff and hospital employees	1	2	3	4	5
69	He/she has had previous nursing experience and training	1	2	3	4	5

ORGANISATIONAL MANAGEMENT IN GERNERAL

70	I believe that my manager should have previous nursing experience and training	1	2	3	4	5
71	I think that a good nurse can make a good manager	1	2	3	4	5
72	I think that the interest of managers and nursing staff are compatible and work hand in hand	1	2	3	4	5
73	I think nursing staff in general trust the management of this organisation	1	2	3	4	5

PART C: PERSONAL INFORMATION

The purpose of this section is to enable us to analyse whether age, length of service and/or grade influence responses to the questionnaire and perception of trust and commitment.

74	Which age bracket do you fall into?	Below 20 <input type="checkbox"/>	21-25 yrs <input type="checkbox"/>	26-30 yrs <input type="checkbox"/>	31-35 yrs <input type="checkbox"/>	36-40 yrs <input type="checkbox"/>	41-50 yrs <input type="checkbox"/>	51- 60 yrs <input type="checkbox"/>	60+ yrs <input type="checkbox"/>
75	Period of time spent working within this organisation	Less than 1 year <input type="checkbox"/>	Between 1-3 years <input type="checkbox"/>	Between 4-10 years <input type="checkbox"/>	Between 11-20 yrs <input type="checkbox"/>	Between 21-30 yrs <input type="checkbox"/>	Between 31-40 yrs <input type="checkbox"/>	Over 40 yrs <input type="checkbox"/>	
76	Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>						

- 77 Your current position is
- 78 Your current grade is

Please return the completed survey using the
ENCLOSED FREEPOST ENVELOPE
Thank you for your assistance in this project.

If you have any questions and/or require further information about this project, please do not hesitate to contact:
Mr T J McCabe, University of Plymouth Business School, Drake Circus, Plymouth PL4 8AA (Tel: 01752 232850; Fax: 01752 232493)

EMPLOYEE COMMITMENT SURVEY

PART 4: COMMITMENT

The purpose of the first part of the survey is designed to measure the level to which an employee feels committed to the organisation in which they work.

Please circle the appropriate number (where 1 = strongly disagree through to 5 = strongly agree) to describe your level of commitment.

	Strongly Disagree	Neither Agree/Nor Disagree	Strongly Agree		
1 I am willing to put in a great deal of effort beyond that normally expected in order to help this organisation to be successful	1	2	3	4	5
2 I talk positively about this organisation to my friends as a great organisation to work for	1	2	3	4	5
3 I feel very little loyalty to this organisation ®	1	2	3	4	5
4 I would accept almost any type of job assignment in order to keep working for this organisation	1	2	3	4	5
5 I find that my values and the organisation's values are very similar	1	2	3	4	5
6 I am proud to tell others that I am part of this organisation	1	2	3	4	5
7 I could just as well be working for a different organisation as long as the type of work was similar ®	1	2	3	4	5
8 This organisation really inspires the very best in me in the way of job performance	1	2	3	4	5
9 It would take very little change in my present circumstances to cause me to leave this organisation ®	1	2	3	4	5

	<i>Strongly Disagree</i>	<i>Neither Agree/Nor Disagree</i>	<i>Strongly Agree</i>		
10 I am extremely glad that I chose this organisation to work for over others I was considering at the time I joined	1	2	3	4	5
11 There is not too much to be gained by sticking with this organisation indefinitely ®	1	2	3	4	5
12 Often, I find it difficult to agree with this organisation's policies on important matters relating to its employees ®	1	2	3	4	5
13 I really care about the fate of this organisation	1	2	3	4	5
14 For me this is the best of all possible organisations for which to work	1	2	3	4	5
15 Deciding to work for this organisation was a definite mistake on my part ®	1	2	3	4	5
16 I care for the patients I look after within the organisation	1	2	3	4	5
17 I care about the other nurses I work with within this organisation	1	2	3	4	5
18 I care about the aims and objectives of the nursing profession	1	2	3	4	5
19 I care about the management of this organisation and their aims and objectives	1	2	3	4	5
20 I think that my own values are also shared by the management of this organisation	1	2	3	4	5

PART B: PERSONAL INFORMATION

The purpose of this section is to enable us to analyse whether age, length of service and/or grade influence responses to the questionnaire and perception of trust and commitment.

21	Which age bracket do you fall into?	Below 20	21-25 yrs	26-30 yrs	31-35 yrs	36-40 yrs	41-50 yrs	51-60 yrs	60+ yrs
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Period of time spent working within this organisation	Less than 1 year	Between 1-3 years	Between 4-10 years	Between 11-20 yrs	Between 21-30 yrs	Between 31-40 yrs	Over 40 yrs	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23	Gender	Male	Female						
		<input type="checkbox"/>	<input type="checkbox"/>						

24 Your current position is

25 Your current grade is

Please return the completed survey using the
ENCLOSED FREEPOST ENVELOPE

Thank you for your assistance in this project.

If you have any questions and/or require further information about this project, please do not hesitate to contact:

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Appendix Two

The management of employee relations within the NHS:
Employee trust and commitment within the newly reformed NHS

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The management of employee relations within the NHS:

Employee trust and commitment within the newly reformed NHS

This paper will essentially focus on the area of employee trust of NHS management.

It is supposed that employee trust of NHS management is an essential pre requisite to the formation of employee commitment to managerial objectives. While NHS management use their HRM departments to implement policies that are designed to disseminate and perpetuate managerial aims, objectives, and values these HRM plans may not however be as effective as they could be if NHS management fail to win over the trust and subsequently the commitment of their employees. After having measured the level of employee trust of NHS management the subsequent aim of this research paper will be to outline and establish the nature and scope of employee commitment and values regarding their work within the NHS. The examination of employee trust of NHS management and their subsequent commitment towards the aims and objectives as laid down by NHS management will be conducted within the context of;

- The impact of organisational change, resulting from market reform, on the management of employee relations within the NHS
- The impact of the alleged introduction of private sector managerial styles on the work practices of NHS employees
- The impact of potential organisational culture change, as a result of market reform, upon the working practices and ethos of NHS employees
- The new proposals from New Labour regarding co-operation and partnership

The management of employee relations within the NHS:

Employee trust and commitment within the newly reformed NHS

Most current research proposes that employee trust of management is an essential prerequisite to the formation and development of employee commitment to the aims, objectives and values of the organisation in which they work. Another linked assumption is that human resource efficiency and effectiveness are positively influenced by high levels of employee commitment. An implication of these two assumptions is that where NHS management use their HRM departments to implement policies that are designed to disseminate and perpetuate managerial aims, objectives, and values these HRM plans may not be as effective as they could be if NHS management fail to win over the trust and subsequently the commitment of their employees. This means that managers maybe failing to maximise the optimum level of effort and output available to them from their human resources. The subsequent aim of this research paper will be to outline and establish the nature and scope of employee commitment and values regarding their work within the NHS.

This program of research will be conducted in the context of:

- organisational change, resulting from market reform and its impact on the management of employee relations within the NHS
- The impact of the alleged introduction of private sector managerial styles on the work practices of NHS employees

- The impact of potential organisational culture change, as a result of market reform, upon the working practices and ethos of NHS employees
- The new proposals from New Labour regarding co-operation and partnership

Introduction

This paper outlines some of the issues and preliminary findings from a research project connected with employee trust and commitment within the NHS. These have been identified from an extensive literature review and some initial structured interviews with the managers in two NHS Trusts, one acute and one community.

It is hoped that through the process of testing, measuring and exploring employee trust within NHS organisations that the relationship between trust and commitment can be more clearly defined and established.

Employee trust defined

The main body of literature on employee trust and commitment implies that in order for employees to feel committed to the goals and aims of the organisation in which they work they must first trust their management. In order for an organisation to obtain and achieve the commitment of its employees and thereby maximise the potential from its human resources it must take initiatives towards gaining the trust of its workforce. In defining trust Butler, 1991, has referred to the definition used by Zand, 1972, who has outlined trust as being essentially,

‘one’s willingness to ‘‘increase one’s vulnerability to another whose behaviour is not under one’s control’’ [Butler, 1991, p. 230]

It would therefore seem that if trust is to be established between management and its employees the latter must be willing to increase their vulnerability to the other (the participation and willingness of both employees and management alike is therefore required).

While Managers can develop and demonstrate behaviour to encourage the trust of their employees (and subsequently their commitment to managerial objectives) their employees must be receptive to managerial overtures and must also reciprocate in terms of making themselves vulnerable within the process of creating and facilitating trust. Despite the fact that managers may attempt to do everything in their power as a way of gaining the trust of their employees the development and cultivation of trust between the two groups will not be possible if the employee has decided at the outset that (as a result of previous experience) for some reason or another not to trust management and as a result will be unwilling to act in any way which they feel makes them vulnerable.

Walsh, 1995, has outlined the role of trust between British and German troops within the trenches in the first world war, although sworn enemies they maintained an implicit form of co-operation to reduce the level of death and injury to troops on both sides.

‘Trust need not require personal liking or close relationships...The great benefit of trust is that it is efficient ; the more there is trust the less necessary it will be to engage in detailed and expensive monitoring of performance’

[Walsh, 1995, p. 50]

In designing a questionnaire which seeks to measure trust Butler, 1991, has reviewed the literature to date in order to distil a base from which a definition of trust could be constructed.

‘In short the literature on trust has converged on the beliefs that (a) trust is an important aspect of interpersonal relationships, (b) trust is essential to the development of managerial careers, (c) trust in a specific person is more relevant in terms of predicting outcomes than is the global attitude of trust in generalised others, and (d) a useful approach to studying trust consists of defining and investigating a number of conditions (determinants) of trust’ [Butler, 1991, p. 647]

From this assessment it may be reasonable to assume that trust is a significant factor in interpersonal relationships, it is conducive and supportive in the development of individual careers within an organisation and what is also apparent is that trust in specific individuals within an organisation i.e. supervisor, manager, employee etc., is of greater importance in determining its outcome than that of a more general kind of trust i.e. whether or not an employee trusts the organisation in which they work or whether or not a manager trusts their employees (in the general sense). When examining, exploring and measuring trust it can be assumed from the above that the researcher must look at a number of different sources or ‘conditions’ that will determine whether or not one individual trusts another.

In his work on trust within an organisational context, Barnes, 1981, has referred to a study conducted by Zand, 1978. The study is based on trust within teams of top level managers. Zand has described the process and creation of trust on a practical level within an organisational context,

‘You have learned from your experience during the past two years (duration of time in which the teams were created) that you can trust the other members of the top management team. You and the other top managers openly express your differences and your feelings of encouragement or of disappointment. You and the others share all relevant information and freely explore ideas and feelings that may be in or out of your defined responsibility. The result has been a high level of give and take and mutual confidence in each others support and ability’ [Barnes, 1981, p.111]

From the above it can be seen that the development and emergence of trust takes place over a period of time and that it is to some extent related to participant honesty and willingness to share information regardless of their particular duties and positions within the organisation.

Employee commitment defined

Although there are many different definitions relating to the concept of employee commitment, most literature to date has however referred to the definition outlined in the work carried out by Mowday, Steers and Porter, 1979, who describe employee commitment as being,

‘the relative strength of an individual’s identification with, and involvement in a particular organisation, It can be characterised by at least three related factors: a strong belief in and acceptance of the organisation’s goals and values; a willingness to exert considerable effort on behalf of the organisation; and a strong desire to maintain membership in the organisation’ [Mowday, Steers and Porter, 1979, p. 226]

According to this definition employee commitment has three dimensions. The first of these would appear to be attitudinal, this is where the employee accepts and identifies with the 'goals and values' of the organisation. The second dimension relates to behavioural commitment, this is concerned with the level of the employee's work 'effort' in carrying out the tasks and duties encompassed within their job title. The third dimension is that of exchange commitment, this is mainly concerned with the level of attachment an employee has with the organisation as a result of the benefits they receive in exchange for their labour. This type of commitment can also relate to what the employee may perceive as 'sunk costs' within the organisation i.e. twenty years of work, and the trouble they may encounter in looking for another job. The employee will exhibit a willingness to 'maintain membership in the organisation' as a result of this form of commitment. The research conducted to date appears to be mainly concerned with two of these dimensions, attitudinal and behavioural commitment. It is widely assumed by researchers of employee commitment that a relationship exists between the behaviour and attitudes of the employees within the workplace. It is also assumed that attitudes can influence behaviour and behaviour can influence attitudes it is therefore believed that the relationship between attitudinal and behavioural commitment is reciprocal.

Guest, 1989 highlights the relationship between employee behavioural and attitudinal commitment by stating that it is,

'concerned with the goals of binding employees to the organisation and obtaining behavioural commitment to high performance'. [Guest, 1989, p. 49]

This definition of employee commitment illustrates the assumed relationship between positive identification with organisational goals with that of positive behavioural outcomes which enhance and maximise organisational performance.

Compliance

In the past organisations have often tended to rely upon securing employee compliance rather than commitment as the driving force behind the management and control of their human and manpower resources. Keenoy, 1992, defines compliance and the role of management within the process of compliance when he says,

‘managers, in attempting to persuade, cajole or coerce employees to do as they are told, are responsible for constructing, operating and maintaining a bewildering array of control mechanisms designed to ensure each individual actually performs their designated work’

[Keenoy, 1992, p.92]

In the process of ensuring employee compliance managers must therefore adhere to an array of systems and bureaucratic machinery required to measure employee output for the terms and conditions offered to the employees in exchange for their labour. Guest, 1991, criticises the use of compliance based models of employee management on the grounds that they represent an inefficient use of organisational resources. If an organisation does however decide to change from a system based upon compliance to one based on commitment, Guest, 1991, implies that managerial assumptions about the nature of their workforce would need to be reassessed accordingly,

‘These represent both inefficiencies (Bureaucratic controls under compliance models of employee management), in that top management, if they believed that they had a trustworthy and competent workforce, could dispense with many of the controls, and inbuilt inflexibilities’[Guest, 1991, p. 114]

Guest, 1991, highlights the unstable nature of the current economic environment as another major reason for organisations to transfer from systems based on compliance to models which are more oriented towards facilitating employee commitment. It is believed that organisations that use systems modelled on compliance are not as flexible to the changing nature of local and global markets,

‘To meet...demands swiftly and effectively, organisations require a workforce which is more than merely compliant. It requires their active help and the use on considerable local initiative’[Guest, 1991, p. 114]

Background: HRM Versus Personnel management

Much of the current HRM literature perceives employee commitment as being more effective than that of the compliance mechanisms used under traditional personnel management and practice. Some authors have sought to associate compliance based approaches to traditional personnel management and practice while models using techniques designed to cultivate employee commitment have been closely associated with soft HRM models and practice.

‘Personnel management is closely associated with compliance-based systems of control while HRM is typically allied to commitment...compared with personnel management, HRM is a more central, senior-management-driven activity’

[Guest, 1990, p.152]

The argument over compliance and commitment can also be seen as part of a wider debate concerning traditional theory and practice of personnel management with that of the newly established HRM. We can deduce therefore that the degree to which there is an optimum level of trust between management and employee and subsequently the level to which employees feel committed to organisational goals, in both attitude and behaviour, may indicate the extent to which the organisation under investigation has adopted a HRM orientation.

The table below (Fig 1.1) outlines and summarises the main features and attributes of compliance and commitment. As mentioned above compliance mechanisms have been traditionally associated with personnel management and practice where systems of employee commitment have been largely associated with contemporary HRM practice.

Fig. 1.1 Alternative assumptions and beliefs Underlying Human Resource Management

[Guest, 1991, p 152]

Aspects of policy	Compliance	Commitment
Psychological contract	Fair day's work for a fair days pay	Reciprocal commitment
Locus of control	External	Internal
Employee relations	Pluralist Collective Low trust	Unitarians Individual High trust
Organising principles	Mechanistic Formal/defined roles Top-down Centralised	Organic Flexible roles Bottom-up Decentralised
Policy goals	Administrative efficiency Standard performance Cost minimisation	Adaptive work-force Improving performance Maximum utilisation

It has been claimed that HRM is essentially different from that of traditional personnel management as it tends to be much more strategically orientated. In many organisations HRM is the concern of senior as well as line management.

During one of the preliminary interviews conducted for this research the personnel officers within one of the NHS organisations being studied said that the old personnel function as the organisation knew it was being changed. The Trust had just created a new HRM/ personnel directorate and which among other related departments was to be absorbed and placed under the control of the new directorate. The interviewee perceived this as a move to significantly

upgrade the function of employee management by placing it at the strategic level of the organisation, marking a break with the purely administrative/personnel role traditionally associated with this function.

Management and employee relations within the NHS

As mentioned previously the function of employee management is becoming much more strategic. This can be seen through the progression of personnel management towards the now much more strategically driven HRM. As mentioned above employee trust and commitment are closely linked to soft HRM models. Most research conducted so far suggests that a high level of employee attitudinal and behavioural commitment ensures that an organisation will receive the optimum level of output from its employees. It is supposed that a high level of trust between manager and employee will facilitate and deepen the process of employee commitment. This paper seeks to look at these issues within the NHS with a view to further research within this area.

Background to NHS reform and managerial change

The initial intentions of government reform within the NHS were signalled by the advent of the Griffiths report, 1983. The Griffiths report essentially recommended the introduction of private sector management techniques and styles into the NHS. Private sector management techniques were perceived as more appropriate and effective than that of the traditional public sector management styles. The introduction of the report marked a departure from the joint decision making between NHS professional and public administrator which had formed the

traditional style of NHS management to that of the more unitarist based styles of private sector managerialism. The report perceived the use of private sector management techniques as a way of making the NHS more cost effective and improving the standard of service provided.

Structural change within the NHS was introduced by the Community care act, 1990. This was to pave the way for the splitting up of the NHS into two sectors , one providing care and another sector which purchased care. The government seen this as a move towards stimulating greater competition within the NHS and as a consequence making it much more efficient and cheaper to run.

The purpose and goals of the traditional NHS tended to be much more explicit and certain than that of the recently reformed NHS. The traditional NHS operated as a professionally driven organisation with the primary goal of serving the health requirements of the nation. Health care was delivered primarily on the basis of need, in relative values the cost of the service received by the recipient was not assigned high priority. The reforms which started with the inception of the conservative government in 1979 have altered the philosophy and goals of the NHS, it is now much more financially controlled and managerially driven than ever before. The NHS is also allegedly much more market driven, this can be observed in the existence of internal markets (established through the introduction of the Community care act, 1990), the introduction of performance management techniques and measures aimed to reduce costs and the customer orientation adopted through the creation of a Citizens Charter, 1991. The creation of Trusts within the NHS and the level of autonomy they received in conducting their own affairs as self managed organisations signalled the introduction of a 'sink or swim' strategy on behalf of the government. The governments intention was to let

those NHS organisations which were been poorly managed and operating at a loss to be closed down while those NHS organisations which were been successfully managed were allowed to plough back profits into the organisation in order to make them function more effectively. The closure of other NHS organisations would allow the more successful NHS Trusts to take over were they left off in terms of receiving more patients and buildings.

‘Trust status was presented as a means of offering greater freedom and autonomy for individual hospitals to manage their own affairs. They were presented as an important part of the competitive supply-side’

[Tilley, 1993, p. 115]

This marked the introduction of the profit motive within the NHS, another concept taken from the private sector.

Employee relations within the NHS

As a result of the changes to the health service introduced by the previous conservative governments the practice and implementation of personnel/HRM management throughout the public sector is being viewed in an increasingly negative light by those who work both within the NHS as well as the rest of the public sector. This is mainly due to the unpopularity of the policies that are been implemented by the personnel function as a consequence of funding restrictions and the increase in competitive pressures arising from the process of market reform. Oswick and Grant, 1996, have commented on the increase of this trend throughout the public sector in general as well as within the NHS,

‘Our participants talked of; voluntary and compulsory redundancy; enforced early retirement; withdrawal of unsociable hours payments; relocation and redeployment; general downsizing; the introduction of more flexible working practices; the removal and reduction of perks and fringe benefits; and moratoriums on the filling of vacant posts. Personnel practitioners are normally at the forefront of implementing and policing the aforementioned measures’

[Oswick and Grant, 1996, p.11]

Government sponsored cuts in financial resources allocated to the NHS combined with new managerial styles informed by Griffiths appear to be having a negative effect on NHS employees in terms of their loyalty to management. In examining factors contributing to high levels of absence within the NHS Whitson and Edwards, 1990, have illustrated the prospect of a decrease in the level of employee loyalty to the NHS organisations in which they work,

“Management has so far been able to depend implicitly on traditional forms of loyalty. As the contradictions between these and commercialism are heightened, this loyalty may begin to erode”[Whitson and Edwards, 1990, p.296]

Kelliher, 1995, has commented on the introduction of private competition in carrying out NHS services which had previously been undertaken in-house e.g. cleaning, catering etc. The evidence from the study strongly suggests that there was a widespread initiative on the part of NHS management in reorganising working schedules as a means of reducing labour costs. While there is evidence to suggest increased ‘customer’ satisfaction and better work

performance, the author provides evidence which strongly suggests that employee satisfaction and morale have deteriorated.

‘61% reported that staff attitudes to work had been affected by the experiences of competitive tendering, more than half of these indicated that staff morale had suffered. Equally, loyalty and job satisfaction were reported as having deteriorated. On the other hand, both work effort and customer orientation were described as having improved...this evidence demonstrated that there have been costs to employee relations, particularly in the areas of workforce morale and employee loyalty.’

[Kelliher, 1995, p.313]

Therefore while NHS staff may appear to exhibit a high level of behavioural commitment to their work, it would appear that morale within the service remains very low.

Walsh, 1995, has commented on the wider implications of market reform within the NHS on the trust and loyalty of NHS employees. As the pace of market reform accelerates the traditional culture and organisational structure which provided a basis upon which trust, loyalty and commitment could be both established and maintained may be replaced with a system that is not as effective in cultivating the optimum level of employee trust, loyalty and commitment,

‘The danger is that the more commercial, market-based approaches to service management can undermine the traditional bases of trust, dependent as they are on service-based commitments and professional organisational cultures.’ [Walsh, 1995, p. 51]

Walsh refers to the work of Hirsch, 1977, in highlighting the importance of trust within a commercialised economy. While trust provides the basis of a good market economy, the very nature of the market economy itself would appear to undermine the existence of trust,

‘Paradoxically, argues Hirsch (1977), a world of markets and contracts needs a basis in values which it itself tends to undermine:

Truth, trust, restraint, obligation - these are among the social virtues grounded in religious belief which are now seen to play a central role in the functioning of an individualistic, contractual economy ‘(p.141) [Walsh, 1995, p.50]

At the moment NHS management’s role is to ensure employee commitment to the aims and objectives as laid down by Trust management. Given the evidence outlined above it is easy to see how this process could at the least be a very challenging one. If (as it has been alleged) the extent and scope of employee commitment is determined by the level and extent to which management and employees trust each other it is hard to see how mutual trust between the two groups can be facilitated and nurtured under the present system.

Findings so far

In the process of conducting this research a small number of preliminary interviews have been carried out with the personnel/HRM departments of organisations within the NHS.

Among the outcomes of this process a number of interesting and relevant points were made.

In one of the organisations it was suggested that most policies and decisions regarding the

organisations human resources were met with disapproval and indeed opposition from the vast majority of the organisations employees, nevertheless managements' ability to implement unpopular policies regarding their human resources was in part facilitated by an existing high level of employee commitment to the objectives of the NHS. The manager spoke briefly of the 'warm glow' and positive feelings which the employee 'may experience' in carrying out a service which has positive repercussions for the community at large. To this extent the employees commitment to task could be relied upon despite the introduction of unpopular policies and plans. The aim of the organisation was to maximise the efforts of the organisation's manpower and to get the most for the least from its employees and to this end the commitment of the Trusts' employees to the service they carried out enabled management to achieve this goal.

The new approach outlined, one based on cost minimisation and maximum utilisation of existing human resources, is to some degree similar to HRM approaches adopted within the private sector.

Coopey, 1995, has criticised what he refers to as the 'short term profit expectations' amongst managers within the private sector. The lack of a more long term investment in organisational human resources is highlighted as providing a poor and ineffective environment for the development of mechanisms geared to enhance employee attitudinal and behavioural commitment. Coopey has criticised private sector notions of employee management on the basis that it values self interest over other stated concerns and values its workers only in so far as they are 'affecting business strategy'. Coopey, 1995, p 59, refers back to Guest's model of the HRM perspective where the policy goals of HRM are stated as being 'improving performance' and 'maximisation utilisation' of employees.

‘In building relationships that encourage greater commitment, company directors are constrained by perceived pressures to meet shareholders’ short-term profit expectations and the need to serve their own interests (p 200)’[Coopey, 1995, p 70]

The tight spending restrictions imposed on NHS managers could possibly curtail and limit the extent to which they can initiate policies designed to foster employee commitment. The promises of the incoming Labour administration to keep within the spending limits set in place by the previous administration offer relatively little chance of a significant relaxation of the constraints given. They therefore act to inhibit long term investment in employees just as the short term profit expectations acts to inhibit long term investment amongst employees within the private sector.

Another of the preliminary interviews yielded the following assessment of the effects of NHS reform upon employees.

The effects of recent organisational change were having a profound effect on the organisations staff in terms of employee morale, motivation and commitment. The process of organisational change was seen as having very negative effects on staff throughout the entire organisation. It was estimated that at present approximately 80% of the organisations staff were in the process of actively seeking employment elsewhere (an indication of the current level of behavioural commitment of the Trusts employees). This was mainly attributed to the current level of insecurity and uncertainty concerning the direction the trust was taking and employee concerns regarding the future stability of employment within the trust.

Other comments included assertions that the Trusts had no strategic plans, communications from management to employees were very poor and many employees were much better

educated than Trust managers were. Employees were therefore able to see through managements slogans, aims and objectives. In the latter context control was difficult. There was also evidence that management believed that organisational change could most effectively be implemented from the top down.

In their work on organisations within the private sector Stiles et al, 1997, have examined the level to which the organisations studied have been successful in cultivating employee commitment and trust when transferring from one form of people management to another. Stiles et al have criticised the organisations studied on the grounds that they failed to adequately consult and involve employees before introducing the new system,

‘In all cases, changes were being driven in a top-down systematic manner and the lack of consultation has brought cynicism and a lack of trust among employees’

[Stiles et al, 1997, p 65]

The style used by the organisations studied whereby the management failed to consult and inform their employees when introducing change would be similar to the style currently adopted by the management of this particular Trust.

Furthermore Stiles et al claim that given the change involved through the introduction of a new system and given the lack of consultation in the way it was implemented within the organisations studied it was felt that the previous level of employee commitment and trust would be very difficult to recapture.

‘such is the extent of the violation of the old contract, it is unlikely that trust and commitment will be easily recovered’ [Stiles et al, 1997, p. 65]

This could also act as a warning to the management of this particular Trust. If they introduce a new system without adequately consulting and involving their employees they could potentially run the risk of losing the employee trust and commitment offered by their employees under the existing and previous system. The high proportion of employees that are actively seeking alternative employment would also backup the conclusions in the study conducted by Stiles et al .

One issue that did arise from the discussion above was that concerning the difficulties management had in managing employees which in alot of cases were much better educated than managers were themselves. This made the process of managing and controlling employees more difficult and had apparently made the employees more cynical and less trusting of managerial aims and objectives.

Further it has tentatively been decided to pursue the research aims via the mechanism of case study development in three different NHS sectors: acute, Community and G.P. fundholders.

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Appendix Three

The management of employee relations within the NHS:

Trust between management and employees within the NHS

Introduction:

In this paper we report the findings of the early stages of research into the nature of trust and the degree to which it exists between employees and managers within the NHS. The research set out and outlined within this paper has assisted the development of some preliminary models on trust between managers and employees within NHS organisations. These tentative models will be developed and tested by carrying out a further series of in-depth interviews and through the application of postal surveys to samples of nursing staff in acute and community units.

Background:

The main body of literature on employee trust and commitment implies that in order for employees to feel committed to the aims and goals of the organisation in which they work they must first trust their management. For example Guest, 1991, has outlined high trust relations between management and employees as forming a central element in gaining employee attitudinal commitment towards the aims and objectives of the organisation, and behavioral commitment towards their daily tasks and duties (Guest, 1989, p.49). In order for an organisation to obtain the commitment of its employees and maximise the output and performance of its human resources it must take initiatives towards gaining the trust of its workforce (O'Creevy and Nicholson, 1994; Marchington et al, 1992).

Research has also highlighted the existence of 'relationship benefits' which can be derived from the existence of trust based relations (Morgan and Hunt, 1994). The history and culture of the organisation in which one works can greatly influence one's own perceptions and views (Anthony, 1990) which can either limit or encourage the level to which one is at liberty to trust one's superior/manager. Differences in the nature of one's training and educational background can also contribute to feelings of mistrust amongst employees and (their) managers (Morgan and Potter, (Eds.) Kirkpatrick and Lucio, 1995; Stewart, 1996).

Trust Defined

As quoted in Butler (1991), Zand (1972) defines trust as being,

'one's willingness to "increase one's vulnerability to another whose behavior is not under one's control"' [Zand; Butler, 1991, p.650]

If employees are to trust their managers they must therefore be willing to increase their vulnerability towards their managers. While managers can demonstrate behavior to encourage the trust of their employees (and perhaps their commitment to managerial objectives) employees must however also be receptive to managerial overtures and reciprocate them in terms of being willing to make themselves vulnerable within the process of establishing trust. While managers may attempt to do everything in their power as a way of gaining the trust of their employees, the development of trust between the two groups will not be possible if the employee has decided at the outset, not to trust

management and as a result is unwilling to act in any way which they feel makes them vulnerable. The process of establishing trust may not therefore always be possible.

Morgan and Hunt (1994) support Zand's definition of trust (op cit) in that the process of trusting another individual involves making oneself vulnerable. The authors suggest a link between trust and commitment when they say that 'because commitment entails vulnerability, parties (i.e. managers and employees) will seek only trustworthy partners' (Morgan and Hunt, 1994, p.24)

Conditions necessary for trust to develop:

Butler (1991) discovered that the literature on trust and commitment converged on the beliefs that , trust is a significant factor in inter-personal relationships, it supports the development of individual careers within an organisation and trust in specific individuals within an organisation i.e. supervisor, manager, employee etc., is of greater importance in determining its outcome than that of a more general kind of trust i.e. whether or not an employee trusts the organisation in which they work or whether or not a manager trusts his/her employees (in the general sense). Butler also discovered that the literature on trust suggested that the researcher should examine a number of 'conditions' or determinants of trust.

In his work on trust, Barnes (1981) refers to the work carried out by Zand (1978). The study is based on trust within teams of top level managers and looks at how trust is initiated and maintained between all the individuals concerned. The author points out that the individuals involved felt that they could trust each other because they were familiar

with the other participants as they had known them for two years, thus indicating the significant role played by time in establishing trusting relationships between individuals.

Zand goes on to describe trust as a process whereby,

‘You openly express your differences and your feelings of encouragement or of disappointment. You and the others share all relevant information and freely explore ideas and feelings that may be in or out of your defined responsibility’ (Barnes, 1981, p.111) the result of which, ‘has been a high level of give and take and mutual confidence in each other’s support and ability’ (Barnes, 1981, p.111)

This study would suggest that the emergence of trust takes place over a period of time and that it is related to participant honesty and a willingness to share information regardless of the particular duties and positions held by the individuals concerned.

Characteristics of trustworthy managers:

In order for one individual to trust another, Morgan and Hunt (1994) argue that the individual must have, ‘confidence in another’s reliability and integrity’ (Morgan and Hunt, 1994, p. 23).

They also claim that an individual is more likely to trust someone in the,

‘belief that the trustworthy party is reliable and has high integrity, which are associated with qualities such as consistent, competent, honest, fair, responsible, helpful, and benevolent’

(Morgan and Hunt, 1994, p.23)

Communication, openness and listening to others have also being identified as behavioral characteristics which can facilitate the development of trust (Morgan and Hunt, 1994). It has been pointed out that communication leads to trust and trust leads to better communication. Communication can prevent misunderstandings and can act in the resolution of disputes both of which create a more trusting working environment.

From the above it is clear that trust is acquired and built up over time, it is something which is usually established between particular individuals, trust is signified by individuals openly expressing their differences and opinions, sharing information and showing confidence in each others ability. Behavioral qualities related to personal integrity as illustrated by Morgan and Hunt (1994), act to establish the confidence necessary for one individual to trust another. It would seem that not only are these the factors required for trusting relations, they are also outcomes that can arise from the existence of trust based relations between managers and employees. The evidence from the literature would suggest that the process of trust building is in a sense circular and cumulative and that the conditions necessary for trust to develop are very often also the outcomes of trust based relations.

Benefits of trust based relations:

Morgan and Hunt (1994) have described the existence of 'relationship benefits' that can arise either as an outcome or a result of the development of trust between two or more parties. Relationship benefits are derived as part of a two way process offering mutually reciprocal benefits to the trusting parties. Naturally this requires the cooperation of the participants involved. The authors have also described the manifestation of cooperation

within an organisational setting as an output which is in turn influenced by the existence of trust and commitment.

When speaking about trust and cooperation, Walsh (1995) refers to the case of British and German troops during the first world war, who maintained an implicit form of co-operation to reduce the level of death and injury to troops on both sides.

‘Trust need not require personal liking or close relationships...The great benefit of trust is that it is efficient ; the more there is trust the less necessary it will be to engage in detailed and expensive monitoring of performance’

(Walsh, 1995, p. 50)

As quoted in Morgan and Hunt (1995), Rotter (1967), argues that trust between individuals within organisations can bring about benefits which can determine the future existence and survival of the organisation itself,

‘One of the most salient factors in the effectiveness of our present complex social organisation is the willingness of one or more individuals in a social unit to trust others. The efficiency, adjustment, and even survival of any social group depends upon the presence or absence of such trust’

(Morgan and Hunt, 1994, p. 20)

From the literature surveyed it is apparent that the presence of trust between individuals within an organisation can lead to the establishment of greater commitment amongst employees towards their daily tasks and duties. Greater commitment can lead to improvements in employee performance and output within the organisation. The presence of trust amongst employers and employees can offer relationship benefits to both parties which can include increased levels of cooperation among employers and employees and higher levels of efficiency within the workplace (improving organisational performance and durability) whereby managers can dispense with the need for 'detailed and expensive monitoring' of employee performance and spend their time more productively.

We will now turn towards the concept of trust within the context of the NHS. The following will look at the results taken from a series of preliminary interviews conducted with nursing staff based within an acute sector organisation within the NHS.

Research issues and questions derived from the literature

The following issues will be explored within this analysis;

- Conditions for the development of trust between management and employees within the context of an NHS organisation
- Characteristics of 'trustworthy' managers within the NHS
- The benefits of trust vs the costs of mistrust
- Policies that might lead to an increase in trust within the organisation

Method

The following is an analysis of a number of preliminary semi-structured interviews involving NHS nursing staff selected at random from a large acute sector organisation. The interviews lasted for forty five minutes and required the respondents to answer questions relating to their level of commitment and the extent and degree to which they trust their management. The following analysis will inform the construction of a model of trust between nursing staff and their management within the organisation. The interviews were analysed with the assistance of a qualitative computer software package. While the findings within this section relate to previous research they are not however identical and may reflect the particular culture of the organisation under investigation.

Conditions for the development of trust

The following section will go on to outline the conditions necessary for the development of trust between managers and employees within an NHS organisation. This section is structured as follows;

1. History of the organisation, its culture and context
2. Coincidence of values, objectives, priorities and performance
3. Evidence of attitudinal/behavioral commitment
4. Reciprocity
5. Time

History of the organisation, its culture and context

The culture and history of an organisation provides the setting in which managers and employees interact, it therefore plays a significant role in determining the extent to which individuals trust one another within the organisation. We will therefore look at the conditions for the development of trust by taking organisational culture and history as our starting point.

When asked whether or not nurses in general trusted their managers one interviewee estimated that approximately 50% of the nurses who worked within the hospital would trust their managers. Out of the 50% of those nurses who do not trust their managers the interviewee said that 25% of them would probably like to trust management and another 25% probably never would.

Historical factors such as class and the existence of a blame culture were highlighted as the main reasons for the lack of trust between nursing staff and hospital management.

‘I think it’s class orientated. You have to strive continually, people always find an excuse to blame somebody else, it’s very easy to blame the directorate management’

This sentiment was reiterated by another interviewee in the following statement;

‘I think a lot of it is historical and I think that nurses are a professional body which are almost marginalised, because of that they are distrustful as a body/collective’

As a group, nurses have traditionally been told what to do, they have lacked the capability to act collectively in articulating their interests as effectively as that of other groups of employees within the NHS i.e. doctors and other medical professionals. Because of this perceived imbalance most nurses feel that they continually receive something of a raw deal when negotiating with hospital management. The interviewee said that in order to change this widely held perception nurses would have to undergo a process of reeducation.

‘I think it’s a question of reeducating, but it stems from the fact that they (nursing staff) have not been included in things. They do not feel that they have a voice, they feel that issues and different things have been dictated to them and they have to follow whereas for medical staff and in other professions it’s been a question of negotiation.’

One interviewee commented upon the particular dispositions of certain nurses as being another factor determining the extent to which an individual nurse allowed themselves to trust their manager. The interviewee claimed that regardless of the particular context or the organisational setting,

‘There are those type of people who will never trust management,’

On the question as to whether or not the interviewees felt that hospital management trusted their employees one of the interviewees replied,

‘I would say certainly not, particularly at the moment in what I am going through I would say that there is no trust at all.

Coincidence of values, objectives, priorities and performance

The following comments illustrate the nature of managerial aims and objectives as perceived by NHS nursing staff and the extent to which they coincide with their own aims and objectives. While trust may be a prerequisite for the development of employee commitment, the aims and objectives of the organisations management are also significant, particularly if they are contrary to those of the employee. In a context where this conflict of interest is extreme the establishment of trust and commitment amongst employees may prove unlikely.

Financial/budget considerations

One interviewee outlined management’s preoccupation with hospital budgets as a significant barrier to the development of trust between nursing staff and management. Given the widespread perception held by many nurses, of managements’ primary concern with hospital finances, many nurses felt that management could not be trusted to make decisions in the interests of the patients being treated or the employees working within the hospital,

‘They (management) will change the rules to suit money therefore employees do not really trust that management are doing things or are making decisions that are in the best interests of the patient’

Professional concerns vs exploitation of labour

One interviewee felt that management looked upon nurses purely as commodities that needed to be financed. She expressed resentment towards management for not valuing nursing staff in the way in which she believed nursing staff should be valued, she also said that in most cases managers would not know who many of the nurses were. The interviewee said that being valued was very important for nursing staff as it motivated and encouraged them to fulfill their role to its fullest potential within the hospital,

‘Nursing staff are seen as commodities, patients are also viewed as commodities, they don't think of us as human beings, this does not make people feel valued. Being valued is very important because it motivates you to work’

Evidence of attitudinal/behavioral Commitment

In order to trust another individual within their working environment the interviewees said that they would like to see evidence of some form of commitment towards the patients and the people they worked with on their ward/unit.

‘Trust to me means that you expect that people are committed to the organisation’

The ability of another individual to carry out their work in the interests of the patients within their care and in the collective interests of their work associates constituted another significant factor influencing the development of trust.

‘If I expected something of one of my nurses, whether or not she agreed with me I would understand that she would have the best interests of the unit or the patient she represents’

The statement above would suggest a link between trust and commitment, this would lend support to the belief that trust and commitment are linked, whereby the presence of one can influence the development of the other within the work place. It must be acknowledged however that there may be considerable differences in the values, of managers and nursing staff which reflect differences in the training and educational background of these two groups. The values, objectives and priorities of nursing staff may not therefore be compatible with those of management.

Lack of management nursing experience/training

One interviewee questioned the ability of hospital managers to manage nursing staff on the basis that they lacked nursing training and experience,

‘Some of them have never worked as a trained nurses, they come from other fields, they therefore do not see things as we do’

The comment above illustrates the potential for conflict and mistrust through misunderstandings and lack of empathy between management and nursing staff. The basis for such conflict could lie in differences in the educational and training background of nursing staff with that of management.

Reciprocity

One interviewee described trust as a two way process. She indicated that when trust is offered to another individual, they must respond by reciprocating the trust.

‘If I think that somebody is beginning to show trust to me and in what I am trying to do, and supporting me in that and investing something in me, then I think it becomes reciprocated’

The interviewee also said that this gave her the confidence to try out new initiatives and schemes upon the ward,

‘By trusting and supporting my team it is reciprocated and that therefore has given me confidence to go on and try new things and so on’

Sharing information and vulnerability

The ability of an employee to share personal information, with their immediate superior was highlighted as an indication of a trustworthy manager. The extent to which an employee would feel comfortable in doing so could indicate the level of trust they had in

the individual concerned. Two interviewees said that they would not feel uncomfortable by sharing information with their immediate superiors, one of the nurses said that sharing information with her immediate superior had, in the past, actually strengthened her position both with her superior and her colleagues.

‘I thought at first not to say anything but when I did everyone crowded around me, supported me and got me through the problem and then I could do my work’

The interviewees said that any decisions made regarding the sharing of intimate or sensitive information with their superior was influenced mainly by the personality of the superior concerned, and the extent to which they felt they had established a good rapport and working relationship with the superior in question. The interviewees would not recommend it as a course of action which they would take in every situation.

‘I would not feel vulnerable with my immediate superior but I can understand why people would, however this would depend on who their superior is...it may not be appropriate if an employee did not have a good relationship with their immediate superior’

The statement above would also confirm the evidence in the literature which places greater emphasis on looking at and exploring trust in specific individuals (Butler, 1991).

The ability of the nurses to share personal information with their immediate superior could be seen as an indication of their willingness to increase their vulnerability. The

definition of trust outlined in the literature section describes trust as being the willingness of an individual to allow themselves to become vulnerable to another individual whose behavior is not under their control (Butler, 1991).

The interviewees who did share personal information with their immediate superiors gave the impression that they trusted the individuals concerned and had a productive relationship with these individuals. One interviewee said that she would not feel comfortable with sharing personal information with her immediate superior because she did not trust them and indicated throughout the interview that her relationship with her immediate superior was one characterised by mistrust and suspicion. As a result they were unable to be progressive or constructive. The two interviewees who claimed that they trusted their superiors/managers felt that they could confide in them by sharing personal information. Despite the fact that the process of sharing this information meant that they would be placing themselves in a vulnerable position with their immediate superiors the interviewees indicated that they would not be concerned, hence indicating their willingness to become vulnerable. Where trust was absent the interviewee indicated greater reluctance to share information of a personal nature with her superior, hence indicating her unwillingness to become vulnerable in facilitating the development of trust.

Time

In order to establish trust between individual managers and work associates the interviewees suggested that they would have to have known and worked with a particular individual over a certain period of time before they could trust them.

‘a lot of that (trust in other individuals) comes down to how long I have known that individual’

Time is required in order for individuals to be able to assess or judge whether or not an individual is trustworthy and the degree to which they can be trusted Barnes (1981, p.111). Trust is therefore something that is built up over a certain period of time and is not something that can be acquired within the short term.

Characteristics of ‘trustworthy’ managers within the NHS

The interviewees outlined the following as desirable behavioral characteristics and personal qualities and attributes of managers in whom they felt they could trust.

Personal characteristics

Competence and consistency:

When talking about trust the interviewees highlighted the issue of competence and consistency. The interviewees said that the person in whom they placed their trust would have to demonstrate a high level of competence and consistency in the way they carried out their daily tasks and duties, and the standard to which they were performed.

‘To me trust is knowing that another person has the same idea as myself and the treatment which I am giving. If they wish to take over or do part of my work they will do it to the same standard and consider the patients health and their dignity’

In order for one nurse to trust another individual they must be confident that the other individual can competently carry out their tasks to an satisfactory standard.

Consistency, in terms of establishing the aims and goals for nursing staff to work towards, also helped to build up trust between nursing staff and management.

One interviewee outlined her own preconditions for the creation of trust to take place. The following would also reflect the view taken by the other interviewees,

‘what I would expect from an individual before I began to trust them would be integrity, honesty, consistency and support, however I think that support also comes with the consistency’

Another interviewee said that she would need to respect the person she trusted. The interviewee said that she would respect someone who showed both integrity and consistency,

‘I would respect what she is saying through the example that she has set by her integrity with all the other individuals within that environment, and her consistency’

The responses outlined above also support the work carried out by Morgan and Hunt (1994), regarding the desirable personal qualities and traits which can influence and encourage the development of trusting relationships.

The ability of a manager to deal with their staff openly and honestly was also considered as another factor influencing the development of trust between nursing staff and management. One respondent explained that one of the reasons why she trusted her superior was because she was honest,

‘she is honest, I have known her a long time... she is a caring person, I have never known her to lie’

Behavioral characteristics

Communication, openness and support:

Regular and open communication with employees on issues affecting both them and the organisation was considered as highly important in developing trust between managers and employees. The process of sharing personal information with other employees and nursing staff was also perceived as being helpful and constructive in maintaining a harmonious working environment. One interviewee looked upon the process of sharing information with colleagues and superiors as a way of counseling those nurses experiencing problems and difficulties which could affect the way they behaved within the workplace. The interviewee said that the other members of staff would understand why a particular

individual was not performing to their usual standard as they would know more about what was going on in each others lives both inside and outside the workplace.

One interviewee looked upon the process of listening to the concerns and problems of her fellow colleges as a supportive one. She said that by listening to others she demonstrated to them that they were cared about and valued,

‘This has positive implications for the work that the nurses do because if you are prepared to listen to peoples personal problems and their professional problems, it shows that you care about them’

She added that when nurses felt valued they were more likely to experience higher levels of job satisfaction and commitment towards their work and were more likely to be cooperative with both work colleagues and managers.

Another interviewee highlighted the role that communication and support played in the development of trust amongst nurses and management in the following statement;

‘The fact that we do talk to each other probably adds to the trust because you know each other and you can actually work better together’

The interviewees claimed that despite the fact that a high level of trust existed amongst nurses and other employees working on the wards, there was in general, a distinct lack of trust between nursing staff and management within the organisation.

The nurses outlined poor levels of communication and support coming from management as the main causes for the lack of trust between the two groups.

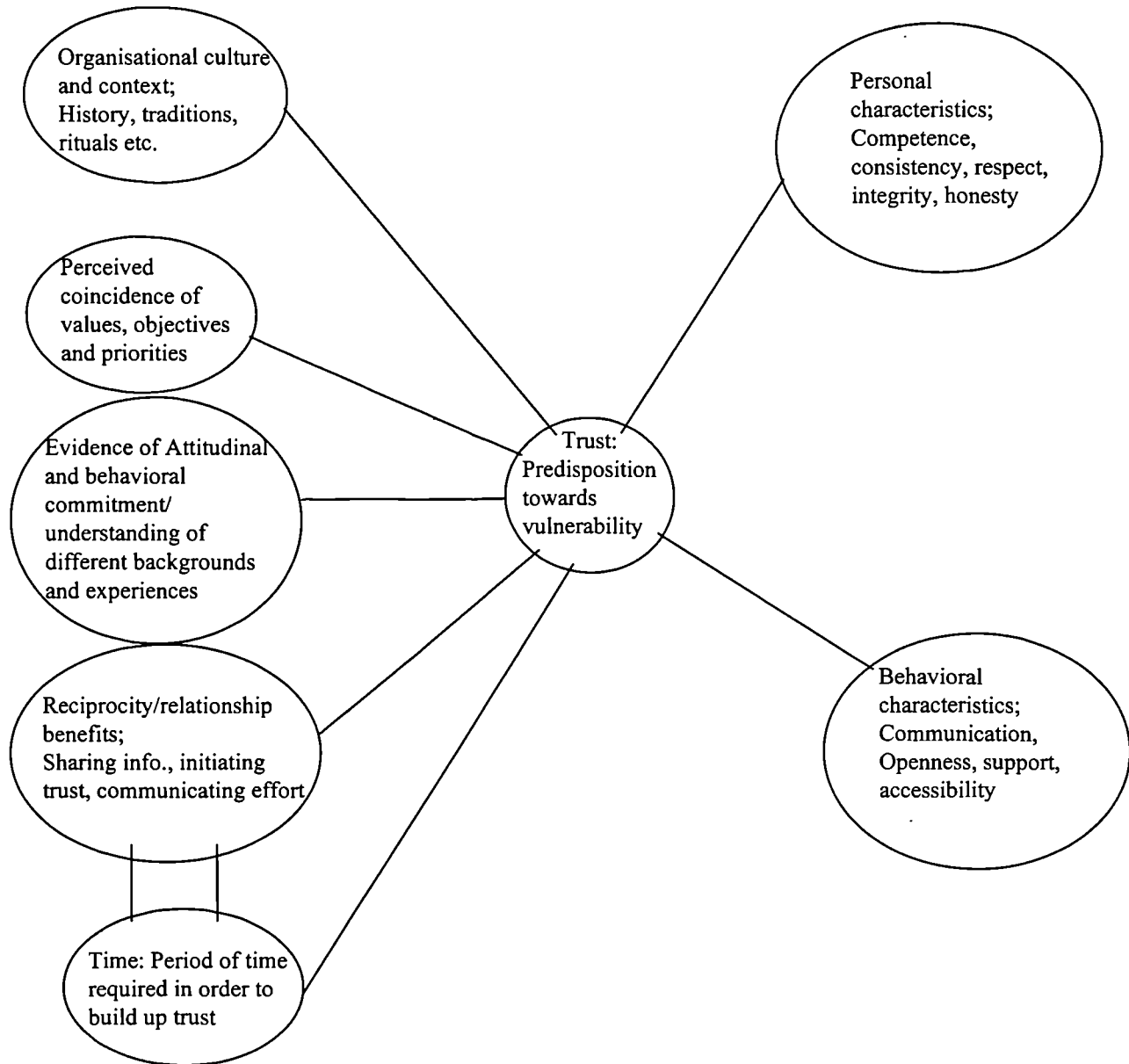
Accessibility/visibility:

The extent to which one's manager could be accessed was also seen as another factor contributing to the development of trust between nurses and their managers. This was highlighted within the following statement,

'My immediate manager makes every effort to make herself available to people on the ward and for people to get to know her. Its very difficult for people to trust somebody who they don't see'

Conditions for the development of trust

Characteristics of trust worthy managers



(Figure 1)

Benefits of trust Vs the costs of mistrust

While the benefits of trust based relations have been explored within the literature section of this paper they are not however reflected identically in the research which was later carried out. Again this may reflect the particular cultural and historical background and norms of the organisation under study. The benefits of trust based relations between nursing staff and their managers will be explored within this section at an organisational and at a personal level.

Organisational benefits

Teamwork:

The interviewees claimed that trust amongst them and their managers, helped them to fulfill the aims and objectives of the organisation and created an appropriate context for the development of team work. The interviewees claimed that team work played an essential role in realising of organisational and professional goals. One interviewee said that knowing that everybody was working towards the same aim contributed towards the maintenance of trust between nursing staff and management and helped to create greater trust amongst the nurses themselves.

‘You need trust to know that they have the same aims as yourself, if you have not got that then you cannot work together’

Another nurse added that,

‘Without the trust I think it would fall apart’

The comments above would suggest that trust between managers and employees can help to increase the level of understanding between manager and employee. This will increase the likelihood that the working environment in which managers and employees operate will be one based on cooperation as opposed to adversity and mistrust.

One interviewee said that the mutual trust which existed between herself and the consultants on her unit meant that they could be both progressive and constructive.

Another interviewee explained that the high degree of trust that existed between her and her superior meant that she was able to get on with her job unhindered and consult her superior when she needed help or advice. This would reinforce the view that trust is a two way process and is reciprocal in nature.

‘At the end of the day it helps us to achieve the main goal which is to the benefit of the patient. My immediate manager knows that she can come to me and know that job will be carried out’

The interviewees indicated that a lack of trust could act undermine the establishment of an effective team work philosophy and structure. The interviewees emphasised the important role team work played in the smooth and the efficient functioning of the hospital on a daily basis. Without the ability to trust one another to carry out their tasks

and duties adequately, the team work philosophy would undoubtedly break down which would adversely effect the ability of each nurse to carry their work effectively.

Quality care Vs Monitoring and supervision:

Data gathered from the interviews indicated that a lack of trust would lower the standard of work carried out by the nurses and undermine their capability to deliver quality care. One interviewee said that she would spend her time constantly checking up on her colleagues to ensure that they had completed their tasks properly;

‘You cannot work efficiently, you don't feel as if you are working as part of a team. If there is somebody you cannot trust there is no point working together’

Previous research suggests that the existence of trust ensures high levels of efficiency and dispenses with the need for monitoring the work of other individuals (Walsh, 1995).

Networking:

One interviewee outlined the role of trust in assisting her to establish an extensive network of contacts throughout the hospital which proved to be of great help and support to the interviewee in helping her to carry out her duties efficiently and effectively. Because the interviewee felt that she could trust the people who formed this network she had the confidence to use them as an invaluable source for information and guidance. The individuals making up this network worked at different levels throughout the organisation and had taken the interviewee a long period of time to establish. Given the considerable

amount of time it had taken the interviewee to establish this network she felt reluctant to leave her post at the hospital as this would involve the loss of her valued network of contacts. The existence of this network made the interviewee's life easier and as a result had positive implications for the way she treated her patients.

'I don't think you can build up trust overnight. Building up trust certainly helped me in my job because I have got connections to whom I can go for help and advice to make my life easier and my colleagues lives easier, which will ultimately have an effect upon the quality of the patient care'

Higher levels of employee commitment:

The interviewees suggested that there was a link between trust and commitment by claiming that were more likely to trust someone who was committed to the patients and the other nurses upon their ward/unit. One interviewee claimed that her commitment to her job and the organisation would cease if she could no longer trust her manager and the other members of staff.

The interviewee described the presence of a high level of trust within her current working environment as being the single biggest factor contributing to her decision to remain within her place of work. If this trust was at any point withdrawn the interviewee said that she would start seeking out an alternative source of employment.

'It would personally lower my morale if I felt that I could not trust people, I don't think that I could continue with the job'

The absence of trust would therefore undermine the commitment of nursing staff to the organisation and increase the likelihood of them leaving the organisation in the near future. This would therefore have the effect of increasing the level of staff turnover within the organisation.

Personal benefits

Self development/relationship benefits:

The sister in charge of one of the hospitals wards spoke of the importance of trust in facilitating the self development of the other nurses upon her ward. She said that when an employee places their trust in their immediate superior they are more likely to undergo a process of self development. This can have a knock on effect upon the other members of staff bringing positive benefits to both managers and employees alike.

‘It has to do with self growth (trust between managers and employees) and I think when an individual starts to grow within themselves then that will impact on the rest of the environment and other individuals will learn from that’

Career development and mobility:

One interviewee referred to her relationship with the F grade nurses on her ward, and the role they played in assisting her career aspirations. F grade nurses have the role of determining the training and educational needs of the other nurses within the hospital.

They do this by conducting and carrying out regular interpersonal reviews on the rest of the ward staff. If a nurse intends to further their educational and career development they need to maintain a close working relationship with the F grade nurses on their wards/units. The nurses must therefore communicate and engage with the appropriate F grade nurse in order to articulate their career goals and to consult with them on their educational and training needs.

‘They know what I want and through negotiation we can usually get it, it may not be this year but maybe next year... We communicate together to get that aim across’

If F grade nurses are to accommodate the educational needs and subsequently the career goals of the nursing staff then a good working relationship and a high degree of trust between the two groups is necessary. This requires good communication and trust between the nurses and the F grade nurses in order for them to guide, advise and support the nurses in whatever career path they decide to take. Butler (1991) has described trust as playing an essential role in the development of managerial careers, this would also appear to be the case regarding the career development of the NHS nursing staff, particularly in reference to their relationship with F grade nurses within this organisation.

Supportive working environment:

As mentioned previously one of the behavioral characteristics of trustworthy managers consists of their ability to support their employees in their work. This support tends to involve looking at and assessing staff training and educational needs and encouraging staff to pursue their own career goals and aspirations. A supportive working environment

establishes the context for the development of confidence, self esteem and high levels of morale amongst an organisations employees.

Morale, self esteem and commitment:

The interviewees suggested that a lack of trust between nursing staff and their management, and amongst nursing staff within the organisation, would lower the level of morale and self esteem of the workforce.

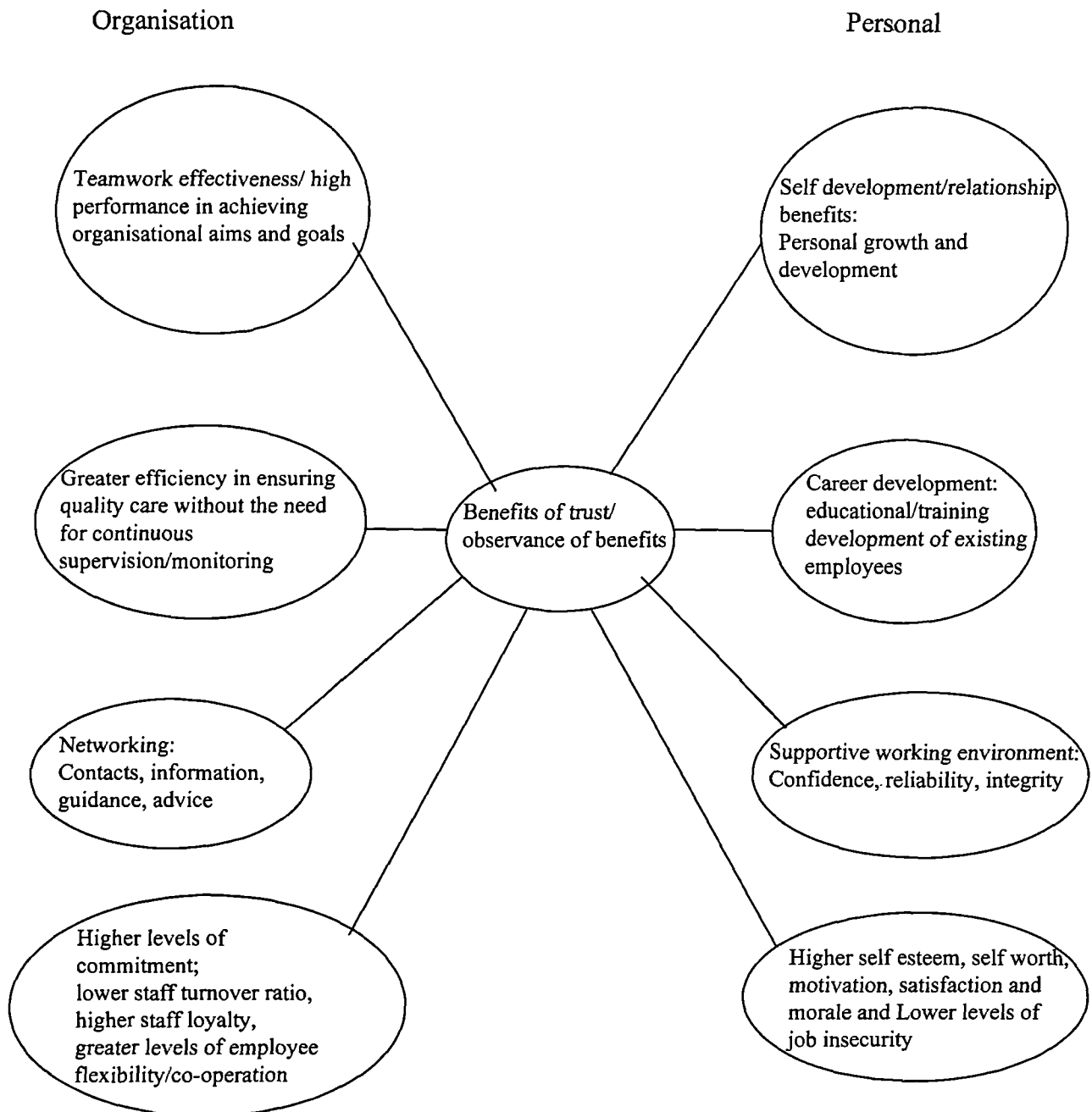
The sister in charge of one of the wards added that she would,

‘be inclined to experience a general lack of morale which would then impact on the rest of the staff and demotivate them to a large extent’

This comment would suggest that a lack of trust amongst middle and top level management could have knock on repercussions upon nursing staff and other employees throughout the organisation.

The following is a model highlighting the various benefits associated with high trust relations amongst nursing staff themselves and with nursing staff and their superiors. The benefits outlined below are derived from the literature on trust and the interviews carried out within this research.

Benefits of trusting one's superior/work associates



(Figure 2)

Policies designed to increase trust within the organisation

The following represent a set of policies, derived from the literature on trust and commitment and the findings taken from the in-depth interviews set out above.

These are policies which organisations can pursue in order to cultivate organisational cultures which support the development of trust between managers and employees. As previously mentioned regular communication and openness with ones employees as a route to increasing employee involvement in organisational decision making can assist in resolving potential disputes and act to create a greater degree of understanding between managers and nursing staff. By sharing information with employees in an open and honest fashion, and by treating them with respect, managers can acquire both the trust and respect of their employees.

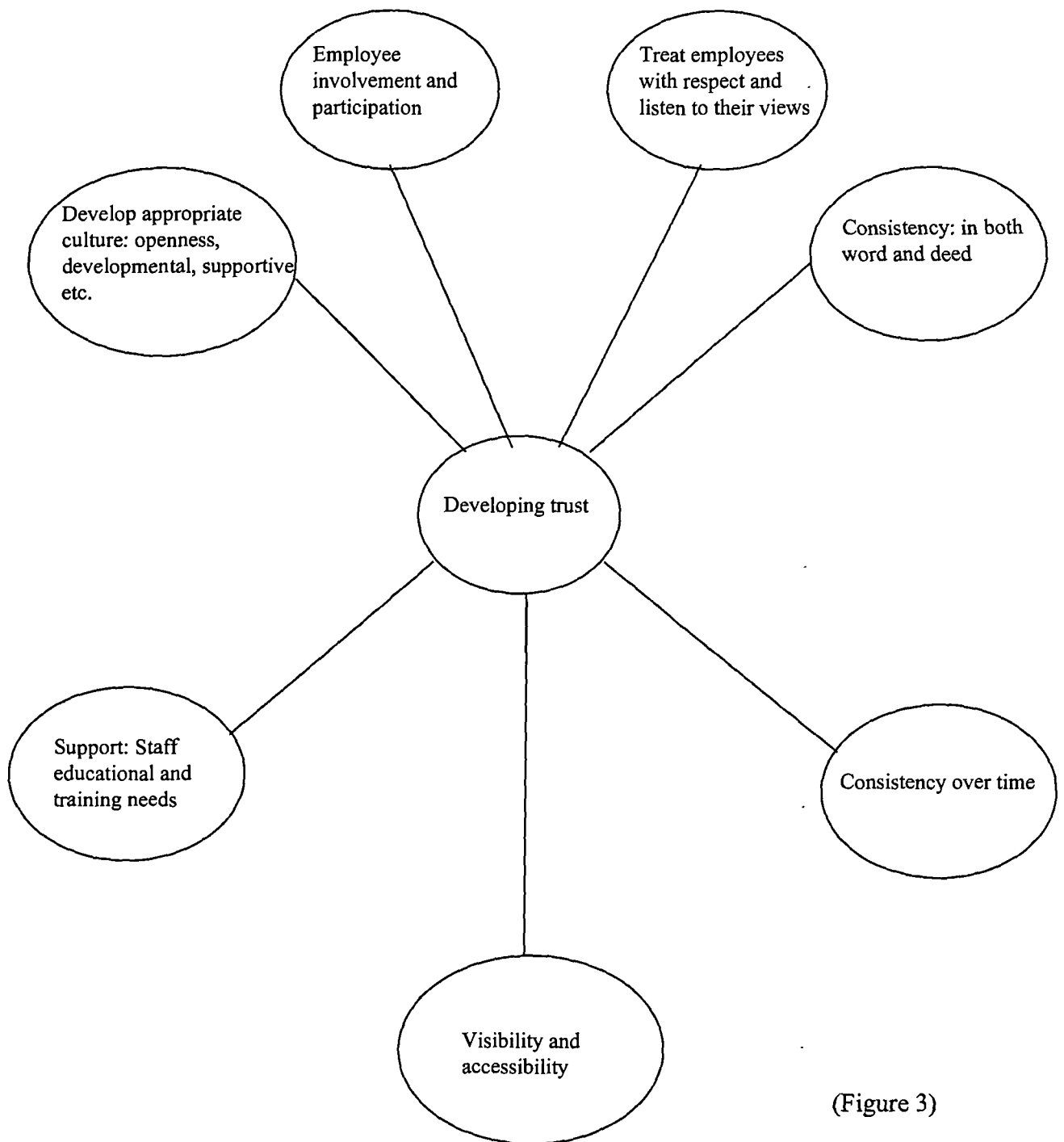
Consistency in terms of one's behavior and the way in which they carry out their duties and tasks creates a certain level of predictability which if demonstrated over a period of time can increase the level of trust between individuals. Managers must practice what they preach by matching their words with the appropriate actions. Nursing staff and other employees will then be able to assess the extent to which their managers can be relied upon.

The level to which a manager is visible within their working environment and the extent to which they can be accessed by their employees is another factor determining the degree to which employees feel that their managers can be trusted. The preliminary interviews suggested that nursing staff would find it difficult to trust managers who they did not have very much contact with.

Supporting the ongoing educational and training needs of ones employees shows them that they are valued and are worth investing in. It also ensures that the organisations employees can carry out their tasks and duties to a higher standard to the benefit of both the patient and the organisation. Employees are more likely to trust managers who are supportive of their long term development.

The following represents a model depicting the various policies managers could pursue in acquiring and developing the trust of their employees.

Policies designed to increase trust



(Figure 3)

Discussion

Conditions for the development of trust between management and employees within the context of an NHS organisation:

When looking at and exploring trust, Butler, recommends investigating a number of conditions and determinants of trust (Butler, 1991, p.647). The search for these conditions, or determinants of trust, was seen as the central objective when carrying out the interviews above. To some extent ones definition of trust can be influenced by the nature of their organisational setting and context. If this is the case then the conditions and determinants of trust may vary from organisation to organisation. The data collected and generated through the interviews outlined above relates specifically to trust amongst nursing staff and their managers within the context of an acute sector NHS organisation.

What does however seem certain about the nature of trust, independent of the context or setting in which the trust takes place, is that the process of trusting one's manager or work associates usually entails some degree of vulnerability. If individuals refuse to allow themselves to become vulnerable with their managers and superiors then the prospect of establishing trusting relations between themselves and others becomes more unlikely (Butler, 1991).

Characteristics of 'trustworthy' managers within the NHS

During the course of the interviews the participants described trust as a two way process that was established over a certain period time and was less likely to be acquired in the short term. It was also discovered that the interviewees would only trust those who they

perceived as being competent, consistent, open, and honest. This would confirm the findings in Barnes (1981), who discovered that trust was built up over time, whereby the participants have confidence in each other's ability, they are willing to share information and they are open and honest.

Taking aside the data collected through the literature review on trust, the interviews revealed that the level to which the participants allowed themselves to trust another individual depended on the extent to which they perceived them as being 'one of us'. One of the interviewees highlighted the break down of trust between nursing staff and management as being mainly due to clashes in the priorities and the values of the two groups. The interviewee also made note of the fact that a lot of the managers did not have any nursing training or experience. The definition of trust offered by the interviewees in general involved high standards and competence in the tasks and duties undertaken by other individual nurses combined with a commitment to their patients and the other nurses working on the ward. The lack of trust between managers and nursing staff could in part be explained by clashing priorities and values reflecting differences in the cultures and practices of each group.

In order for trust to be established, the findings from the literature and the interviews above, would advise managers to make themselves more visible and accessible upon the wards they manage. The interviews suggested that managers should value nursing staff in small, but significant ways, and increase their involvement by giving nursing staff more information openly and honestly, as confirmed in the current literature on trust and commitment (Barnes, 1981; Morgan and Hunt, 1994).

The benefits/outputs of trust vs the costs of mistrust

The findings from the literature and the interviews would suggest that there are a considerable number of benefits associated with high levels of trust amongst employees and management. As pointed out in the interviews some of these benefits include, increasing the effectiveness of organisational teamwork and improving the ability of individuals to network within the organisation. The interviews also suggested that a high degree of trust can establish greater scope for self development amongst individual employees which can have a knock on effect upon other employees throughout the organisation in general.

The literature on trust and the data taken from the interviews above would suggest that trust within the workplace can create a more efficient environment to work in. The existence of trust between managers and employees can enable managers to get on with their own tasks while effectively delegating other tasks and duties to their employees. This means that managers do not have to spend their time constantly checking up on their employees to ensure that they are carrying out their tasks and duties properly. The interviewees claimed that if they did not trust their work associates they would spend most of their time continually checking up on them behind their backs. The existence of trust therefore allows management and other employees to carry out their tasks and duties without the need for monitoring or supervision (Walsh, 1995, p.50).

The interviewees suggested that trust and commitment were linked and that employees will show a greater desire to commit themselves to the organisation in which they work if

they feel that they can trust their managers and superiors (Guest, 1991; Morgan and Hunt, 1994). Some of those interviewed spoke of their reluctance to leave the organisation because of the high level of trust the interviewees had built up with either their managers or work colleagues over the period of time they had spent working within the hospital. While data taken from both the literature surveyed on trust, and the interviews conducted above, would suggest a link between trust and commitment, it would also indicate that trust takes time to establish and is done so by an individual demonstrating consistent behavior over a period of time.

Conclusion

The definitions and theories surrounding the development and establishment of trust in the literature reviewed to date have by and large been confirmed through the course of carrying out the preliminary interviews. However, the data generated through the interviews highlights organisational culture and context as significant factors in employee trust and commitment. The idea that trust entails a degree of vulnerability and that commitment involves choosing trustworthy partners would seem to be consistent with the comments given by the interviewees. Yet the way in which trust, its attributes and benefits were described by the participants would indicate that the concept of trust is to some extent organisation specific. Peoples' description of trust and its attributes can also reflect the context and setting of the organisation in which they work.

Further research is to be undertaken to explore how the nature of the organisational context and setting influences trust between employees and their managers. This will be conducted through the use of in-depth interviews with managers and employees and

through postal questionnaires issued to a large section of nursing staff in acute and community sector organisations.

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