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CORPORATISING COMPASSION? A CONTEMPORARY HISTORY STUDY OF ENGLISH NHS TRUSTS' NURSING STRATEGY DOCUMENTS

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AUTHOR DETAILS:

RAMSEY, Sarah M., PhD RN, Advanced Clinical Practitioner, Trafford Hospital, Manchester, UK

BROOKS, Jane, PhD RN, Senior Lecturer, School of Health Sciences, The University of Manchester, UK

BRIGGS, Michelle, PhD RN, Florence Nightingale Foundation Clinical Professor of Nursing, School of Health Sciences, The University of Manchester, UK

HALLETT, Christine E., PhD RN, Professor of Nursing History, The University of Huddersfield, UK

Correspondence to: S. M. Ramsey: sarah.ramsey@mft.nhs.uk. 0161 746 2130. Trafford Hospital, Moorside Rd, Davyhulme, Manchester, M41 5SL

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ABSTRACT

The purpose of this contemporary history study is to analyse nursing strategy documents produced by NHS Trusts in England in the period 2009–2013, through a process of discourse analysis. In 2013 the Francis Report on the Mid-Staffordshire NHS Foundation Trust was published. The Report highlighted the full range of organisational failures in a Trust that valued financial efficiency over patient care. The analysis that followed however, dwelt heavily on the failings of the nurses. Nursing strategy documents at that time served to set the future direction for NHS Trusts, prescribing specific value frameworks for each nursing workforce. However, the values chosen frequently conflicted with each other pitting nursing values against a managerial trope. It is argued that documents provided a response to wider NHS concerns and high-profile failures in care, particularly the Frances Report, paying lip service to staff engagement whilst maintaining a corporate focus. Nursing values were placed firmly within a managerialist discourse, one that has needed to be re-evaluated in the current Covid-19 pandemic. Wider implications of the research suggest discussion of value conflict may be beneficial within nursing education, and a truly local approach to strategy creation would potentially promote staff buy-in to strategy documents.

INTRODUCTION

In the midst of the Covid-19 pandemic, the King's Fund (2020) noted the impact of the pandemic on nurses, highlighting work pressures, inequality and inadequate working conditions; such appreciation of challenges faced by nurses and midwives is welcomed. Williams (2020, p.2469) argues that the pandemic has seen nurses 'characterized as superheroes on Facebook and other media outlets.' Whether this positive affirmation can be sustained is less clear. Catton (2020, p.158) argues that '2020 will cement our approval rating in the eyes of the public for years to come.' Given the stark contrast to the vilification of the nursing profession in the wake of the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' (Francis Report) (2013) a few years ago, it is likely that the volte face could just as easily swing in the opposite direction.

National Health Service (NHS) Trusts provide healthcare covering a specific geographical area or patient group in the UK. There are over 200 NHS Trusts responsible for providing acute hospital care, community services, ambulance services or mental health care, or a combination of these (NHS Providers, 2015). Poor standards of care along with multiple avoidable patient deaths were identified at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. A public inquiry into these events was carried out in 2010-11, the results of which were published as the Francis Report (2013); the Report concluded that patients had been neglected, with the Trust failing to meet its responsibility to provide safe care. The Report itself acknowledged that the remit of the investigation went as far back as January 2005 (Francis, 2013, p.10).

Health Policy in the UK emphasised patient experience and care quality in documents produced from 2008 onwards. As shown in Table One, these were ongoing priorities for the UK Department of Health during the time period covered by the strategy documents analysed. NHS Values have evolved over time as a result of organisational restructuring and in response to the media, politics and 'an increasingly knowledgeable public' (Giddens, 1998). Hewison (2001) suggests viewing the NHS as a mature institution engaged in a difficult task of managing competing responsibilities, with inevitable conflict between individual and corporate

values (New, 1999). In the period that surrounded the Mid-Staffordshire Trust scandal, negative media attention focussed on loss of specific values within nursing; pandemic media attention focused on the opposite.

Milton noted in 2007 that neither patients nor healthcare professionals were satisfied with loss of focus on human relations in 'a place where illness is not a problem to be solved, but is a situation to be lived' (p. 214). A 2013 *Nursing Ethics* editorial described the 'seeming tsunami of values statements' imposed on nurses at that time, including the NHS Constitution (DoH, 2013a), the 6 C's (DoH, 2012a) and the RCN's Eight principles (RCN, 2010) among many others (Gallagher, 2013, p.615). In light of the acknowledged worth of nursing during the current pandemic, such value statements seem unnecessary at best and arguably spurious. The provision of nursing care in the context of a pandemic has been viewed as a demonstration of nursing values in and of itself. As a contrast, data has been reviewed to illuminate the attitudes towards nurses and nursing values at a time of high-profile scandal. What can we learn from the last time nursing was under such media scrutiny before the current COVID crisis?

In the USA, strategy documents have been used in private businesses from the 1950s and healthcare from the mid-1970s, being adopted in the UK from the 1980s (Tomey, 2004). Strategic management has been used by nursing leadership to strengthen the position of nursing within an institution (Huber, 2006). The purpose of this contemporary history paper is to analyse the Trust documents used in 2014 to set out their agenda, most specifically their nursing agenda. These documents will be used to make sense of the power struggle at that time between nursing values, managerial angst and loss of public trust. Political undercurrents of the Trust documents will be considered against the change in public perception of nurses, highlighting the unhelpful nature of knee-jerk and blame-culture reactions to the scandal.

Background

A literature review was conducted in order to explore creation of nursing value statements at the time the strategies were produced. Literature was published before 2009, a year before the Public Inquiry into the Mid-Staffordshire NHS

Foundation Trust was announced in 2010. The decision to review the literature of the period, was made in order that the research team not 'contaminate' the findings with studies produced in light of the Inquiry. Studies stressed the necessity of nursing values and nursing philosophy statements, suggesting that these provided direction to staff (Koerner, 1996; Schank et al., 1996; Tuck et al., 1998, 2000). Importance was placed on including the 'right' values in such documents, though analysis of rationales for inclusion of specific values lacked depth. No studies questioned the purpose of organisations who created nursing philosophy documents. An attempt to elucidate values held by specific groups of nurses was a theme of many of the studies (Fagermoen, 1997; LeDuc & Kotzer, 2009; Maben et al., 2007; Rognstad et al., 2004). A link between culture and values was identified, with culture vital in determining the values of a particular population (Rassin, 2008). Change was identified as causing turbulence and threatening nursing values (Irurita, 1994).

The main theme identified from the literature was a tension between nursing values and organisational values. Nurses sustained their values in an organisation with a strong values focus (LeDuc & Kotzer, 2009); those in situations where values could not be sustained became frustrated and burnt-out (Altun, 2002; Maben et al., 2007; Molloy & Cribb, 1999). Conflict arose when nurses were unable to provide patients with the desired level of care due to organisational constraints (Von Post, 1998). Maben and colleagues (2007) listed 'unwritten rules' of an organisation which conflicted with implementing values in practice. Constraints such as time pressure and staff shortages, suggesting emphasis on value for money, were key determinants in limiting implementation of values. In the USA, Schank et al. (1996, p.3) identified value conflicts across various settings, concluding that 'to attain fulfilment in professional practice, the individual nurse must work in an environment in which the institutional values are compatible with the nurse's personal values.' Managerialist culture and emphasis on value for money were found to impact on nursing practice and lead to double standards (Molloy & Cribb, 1999). Tensions between professional and managerial agendas were identified, along with philosophical changes in organisations aiming for commercialisation. Nurses as moral agents were reluctant to assert their views due to the repressive nature of the institution, and it was noted that 'in order to 'perform', in order to be 'good' nurses are, at least to some extent, obliged to collude with these practices and to live with

the dilemmas and double standards generated by them' (Molloy & Cribb, 1999, p.419). Verplanken (2004) concluded that value congruence, a match between values held by the nurse and those experienced at work, was predictive of organisational commitment. Overall, nurses who felt able to perform according to their personal values were more satisfied in their roles (Gaudine & Beaton, 2002; Maben et al., 2007; McNeese-Smith & Crook, 2003; Takase et al., 2005; Verplanken, 2004).

The Francis Report (2013, pp. 43-44) describes a 'culture of tolerance of poor standards, a focus on finance and targets, denial of concerns, and an isolation from practice elsewhere.' Traynor (2013) agrees, highlighting the overarching determination of the Trust to save money over the needs of patients and staff. However, some degree of caution is needed here. It is arguable that there is nothing inherently contradictory in the wish to save money and safe and effective nursing care. The problem occurs when Trust policy is entirely predicated on a financial model. Gaudine and Beaton (2002) identified ethical conflict experienced by nursing leaders in four areas. Values of nursing managers were identified as providing quality care, doing what was best for each client, family and staff member and fair treatment of nurses and nurse managers in the workplace. However, hospital values were viewed as balancing the budget and protecting their legal position. Such conflicts led to feelings of powerlessness, distress and frustration and a desire to leave the profession.

The literature review identified little research conducted regarding this subject in the UK. Reliance on studies conducted in countries such as the USA, under a very different healthcare system, might be viewed as failing to shed light on issues faced locally. However, it was found that themes identified were similar across all western, developed countries as indicated above. Studies were of limited quality overall, with those utilising documentary sources providing only superficial analysis. It was therefore established that there was a need for an in depth, high quality study of the values expressed in UK nursing strategy documents.

THE STUDY

Aims

The aim of the contemporary historical study was to analyse nursing strategy documents used by NHS Trusts in England in 2014. Strategy documents were felt to be worthy of analysis as they served to set the future direction for NHS Trusts, prescribing value frameworks for each nursing workforce. As primary sources for historical study, they also offer insight into the cultural and political concerns of senior NHS managers during a time of crisis.

The research questions underpinning the study were:

- How were Trust nursing strategy documents constructed in terms of language and presentation?
- Can we ascertain why these documents were constructed in this way?
- Which value statements are present in the documents?
- What do the documents tell us about how NHS Trusts responded to the apparent crisis in nursing at the time?

Methods and methodology

The study takes a framework of contemporary historical analysis to make sense of the expression of nursing values in strategy documents produced at the time of the Mid-Staffordshire Hospital Inquiry. Documents analysed were all in the public domain, identifying Trust strategies projected to be current up to and including 2018, one year prior to the first cases of COVID-19.

Contemporary history is usually defined as history since 1945. Tosh (2002) puts the case that being so close to one's history makes it difficult to achieve sufficient detachment to produce critical work. Nevertheless, as Barry (1990) argues with reference to Ginette Castro's study of contemporary feminist history, those women who engage in the research have lived through the changes and are embedded in the vital nature of the struggle, which can be recognised as 'our own history'. For those whose struggles were only partly achieved, this nearness can seem to

tantalise with what could have been (Tonghi, 1988). By studying the near past it is possible to see the 'seep' of current political and social movements (Broun, 2020, p.331).

Our study employed historical methodology to analyse primary sources. The work was also informed by discourse analysis – a methodology that lends itself to the analysis of ideological power-structures. Given that strategy documents are, almost invariably, authored from the perspective of those members of NHS Trusts in whom power and authority are invested, it was determined that discourse analysis would provide the most suitable methodology to realise the research aims. Powers (1996, p.216) emphasises this 'power perspective' is often lacking within nursing literature. Nevertheless, discourse analysis has been used by nursing scholars to investigate a variety of topics, where the analysis of text-based data and the exploration of power relations was important (McCabe & Sambrook, 2013; McNamara, 2009; Powers, 2002).

Holloway (1983, p.231) defines a discourse as 'an interrelated system of statements which cohere around common meanings and values [that are] a product of social factors, of powers and practices, rather than an individual's set of ideas' while Parker (1992, p.6) notes that 'discourses do not simply describe the social world, they categorise it, they bring phenomena into sight.' Discourse analysis, with roots in literary studies, linguistics and anthropology (Ward, 1997) has been described as a reflexive process aiming to account for how the world is constructed against socially shared understandings (Durrheim, 1997) and a form of social critique (Zeeman et al., 2002). According to Jordanova (2000, p.81), discourse analysis elucidates 'the power of ideas and of the language through which they exist and in which they are expressed.' Critical discourse analysis, based on Foucault's theory of discourse, considers questions around the creation, validity and function of knowledge and subsequent societal consequences (Jäger & Maier, 2009). For Foucault, a discourse was a set of statements in relation to other statements. Each discourse would include only a limited number of statements which were repeatedly referred to (Danaher et al., 2000) and which constitute 'the objects of which they speak' (Foucault, 2002, p.54). Something is not true or does not exist until it is described through discourse (Danaher et al., 2000), and it is not until something enters the

discourse that is has a status within practices and concerns of institutions (Hughes & Sharrock, 1997). Discourses exercise power in a society because they institutionalise and regulate ways of talking, thinking and acting (Jäger & Maier, 2009). Discourse usually refers to language associated with an institution, including statements and ideas expressing the values of the institution, and the way an institution 'speaks of itself to itself' (Danaher et al., 2000). When viewed in such terms, critical discourse analysis appears of particular relevance to the study to be undertaken.

Through genealogy, Foucault was interested to explore historically 'how effects of truth are produced in discourses which in themselves are neither true nor false' (Foucault, 1984, p.88). Foucault was interested in the influence of social practice on discourse (Heartfield, 1996) and viewed genealogy as a means of uncovering a historical relationship between power, truth and knowledge. Genealogy considers 'how power works within discourses to produce knowledge and how knowledge involves the exercise of power' (Hicks & Taylor, 2008). According to Foucault, genealogy questions 'how did a series of discourses come to be formed, across the grain of, in spite of, or with the aid of these systems of constraints; … and what were their conditions of appearance, growth, variation?' (Foucault, 1981, p.70). For Foucault, truth and knowledge were directly related to power, as laws and policies are based on knowledge produced by institutions, with knowledge legitimising the exercise of power (Bilton et al., 2002). Foucault's understanding of discourse therefore has implications for studying the way institutions operate (Danaher et al., 2000), and this will be applied to the NHS Trusts under consideration. Power is transmitted through discourse, with 'expert' discourse determined by authoritative or powerful institutions usually only countered through competing expert discourse (Giddens, 2006). Truth and knowledge arise through power struggles between institutions and are used by such institutions to legitimate their power (Danaher et al., 2000). This is of particular relevance in examining the position of nursing within NHS Trusts. Danaher et al. (2000) suggest that the authority of institutions comes from their ability to 'speak the truth' about something, and according to Carabine (2001) the power of discourse comes from its ability to define what truth is at a particular moment. Such notions are particularly relevant in examination of the

intentions behind strategy document creation; Foucault's writings have therefore been utilised as a framework to underpin the analysis.

The value of discourse analysis for contemporary history is that it enables the researcher to consider the power shifts as articulated in the documents through the lens of a changing world. Tosh (2002) argues that texts cannot be read in isolation, because nothing is ever written in isolation. The strategy documents can therefore be read within a context of scandal, but through the lens of a pandemic that has changed the manner in which nursing is valued and nursing values are supported. More, recently, Anthony Grafton asserted that 'even when historians confront an idea at its creation, they face difficult problems' adding that a particular difficulty lies in what he calls 'the puzzle of motivation: of identifying the circumstances, intellectual or personal, biographical or collective, which form the context for a particular idea' (2012, p.359).

The method of data analysis followed that of Carabine (2001) who outlined a research method based on Foucauldian genealogy. Though specific steps in the process are outlined below, Carabine (2001, p.285) noted difficulty in following the method step by step as some processes occur simultaneously, with the analysis process in practice being fluid and dynamic, involving interpretation and reinterpretation. Choice of topic and identification of data source is followed by immersion in the data, developing familiarity in order to aid interpretation and analysis. Categories, themes, and the 'objects' of the discourse are then identified, before looking for evidence of inter-relationship between the discourses by cross referencing and considering discursive techniques and strategies used. At this point specific note was taken of links to the Mid-Staffordshire Inquiry, either explicit or implicit. Following this, the discourse is searched for absences and silences, including those things not stated overtly but still assumed to be inferred, for example the documents were examined to determine any evidence of 'blame culture' through placing nursing staff at the forefront of any potential criticisms or failures. Counter-discourses and resistances are identified along with the intended and actual effects of the discourse. Care was also taken to review areas of conflict between nursing and managerial values. This was followed by examination of context, firstly by outlining the background to the issue, and contextualising the discourse in the power

and knowledge networks of the time; the final step is to be aware of the limitations of the data, sources and research (Carabine, 2001).

Sample

The study takes as its primary source material, Trust strategy documents which delineated each Trust's philosophy between the years 2009 and 2018. All the documents were current in 2014, one year post-Francis and most were embued with the anti-nursing bias of the time. The year was also only one year following the changes in nurse registration that created nursing as a graduate profession. The anti-nursing bias was therefore also replete with criticisms in the media of 'Too posh to wash' (Hall, 2004). Within this data set purposive sampling was adopted (Field & Morse, 1985; Ploeg, 1999). Maximum variation (Suri, 2011) was achieved through analysis of all publically available nursing strategies which met specific inclusion criteria. Strategies were excluded if the NHS Trust was non-acute or community, or specialist, including paediatric Trusts. The nature of the texts as freely available to the public was felt to be of particular importance in analysis of the texts as 'language in action' relating to public relations. Table Two provides further information regarding the date ranges covered by the strategies and geographical location of the Trusts involved.

Ethical considerations

In contemporary historical research, given the proximity to the source material, ethical considerations must be taken seriously. Data selection is an important ethical issue in terms of whose reality is presented (Lincoln & Guba, 1987), with attempts made during sampling to capture as many outputs as possible. It was decided that pseudonyms (T1, T2 and so on) would be used for the Trusts concerned in order to preserve anonymity and avoid silencing of potentially problematic aspects of the texts. It was noted that the very nature of such considerations provided an interesting insight into dynamics of power within the NHS and the potential effect of the discourse to be produced through the study (Parker & Burman, 1993).

Rigour

A reflexive approach to the research was taken, recognising that the texts examined did not transparently and simply describe a single order of reality (Atkinson, 1990). Several authors have noted that rigour can be demonstrated through providing rich detail in the analysis (Nixon & Power, 2007) and providing readers with extracts from the data (Yardley, 2000). To this end, brief illustrative quotations will be embedded in the presentation of the findings.

FINDINGS

The creation of a strategy

Strategies were current in 2014, with some devised as early as 2009 and others projected to be current until 2018. All the documents appeared professionally produced to a high standard. Pictures of smiling members of staff, sometimes with patients, occurred repeatedly throughout the documents. Photographs of nurses holding patients' hands were common.

Many strategies failed to address the question of authorship; if it *was* addressed this was typically to emphasise staff involvement: 'In writing this strategy there has been wide consultation' (T24). Although authorship was attributed to the nursing and midwifery workforce in most cases, intended readership was less clear. A small number of strategies were unmistakably aimed at nursing staff, with one (T3) directly aimed at patients.

Before examining strategy content, it was useful to examine the reasons provided for their composition (Hammersley, 1993). These included a need 'to embrace local and national policy' (T20) and a desire to respond to negative media perception and poor public opinion of nursing. Ten strategies mentioned the Report of the Mid Staffordshire Public Inquiry (Chairman Robert Francis, 2013) directly: 'We will ensure that recommendations such as those from the Francis Report will become embedded within the values of our organisation' (T10). Other strategies were presented as responses to change or challenge: 'The NHS is embarking on a period of unprecedented change' (T2), with change in the NHS viewed as a motivating force for the need for strategy development. Change was viewed both as an external

force which affected the Trust and which must be responded to, and also an internal process, deliberately embarked on to improve care: ‘Strong clinical leaders will drive change’ (T21). Facing challenge was a similarly recurring theme: ‘I do not underestimate the size of the challenges we face’ (T29), with challenges portrayed positively, as providing opportunities for development. Three Trusts specifically mentioned financial challenge: ‘finances are getting tighter’ (T12), ‘the changing financial climate’ (T20) and ‘in such financially challenging times’ (T28).

Use of language

In terms of language used within the strategies, the first point of note was use of emotive quotations: ‘We will not forget how nice it is to smile at our patients and hold their hands for comfort’ (A staff member) (T23). However, language was at times very ‘corporate’: ‘identify a robust set of metrics’ (T20), ‘excelling within a regulatory framework’ (T22), notable since most Trusts emphasized the input of ward-level nurses in strategy development. This contrasted with the concurrent use of romanticized, emotive language, for example ‘*embrace* new role development’, ‘*touch* people’s lives’ and ‘patients at the *heart* of everything we do’ (all T9). Adding to the emotive feel of the strategies, the language used, particularly in the Introductions, was overwhelmingly positive: ‘I see the amazing work you do every day keeping positive, smiling, caring’ (T4). Strategies commonly used terms such as ‘service’ and ‘belief’; the term ‘deliver’ was also repeatedly encountered: ‘We will deliver the high quality, compassionate care we want for our patients’ (T20); as was ‘mission’: ‘It is our mission to support excellence in health and health care’ (T13). This demonstrates ‘corporate’ appropriation of terms with etymological foundations in religious language.

Several Trusts used words such as *must*: ‘Nurses and midwives *must* understand the changing demographics’ (T20) or *will*: ‘nurses *will* embed the changes’ (T21). Lipscomb and Snelling (2010) note that use of declamatory language within policy documents serves to limit nurse autonomy and might be perceived as insulting by competent practitioners. Language such as ‘using the workforce’ was incongruent with the emphasis on positive staff experience found in the majority of strategies, focussing on efficiency and effectiveness rather than portraying staff members as autonomous professionals. Several Trusts identified the possibility of ‘random covert

assessment' of nursing practice, such as implementing a 'secret shopper' initiative (T21). Threats of covert monitoring or surveillance demonstrated an interesting contrast between celebratory and emotive language and contrasting dark tones hinting at a punitive culture. It is this blame culture that is most critical to this paper, both when viewed in the period itself and in the current climate. Although there was some acknowledgement in the Francis Report (2013), that there were elements of nursing care that were wholly inadequate, the main thrust of the Inquiry's findings were directed to the callous and self-seeking culture of the management. Yet, in the strategy documents that followed, the narrative of blame clearly lies firmly with the nursing staff. 'The Courage of Compassion' (2020) notes that a positive attitude towards nurses and midwives is essential to foster compassionate and high quality care, an attitude which was apparently lost on the authors of many of the strategy documents.

'Living the Values'

Value statements were common throughout, with values identified including compassion, dignity, respect (T3), empathy, consideration, pride (T4), care ethics, humanity (T6), kindness (T10), service, ambition, courtesy (T12), professionalism (T13) and care (T24). Listed in the Chief Nursing Officer's Vision and Strategy (DoH, 2012b) the 6 C's are care, compassion, competence, communication, courage and commitment; it was recommended that the 6 C's be integrated into any new local nursing and midwifery strategy (DoH, 2012a). Half of the strategies referred to the 6 C's directly and there were indirect references in most other documents. Perhaps unsurprisingly, strategy documents employed the term compassion repeatedly. Though, as Hart (2004) notes, compassion and kindness are at the core of the nursing process, this is less likely to be the reason for such sustained heavy usage of the term than the influence of *Compassion in Practice* (DoH, 2012a). 'Care' was a main section heading in twelve strategies, typically focused on caring activities: 'best patient care' (T4), 'excellent care' (T30). Although all Trusts utilised the term 'care', only one Trust elucidated the components to caring in nursing identified by Griffin (1983), acknowledging that patients wish to feel 'cared about' as well as 'cared for'. Many strategies moved from determining values to imposing behaviours. This was generally in the form of listing standards or expectations of behaviour or including a

behavioural framework. Several strategies discussed 'attitude', with implication that the 'right' attitude was expected. A threatening undertone was detected in a small number of strategies which detailed consequences for failure to maintain the desired attitude or behaviour.

Efficiency and/or effectiveness were discussed in over half the strategies: 'Nurses and midwives take all opportunities to maximize income for the Trust and spend resources in the most efficient and effective way' (T20). Trusts discussed professionalism in contexts such as 'challenging professional boundaries' (T5) or through vague allusion to the 'values' of the profession. Nine of the strategies included aims and objectives relating to uniforms, such as 'monitor the appearance of nurses and midwives to inspire trust and confidence' (T30). Such aims were linked to both professionalism and pride, with implications of corporate branding, though this was discussed overtly in only two of the strategies: 'This will include a review of the uniform policy and a marketing exercise to develop and sustain the 'Nurse brand' (T2). Pride was discussed in most strategies, linked to both professionalism and branding. For example, in T11 'being a nurse or midwife at our Trust is a role to take pride in' was accompanied by a large close-up photograph of a nurse's uniform.

Improving Staffing Levels

A repeated aim throughout the strategies was to have the right staff, with the right skills, in the right place at the right time. To achieve this, many Trusts looked to reduce sickness absence, 'through utilizing fully the sickness and absence policy' (T2), and most Trusts planned to reduce temporary, bank or agency staff. 'Using' the workforce more effectively was mentioned by several Trusts. The most common way this was to be achieved was through e-rostering, developed 'to ensure efficient and effective use of available staff resources' (T8). For most Trusts, 'getting staffing right' involved reviewing skill mix or staffing levels. Other approaches were to 'develop a more detailed traffic light system for nurse staffing levels' (T3), 'implement a tool for assessing and benchmarking nurse staffings' [sic] (T4), 'strengthen the vacancy monitoring process' (T19) or 'review shift patterns' (T30). Interestingly, only one Trust stated that they would 'increase staffing numbers in general medical and surgical wards' (T10), with overall lack of acknowledgment of need for safe staffing

levels, despite inadequate staffing being a key criticism in the Francis Report (2013, p.45). Recruitment was discussed in almost all strategies, not in terms of recruiting additional staff but through changing processes to ensure the 'right' staff were recruited, nurses who shared the values of the organization: 'we will recruit based on values and behaviours.'

'Quality Improvement Initiatives'

All strategies included plans to improve the patient experience, by means such as the Friends and Family Test, Patient Experience Trackers, Patient Advice and Liaison Services and 'feedback from patient stories' (T18). The term quality was used repeatedly in the strategy documents, commonly found in relation to care, such as 'providing high quality care'. All of the strategies included discussion of patient safety, with recurring areas of focus including infection control, learning from incidents and use of the Safety Thermometer and Harm Free Care Tools (DoH, 2012b).

A recurring theme was responding to 'things going wrong'. Trusts stressed 'we must not tolerate poor standards' (T25) or 'we will rid the profession of poor performance' (T23). In contrast to the overwhelmingly positive language encountered throughout the strategies, several Trusts made brief acknowledgement of ongoing problems with quality of care ('*when* care falls below standard'). Use of the phrase 'things going wrong' demonstrated a fatalistic approach, serving to diffuse blame away from the Trust itself. Several Trusts emphasized the importance of action following complaints: 'it is essential that action plans following complaints, incidents and claims are robust, implemented and that lessons learned and examples of good practice are shared, disseminated and embedded across the Trust' (T21). Use of such language was a clear response to the findings of the Keogh Review (NHS England, 2013, p.9), which recommended that 'transparent reporting of issues, lessons and actions arising from complaints is an important step.'

Autonomy or obedience

Examination of absences and silences identified many statements regarding challenges to be faced, with conspicuous absence of detail regarding the nature of such challenges. Few Trusts identified the challenge as being financial, though

recurrent emphasis on efficiency and effectiveness suggested an unacknowledged undercurrent to many strategies. Though 'staffing levels' was a theme addressed consistently throughout, only one Trust aimed to increase numbers of nursing staff, with others aiming to increase effectiveness of the current workforce.

Counter-discourses, conflicts and resistances were noted in use of declamatory language and hints of a punitive culture in documents simultaneously stressing a need for professionalism, revealing conflict between the managerialist culture prevalent within the NHS and the autonomy required in nursing's quest for professionalism (Molloy & Cribb, 1999). According to Gastmans (1998, p.237) 'in nursing, obedience still seems to prevail over autonomous action.' Such language was in stark contrast to the emphasis on 'positive staff experience' and general overwhelming positivity of the documents. It is unfortunate that in addressing a professional workforce it was deemed necessary to make undisguised threats should staff not follow the strategy to the letter. It is possible that such statements were included to reassure the public readership of the strength of the Trust's commitment to the strategy. However, such blaming was reminiscent of the anti-nursing trope of the time, perpetuated through the media, with its antecedents in the 'too posh to wash' narratives. This blame culture appears to have also emanated from the Francis Report (2013), though criticisms of the registered nursing staff formed only a small aspect of the Inquiry, with concerns mostly focused on the culture of the Trust Board. It was also intriguing that many strategies were portrayed as responsive to staff and local priorities, stressing staff authorship, yet adopting corporate language unlikely to have derived from staff engagement and conspicuously in line with government targets. Documents were legitimised through naming the Trust Board as author; any input from staff members had clearly been 'corporatised' and distorted, effectively coercing nurses into signing up to a board-centric and Department of Health driven strategy, under the premise of staff ownership.

DISCUSSION

Contemporary historical analysis is a valuable way to witness the shifts and seeping of undercurrents in politics, policy and social change. Availability of documents relating to the history to be uncovered make its proximity all the more tantalising

(Evans, 2003). On discourse analysis of the strategy documents, none emerged as being conspicuously different from the others, with considerable overlap in content and language. Corporate language was predominant, emphasising the professionalism of nursing and demonstrating compliance with managerialist agenda. Romanticist language: '*embrace* the challenges' (T19) provided a stark contrast. Such language was emotive, potentially employed to appeal to the workforce or patient readership. Vestiges of the language of religion were identified in many strategies, particularly in terms of vocation such as 'good of the patient' and 'needs of the service.' According to Hart (2004) such language has connotations of duty and sacrifice and implies that nurses should subordinate their needs to higher ideals. However, juxtaposition of such phrases with statements such as 'nurses … take all opportunities to maximize income for the Trust' (T20) implies the corporate view of the 'higher ideal' to be value for money rather than altruism.

Examination of the strategy documents demonstrated 'an inherent tension and ambiguity in the NHS as several strongly held and conflicting values are aspired to' (Hewison, 2001, p.255), an internal struggle within Trusts to meet Department of Health demands whilst functioning as profitable businesses. Despite the emphasis placed on 'values', a tension between nursing values such as altruism, and corporate values such as efficiency, can be identified, with corporate values emerging as dominant. Value conflicts identified in the strategy documents echoed those previously identified in studies describing incongruence of values between nurses or nurse managers and organisations (Gaudine & Beaton, 2002; Irurita, 1994). Sellman (2011) describes an inevitable corrupting influence of institutional values, with the imperative to meet targets undermining the traditional values of nursing.

From a Foucauldian perspective, the documents were of interest as 'language in action' (Gee, 2011). The primary action accomplished was the most overt – strategizing. According to Tomey (2004) strategic planning determines a direction for the organisation to improve efficiency, clarify beliefs and values, prepare for change and improve communication. Whilst strategising was the declared focus of the documents, analysis revealed four further activities. The first was an attempt to motivate the workforce in order to enhance efficiency at a time of low morale within nursing and increased financial challenge. Most Trusts took pains to emphasise pride in their workforce, a counterbalance to the onslaught of negative media

attention besetting nurses. Yet, the language of the documents at times corroborated the blame culture of the press in the period of the Mid-Staffordshire scandal, rather than upholding the values and integrity of the nursing staff.

The second activity performed by the documents was a demonstration to patients that they would be listened to and their opinion valued, with Trusts promising to respond to feedback and improve the patient experience. A further activity sought to reassure the public that the Trust in question was not like those who had suffered high profile failures (or in one particular case, that they were no longer like that). By distancing themselves from past failures, Trusts defined or redefined themselves according to their perception of public feeling. The final activity demonstrated was compliance with Department of Health objectives, a common feature of the documents. Many of the strategy aims were in line with Government targets, though this was not usually stated overtly.

This study supports the suggestion that the traditional values of nursing had been subsumed at least in part by the demands of the managerialist agenda. It has been noted that values esteemed by nursing cannot compete with the strong tide of managerialism which values 'what works' and 'league tables' above all else (Sellman, 2011). However, for many individual nurses and nurse theorists, the traditional values of nursing have continued to permeate everyday practice, despite being excluded from Trust and Governmental agenda and discourse. In reaction to negative public and media attention, along with high profile failures in care delivery, nursing as a profession has been forced to re-focus attention on neglected values. By accepting such values into the discourse of the strategy documents they once again became 'real' in Foucauldian terms: 'once an object has been elaborated in a discourse, it is difficult not to refer to it as if it were real' (Parker, 1992, p.6). Discourses create discursive frameworks which order reality in a certain way, so the strategies may have fostered a truly value focussed reality for the nursing workforce. However, there is no evidence from the strategy documents that Trusts recognised and addressed organisational constraints preventing expression of nursing values. According to Edgar (1993) healthcare managers use rhetorical devices 'to maintain a fiction of upholding practitioner values while knowingly undermining the possibilities for those values to thrive.' It is possible that Trusts were simply paying lip service to the aforementioned values, following the discursive framework set by the

Department of Health. It will be interesting to observe whether emphasis on nursing values in the discourse is enduring or faddish, and whether Trusts are able to achieve operationalisation of the values in practice.

Limitations

One limitation of the study is that any future researchers may struggle to review the strategy documents themselves as they were originally gathered by the first author in 2014. As the documents are now part of Trust history, it was not possible to consult those involved in drawing up the documents; it would have been useful to interview the authors regarding their intentions. Documents may have been worded cautiously since they were to be placed in the public domain, though awareness of this possibility underpinned analysis. Selectivity, 'drawing upon apposite extracts to support the argument' (Carabine, 2001, p.306) was considered and attempts were made to seek out statements which challenged the analysis, though this proved difficult due to similarities between documents.

CONCLUSION

This contemporary historical study focuses on strategy documents produced by Trusts during the period of the Mid-Staffordshire NHS Foundation Trust Inquiry (The Francis Report, 2013). Reviewing these documents seven years later, during a pandemic that has seen the image of nurses turn from vilification to hero-worship brings into stark relief the blame culture of the media and Trust management in 2013/14. Documents were professionally produced, copiously illustrated in full-colour, polished advertisements for pride and professionalism to counter the tarnished public perception of nursing. High standards of presentation aimed to demonstrate local investment in the nursing workforce, though plans to increase nursing workforce numbers were conspicuously absent; perhaps the effort put into creation of the documents represented an element of over-compensation.

From the data, it is apparent that NHS Trusts strive to provide a high-quality service in order to attract patients. In terms of strategy development, public and patient consultation might enable Trusts to prioritise local goals, which could form the centre of the vision. Rather than simply disseminating Department of Health priorities,

Trusts are in a position to represent their population group, fitting Governmental policy to meet local needs. A truly local Trust nursing strategy could provide vision and direction through key goals to achieve the desired outcomes of the community (Steele, 1999).

The language used to construct the strategies was found to be a mix of the corporate and the compassionate. Consideration of the value statements present in the documents demonstrated that nurses in individual Trusts were being presented with the plethora of value statements about which caution has previously been expressed. There was also evidence of conflict between organisational values such as effectiveness and efficiency, and nursing values such as compassion and altruism. Our final research question considered the response of NHS Trusts to an apparent crisis in nursing at the time. According to Foucault it is not until something enters the discourse that it has a status within practices and concerns of institutions (Hughes & Sharrock, 1997). Following the collapse of nursing culture, superseded by organisational culture, the strategy documents represented a top-down attempt to re-instate nursing culture into the resulting vacuum, though corporate values remain within the discourse also.

Study findings concur with Malby and Pattison (1999) who suggested that prior to composing NHS value statements it would be useful to confront the day to day reality of nursing practice which prevents nurses from achieving organisational values, and identify individual values which may conflict with organisational values. By identifying the motivating factors for their employees, Trusts would be better positioned to connect organisational goals with personal values. Simply imposing value statements on nurses is not likely to achieve positive changes in care. As Gallagher (2013, p.616) notes 'flooding our minds with checklist statements is more likely to deaden our hearts than stimulate our moral imaginations and passion.'

Whilst discussion of nursing values might seem irrelevant to nurses and managers struggling with the reality of staff shortages and service demands, it is to some extent a lack of clarity around the values guiding the service which led to the conflicts of the time (Hewison, 2001). When viewed against 'The Courage of Compassion', lack of empathy for the challenges nurses faced becomes all the more apparent. The findings of this study illuminate the earlier crisis in the NHS, challenging the

assumption that poor care is due to nurses having the 'wrong' values. This is especially clear when we witness the challenges faced by all healthcare professionals in the current pandemic. In September 2020, the King's Fund published, 'The Courage of Compassion: Supporting nurses and midwives to deliver high quality care.' The report argues,

> The impact of the pandemic on the nursing and midwifery workforce has been unprecedented and will be felt for a long time to come. The crisis has also laid bare and exacerbated longstanding problems faced by nurses and midwives, including inequalities, inadequate working conditions and chronic excessive work pressures (King's Fund, 2020)

The power of discourse emanates from illumination of truth and solidification of existence. Assimilation of the nursing response to the COVID-19 pandemic into the discourse, therefore, has had a two-fold impact. Media representation of nurses demonstrating values such as courage and compassion garners public attention, bringing these concepts to life in a way the strategy documents could not hope to achieve; the emotional labour of nursing work, on which the glossy booklets were silent, has also become a tangible reality within public perception. The response of the nursing workforce to the pandemic, and media portrayal of this, has more significantly impacted the discourse than any preceding Policy or Strategy.

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Table One: UK Health Policy 2008-2018 as relevant to Nursing Strategy

Title, Author	Year	Relevance
High Quality Care for All (The Darzi Report) (Secretary of State for Health)	2008	Stressed the importance of patient experience and aimed to 'drive improvements in the quality of care' (p.2).
Equity and Excellence (Secretary of State for Health)	2010	The Coalition Government's vision for the future of the NHS included plans to link payment systems to quality standards, furthering the quality agenda with the aim of improving patient experience.
Front Line Care (The Prime Minister's Commission)	2010	Placed increased emphasis on compassionate, high quality care.
2012/13 NHS Operating Framework (Department of Health)	2011	Prioritised the patient as the centre of the NHS, focussing on improvement of patient experience.
Time to care? (Sawbridge and Hewison)	2011	Advocated use of patient focused rounding to improve care quality and safety, and recommended use of clinical quality dashboards.
Compassion in practice: Nursing, midwifery and care staff – our vision and strategy. (Department of Health)	2012a	Sets out the vision for Nursing, based around six values: care, compassion, courage, communication, competence and commitment, aiming to embed these values across NHS and social care settings.
Delivering the NHS safety thermometer CQIN 2012/13; A preliminary guide to delivering 'harm free' care (Department of Health)	2012b	Guidance to support implementation of the NHS Safety Thermometer, a template to check basic levels of care and identify where things are going wrong. CQUIN incentive payment to reward Trusts who collect data on the safety of the care they provide.
NHS Outcomes Framework 2013/14 (Department of Health)	2012c	Aimed 'to act as a catalyst for driving up quality throughout the NHS' (p. 4). Domain 4 focused on ensuring patients had a positive care experience.
Transforming Care (Department of Health)	2012d	Stressed the importance of developing mechanisms to quickly highlight poor quality care.
The Power of Information: putting all of us in control of the health and care information we need (Department of Health)	2012e	Noted the importance of gathering patient feedback and making such information available to the public.
NHS England Business Plan Putting Patients First (2013/14 – 2016/17) (NHS England)	2012	Stressed the importance of gathering patient feedback regarding their healthcare experiences. Prioritised patient satisfaction.

Caring for our Future (Secretary of State for Health)	2012	Emphasised patient choice along with care quality and safety.
The NHS Constitution (Department of Health)	2013a	Detailed the rights of NHS patients to expect safe, effective, high quality care that is focused on patient experience.
Patients First and Foremost (Department of Health)	2013b	Aimed to develop an NHS-wide culture of compassionate care, ensuring that patient complaints were heard and quickly acted upon.
Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis)	2013	Recommended embedding the voice of the patient in healthcare systems, with collection and reporting of feedback as near to 'real time' as possible.
After Francis: Making a Difference (House of Commons Health Committee)	2013	Stressed the importance of the NHS maintaining a culture of constant dialogue about care quality.
Government response to the House of Commons Health Select Committee Fourth Report of Session 2014-15 Complaints and Raising Concerns (Department of Health)	2015a	'The challenge ahead will be to make listening and responding to patients and staff a natural and highly valued element of the culture of the health and care system everywhere' (p.2).
Government Policy: Compassionate Care in the NHS (Department of Health)	2015b	Introduction of the Friends and Family Test, emphasis on compassion in all health and social care services, learning from mistakes, use of national patient survey programme.
Guidance: The NHS Choice Framework (Department of Health)	2016a	'The government is committed to giving patients greater choice and control over how they receive their health care, and to empowering patients to shape and manage their own health and care' (online).
Annual Assessment of the NHS Commissioning Board 2015-16 (Department of Health)	2016b	Assessment of NHS performance. 'I am encouraged to see over 20 million pieces of individual feedback have now been received using the FFT. I anticipate seeing further evidence of tangible improvements being made across the health service as a result of this feedback. You should also continue to ensure that effective use is made of the insights from all forms of patients' and service users' feedback about their experiences of services' (p.11-12).
The Government's mandate to NHS England 2016-17 (Department of Health)	2016c	Objectives include 'NHS England should ensure the NHS meets the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality' (p.8).
NHS Outcomes Framework 2016-17 (Department of Health)	2016d	Domain Four: ensuring that people have a positive experience of care. Improvement area – improving hospitals' responsiveness to personal needs.

The Handbook to the NHS Constitution (Department of Health)	2015, updated 2017a	'The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care that is safe, effective and focused on patient experience' (p.13).
The Government's revised mandate to NHS England for 2017-18 (Department of Health)	2017b	Reduction in inequality of people's experience of the NHS. NHS to be a learning culture which uses all sources of insight, including complaints, to improve services and quality of care. 'Ensure the NHS meets the needs of each individual with a service where people's experience of their care is seen as an integral part of overall quality' (p.9).
Adult Social Care: Quality Matters (Department of Health)	2017c	Emphasises high-quality, person-centred care for all, including a positive experience of a service which is caring and responsive and where people are treated with compassion, dignity and respect.
Draft Health Service Safety Investigations Bill (Department of Health)	2017d	Proposes whole-system change to learning from error and increasing patient safety and care quality.
Care and Support Statutory Guidance (Department of Health and Social Care)	2018	Emphasises patient choice and control over their own care.

Table Two: Details of NHS Trusts and Strategy Documents included in the analysis

Trust	Date range covered by Strategy	Location	Strategy Title
T1	None stated	East of England	Every Patient Matters
T2	2012-2015	South East England	Nursing and Midwifery Strategy 2012-2015
T3	None stated	South East England	Safe, High Quality Nursing, Midwifery and Therapy Care at [T3]
T4	2013-2014	North West England	Nursing and Midwifery Strategy 2013/14
T5	2011-2014	East of England	Nursing and Midwifery Strategy 2011-2014
T6	2014-	North West England	Nursing and Midwifery Strategy 2014 and beyond
T7	2012-2015	East of England	Nursing and Midwifery Ambitions 2012-15
T8	2012-2015	North West England	Nursing, Midwifery and AHPs Strategy: Delivering Excellence
T9	2013-2016	North West England	Nursing and Midwifery Strategy 2013-2016
T10	2013-2016	South East England	Our Nursing and Midwifery Strategy 2013- 2016
T11	2013-2015	South West England	Nursing and Midwifery Strategy 2013 – 2015
T12	None stated	South West England	Nursing Together: A Strategy for Improving Patient Care
T13	2009-2014	East of England	Nursing and Midwifery Strategy 2009 – 2014
T14	2013-2017	East of England	Nursing and Midwifery Strategy 2013-2017
T15	2013-2016	London	Everyone Counts: Nursing and Midwifery Strategy 2013-2016
T16	2012-2015	West Midlands	Nursing & Midwifery strategy 2012-15
T17	None stated	London	Strategy for Nurses and Midwives
T18	2012-2015	South East England	Nursing and Midwifery Strategy 2012–2015
T19	2013-2015	East Midlands	Our Nursing and Midwifery Strategy 2013-15
T20	2010-2015	North East England	Nursing and Midwifery Strategy 2010-2015
T21	2014-2018	North West England	Nursing and Midwifery Strategy 2014-2018
T22	2013-2016	South East England	Your Care First: Nursing and Midwifery Strategy 2013-2016
T23	None stated	West Midlands	The Way We Care: The Strategy for Nursing and Midwifery at [T23]
T24	2013-2016	North East England	Proud of Nursing and Midwifery in [T24]: ‘Compassion, Quality and Excellence in all we do‘ The Trust’s Nursing and Midwifery Strategy 2013-2016
T25	2014-2016	Yorkshire and the Humber	Nurses and Midwives Care Strategy 2014-2016: Safe Caring and Reliable: Patients at the heart of what we do
T26	2012-2015	London	Nursing and Midwifery Strategy 2012-2015
T27	2009-2014	North West England	Nursing and Midwifery Strategy 2009-2014: Embracing the Future and Building Confidence

T28	2012-2016	London	The Nursing, Midwifery and Allied Health Professionals Strategy 2012-2016: Delivering High Quality Compassionate Care
T29	2011-2016	East of England	Nursing and Midwifery Strategy for 2011-2016
T30	2013-2018	North West England	Modern, patient focused nursing and midwifery based on traditional values: Nursing and Midwifery Strategy 2013 – 2018