

'I mean, obviously you're using your discretion': Nurses Use of Discretion in Policy Implementation

Louise Hoyle

School of Nursing, Midwifery & Social Care, Edinburgh Napier University
E-mail: L.Hoyle@napier.ac.uk

This article explores the application of Lipsky's (1980) notion of street-level bureaucracy for nursing staff. This article aims to demonstrate the importance of discretion within the day-to-day work of front-line nursing staff, which is similar to that of other public-sector workers. The findings are from an exploratory case study based within a Scottish inner-city hospital. It specifically focuses on how nurses can be seen to be street-level bureaucrats and how front-line nursing staff interpret policy. Discretion can be seen to be a significant feature within the front-line practice of nursing staff and this may have implications for the implementation of health policy.

Keywords: Discretion, health policy, Lipsky, nursing, policy implementation, street-level bureaucracy.

Introduction

A recent revival in policy implementation has brought street-level practice to the forefront of the policy debate (Evans, 2010; Van Berkel and Van der Aa, 2012). The practice of nursing has been inextricably linked to changes in health and policy (McMahon, 1998; Bergen and While, 2005; Hoyle, 2011), and the delivery of care is set against a context of constant social and political change. Drawing on the works of Michael Lipsky (1980, 2010), who linked policy, organisational structures, resources and individual practitioners (street-level bureaucrats) as influencing the implementation of policy, this article explores the extent to which hospital nurses can be seen as street-level bureaucrats and can shape the implementation of policy.¹ More specifically, it examines how nurses interpret policy and how this influences decision-making and the use of discretion within the ward setting. Furthermore, it will demonstrate the importance of discretion within the day-to-day work and decisions of front-line nursing staff.

Lipsky defines street-level bureaucrats as 'public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work' (Lipsky, 2010: 3). The core argument is that discretion is not only unavoidable but is also necessary within welfare bureaucracies. Those individuals directly involved in delivering policy at street-level will exercise their discretion in how policies are carried out. Durose (2011: 980) views discretion as a 'choice or judgement within recognised boundaries' taken by front-line workers. According to Tummers and Bekkers (2012), it is the freedom in which street-level bureaucrats make choices concerning the provision, quantity and quality of resources, alongside the sanctions or rewards available to the public. When implementing a policy, role conflicts can arise when

professionals perceive the demands to implement policy to be incompatible with their professional experience (Lipsky, 1980; Ham, 2009; Tummers *et al.*, 2012). According to Taylor and Kelly (2006: 631), three types of discretion can be identified within street-level bureaucracies: (1) rule discretion, which is bounded by legal, fiscal or organisation constraints; (2) value discretion, which may be determined by notions of fairness or justice and can involve professional and organisational codes of conduct and ethics; and (3) task discretion, the ability to carry out prescribed tasks which involve working with clients.

In the study of public bureaucracy, there is an inherent tension regarding the role of politicians and public bodies in relation to the freedom the latter possess in implementing policy; and there is also tension between organisational administration and front-line workers concerning policy implementation. There have been many studies which apply the work of Lipsky for analytical purposes, although these have mainly been in public sector areas such as employment services and social work services. To date, very little has been written which draws upon Lipsky's (1980) classic study of street-level bureaucracy in relation to the use of discretion by allied health professionals, including nurses (Hoyle, 2011).

This article draws upon data from a single case study site where thirty-one qualitative interviews with qualified nursing staff were carried out. Firstly, it will discuss the continued relevance of Lipsky's (1980) work for ground-level bureaucrats before examining how nurses can be defined as street-level bureaucrats. Secondly, an overview of the research methodology will be provided. Thirdly, the findings will focus specifically on nurses' interpretation of policy and the conflicting goals of managers and professionals. Finally, the forms of discretion that are used by nurses as part of their nursing role and the influence this can have on patient care will be considered.

The continued relevance of Lipsky?

There has been a debate over the continued relevance of Lipsky's approach for today's ground-level practice in health and social welfare (cf. Howe, 1991; Cheetham, 1993), given that Lipsky (1980) wrote his book in the late 1970s prior to the rise of neo-liberalism and New Public Management (NPM). Through the 1980s in the UK, the National Health Service (NHS) was seen by some as inefficient and unresponsive to consumer demands, a drain on the public resources and part of a dependency culture which prevented the success and growth of the organisation (Lapsley, 1994). In response, the government introduced organisational changes into the NHS and adopted ideas such as efficiency and value for money within policy guidelines (Hudson, 1997; Harvey, 2005; Evans, 2009). This led to fundamental changes to structures, cultures and practices of public sector organisations (Exworthy and Halford, 1999).

Since the publication of Lipsky's *Street-Level Bureaucracy*, there have been numerous developments within the public sector. However, the view that Lipsky is no longer applicable is disputed (Baldwin, 2004; Evans, 2010). Within social work literature, there has been a sustained interest in Lipsky's ideas on resources and discretion (Lewis and Glennerster, 1996; O'Sullivan, 2011). For example, the use of discretion by practitioners has been found to still exist in social services bureaucracies in the UK (cf. Ellis *et al.*, 1999; Baldwin, 2000; Evans, 2010), as well as employment and welfare services (cf. Fletcher, 2011). However, other authors argue that due to the rise of NPM, discretion has been limited and work has become increasingly more regulated (Harris, 1998; Jones,

1999, 2001). Frenkel *et al.* (1998) and Kinnie *et al.* (2000) have argued that managerial approaches which incorporate individualising strategies have severely reduced any form of resistance within the workplace as the degree of autonomy held by workers is limited (Frenkel *et al.*, 1998; Mulholland, 2004). Despite this, Van den Broek (2004) asserts that these managerial imperatives have not been successful in causing increased individualisation. Numerous studies have shown that discretion continues to be used by street-level bureaucrats and plays an important role in their day-to-day work (Scott, 1997; Wells, 1997; Baldwin, 2000; Wright, 2003; Evans and Harris, 2004, 2007; Evans, 2010; Johansson, 2011; Grant, 2013). Lipsky's approach has also recently been extended to non-traditional areas such as cultural services (McCall, 2009). Lipsky drew upon findings from research in the 1970s, which was undertaken at a time of financial constraints, and references to financial crises and cuts are common through the text. Governments were arguing for dramatic reductions in spending and taxation to stimulate growth. The echoes to today are clear, where there is much talk of austerity, and government policies are aimed at cuts in public spending and improving the economy following the economic crisis within the UK (HM Treasury, 2010).

Lipsky's (1980) work showed a variety of problems which street-level bureaucrats can encounter. For example, excessive rules and regulation which impose goals could conflict with professional norms (Lipsky, 2010: 29), meaning there can be a conflict for nurses who prioritise patient care over organisational goals. Newman and Clarke (1994: 22) define bureau-professionalism as a 'combination of professional expertise coupled with the regulatory principles of rational administration as the means of accomplishing social welfare'. Nurses can be seen as street-level bureau-professionals because their role involves both professional and administrative functions, and, as such, the debate regarding policy implementation and discretion at ground level for nurses must be considered similar to other professional arenas, such as social work, employment and welfare. This article applies Lipsky's concepts within a contemporary managerialist context and demonstrates that nurses use their own discretion within their work (in terms of rule, value and task discretion): strategies are being employed to circumvent policies which are not agreed with, and coping mechanisms are developed to help overcome difficulties such as financial constraints. This is about the actions nurses take and their own use of discretion during their day-to-day work, which in turn influences the way in which policies are implemented at the front-line.

Nurses as street-level bureaucrats

Nursing has transformed itself into a profession, having gained professional status in 1992 in the UK (Warren and Harris, 1998; Greener, 2009; Kirkpatrick *et al.*, 2011; Noordegraaf, 2011), and has moved away from a traditional hierarchical structure (Hunter, 2007). This means that nurses have become increasingly responsible and accountable for their actions. The current nursing priorities within Scotland are around: caring and compassionate staff and services; clear communication and explanation about conditions and treatment; effective collaboration between clinicians, patients and others; clean and safe care environments; continuity of care; and clinical excellence (Scottish Government, 2010). However, nurses face many constraints in their work; these have arisen due to the influence of marketisation. There is continued emphasis on targets, audits and value for money imposed by the government, and within the current economic climate rather than

more qualified nurses being employed there has actually been a reduction of registered nurses, meaning that workloads are growing (Buchan and Seccombe, 2012).

In Lipsky's analysis, the characteristics shared by street-level bureaucracies include: a need to 'process workloads expeditiously' (Lipsky, 2010: 18), conditions of work that include inadequate resources (including financial, personnel and time), a demand that exceeds supply, ambiguous and multiple objectives, difficulties in defining or measuring good performance, a requirement for rapid decision-making and 'non-voluntary' clients (Lipsky, 2010: 56). Street-level bureaucrats will have substantial autonomy in their individual interactions with clients and an interest in ensuring and furthering that autonomy (Lipsky, 2010: 56). However, according to Maynard-Moody and Musheno (2000, 2003), Lipsky views public sector staff as agents of the state, whereas Maynard-Moody and Musheno believe the term 'citizen-agent' would be better. This is because the 'citizen-agent' allows front-line workers to be defined by their relations with citizens and other street-level workers, rather than by terms such as hierarchy, legitimacy, implementation and discretion which are inherent within the term 'state-agent'. The term 'citizen-agent' perhaps more accurately reflects the way in which street-level workers (such as nurses) negotiate their role and make pragmatic decisions and use discretion in their work.

Lipsky argues that policy-making can take place as much at street-level as it does via the more traditional top-down approach (Hill, 1997). The position of nurses in implementing policy is a unique one which can be very influential (Loyens and Maesschalck, 2010) and they can be thought of as 'agents of social control' (Lipsky, 2010: 4). Nurses working within the NHS interact with citizens on a daily basis, and can influence the treatment and experience of these citizens by using their discretion, thus influencing and producing policy, despite being in the lower layers of a hierarchy (Meyers and Vorsanger, 2007; Loyens and Maesschalck, 2010).

Methods

The research project reported here was a qualitative interpretivist (cf. Atkinson *et al.*, 1988; Denzin and Lincoln, 2000; Crotty, 2005) study grounded in the methodology of adaptive theory. A case study approach (cf. Yin, 1994; Cresswell, 1998; Robson, 2002) was taken in order to understand how managerial practices shaped working relationships in an acute hospital setting. During a three month period, from June to August 2010, semi-structured interviews were undertaken with thirty-one front-line nursing staff based in accident and emergency department (five participants), medical assessment and surgical receiving units (six participants), medical wards (nine participants) and surgical wards (eleven participants) within a large inner-city hospital in Scotland. Further details about the study site are not given to maintain the anonymity of the study site. For this study, ethical approval was obtained from the NHS ethics service and the appropriate research and development department.

Participant recruitment

A flexible approach was used for gaining access to and recruiting participants. This meant some participants were recruited by the researcher approaching individuals on the wards and asking for participation. In other areas, the Ward Manager disseminated information

Table 1 Participant criteria

Inclusion criteria	Exclusion criteria
Must be a registered qualified nurse	Auxiliary nurses or nursing assistants
Must be clinical and ward based (medical or surgical)	Bank or agency nurses
Must have a minimum of two years' experience of nursing as a qualified nurse	Nurses not fluent in English
Nurses who are fluent in English	Nurses who do not have two years nursing experience
Nurses who are contracted to work on the ward	Nurses who had only recently returned to work after a prolonged absence (more than six months)
	Non-clinical nurses

sheets and then provided the researcher with the details of those willing to participate. Interviews were undertaken with registered nursing staff who were between Band 5 and Band 7 who met the inclusion criteria (Table 1). These bands were chosen as it is these grades that generally work in the ward areas. Newly qualified nurses are eligible to work in Band 5 roles. Nurses can then progress onto Band 6 and then onto Band 7 and above. As staff progress, they will be required to take on more responsibilities and managerial type roles (at Band 7, staff tend to be in a position of management such as a Ward Manager). The mean length of the interviews was forty-five minutes, but they varied from twenty minutes to sixty minutes.

A semi-structured interview guide was developed and used during the face-to-face individual interviews. The questions were structured around key themes; these being the role of nursing and relationships with management, financial accountability, efficiency, the impact of targets and monitoring, policies, working conditions and consumerism. For example, with regard to policy, participants were simply asked 'What does the term policy mean to you?' The themes explored within this article were not asked about specifically, but rather emerged from the data during analysis.

The interviews were either audio recorded or notes were taken at the time of interview if consent for recording was not given (as occurred in three interviews). The transcriptions were analysed using QSR NVivo 8 software. Once fieldwork had been completed, a set of thematic categories (cf. Ritchie *et al.*, 2008) was developed. Further themes were also identified throughout the analysis process. This research study has been an exploration for understanding and has not been about achieving quantifiable results. The interpretive approach taken within this study does not seek to make claims of generalisability, but rather to offer a narrative from the front-line.

Findings

Nurses' interpretation of policy – use of discretion

Policy can have a variety of interpretations, but generally it can be seen to be a statement of intent. According to the *Oxford English Dictionary* (2006: 1109), the term policy means 'a course or principle of action adopted or proposed by an organisation or individual'. Within the discussions there was often ambiguity and confusion as to what was actually meant by the term policy. Targets, audits, guidelines, codes of conducts, procedure guidance,

and memoranda from managers were all spoken of as types of policy. There were those staff who viewed policy as:

a written rule or regulation or procedure regarding an aspect of nursing or medicine or whatever it is. Something that's been printed and is to be adhered to and followed. (Female, Staff Nurse (SN), 2–3 years)

This was in comparison to those who view policy more flexibly as:

essentially as a set of guidelines to achieve an end result. (Male, Ward Manager (WM)/Charge Nurse (CN), 15+ years)

This shows that the term policy, according to staff, can encompass anything that the institution or managers use to help shape behaviours, actions and practices within the workplace. These differing understandings of policy meant that nurses would use differing levels of discretion when interpreting and following what they perceived as policy, and this would vary for each individual nurse.

Those who viewed policies more in terms of rules and regulations demonstrated an increased concern regarding the potential for blame:

nursing management are not responsible, it's the individual. (Female, SN, 15+ years)

along with the lack of support from management:

If you do something wrong and it comes back to you, the management will say 'well it's your own fault because there was policies there for you to read' so they've got the policies there to cover themselves. (Female, SN, 6–10 years)

Mulgan (2000) and Khatri *et al.* (2009) both suggest that there has been a growth in accountability and responsibilisation within the professions, which has led towards a culture of assigning blame. The blame culture can develop within an organisation where there is a fear of criticism or management admonishment (Khatri *et al.*, 2009; Gorini *et al.*, 2012) and this can then lead to defensive practice by staff. This has caused raised levels of anxiety, as the majority of staff declared that it was unrealistic to assume that staff would always adhere to regulations:

there's a policy for everything, isn't there and you can't – with the best will in the world, you'll not know every single one. (Female Ward Manager (WM)/Sister(S) 15+ years)

The front-line nurses developed ways to cope with an unmanageable quantity of information. This often meant that many of the policies were not implemented or not fully adhered to, if they were felt to be irrelevant:

the policies that do fall by the wayside are policies which some of the nurses regard as a bit daft, like some of the health and safety policies. (Female, SN, 2–3 years)

I think some of the policies that come in, don't really apply to, or can't apply to us... and sometimes you look at them and think 'how can you possibly work by that, because it just doesn't make sense for a department like this'. (Female, SN, 3–5 years)

It was not a case that they were not co-operating with the regulatory mechanisms of the organisation, rather they were more selective when they accessed and engaged with policies that controlled their working practice:

I mean, obviously you're using your discretion. (Female, SN, 6–10 years)

This means policies were not being implemented as was perhaps intended, and the implementation varied from nurse to nurse. The values of the front-line nursing staff were prioritised over perceived management values in the application of policy. Due to the nature of the type of work, nurses were undoubtedly influenced by their own moral judgements, for example whether the patient was seen as 'deserving' or not:

some people are just genuinely daft and just don't know how to behave, don't know how to act... you get to see the twenty year old drunk 'NED'² who can be so demanding, then you get to see the eighty year old wee wifey with a broken hip who will not ask for pain relief, purely because she doesn't want to hassle you. (Male, SN, 6–10 years)

Although all patients were entitled to treatment, nurses were willing to make extra allowances for those individuals who they felt were deserving or whose behaviour they chose to overlook. This, however, was not explicitly highlighted by responses. Discretion allowed the front-line staff to intervene on behalf of clients and also to discriminate amongst them, allowing some individuals to be prioritised over others (which is needed within the medical area: some individuals will require quicker or more extensive treatment than others).

Conflicting goals - managers versus nurses

With regard to conforming to the formal structures of authority, Lipsky (2010: 16) indicates that workers for the most part accept the legitimacy of these structures, and are not in a position to disagree with them. However, if street-level bureaucrats (in this case nurses) did not agree with the organisational views and preferences of the managers, then their goals were not the same. This can lead to non-compliance by nurses and also to conflict between managers and nursing staff:

Because a lot of the time these people are only managers, they don't actually have background knowledge within a ward area, or how behind the scenes works in regards to the running of a ward, or, you know, they're not medically minded, they're management minded. (Female, SN, 6–10 years)

Discretion, as opposed to resistance or non-compliance, was used in coping with a large workload when working with fewer resources, including staff and time that were less than optimal, which means that short-cuts and simplifications are developed in order to cope:

If everybody else is a lot busier, then you've got less time to spend with patients or you're maybe doing your job a bit more quicker than you should, or trying to rush things through. (Male, SN, 3–5 years)

Such coping mechanisms were generally unsanctioned by the management. The priorities of staff nurses, compared to those of management, can lead to difficulties and potentially to conflict (Lipsky, 2010: 18). It was felt that managers tended to be focused on performance and the cost of such performance:

Obviously budgets are the big issue and they're complaining about overspending, but they've not been in the wards to see that it's not suitable for them to run understaffed or without products that we need. (Female, SN, 6–10 years)

Managers were seen to be trying to restrict workers' discretion to ensure results were achieved. Due to nurses expecting the right to exercise their clinical autonomy to make critical discretionary decisions, the restrictions imposed by managers on staff were often seen as illegitimate. There was a tension between having a professional status as a nurse and the need to comply with superiors' directions:

It angers you a bit, but then I know there's nothing I can do. We can only do what we can, we can try; we see a lot of things change which we feel is for the worse, but it's out of our hands to change it. It's frustrating a lot of the time but you have to get on with it. (Male, SN, 3–5 years)

In order to cope with such tensions, Lipsky (2010: 21) argues that street-level bureaucrats will use the rules, regulations and administrative provisions to evade or change policies that will limit their discretion. In Lipsky's view, workers are aware of constraints and they 'see themselves as fighting on the front-line of local conflict with little support and less appreciation by a general public whose dirty work they have to do' (Lipsky, 2010: 82). If they are working inadequately, then workers do not see it as their fault.

Identity within nursing – the case of the ward sister/charge nurse versus the ward manager

According to Lipsky (2010: 18–19), street-level bureaucrats will have different aims and goals to those of their managers. This view was often reflected by the participants when asked generally about managers; however Ward Managers were not seen to fulfil the role of a manager as viewed by Lipsky. Evans (2010) showed that street-level ideas of managers are more complicated than suggested by Lipsky's analysis, instead showing that managers who are also clinicians often have both the professional and sympathetic values shown by front-line staff. There was a difficulty in how staff classified Ward Managers; they were not perceived by the participants as a 'manager' in the way they viewed 'other' managers, but were seen as more akin to a member of the nursing staff. For Lipsky, managers and street-level bureaucrats worked in different ways, they had different priorities, values and commitments. Managers were focused on policy implementation whereas the workers attempted to make working conditions acceptable and tried to control the direction of their own work. However, there must be compromise between such managers and

workers. Within nursing, this raises questions with regard to local managers (such as Ward Managers and lead nurses), as according to Lipsky these managers would be presented as obedient to the organisation.

One managerial role discussed in some detail was that of the Ward Manager. This position has seen considerable change over the past decade and has been influenced by the ideology of NPM. Traditionally, these individuals would have been known as 'Sister' or 'Charge Nurse', which has little connotation with manager or management within the names, and more recently these individuals have been re-named as 'Ward Manager':

I'm soon not going to be a Sister, I'm going to be a Ward Manager. (Female, S/WM, 15+ years)

and as such, has led to a change in their role:

The Ward Sister is a very different job now from when I qualified . . . there wasn't anything like as much management involved in the day-to-day running of the ward, it was more . . . you were more clinical based, you were more looking after your staff rather than all the other . . . the budgetary responsibilities and all that that we have now, Ward Sisters didn't have that initially. (Female, S/WM, 6–10 years)

This means that Ward Managers continue to have a case load of patients and are responsible for the running of the ward area, but the Ward Manager's role also includes budgetary and other managerial responsibilities (Pope *et al.*, 2002; Wong, 2004). This can lead to conflict as it will restrain their autonomy to make clinical decisions that are best for the patient, given that they will be balancing any clinical decision with those of costs and resources (Som, 2009), leading to tension between the 'professional ethos of patients welfare and the managerial perspective of efficiency' (Som, 2009: 305). Such significant changes in working practices for senior staff means that there was discontent with the managerialist approach (Brunnetto, 2002; Townsend and Wilkinson, 2010; Hutchison and Purcell, 2010). This leads to demoralised staff (not just Ward Managers), who feel vulnerable and suspicious of change (Maddock and Morgan, 1998).

The Ward Manager role has different responsibilities and connotations when compared with the previous roles associated with Sister/Charge Nurse titles, and several of the respondents remarked that the increased managerial role was not what they became a nurse for:

I don't think I personally came into nursing to be a Manager. I came into nursing to look after people. And I took the role on not realising there was probably a bit of management in it as well, I thought it would be more . . . the same as what my colleague before me had done, and then I took her job, and then that changed. (Female, S/WM, 15+years)

This echoes findings from Bolton (2000: 6) who stated that: 'nurses are keen to dissociate themselves from the title of managers and see their role as that of mediating the excesses of NPM'. Historically, Ward Sisters have undertaken line management responsibilities in the form of training, organising and the monitoring of junior nurses work (Bolton, 2003). But, as highlighted by Brunnetto (2002), the cost cutting aim of NPM means that those professionals acting in a position of management (such as Ward

Managers) are being forced to adopt bureaucratic strategies in order to ration and limit resources, which conflicts with their professional ethics:

I feel sometimes that it's a lot more kind of politics now within the ward area. From basic things to the budget, I mean, even when I was doing my auxiliary many years ago, the nurses would use things and it wouldn't even cross their mind how much it was. But now we're constantly being reminded that if there's an alternative we can use that's cheaper ... Our stock levels aren't great now as well because we're trying to cut down on our budget and we tend to run out of dressings, and it's a surgical ward. I feel I just didn't see that happen in the past before, so I feel that's kind of – but I understand that they're concentrating on the budget and trying to find ways to cut down on that. But sometimes it is affecting patient care because we don't have the appropriate dressings or tablets that have been ordered up. (Female, SN, 3–5 years)

This leads to resistance to change, for example, staff who referred to themselves as 'Sisters' or 'Charge Nurses' compared to those who referred to themselves as 'Ward Managers'. Resistance can indicate a lack of communication, the way changes were imposed on staff, a clash of values, and a cultural clash with differing perspectives on what was important or necessary.

Conclusions

If street-level bureaucracy is an 'inescapable feature of the modern (welfare) state' (Rowe, 2012: 15), then the need to understand how street-level bureaucrats respond to policy, management and financial constraints, along with their interactions with the public is essential. As has been seen in this article, nurses are street-level bureaucrats who can influence the implementation of policy via their use of discretion in their work.

Within Lipsky's analysis of street-level bureaucrats, there are many reasons why workers will resist management policies. If the traditional view of nursing being a hierarchical model of governance is considered, it would be expected that nurses would follow policies, and be unlikely to deviate from them. However, as street-level bureaucrats, nurses have considerable discretion in determining the nature, amount and quality of benefits and sanctions provided by their organisation, despite policy which dictates that discrimination will not occur within the NHS.

Nurses held differing views as to what the term policy meant, and this influenced their use of discretion when enacting a policy and decision-making. Nursing staff developed strategies in order to cope with the influence of policy decisions and the interactions which occur between themselves, managers and the public. The staff reported feelings of powerlessness, but due to their status as street-level bureaucrats, they were actually in a position to influence the implementation of policy. If the nurses did not view a policy as legitimate and in the best interest of patients or their working conditions, then they were able to use limited strategies to adapt, change and resist policy at the implementation stage.

There were often conflicting goals between management and front-line staff. This again has led to the use of discretion and resistance by nursing staff in the application of policies. Nursing staff would question the legitimacy of management to make decisions and this could often lead to conflict. It should be noted that Lipsky largely discounted the existence of value-based discretion (Lipsky, 2010: 71). However, within this research

it was found that although all patients would have been entitled to treatment, nurses were willing to make extra allowances for those individuals who they felt were deserving or whose behaviour they chose to overlook. Using Lipsky (1980, 2010) as a way of analysing the use of discretion within the nursing workforce, it can be seen that staff employed several methods in order to resist or to alter management policies.

The changing role of Sister/Charge Nurse to Ward Manager has been explored in this article and can be seen as a clear example of staff attempting to resist to managerial policies. This role change can be seen to have created conflict for these individuals as they tried to reconcile a managerial role with a clinical role, when they found that both had differing priorities which could not be reconciled. Lipsky (2010: 19) characterises managers as a unique group which, cast in a particular role, is seeking to control practice and limit discretion. But according to Evans' (2010: 165) findings, which focus on managers (as opposed to Lipsky's 1980s study, which focused on practitioners), managers are 'using their discretion to adapt, change and subvert policies' in similar ways to practitioners. Lipsky portrays local managers and street-level bureaucrats as having fundamentally different orientations, but this may not always be the case. For example, Ward Managers who remain clinical will find themselves torn between management priorities and the goals of ward level patient care.

The ever-changing health policy environment which characterises nursing has given rise to a challenge within the profession, where responding to sometimes ambiguous government demands can conflict with maintaining a professional ethos. Lipsky's concept of street-level bureaucracy has been used in this article to offer some explanation as to how nurses interpret and implement (or do not implement) policy at ward level. The role of nurses as policy implementers has been largely overlooked in comparison to studies within other allied health professionals and medical counterparts. Furthermore, the influence of NPM in shaping the working practices of nurses has also been overlooked. This is perhaps due to nursing having been viewed as retaining a hierarchical structure. In this article, however, nurses have been shown to be affected by managerialism, and it is clear that they are not just practitioners who follow policy, but also are active, resourceful and credible agents within policy implementation, and as such have much influence at the ground level. The use of discretion (in terms of rule, value and task discretion) by front-line nursing staff is important for them to be able to continue to provide effective patient care.

This article has offered insight from a small scale piece of research, but has clearly demonstrated the conflict that arises between the goals of managers compared to those of front-line staff and thus leading to the use of discretion when implementing policy. The way in which front-line nursing staff interpret and enact policy will clearly influence the care that patients receive whilst in hospital. This needs to be studied further to see how the use of discretion can impact on the quality of a service.

Notes

1 The original book 'Street-Level Bureaucracy: Dilemmas of the Individual in Public Services' was published in 1980; however, an updated expanded edition was published in 2010. In this latest edition, there is an additional chapter where Lipsky revisits and reflects on significant policy developments that have occurred since the original edition. It is this 2010 edition that has been quoted throughout this article.

2 'NED' – this is a Scottish colloquialism meaning a youth who is uneducated and seen as a hooligan. In other parts of the country, they might be called things such as hoodies, scallys, louts.

References

- Atkinson, P., Delamont, S. and Hammersley, M. (1988) 'Qualitative research traditions: a British response to Jacob', *Review of Educational Research*, 58, 2, 231–50.
- Baldwin, M. (2000) *Care Management and Community Care: Social Work Discretion and the Construction of Policy*, Aldershot: Ashgate.
- Baldwin, M. (2004) 'Critical reflection: opportunities and threats to professional learning and service development', in N. Gould and M. Baldwin (eds.), *Social Work, Critical Reflection and the Learning Organisation*, Aldershot: Ashgate.
- Bergen, A. and While, A. (2005) 'Implementation deficit and street-level bureaucracy: policy, practice and change in the development of community nursing issues', *Health and Social Care in the Community*, 13, 1, 1–10.
- Bolton, S. C. (2000) 'Nurses as managers: between a professional rock and an HRM hard place?', *Human Resource Development International*, 3, 2, 229–34.
- Bolton, S. C. (2003) 'Multiple roles? Nurses as managers in the NHS', *The International Journal of Public Sector Management*, 16, 2, 122–30.
- Brunnetto, Y. (2002) 'The impact of growing managerialism amongst professionals in Australia: a comparative study of university academics and hospital nurses', *Research and Practice in Human Resource Management*, 10, 1, 5–21.
- Buchan, J. and Seecombe, I. (2012) *RCN Labour Market Review: Overstretched, Under Resourced – the UK Nursing Labour Market Review 2012*, London: Royal College of Nursing.
- Cheetham, J. (1993) 'Social work and community care in the 1990's: pitfalls and potential', in R. Page and J. Baldock (eds.), *Social Policy Review*, 5, Canterbury: Social Policy Association.
- Cresswell, J. (1998) *Qualitative Inquiry and Research Design: Choosing among Five Traditions*, London: Sage.
- Crotty, M. (2005) *The Foundations of Social Research*, London: Sage.
- Denzin, N. K. and Lincoln, Y. S. (2000) 'The discipline and practice of qualitative research', in N. K. Denzin and Y. S. Lincoln (eds.), *Handbook of Qualitative Research*, 2nd edition, London: Sage.
- Durose, C. (2011) 'Revisiting Lipsky: front-line work in UK local governance', *Political Studies*, 59, 4, 978–95.
- Ellis, K., Davis, A. and Rummery, K. (1999) 'Needs assessment, street-level bureaucracy and the new community care', *Social Policy and Administration*, 33, 3, 262–80.
- Evans, T. (2009) 'Managing to be professional? Team managers and practitioners in modernised social work', in J. Harris and V. White (eds.), *Modernising Social Work: Critical Considerations*, Bristol: Polity Press, pp. 145–64.
- Evans, T. (2010) *Professional Discretion in Welfare Services: Beyond Street-Level Bureaucracy*, Aldershot: Ashgate Publishing.
- Evans, T. and Harris, J. (2004) 'Street-level bureaucracy, social work and the (exaggerated) death of discretion', *British Journal of Social Work*, 34, 6, 871–95.
- Evans, T. and Harris, J. (2007) 'A case of mistaken identity? Debating the dilemmas of street-level bureaucracy with Musil et al.', *European Journal of Social Work*, 9, 4, 445–59.
- Exworthy, M. and Halford, S. (1999) 'Professionals and managers in a changing public sector: conflict, compromise and collaboration?', in M. Exworthy and S. Halford (eds.), *Professionals and the New Managerialism in the Public Sector*, Buckingham: Open University Press, pp. 1–17.
- Fletcher, D. R. (2011) 'Welfare reform, jobcentre plus and the street-level bureaucracy: towards inconsistent and discriminatory welfare for severely disadvantaged groups?', *Social Policy and Society*, 10, 4, 445–58.
- Frenkel, S. J., Tam, M., Korczynski, M. and Shire, K. (1998) 'Beyond bureaucracy?' Work organisation in call centres', *The International Journal of Human Resource Management*, 9, 6, 957–79.
- Gorini, A., Miglioretti, M. and Pravettoni, G. (2012) 'A new perspective on blame culture: an experimental study', *Journal of Evaluation in Clinical Practice*, 18, 3, 671–5.

- Grant, A. (2013) 'Welfare reform, increased conditionality and discretion: Jobcentre Plus advisors' experiences of targets and sanctions', *Journal of Poverty and Social Justice*, 21, 2, 151–62.
- Greener, I. (2009) *Healthcare in the UK: Understanding Continuity and Change*, Bristol: Polity Press.
- Ham, C. (2009) *Health Policy in Britain*, 6th edition, Hampshire: Palgrave Macmillan.
- Harris, J. (1998) 'Scientific management, bureau-professionalism, new managerialism: the labour process of state social work', *British Journal of Social Work*, 28, 6, 839–62.
- Harvey, D. (2005) *A Brief History of Neoliberalism*, Oxford: Oxford University Press.
- Hill, M. (1997) *The Policy Process: A Reader*, 2nd edition, London: Pearson/Prentice Hall.
- Hoyle, L. P. (2011) 'New public management and nursing relationships in the NHS', Ph.D. thesis, University of Stirling, Stirling.
- Howe, D. (1991) 'Knowledge, power and the shape of social work practice', in M. Davies (ed.), *The Sociology of Social Work*, London: Routledge, pp. 202–20.
- HM Treasury (2010) *Budget 2010*, London: The Stationery Office.
- Hudson, B. (1997) 'Michael Lipsky and street level bureaucracy: a neglected perspective', in M. Hill (ed.), *The Policy Process: A Reader*, 2nd edition, London: Pearson/Prentice Hall, pp. 393–403.
- Hunter, D. J. (2007) 'Exploring managing for health', in D. J. Hunter (ed.), *Managing for Health*, Abingdon: Routledge, pp. 54–79.
- Hutchison, S. and Purcell, J. (2010) 'Managing ward managers for roles in HRM in the NHS: overworked and under-resourced', *HR Management Journal*, 20, 4, 357–74.
- Johansson, S. (2011) 'Who runs the mill? The distribution of power in Swedish social service agencies', *European Journal of Social Work*, 15, 5, 679–95.
- Jones, C. (1999) 'Social work: regulations and managerialism', in M. Exworthy and S. Halford (eds.), *Professionals and the New Managerialism in the Public Sector*, Buckingham: Open University Press.
- Jones, C. (2001) 'Voice from the front-line: state social works and New Labour', *British Journal of Social Work*, 31, 4, 547–62.
- Khatri, N., Brown, G. D. and Hicks, L. L. (2009) 'From a blame culture to a just culture in health care', *Health Care Management Review*, 34, 4, 312–22.
- Kinnie, N., Hutchinson, S. and Purcell, J. (2000) '"Fun and surveillance": the paradox of high commitment management in call centres', *International Journal of Human Resource Management*, 11, 5, 967–85.
- Kirkpatrick, I., Dent, M. and Kragh Jespersen, P. (2011) 'The contested terrain of hospital management: professional projects and healthcare reforms in Denmark', *Current Sociology*, 59, 4, 489–506.
- Lapsley, I. (1994) 'Market mechanisms and the management of healthcare: the UK model and experience', *International Journal of Public Sector Management*, 7, 6, 15–25.
- Lewis, J. and Glennerster, H. (1996) *Implementing the New Community Care*, Buckingham: Open University Press.
- Lipsky, M. (1980) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*, New York: Russell Sage.
- Lipsky, M. (2010) *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*, 30th anniversary expanded edition, New York: Russell Sage.
- Loyens, K. and Maesschalck, J. (2010) 'Towards a theoretical framework for ethical decision making of street-level bureaucracy: existing models reconsidered', *Administration and Society*, 42, 1, 66–100.
- Maddock, S. and Morgan, G. (1998) 'Barriers to transformation: beyond bureaucracy and the market conditions for collaboration in health and social care', *International Journal of Public Sector Management*, 11, 4, 234–51.
- Maynard-Moody, S. and Musheno, M. (2000) 'State agent or citizen agent: two narratives of discretion', *Journal of Public Administration*, 10, 2, 329–58.
- Maynard-Moody, S. and Musheno, M. (2003) *Cops, Teachers and Counsellors: Stories from the Front-Line of Public Service*, Ann Arbor, MI: University of Michigan Press.
- McCall, V. (2009) 'Social policy and cultural services: a study of Scottish border museums as implementers of social inclusion', *Social Policy and Society*, 8, 3, 319–31.

- McMahon, A. (1998) 'Developing practice through research', in B. Roe and C. Webb (eds.), *Research and Development in Clinical Nursing Practice*, London: Whurr Publishers, pp. 219–46.
- Meyers, M. K. and Vorsanger, S. (2007), 'Street-level bureaucrats and the implementation of public policy', in B. G. Peters and J. Pierre (eds.), *Handbook of Public Administration*, London: Sage, pp. 153–64.
- Mulgan, R. (2000) 'Accountability: an ever expanding concept?', *Public Administration*, 78, 3, 555–73.
- Mulholland, K. (2004) 'Workplace resistance in an Irish call centre: slammin', scammin' smokin' an' leavin'', *Work, Employment and Society*, 18, 4, 709–24.
- Newman, J. and Clarke, J. (1994) 'Going about our business? The managerialization of public services', in A. Clark, A. Cochrane and E. McLaughlin (eds.), *Managing Social Policy*, London: Sage.
- Noordegraaf, M. (2011) 'Remaking professionals? How associations and professional education connect professionalism and organizations', *Current Sociology*, 5, 4, 465–88.
- Oxford English Dictionary (2006) *Concise Oxford English Dictionary*, Oxford: Oxford University Press.
- O'Sullivan, T. (2011) *Decision Making in Social Work*, 2nd edition, Basingstoke: Macmillan.
- Pope, C., Royen, P. and Baker, R. (2002) 'Qualitative methods in research on healthcare quality', *Quality and Safety in Health Care*, 11, 2, 148–52.
- Ritchie, J., Spencer, L., and O'Conner, W. (2008) 'Carrying out qualitative analysis', in J. Ritchie and J. Lewis (eds.), *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, London: Sage, pp. 219–62.
- Robson, C. (2002) *Real World Research*, 2nd edition, Oxford: Blackwell.
- Rowe, M. (2012) 'Going back to the street: revisiting Lipsky's street-level bureaucracy', *Teaching Public Administration*, 30, 1, 10–18.
- Scottish Government (2010) *NHS Scotland Quality Strategy – Putting People at the Heart of our NHS*, Edinburgh: The Scottish Government.
- Scott, P. (1997) 'Assessing determinants of bureaucratic discretion: an experiment in street-level decision making', *Journal of Public Administration Research and Theory*, 7, 1, 35–57.
- Som, C. V. (2009) '"Quantity" versus "quality" dilemma of health staff in NHS UK', *Clinical Governance: An International Journal*, 14, 4, 301–14.
- Taylor, I. and Kelly, J. (2006) 'Professionals, discretion and public sector reform in the UK: re-visiting Lipsky', *International Journal of Public Sector Management*, 19, 7, 629–42.
- Townsend, K. and Wilkinson, A. (2010) 'Managing under pressure: HRM in hospitals', *HR Management Journal*, 20, 4, 332–8.
- Tummers, L. and Bekkers, V. (2012) *Discretion and Its Effects: Analysing the Experiences of Street-Level Bureaucrats during Policy Implementation*, <http://repub.eur.nl/res/pub/34967/> (accessed 13 November 2012).
- Tummers, L., Vermeeren, B., Steijn, B. and Bekkers, V. (2012) 'Public professionals and policy implementation', *Public Management Review*, 14, 2, 1041–59.
- Van Berkel, R. and Van der Aa, P. (2012) 'Activation work: policy programme administration or professional provision?', *Journal of Social Policy*, 41, 3, 493–510.
- Van den Broek, D. (2004) '"We have the values": customers, control and corporate ideology in call centre operations', *New Technology, Work and Employment*, 19, 1, 2–13.
- Warren, J. and Harris, M. (1998) 'Extinguishing the lamp: the crisis in nursing', in D. Anderson (ed.), *Come Back Miss Nightingale: Trends in Professions Today*, London: The Social Affairs Unit, pp. 11–36.
- Wells, J. S. G. (1997) 'Priorities, "street level bureaucracy" and the Community Mental Health Team', *Health and Social Care in the Community*, 5, 5, 333–42.
- Wong, W. H. (2004) 'Caring holistically within new managerialism', *Nursing Inquiry*, 11, 1, 2–13.
- Wright, S. (2003) 'The street-level implementation of unemployment policy', in J. Millar (ed.), *Understanding Social Security*, Bristol: The Policy Press, pp. 235–54.
- Yin, R. (1994) *Case Study Research: Design and Methods*, 2nd edition, Thousand Oaks, CA: Sage.