The Contradictory Simultaneity of Care and Technocracy: Understanding Vertical and Horizontal Pressures on English Nurse Middle Managers in Intensive Care

Author: Nick Krachler, Associate Consultant at the Work & Employment Research Unit, Business School, University of Greenwich. Email: krachler@gmail.com.

Abstract: Part of the Coalition Government’s health policy has been to enact austerity measures and restructure local health economies causing efficiency drives, even in trusts which are surplus-making. This paper evaluates the impact of this reconfiguration strategy on the intensive care workplace in London. To achieve this aim, a characterisation of the intensive care workplace is developed based on the perceptions of 10 nurse middle managers. It is demonstrated that the Coalition Government’s reconfiguration strategy has been translated into the transformation of the intensive care workplace towards workforce restructuring, optimised asset utilisation and the beginnings of deprofessionalisation. However, top-down structural pressures comprise only one form of pressure bearing down on middle management with bottom-up pressures arising from the workforce and horizontal pressures emanating from the contradictory simultaneity of care and technocracy in the ICU. While technocracy tends to depoliticise the workplace, care can lead to instances of resistance, especially where patient need is affected so that the effects of reconfiguration are not linear or uniform.
Introduction

Apart from reforming National Health Service (NHS) commissioning through the Health and Social Care Act 2012 (Pownall 2013: 424), the Coalition Government’s health policies have so far consisted in reconfiguring the NHS by establishing a failure regime, centralising services, merging trusts deemed to be underperforming with surplus-making trusts, and enacting challenging austerity measures with an aim of saving £20bn by 2015 through the Quality, Innovation, Productivity and Prevention (QIPP) programme (HM Treasury 2013: 35) and by targeting the national (Payment by Results) tariff with an annual 3% reduction in reimbursements since the beginning of the 2000s (DoH 2012: 65). This reconfiguration strategy has been facilitated by debt pressures rooted in financialisation through Private Finance Initiatives, which was the case, for example, for the South London Healthcare Trust (Pollock/Kondilis/Price 2013). The ensuing reconfiguration involving the University Hospital Lewisham was met by the community-wide campaign ‘Save Lewisham Hospital’ and led to a judicial review declaring the administration measures to be unlawful (BBC News 2013). Campaigns around local hospitals have been a common response to reconfigurations with over 30 campaigns since the late 2000s challenging expectations of optimised patient care and increased efficiency through reconfigurations (Ruane 2011: 126f.).

Within this context of contestation around the nature of the NHS, the role of the workforce has gained relatively little attention. This is somewhat surprising, since the traditional public sector ethos in the NHS enabling high performance for lower financial input has been deemed to be eroding due to financialisation processes (Hebson/Grimshaw/Marchington 2003: 499) and the public service habitus has been conceptualised to include an inherent adversarial stance towards transforming the public sector (McDonough 2006). Moreover, as a consequence of downsizing overall in the 1990s in the UK, middle managers’ job security and promotion prospects declined (McGovern/Hope-Hailey/Stiles 1998: 466). Evidence of further intensification of the general trend towards increased pressure on middle managers has been presented (McCann/Morris/Hassard 2008: 365), though with the seemingly contradictory finding of high levels of motivation and job satisfaction (ibid.: 366). Therefore, the question of how the Coalition Government’s reconfiguration strategy has impacted the NHS workforce is not only theoretically interesting, but also relevant to both policymakers and campaigners, particularly as it is likely that such a large-scale transformation of a health system will not be successful without the compliance of staff, with special reference to middle and upper middle managers, who act as the primary drivers of change.
Focussing on intensive care in London, the aim of this paper is to show how the top-down pressures of reconfiguration as well as the bottom-up pressures of a highly professionalised and empowered staff are experienced and met by middle and upper middle managers. In order to fulfil this aim, the structure of work in intensive care as experienced by nurse middle management is analysed. It will be demonstrated that the experiences of middle managers cannot be understood without considering the interaction of vertical pressures with practices and motivations. Moreover, in the context of intensive care, a two-dimensional model incorporating horizontal as well as vertical dimensions is necessary to explain the contradictory simultaneity of care and technocracy. Lastly, it will be shown that though the Coalition Government’s reconfiguration strategy has led to an extensive transformation of the intensive care unit (ICU), including workforce restructuring, optimised asset utilisation and the beginnings of deprofessionalisation, there remains a potential for resistance due to the dominance of a care logic in the ICU.

The paper is structured as follows: after discussing recent pressures on public sector middle management and previous studies of the ICU, the theoretical basis for analysing the two dominant logics in the ICU workplace will be laid out. Following this, the methodology of the study and its results will be presented. A discussion of the results incorporating the development of the two-dimensional structure of work in the ICU will ensue and the paper will conclude with the study’s implications.

**Public Sector Management and Intensive Care**

Middle managers have generally been conceptualised as fulfilling the functions of supplying information and alternative strategies to senior management while also exerting downward influence into their organisations and “translating corporate strategy into action” (Currie 2006: 8). The translational function is often seen as the most important and common function. Within the British NHS, nursing middle managers are often constrained by the dominance of the medical profession, central government intervention and job insecurity (ibid.: 10). However, with the introduction of general management and efficiency as the primary driver in the NHS since the early 1980s (Klein 2006: 105), the introduction of the quasi-market in the early 1990s and financialisation from the end of the 1990s onwards structural pressures on middle management have steadily increased. The general trend of increasing structural pressures as part of increasing global competition and efficiency drives constitutes a major factor for the
normalisation of intense working conditions for middle managers (McCann/Morris/Hassard 2008: 345).

However, high workloads and long working hours are often met with high levels of job satisfaction and motivation, even where financial incentives tend to be lacking as is the case in the public sector (ibid.: 365). Additionally, survey evidence from the late 1990s indicated that managers in the NHS with NHS backgrounds were more permissive in interpreting bureaucratic rules than managers with non-NHS backgrounds (Sheaff/West 1997: 197), often in instances where following rules strictly would be impractical or harmful to organisational interests (ibid.: 199). Moreover, evidence from studies on the effects of Private Finance Initiatives on NHS hospitals found that public sector managers assumed the existence of private sector supplier opportunism (Lonsdale/Watson 2007: 690). The response of public sector managers was to employ assiduous management practices (ibid.: 696) exchanging trust-based relationships to private sector suppliers with high levels of scrutiny and management according to contract specifications (Hebson/Grimshaw/Marchington 2003: 489). These studies show that NHS managers exhibit autonomous decision-making and can respond flexibly to increasing structural pressures from reconfigurations and marketisation.

Furthermore, a survey of Canadian acute care nurse middle managers (including a small sample of critical care managers) indicated a reason for the interesting combination of high job satisfaction despite increasing structural pressures: job satisfaction was positively associated with structural empowerment (understood as being supported and having access to information, resources and development opportunities) and perceptions of organisational support due to feedback and recognition from senior managers (Patrick/Laschinger 2006: 18f.). The implication is that where senior managers are able to enact supportive and empowering management practices, nursing middle managers are able to manage structural pressures effectively.

With regard specifically to intensive care in the UK, one study found that the pressures from the introduction of general management and efficiency imperatives had not greatly affected ICUs due to their insular nature and strategically important position in public hospitals: “Its role as an essential service provides protection against market forces with budgets being top-sliced from the Trust’s budget and few ICUs being involved in contracting” (Kowalcyk 2002: 26). Moreover, a programme for reforming intensive care services in the UK called ‘Comprehensive Critical Care’ in the beginning of the 2000s aimed at optimising clinical outcomes was found to have led to a decrease in delayed discharges, a significantly lower increase in lengths of stay and high decreases in hospital and unit mortality rates (Hutchings et
al. 2009: 4) leading to significant cost reductions (ibid.: 5). The programme meant that from 2006 onwards, a large amount of efficiencies had already been achieved through clinical improvements. Furthermore, a review of London’s intensive care services found that they had expected mortality rates which were consistent on weekdays and weekends (NHS London 2013: 8) while quality improvements could be achieved by reducing the number of out-of-hours discharges (currently at 5%; ibid.: 18) and systematically recording nursing ratios and nursing skill levels (ibid.: 24). Overall though, intensive care in London was found to be “a well-staffed service which has a highly skilled and motivated nursing base” (ibid.: 4). This view of intensive care as a high-quality and clinically optimised service was confirmed in this study’s sample when reviewing CQC reports about the quality of intensive care and the trusts’ Summary of Hospital-Level Mortality Indicators which were as expected or over-performing (HSCIC 2014).

High levels of quality are achieved by adequate funding, and a highly specialised and educated workforce corresponding to the demands of the sickest patients in a hospital. The strong reliance on technology in intensive care means that nurses require a high level of technological competence (Little 2000: 395) while also requiring non-technical skills such as the ability to manage diverse tasks, situational awareness, decision-making and team-working (Reader et al. 2006: 552). In addition to these skills, ICU nurses exhibit high levels of commitment and the ability to work in stressful and emotionally burdensome situations (Lakanmaa et al. 2012: 333) as a result of higher levels of mortality in the ICU. The emotional stress associated with working in an ICU can be one reason for leaving intensive care (Cartledge 2001: 350) amongst others, such as lacking professional development opportunities, lacking respect from colleagues and/or lacking flexibility regarding working times (ibid.: 352f.). Taken together with the general status of intensive care in the UK, the high skill level of intensive care nurses indicates a workplace which is dominated by clinical concerns and a strong quality imperative. Moreover, bearing in mind the afore-mentioned semiautonomous decision-making and behaviour of NHS managers, it is possible that middle management in intensive care exhibits a complex structure in which consent and resistance may be intertwined (Bolton/Houlihan 2009: 7), and therefore not only conflict, but also the alignment of interests, orientations and motivations (Vincent 2011: 1376) should be considered.
The Effects of Care and Technocracy on Politicisation and Resistance

Having discussed previous studies regarding NHS managers, nurse middle managers and characteristics of intensive care in the UK, it is now necessary to turn to a discussion of potentially conflicting logics which will be used to interpret the findings of this study. As mentioned previously, intensive care nursing requires technological skills in addition to nursing’s traditional empathic and caring skills, which is why the effects of care and technocracy on the potential for politicisation and resistance will now be considered. Care is often conceptualised along three dimensions as a particular disposition towards considering and having an interest in the wellbeing of others; as a form of physical labour aimed at meeting people’s basic corporal, health and reproductive needs; and as a social relationship between the person receiving care and the one giving care, often understood as an asymmetrical relationship (Rummery/Fine 2012: 324f.). Within the context of nursing, these three dimensions take on a special character due to care being imbued with medical knowledge (Latimer 2005: 6). Nursing care is generally focussed on the individual needs of a patient whereby the improvement of health and meeting patient need become the primary drivers of the actions of nurses and nurse-patient interactions (Mol 2008: 20-23). The primacy of need within care can lead to a self-understanding of nurses as advocates for patients and to instances of resistance where efficiency and marketisation pressures seek to change nursing practice (Cooke 2006: 233). Within intensive care, however, this potential for resistance can be mitigated by the attempt to derive recognition from technical skills rather than caring skills potentially resulting in subordination to the medical profession (Zussman 1992: 78f.) and/or in a delegation of basic caring tasks to lower-skilled nurses (Latimer 2005: 121). However, as a disposition and practice in itself, care has the character of a substantive logic with the potential of forming the basis for acts of resistance such as militancy (Briskin 2011: 487).

On the other hand, technocracy is a form of instrumental rationality which can serve as the legitimation for an entire social formation through the accumulation of productive forces (Habermas 1969: 51). Technocracy can be understood as the conceptualisation of social problems in technical terms via the pursuit of “the most efficient problem-solving strategies” (Fischer 1990: 42). The basic view of social reality in technocratic terms is by understanding it as divided into systems and subsystems which require the optimal coordination of information and allocation of resources (ibid.: 205). The state is assigned the role of primary system stabiliser through rational planning (Habermas 1969: 78). In accordance with this world
view, the NHS was characterised by the dominance of top-down rational planning in which central government controlled levels of expenditure, but doctors had autonomy regarding the use of resources and clinical regulation from 1960 to 1975 (Klein 2006: 59). As a result, patient voice was minimal which is in line with the consequences of technocratic practices of abstracting from individual needs by calculating the optimal aggregate allocation of resources. The corresponding form of labour control has been conceptualised as ‘technocratic control’ which is a combination of bureaucratic, technical and professional forms of control (Burris 1993: 2). Professional control is based on self-regulation, autonomous working and credentialing (ibid.: 11f.). As a part of technocratic control, authority is “derived from expertise and system maintenance (ibid.: 151) leading to a workforce divided into experts, paraexperts and non-experts (ibid.: 148).

The effect of technocracy and technocratic control is a depoliticisation of social relations, since it is assumed that social problems can be solved by technical means and that the goals of efficiency and optimal resource allocation are shared unequivocally among members of societies and organisations (Fischer 1990: 273). On the level of subjectivity, technocratic thinking eliminates the ability to conceptualise a distinction between instrumental and substantive rationality (Habermas 1969: 84) as well as between praxis and technology (ibid.: 91).

Care and technocracy, as they are conceptualised here, are therefore assumed to have contradictory effects in terms of consciousness, politicisation and resistance: whereas care seeks to focus on individual needs and the substantive dimensions of social relations, technocracy abstracts from the individual by calculation and by transforming social relations into technical problems. While care is aimed at advocacy and resistance against logics which erode the quality of health services, technocracy is driven primarily by efficiency imperatives and reduces resistance by assuming an overarching narrative of goal alignment instead of political contestation concerning social and organisational goals.

**Context and Methodology**

Since relevant studies and conceptualisations have been discussed, the main aim of this section is to give an overview of the study context and its research design. A qualitative approach was chosen, since no previous study of intensive care focussing on middle management was found in the literature search and qualitative methods are generally suited for explorative purposes (Silverman 2001). Moreover, one main aim of this paper is to relate the levels of structures,
practices and subjectivity (referred to here as motivations and experiences of work) to understand how work is structured in the ICU, and it was felt that this type of combinatory approach could best be realised via the use of in-depth interviews to probe into experiences. Lastly, the other aim of this paper, namely to understand the impact of the Coalition Government’s reconfiguration strategy on the ICU workplace, could also be realised by interviewing the people tasked with implementing and dealing with this strategy and its consequences.

With regard to data generation, a grounded theory approach (Glaser/Strauss 2010) was chosen, as its mix of induction and deduction allows for emergent theory generation regarding under-researched phenomena (ibid.: 45). A first round of 3 interviews was conducted in early 2013 which provided first themes to be further explored. A second round of the remaining 7 interviews was conducted in early 2014 to develop categories. Rather than asking direct questions regarding care, technocracy and reconfiguration effects, the interviews were based on open questions covering the general themes of these concepts to allow the interviewees a large amount of autonomy in answering the posed questions. As mentioned above, the quality of intensive care services in London is high so that questions did not regard clinical management, but were rather focussed on motivations for becoming a nurse and a manager, how performance and people are managed, how efficiencies are achieved, how labour relations are structured and how campaigns are viewed. The interviews lasted around 50 minutes on average. In accordance with grounded theory (Charmaz 2008: 472f.), the interviews were fully transcribed, coded line-by-line with MAXQDA, emergent concepts were refined and lastly, the resulting categories were integrated.

The sample for this paper consists of 10 qualitative, semi-structured interviews conducted predominantly with middle managers located in 9 different trusts in London: 5 Band 8b Managers, 3 Band 8a Managers, 1 Band 7 Manager acting also as Lead Practice Educator, and 1 Band 6 Senior Nurse acting as Band 7. The Band 8b Managers had responsibility for the operations and some strategy development either of all intensive care units in a trust, of an intensive care unit and a non-intensive care unit, or of an intensive care unit along with fulfilling functions pertaining to a different non-intensive care unit. Band 8a Managers on the other hand were solely responsible for the operations of one ICU. The Band 7 Manager gave the perspective of an ICU team leader, but also fulfilled the function of understanding the perspective of a practice development lead coordinating induction and development activities on the unit. Lastly, a Band 6 Senior Nurse who had acted as a Band 7 Manager for several
months was also included in the sample to complement the 9 middle and upper middle managers’ perspective with the perspective of a predominantly operative worker.

With regard to the trusts in which the ICUs were located, table 1 summarises the trusts’ status (either as NHS or foundation trust), the existence of non-NHS revenue streams, the financial balance of the trusts and whether regional restructuring such as service centralisation or mergers had occurred since 2010 (with ‘upgrading’ referring to a trust benefitting from the merger through increased activity while ‘downsizing’ means a reduction in activity through the loss of services):

<table>
<thead>
<tr>
<th>Trust 1</th>
<th>Trust Status</th>
<th>Non-NHS Revenue Streams</th>
<th>Balance</th>
<th>Regional Restructuring</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Recent FT</td>
<td>Large CH, Large PP/O</td>
<td>High Surplus</td>
<td>-</td>
</tr>
<tr>
<td>B</td>
<td>Recent FT</td>
<td>Large PP</td>
<td>High Surplus</td>
<td>Regional Merger/Upgrading</td>
</tr>
<tr>
<td>C</td>
<td>Early FT</td>
<td>Large CH, Large PP</td>
<td>Surplus</td>
<td>-</td>
</tr>
<tr>
<td>D</td>
<td>Early FT</td>
<td>Large PP</td>
<td>Surplus</td>
<td>-</td>
</tr>
<tr>
<td>E</td>
<td>Early FT</td>
<td>Some CH, Large PP</td>
<td>Surplus</td>
<td>Regional Merger/Upgrading</td>
</tr>
<tr>
<td>F</td>
<td>NHS Trust</td>
<td>-</td>
<td>Low Surplus</td>
<td>Regional Merger/Downsizing</td>
</tr>
<tr>
<td>G</td>
<td>Recent FT</td>
<td>Some O, No PP/CH</td>
<td>Low Deficit</td>
<td>Upgrading</td>
</tr>
<tr>
<td>H</td>
<td>NHS Trust</td>
<td>Large Some O, PP</td>
<td>High Deficit</td>
<td>Centralisation of Services</td>
</tr>
<tr>
<td>I</td>
<td>NHS Trust</td>
<td>-</td>
<td>High Deficit</td>
<td>Regional Merger/Upgrading</td>
</tr>
</tbody>
</table>

1 The estimates are derived from the trusts’ annual reports for 2012/2013 and information from the interviewees. ‘CH’ stands for charity income while ‘PP’ refers to private patient income and ‘O’ to income from overseas patients. Large private patient income consists of 4+% of overall operating income while a high surplus was understood as a net surplus of 2+% of operating income and a high deficit as an adjusted deficit of 4+% of operating income.
Table 1 shows that the sample included predominantly surplus-making trusts, most of which were foundation trusts. Moreover, these trusts often had significant non-NHS revenue streams and had experienced no or a low impact of regional restructuring activity. Though 6 out of 9 trusts had experienced either mergers or a centralisation of services, only 2 trusts (F and H) had experienced these restructuring activities as resulting in a reduction of service capacity. Therefore, the sample incorporates ICUs located in trusts which were predominantly financially sustainable and benefitting from the Coalition Government’s reconfiguration strategy. All the more surprising it is that all trusts reported significant changes in the workplace resulting from austerity and restructuring measures, as will be shown in the following section which reports the results of the interviews.

Results

First, the general characteristics of management in the ICU will be described, after which the manager’s motivations and experience of work will be presented. This is followed by presenting vertical and horizontal pressures, and the structure of work in the ICU as a simultaneity of care and technocracy.

General Characteristics

The ICU was reported to have a strategically important place in any hospital, since other major emergency and invasive services such as Accidents & Emergencies or surgical wards were strongly linked to a well-functioning ICU. Moreover, activity in the ICU is mostly reimbursed via the tariff meaning that hospitals have an interest in increasing ICU activity, because, even though this may create an overspend in the ICU budget, activity in intensive care generates a lot of income (with one manager reporting £2500 per day for an NHS patient and £5000 for a private patient). Additionally, the highly specialised work means that ICU managers are highly regarded in the hospital management hierarchy and have historically been allowed to manage their units with great autonomy.

Since intensive care is labour-intensive, but at the same time also capital-intensive and highly technologised, management in intensive care is focussed on optimising both staff performance and physical asset utilisation (mostly in terms of technology, instruments and pharmaceuticals). However, due to its high level of expenditure, people management receives primary attention:
“when you look at our budgets, you have sometimes something like a 65, 70% cost on labour as opposed to disposable products, then you have to concentrate that time on the main resource which is the people” (Band 8b-2).

An important characteristic which was emphasised by most interviewees and is related to the high degree of expertise needed in the ICU is that management in intensive care takes on a hybrid character between clinical management and what was referred to by one interviewee as ‘pure management’ (people, performance and budget management). This means that ICU managers have a strong presence on the unit, make a point of meeting patients, their family and the staff on duty before starting any other work, and also do bedside nursing once a week or once a month to maintain their clinical skills. This intertwining between clinical and managerial work is one major difference to other wards in which already at team manager level, a clear separation between the two types of work is made. This hybrid character of management makes the work of middle managers highly varied:

“I can go from doing anything on the shopfloor either with a patient or coordinating or floating, supporting the unit, all the way through to being sat at really high-level meetings, talking about the strategy of the unit and where we're going to go and so it's really varied for me” (Band 8b-3).

Equally, the hybrid character means that progression up the nursing hierarchy from junior operative work (Band 5) to middle and upper middle management (Band 8b) is practised (without being strictly necessary, as one interviewee reported) rather than entering middle management without having operative work experience. This was often presented as a natural progression and all of the participants in this sample had ascended this way: “I went from clinical into management, because it was just a progression, because I like to maintain the clinical aspect of my role” (Band 8b-2).

Motivations and Experience of Work

With regard to their backgrounds, educational qualifications are important for middle managers but also vary strongly with most managers having Bachelors or Masters degrees while others had nursing diplomas combined with special clinical and management training. In terms of motivations to become a nurse, 5 interviewees reported having someone in their family who was part of the nursing or medical profession. Beside a nursing or medical family background, the other important factor was a caring disposition which was reported by 6 participants. This
caring disposition was seen as something that was “in-built” (Band 8b-4) or developed by doing a placement in a care institution during adolescence. The manifestation of this caring disposition in the ability to contribute to health improvements was also mentioned as a major driver for working as a nurse and in intensive care:

“working with people and seeing improvement that particularly intensive care, it can be amazingly interesting to get into just one patient you're looking after and then seeing that change of that patient over a shift or over 6 weeks sometimes. But seeing them sometimes from going from being so critically ill that they're likely to die to the patients that come back and see you 6 months later and they're giving you a hug and saying thank you and you can't believe it's the same person. That is really what makes it worthwhile” (Band 7/Practice Educator).

With regard to becoming a manager, the caring disposition was also manifested in wanting to be able to support and care for staff, as well as in the intertwine of clinical and managerial work named by 4 managers as a source of job satisfaction. On the other hand, a desire to progress up the career ladder and engage in more challenging work was important to some participants. Additionally, the ability to exert control and lead on changes in the ICU was a separate driver for engaging in managerial work. In one case, both major motivations, caring and control, were combined as the motivation for growing one’s own sphere of influence in order to maximise the impact of one’s caring activities:

“When I was on the shopfloor with my patient, one-to-one, I can make a difference for that one patient, then I got frustrated about all the other patients on the unit that I couldn't make a difference for. And that's what drove me to be in this position, because I thought I could then make a difference to all of the patients” (Band 8a-1).

The experience of work was equally divided into a hybrid form exhibiting both happiness, motivation and fulfilment for most managers alongside a feeling of relentless work demands and high stress-levels. The fact that the work of middle managers is highly varied was therefore experienced as positive and negative at the same time. For most managers, this meant that moving upward would not be a possibility at all, only in the distant future or that the intensity of simultaneous happiness and stress in middle management warranted staying in the position for many years:
“I think that it's the hardest job that I've ever, ever done. And it's the most stressful job that I've ever done. Maybe that's because you kind of are on your own and I don't think I ever feel lonely, but I just think it is very stressful and the demands of the job. I think for me looking at myself, I think I could only do it for probably another year and then I'll be ready to do something that's maybe not quite as intense as this. I don't know what that is yet, it's definitely not upwards” (Band 8b-5).

Lastly, the intensity of the job is particularly felt where support is lacking while those who are able to cope with the stress generally described having a supportive work environment (on peer, subordinate and senior management level):

“I do have support from my own line manager, my colleagues here. I do have a lot of support from the Clinical Lead, the consultant who's in charge of the unit. And I also think I've got a fantastic team and I get a lot of support from them. Yea, I think that's what, how I actually cope with the stress of the work” (Band 8b-1).

**Vertical Pressures**

While being able to cope, almost all participants, reported experiencing an increase in stress and pressures since the mid-2000s and particularly, since the advent of the QIPP programme. On the level of subjectivity, this was experienced as the pressure of ‘having to do more with less’ and as the relentless pursuit of more initiatives for attempting to institute efficiencies:

“every meeting that we go to with the directors etc. is all just: 'We've got to get better, we've got to do more with less', we've got to constantly be thinking of new ways of working, you can't stand still. You do one thing and it saves some money, lovely, tick that box! And then a couple of months later, it's: 'Oh no, we need to do something' [...] we're kind of getting to a, I don't know how much more we can squeeze efficiency-wise, so I think it's going to be challenging times over the next year or two” (Band 8b-3).

On the level of practices, the top-down vertical pressures from structural change (austerity measures and regional restructuring) were translated into different measures designed to enhance efficiency. These measures were instituted in varying degrees, but generally affected the management of physical assets and the constitution of staff.
Regarding physical assets, some managers reported attempting to optimise the utilisation of stock, as sometimes stock would be left to run out, staff might not use the best preparation of medication or stocking more medication than is necessary might occur. Two managers mentioned attempting innovations by using more cost-effective therapies or looking into patient-level costing. However, overall the effects of austerity were not reported as forcing innovation in the use of therapies. In most cases, cost-cutting related to physical assets referred to attempting to reduce the cost of procuring medication and technology which was reported by 7 interviewees. The remaining participants had used cheaper procurement methods before already or in one case, the trust had centralised procurement so that this function had been removed from the control of the ICU middle management.

Reducing costs via physical assets was generally favoured over targeting staffing-numbers: “every year we've got to save 5.5% of our budget and I'd rather do it on products than look at head counts” (Band 8a-1). In accordance with this preference, no participant reported a general reduction of staffing numbers as would be required by the number of beds occupied in the ICU. Instead, staff-related efficiency strategies were based on reducing absenteeism and the beginnings of a process of deprofessionalisation.

Absenteeism referred to being absent from work due to sickness. The policies behind managing sickness were often based on a trust-wide triggering system, the threshold for which had been considerably lowered. If a member of staff triggered the system, various procedures were put in place such as conducting back-to-work interviews, referring staff to occupational health and/or increasing the level of monitoring with regard to permitted relapses into sickness. In one trust, the decision had been made to seek all efficiency gains via managing down sickness rates, particularly in order to avoid cutting staff. Another variant of managing sickness was related to the ability of foundation trusts to set terms and conditions locally leading to a loss of unsocial hours pay if staff were sick.

Apart from reducing sickness rates, the beginnings of a deprofessionalisation process to reduce personnel costs were reported. Whereas historically, all ICU patients received one nurse regardless of severity, this had now been changed to predominantly include Level 3 patients with multiple organ failure and a ratio of two patients to one nurse for Level 2 patients with one organ failing or on respiratory assistance (which is in line with nursing guidelines from prominent professional associations, indicating that the previous practice of a one-to-one ratio for all patients was not clinically necessary). Additionally, before the mid-2000s, operative workers had little awareness about costs and focused primarily on delivering patient care.
irrespective of cost, whereas now instilling an awareness about cost-efficient working had become a strategy reported by 7 participants:

“I try and filter certain things down to the very junior staff, just to make them think about money. So there's this one probe that we need that, it measures your temperature [...] These probes cost 175 pounds each and they're disposable. And sometimes people will open things and just not think: 'Oh, actually I didn't want that' and I've had to really, really start to make people think about what they're doing” (Band 8a-2).

The most prominent change associated with deprofessionalisation were changes in skill-mix. One interviewee reported reducing the number of Band 6 Senior Nurses and replacing them with Band 5 Junior Nurses which enabled recruiting some more staff and generating more income. Moreover, almost all interviewees described the introduction of healthcare assistants into the ICU workplace as a strategy for reducing costs, especially when they could be employed in conjunction with one registered nurse to care for two patients or to do a lot of basic caring and manual work. This was interpreted by the Practice Educator as the beginnings of moving to the US-American system of intensive care nursing in which registered nurses delegate tasks rather than directly giving care and work together with specialised technicians:

“you're likely to have probably 2 patients, but you have more technicians to help you in the role, so healthcare assistants who will wash the patients, a team of people who will turn the patients, and respiratory therapists who come in and do all the work [...] I think the movement long-time is to try and look at more technician roles as well that can lessen the work from the nurse in charge on ITU” (Band 7/Practice Educator).

It should be noted, however, that the proportion of healthcare assistants among the ICU nursing workforce did not exceed 10% in any workplace in the sample indicating the beginning of deprofessionalisation rather than a strongly transformed workplace skill structure. In addition, the introduction of healthcare assistants increased the overall size of the workforce to be able to increase activity.

With regard to efficiencies related to patients, though it was stated by some participants that an increase in private patient income was encouraged, generating private patient income was a strategy pursued outside of the ICU, since activity in the ICU is often reactive in the sense that patients are either referred internally from other departments or from other hospitals. Moreover,
private and NHS patients are treated equally once they arrive in the ICU. However, in one instance, an increase in private patient income was actively resisted due to the position taken that caring resources should not be drained from the NHS:

“So we've had a lot of pressure put on us: ‘Oh, you need to do more, you need to do more’. But at the same time, because we've stuck together as a team and said: ‘Actually, no, we're not taking all these private patients' that has worked, but that has had to be a team decision” (Band 8a-2).

The second way that patients have been involved in achieving efficiencies is via an increase of patient turnover. However, again, this was reduced to a small number of units in the sample and in one case, delayed discharges were reduced and the number of non-ICU patients was reduced to 0. In two cases increasing patient turnover and thereby increasing activity was a strategy set out to increase the output of the unit:

“The nursing assistant initiative was part of our efficiencies 3 years ago and then we’ve looked at what else we could do, is there any more efficiencies that we can make and we couldn't really see any. So what we had done, the overperformance, so if you're funded 28 and we actually manage, well our average was 33, that overperformance would be our efficiency saving” (Band 8b-5).

Apart from the effects of austerity measures, the Coalition Government’s reconfiguration policies include regional restructurings in the form of service centralisation and mergers. One significant effect of this regional restructuring was a decrease in service capacity which led some trusts to specialise in certain areas, in turn leading to increased activity in those areas. In two instances, the downsizing of emergency services led to a strong reduction in intensive care capacity. This led to the second major effect of regional restructurings, namely staff insecurity, distress and exits. One unit changed from having a low turnover rate to having 13 exits in 3 months and also to using agency staff for the first time in 7 years. The use of agency staff was in turn described as leading to further exit, since staff were able to learn about the high pay rates in temping agencies which prompted some nurses to leave.

Clearly, there is significant evidence that the top-down structural pressures caused by the Coalition Government’s policies have had significant effects on practices in the ICU. However, vertical pressures do not only arise from outside structures, but also from within in the form of bottom-up pressures from the workforce which are met by technocratic control strategies.
The bottom-up pressure from the workforce is related to intensive care’s requirements for highly skilled and professionalised labour, and the general shortage of practising nurses in the UK. Operative nurse workers in the ICU enjoy autonomy in diagnostic and clinical decision-making and are also respected by medical professionals:

“nowadays [...] nurses' voices are heard, in making the decisions for the patients. Because I don't think, before it was always 'doctor's ordered', but nowadays it is 'doctor's suggested' or it was discussed. It is a discussion more than an order and just following it” (Band 6/Acting Band 7).

Operative workers were also described as being generally senior and making demands on management such as suggesting changes in clinical practice, leading on those changes or doing research work. In addition, operative workers were also viewed as being highly self-motivated and autonomous. The strong confidence of staff also led some managers to feel the need to perform clinically so as to ‘lead from the front’: “people always make assumptions about people being in offices: 'Oh, you're not doing a proper job' or something like that” (Band 8b-4).

However, the most important way that bottom-up pressure is exerted on middle management is via the senior operative staff’s ability to exit the organisation. The strong labour market position ICU nurses is reflected in the fact that staff have been recruited from overseas or have exited to migrate overseas, for example to Australia. Additionally, though the majority of units in this sample had low turnover rates, some units were reported as having vacancy rates of up to 40%. Conversely, recruiting into senior positions was described as challenging: “Band 6 and 7 we find it extremely difficult to recruit into, particularly to attract outside candidates” (Band 8a-1).

The strong labour market position of operative workers means that they can enact calculative logics in terms of being able to combine working in the NHS with doing part-time agency work to earn sometimes over double the NHS’s pay rate or to wholly exit the NHS for agency work. An additional effect is that working times and patterns are often adjusted to the workers’ individual needs, such as balancing family with work life. Most prominently though, middle managers emphasised the need for engaging staff and communicating in an open fashion with them in order to avoid alienative working conditions. Not having meetings or communicating information to staff was described as creating discontent amongst staff and in one extreme example, a matron had centralised most management work and information in her own position.
which led to organisational inertia, high staff turnover rates and a reduction of organisational performance.

To meet the strong bottom-up pressures coming from operative nurse workers, middle managers used techniques of technocratic control. One reason for using this control strategy was that simple control would be ineffective in the autonomous work environment of the ICU while another was that the NHS was a low-input employer incapable of providing strong financial incentives to most of its workforce. However, emphasis was put on bureaucratic control in the form of career progression to incentivise workers. Additionally, the importance of monitoring standards, sometimes through electronic means, resembled technical control and was often stated.

With regard to professional aspects, binding people to the organisation via the provision of educational opportunities was a prominent strategy: “You can keep people for 2 years, because along the way you're giving them loads of courses to do [...] Then you might get more people in the back way and grow your own and then internally promote them” (Band 8b-4). Furthermore, the need for positive feedback and recognition for good work was named as well as the definition of separate unit values and the launch of unit awards for best performance:

“last year we held our own internal celebrating excellence award, so the whole team nominated their peers along with the same categories. 8 winners and 8 runners-up were nominated for leadership awards [...] so that really was motivating for them and hopefully it will inspire everybody this year that they will be the ones who are nominated by their team” (Band 8b-5).

Overall, there was strong evidence that vertical pressure was concentrated on middle managers which resulted not only from austerity measures and regional restructurings, but also from the strong bottom-up pressure from operative workers and the need for technocratic control to generate consent and bind workers to the organisation. The second dimension of pressures on ICU middle managers, however, refers to horizontal pressures, the evidence of which shall now be presented.

**Horizontal Pressures**

Apart from the contradictory simultaneity of care and technocracy in the ICU which shall be presented further below, pressures arise horizontally throughout the organisation via teamworking. Due to the high need for expertise in the ICU and to avoid alienation between
workers, teamworking was widely utilised. This also refers to sharing management responsibilities with team leaders, medical professionals and senior sisters. This means that intensive care middle managers are not solely oriented towards controlling the organisation’s functioning but require the ability to delegate managerial work to other members of staff. As mentioned before, an overt centralisation of management responsibility was reported to have led to a reduction in organisational performance. This need for sharing control can be at odds with the aforementioned motivation for going into management in order to gain more control. The need for flexibility is also a form of horizontal pressure. Flexibility amongst operative staff is achieved by daily flexing staffing numbers up or down according to the number of patients on the unit. This is facilitated by the long working hours in the ICU which consist of between 12 and 13 working hours per shift meaning that staff work 3 days per week. Often managers also reported being given flexible working times in the form of determining when to come in, how long to stay or how many days per week to work. This organisational culture of flexibility was viewed as a positive form of pressure which allowed middle managers to balance their work and home lives and therefore relieved the negative aspects of vertical pressure outlined before.

A further horizontal source of pressure can be the intertwinement between clinical and managerial work. Here, the motivation for going into nursing, namely to provide direct bedside care to patients, can (but was not always reported to) come into conflict with the practical demands of the organisation:

“I get far less clinical time than I would really like, because I'm obviously being pressured on me to go to, I think things in a respect they've been centralised [...] from infection, the way we do things like that, to our staffing, how we manage staffing, and everything is on more central, so of course I'm expected to go to more meetings” (Band 8a-2).

The conflict implied here is between normative and practical work structures of care and technocracy which constitutes the main horizontal pressure apart from teamworking and flexibility.

*Care in the ICU*

One notable aspect of managers’ accounts of their ascendance was that they spoke of it as an opportunity which presented itself to them without any action of their own. This lacking
calculus towards their own ascendance expresses a tendency of middle managers to invisibilise themselves, since one of the primary goals in intensive care is the improvement of patient outcomes:

“Myself with my nursing background, the main thing I want to know is that when patients come into the ward, that they're happy with the standard of care, that they're happy with the way we approach members of the public, their family, and that they feel that they're getting the best care provided” (Band 8b-2).

Related to care’s primacy of health improvement were acts of resistance if cost-savings were enacted at the expense of quality:

“for example urinary catheter bags, they wanted us to change these, we trialled some of these bags, they were dreadful, they didn't do what they said on the tin, and so I said I'm not having them. So we kept the old ones and all the rest of the trust changed, because they were cheaper. So there was this inferior quality. But I have heard last week that the trust has gone back to the ones we have” (Band 8a-3).

A dominance of care also expresses itself in the motivation for becoming a nurse (as mentioned above) which is reproduced by middle managers through an oppositional attitude towards leaving clinical work. In one instance, this was manifested as expressing opposition to being overburdened with demands by the organisation, as this can negatively affect the quality of care:

“If you get pulled away with other things, the clinical element of that job will get eroded and some people may like it that way, but I don't and I feel you need to protect that and because of protecting it, you're able to make sure that the quality of nursing that the patients get on intensive care is supported at high level” (Band 8b-1).

Care as expressed as a disposition towards the wellbeing of others is not just directed towards patients but also towards supporting staff while also being supported by senior management and peers in intensive care. A caring management style was associated with this support of staff:
“I say: 'I feel like your mother' sometimes. I don't know how sometimes these young girls actually live their life, because they come to me with the most banalest things. One of the girls said: 'You know what? You like to put your arm around us all' and I think that's very much my management style” (Band 8a-2).

Though it was acknowledge by several participants that a drive towards increasing consumerism had been instituted in the NHS over the past decade, almost all participants rejected any notion of patients as consumers and reported the practice of attempting to give equal patient care irrespective of insurance status: “Patients should be patients. I mean they have their individuality, in whichever way they are. However, as we say, paralysed, sedated, vegetative, or fully active, whichever way they are, they have their individual needs” (Band 6/Acting Band 7). Even where patients were considered to be consumers, the notion of consumerism was felt to divest the relationship to patients of compassion and empathy:

“I think it depersonalises them to be viewed as consumers. I believe they are consumers, I believe they are service users and that they are basically paying into a service which they should get the best from. I don't like them to be termed as consumers, because I think it does take away the sort of care-side of things, the empathetic side of things” (Band 8a-1).

Moreover, the staffing ratios of one-to-one for Level 3 patients and one-to-two for Level 2 patients, were advocated by all participants. Some participants mentioned having to resist pressures to decrease the nurse-to-patient ratio for Level 3 patients: “So for example, people might say to me: 'Well, you've got 1 nurse per patient, for a very sick patient, do you need that?', so I'll say: 'Of course I need it!'” (Band 8b-4).

Lastly, care was sometimes expressed in the resistance by operative workers and middle managers to the introduction of healthcare assistants, as this was interpreted as a process of diluting skill levels harmful to providing patient care. However, the middle managers in this sample recognised the utility and cost-savings accrued from introducing healthcare assistance which indicates the complex relationship between care and technocracy: “There was a lot of resistance about that, including myself, because I was quite new in post, I didn't really understand the impact, but that has been a really brilliant exercise” (Band 8b-5).
Technocracy in the ICU

Turning now to present the findings related to technocracy in the ICU and its depoliticising effects, apart from the use of technocratic control mentioned above, one striking feature of middle managers’ discourses was their general lack of mentioning the politicisation of the health system (except for one participant and some notable side-comments). In the same vein, the Practice Educator also stated not including political content in any teaching course due to the large amount of clinical knowledge needed in intensive care practice. Additionally, a strong belief in system evaluations as a means of enacting change was exhibited:

“I mean actual results showing that these cuts and cost-cutting and everything has had impact on patient care, it might actually open the eyes that ok, we have been a bit too drastic with the things and we have to just slow-down” (Band 6/Acting Band 7).

Technocracy also consisted of manifestations of instrumental logic. For example, teamworking was frequently viewed not only as a form of horizontal pressure relieving management responsibilities, but also as a means of achieving results and improved performance: “I think if I've got a team, I want to know them. And I want to know them both individually, know what makes them tick, because I think I get better results by being personable with people” (Band 8b-4). Equally, when talking about trade unions, though most staff and middle managers were perceived to be members of a union, this was often presented as an insurance policy against claims of malpractice or poor performance rather than as an expression of political consciousness: “Everyone's advised to have union backup, because you just never know really what situations you're going to be in, from patients accusing you of all sorts of things to even your employers” (Band 7/Practice Educator).

When talking about labour relations, all middle managers attested to having few interactions with unions in the ICU, particularly due to a lack of disciplinary activity. Disciplinary activity was generally related to issues of sickness rather than performance and it was reported as occurring once or twice a year (even with workforce sizes up to 200 staff members). One participant explained that this was due to the sedimentation of protective formal procedures for dealing with sickness and performance issues which channel conflict:

“So in terms of fairness, I must say, as the NHS we are very fair. I say this as a manager in the NHS, but [...] we have set guidelines for conduct reviews, you would give a first notice if required
and if you think it's very serious, you would do an investigation, you would have a meeting with that person and a union representative before you go for a stage further when you would have the head of nursing, their union representative, a senior manager, before you can take chances in terms of warnings, there's sort of 3 grades of warnings that a person would have. In terms of attendance and sickness, there's also 3 stages for that. So we are very fair” (Band 8b-2).

Questions about Save Our Hospital Campaigns were also included in the interviews to understand middle managers’ perspectives around issues of local contention. No participant mentioned having been part of a campaign, but most participants were of the opinion that local campaigns were legitimate as an expression of the fears of local populations. However, in general, campaigners were interpreted as misunderstanding the utility of reconfigurations which were seen in a technocratic manner as increasing efficiency and outcomes:

“I really do believe that we have to make a 21st century NHS and I really believe there have to be changes. And that might mean that my workplace and my job indeed seize to exist in a new structure (laughs) [...] I think patients are better being treated at one site where they’ve got all the specialist input that they need at that site. I think specialists, super hospitals will attract the best nurses, the best doctors, the best teams to provide the best quality care” (Band 8a-1).

Discussion

The results show that the ICU workplace as discussed by middle managers exhibits a horizontal structure of care and technocracy. Particularly important for this horizontal constitution is the hybrid character of management as focussed on clinical and managerial concerns, and the practice of career progression from operative worker levels to upper middle management levels. Both of these characteristics are a function of the great need for expertise and knowledge to care for the sickest patients in the hospital, the historically resulting low interference from senior management and other wards (Kowalcyk 2002), as well as the strategic position intensive care is attributed in a hospital.

Care was expressed on a subjective level in the motivations for becoming a nurse and (sometimes) for becoming managers as well as for rejecting consumerism and not engaging in managerial work related purely to performance and people management. On the level of practices, care was manifested in generally maintaining set staffing ratios according to national guidelines and supporting staff as well as being supported by senior management and peers.
Additionally, the practical manifestation of care lay in various instances of resistance, for example against cost-cutting measures which might deteriorate quality and against pressures to increase the number of patients to nurses as well as the private patient ratio. However, resistance against the introduction of healthcare assistants was relinquished when the potential for personnel cost savings was realised indicating that the caring logic may be overridden by technocratic concerns.

On the subjective level, technocracy articulated itself as a depoliticised discourse, a belief in system evaluations as levers for change, and as a technocratic interpretation of regional restructurings. The use of teamworking as a means of achieving results, an instrumental relationship to union membership, the use of technocratic forms of control and the channelling of conflict into formal and protective procedures were indications of technocracy as a practice. The lack of union activity and disciplinary procedures also indicate that these practices are effective in depoliticising the ICU workplace. However, the horizontal sedimentation of caring and technocratic motivations most likely also means that values are aligned throughout the workplace hierarchy which contributes to the generation of consent along with technocratic control and the formal channelling of conflict. This does not lead to a completely depoliticised workplace, however, as the instances of resistance due to care and the high demands of staff on middle management evidence.

In addition to this horizontal structure of work in the ICU, a vertical structure is constituted by top-down pressures arising from austerity measures and regional restructurings, and by bottom-up pressures from the highly skilled, autonomous operative staff empowered by favourable labour market conditions. It was demonstrated that the top-down pressures had led to a transformation of the intensive care workplace, most notably in the form of optimising the use and procurement of physical assets and strongly managing sickness, beginning a process of deprofessionalisation, and in some instances, increasing patient turnover to increase the output of the unit. These effects mean that the previously shielded nature of ICUs has now been transformed by the Coalition Government’s reconfiguration strategy and that intensive care in London has also become an area for efficiency imperatives irrespective of a trust’s overall performance. It was possible to demonstrate the complex two-dimensional structure of work as experienced by intensive care middle management, since the subjective levels of motivations and dispositions were analysed in addition to practices and structures. The intense position of middle management as it is intersected by the contradictory horizontal pressures of care and technocracy and vertical top-down and bottom-up pressures is summarised in figure 1:
Curiously enough, though clearly experienced as highly stressful and burdensome, this intense position was also the source of a high amount of job satisfaction. The factors associated with this positive experience of work consisted in a large amount of flexibility enabling a balance between work and home life; it consisted further in a feeling of being supported by peers, senior management and operative workers, and in the ability to enact the primary caring motivations through the performance of clinical work. The evidence presented here lends weight to previous studies showing that supportive organisational structures can lead to higher job satisfaction (Patrick/Laschinger 2006) and lower levels of alienation (Lopez 2006). Furthermore, the factors presented also constitute an explanation for how the “normalized intensity” (McCann/Morris/Hassard 2008) of middle management can be sustained and experienced in a positive light.

**Conclusion**

The aims of this paper were to understand the impact of the Coalition Government’s reconfiguration strategy on intensive care in London as well as to understand how pressures arising from this strategy were met by nurse middle managers. This was performed via an approach which attempted to analyse the horizontal as well as the vertical work structure of intensive care by incorporating the levels of subjectivity, practices and structures. It was demonstrated that ICUs in London had been significantly transformed, though not uniformly
and not without significant instances of resistance which protect core principles of the functioning of intensive care.

The limitations of this paper are that the views of predominantly middle managers were incorporated which means that aspects referring to the characteristics of staff could not be verified. Additionally, the limited sample does not allow for generalisability. This limitation is mitigated by the fact that the population referred to is relatively small, since there are around 27 public ICUs in London (NHS London 2013: 11), each with one Band 8b Manager. Lastly, a limitation lies in the fact that intensive care in London is embedded within a national health system with a particular history. It is possible that the model of work developed here varies according to health system type and national traditions.

Setting aside these limitations, however, the implications of this research are on the one hand that organisational culture can strongly influence the impact of governmental reforms. This was expressed by the fact that despite many similar trends, there was no uniform response to reconfiguration pressures. However, many of the transformations described bore down on the workforce. This most likely means that pressures on the workforce will continue, since intensive care had already been successfully reformed before 2010 and many managers reported having instituted many efficiencies already now while efficiency pressures are likely to continue in the future. The historically strong facilitation of organisational support, while exhibiting an example of an empowering and engaging work environment, may come to be more severely transformed than it has been so far.

Apart from this political implication, there are two theoretical implications of this paper: first, the incorporation of the level of subjectivity in the analysis of work and its combination with practices and structures allowed for a richer conceptualisation along the lines of a two-dimensional model based on horizontal and vertical pressures. It equally permitted the explanation of the reproduction of intense working conditions grounded in specific work practices and traditions rather than the functionalist assumption of system reproduction. Second, this rich conceptualisation demonstrated the complexity of work which transcends reducing it to a debate about control versus resistance. The paper demonstrated the contradictory simultaneity of care and technocracy as well as depoliticisation, resistance, consent, engagement and exit. Though it is clear that a focus on control and resistance is important, the reduction to these conceptualisations blends out other important political, economic and identity-related phenomena which are manifested in the everyday contestation of work.
References


