COMMUNICATIONS IN A CHANGING ENVIRONMENT

GLADYS MARY JONES

A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the Degree of Doctor of Philosophy

This research programme was carried out in collaboration with Greenwich Healthcare NHS Trust

May 2000

ABSTRACT

This research consists of a collaborative study of internal communication in a National Health Service Trust. Information was obtained by means of interviews, discussions and surveys of staff. A small comparative study was carried out with senior officers from a Borough Council.

Strengths and weaknesses in organisational communications have been identified. The most important of these strengths was recognition in the Trust that communication is everybody's responsibility. Weaknesses were apparent in interdepartmental communication, visibility and approachability of management and lack of information and briefing on general matters and changes.

The study has demonstrated the successful use of mechanisms for identifying both weak areas and groups. A new scale has been utilised and indices have been developed and evaluated to measure specific aspects of communication. These include:

(i) Overall communication satisfaction and level.
(ii) Frequency of communication.
(iii) Information overload.
(iv) Non-occurrence or breakdown of communication.

These measures have facilitated the identification of categories of staff in the Trust that are either communication advantaged or disadvantaged.

As a further contribution, the measures can be used to examine certain hypotheses such as those relating communication to involvement with the organisation.

The thesis also describes key areas that need to be addressed in the future. The NHS Trust has accepted and utilised the findings of this study and is implementing improvements. The mechanisms and management of the improvement processes are detailed.

CONTENTS

TABLES

FIGURES

ACKNOWLEDGEMENTS

Very great thanks are due to Linda Marsh, Director of Communications, and David Ashley, former Chief Executive, at Greenwich Heathcare NHS Trust for their collaboration and championing of this work. I should also like to thank the many other members of staff at Greenwich Healthcare who assisted in the study. I particularly wish to thank Bill South a former Trust Non Executive Director who recognised the need for a communication study and introduced me to the Trust.

Acknowledgements and thanks are due to the Chief Executive and senior management at Dartford Borough Council for taking part in the comparative study.

I should like to thank my supervisors: Professor Martin Everett and Professor David Chambers as well as other colleagues at the University of Greenwich for their help and guidance.

CHAPTER 1

INTRODUCTION

1 The case studies

This thesis describes research on internal communications between staff in two organisations subject to change. The main study was carried out with the active collaboration of Greenwich Healthcare NHS Trust.

A small study was also carried out with senior staff from Dartford Borough Council.

These organisations were selected for the following reasons:

(i) Both are in the public sector, so would offer particular opportunities for comparison.

(ii) Both were subject to major change.

(iii) Most importantly, both were ready and willing to co-operate in the study.

2 The pressure for change in the public sector

An important aspect of the public sector of the last two decades has been the continuing pressure for change. This has often been politically driven. Each successive government always thinks it can do better than the last. In the 1980s there was a perception of under-performance by public sector management and solutions sought from the private sector. Throughout the 1980s line management has been strengthened. There has also been a continuing trend for privatisation of part or all of public services and the Private Finance Initiative has meant that many capital projects have been privately funded. Public sector bodies are constrained to secure value for money. They have been required to make themselves more efficient and encouraged to sell 'redundant' property in order to raise funds, often with major impact on the workforce.

However, public employees can be hard to convince about the need for change. Prime Minister Tony Blair was quoted in 'The Times' by Webster and

Sherman (1999) as saying: [1]

> *"People in the public sector were more rooted to the concept that 'if it has always been done this way it must always be done this way' than any group of people I have come across".*

Indeed having correct policies for change is not enough, the organisations must also be capable of change (Pettigrew et al, 1992).

3 Change in the NHS

The NHS has been subject to a continual series of changes since its inception in 1948. Appendix A lists some key events. Historically, healthcare organisations have been looked on as professional bureaucracies, (Mintzberg, 1990), with strong resistance to change and innovation (Alford, 1975).

A major change relevant to today's organisation occurred in the early 1980s, when the management arrangements in England were the subject of an inquiry team chaired by Roy Griffiths. Its recommendations, encompassed in the Griffiths Report (1983), were later applied to the whole of the UK. One of the key recommendations was that general managers would take overall responsibility for service performance and management at regional district and unit level, see Appendix A.

The interaction between such managers and the professionals in the health service has been the subject of much study, see Spurgeon and Barwell (1991) and Harrison (1988). However, the Griffiths reforms did not significantly alter the balance of power between doctors and managers. Doctors have successfully resisted efforts to limit their autonomy (Strong and Robinson, 1990). Indeed a consultant group was sufficiently powerful in at least one instance to cause the resignation of a trust chairman and chief executive, (Kennedy, 1996).

NHS Trust boards must now include a senior nurse but nurses have remained the weaker profession compared with doctors. It is clear that many of the old hierarchies still exist.

4 The importance of communication in the NHS

A survey by the Office for Public Management in 1997 reported by Lloyd (1998, 1998a) showed that 46% of trusts and 69% of Health Authorities had a

[1] Italic script is used for original quotations throughout this thesis.

specialist communications post but only 5% of these posts were senior director level ones. Budgets are very low compared with other types of organisation. However, about 70% have communications strategies for both internal and external communications.

The survey also indicated that the priorities for internal communications, identified by chief executives, were to develop systems and skills in order to explain objectives to staff. There was a growing recognition by managers of the importance of communications in relation to change. Many understood the need for discussion with staff on how these changes would take place. Frequently there have been difficulties with communicating consistently with staff who are often geographically spread out. There have also been problems with complex issues, time pressures, staff resistance to change and managers' poor communication skills.

Pettigrew et al, (1992a) have examined the management of change within eight high change District Health Authorities and found a number of receptive and non receptive contexts for change. Those directly relevant to communications issues include supportive organisational culture, co-operative inter-organisation networks and managerial/clinical relations.

The NHS Executive (1996) has published a set of standards for communication. These include aspects such as openness and consistency. The Directors Guide, published by the NHS Confederation in 1997, sets out an overview of modern communication principles and practices. It is clear that while many Trusts have travelled far in a short time, there are still many challenges ahead (Wylie, 1997).

5 Need for a communications study

Communication is a key enabler. Clampitt and Downs (1993) have stated that improved communication results in improved morale, increased productivity, reduced absenteeism, greater innovation and more widespread commitment to organisational goals. Indeed if an employee is proud to work for the organisation and effectively contributes to an employer's goals he or she is more likely to perform at a higher level, (Steers and Porter, 1991).

Certainly the employee must know what is going on, what the goals are, and what is required of them. Staff need to be able to communicate freely and satisfactorily with their fellow workers, subordinates and management in order to

achieve:

(i) Better personal involvement

(ii) Good teamwork

(iii)Better job performance - improvements in both quality and quantity

(iv)Improved job satisfaction

DeCotilis and Summers, (1987) found that commitment was related to the work environment and in particular could be linked to participation in the decision process and good communications about organisational intentions. Arnott, (1987) found that where staff had an open and communicative manager they were much more likely to be satisfied with their job and committed to the organisation.

Management with an accurate knowledge of communication practices within the organisation will be better equipped to manage change. Indeed good change management has been associated with good communication, (Bertsch and Williams, 1994). It is also especially important, where the organisation is to undergo significant change, to equip its staff not only with the ability to be resilient but actually to be able to take a positive role in the change process. There is a need for a receptive climate for change.

It is necessary in any organisation to begin by establishing the current status before improvements can be instigated. It is costly in time both for the researchers and the subjects to carry out communications studies - so cost must be outweighed by advantages. Any study should be objective. and ideally be monitored by someone external to the organisation as management is notoriously complacent about its ability to communicate, (Smetzer, 1991) and thus might adversely influence the study. However, if such an exercise is to be useful to the organisation it is important to involve staff as stakeholders. They need to understand and own the problems.

6 Outline of research in this thesis

6.1 Questions to be answered

It is important at an early stage of any research to formulate specific research questions. These are needed to specify exactly what is to be found out about the topic. The questions need to be sufficiently qualified for the researcher to assess the

feasibility of the research, (Barrett, 1995), and also to ensure that the data collected actually addresses the problem. It is not useful to go out and gather some data to see what it tells us about communications, this is mindless empiricism, (Bechhofer, (1974) and is likely to result in some major omissions.

The following questions have been addressed in the study:

(i) *Is there a way of assessing the organisation for communication to determine both strong and weak areas and groups of staff?*

Clearly there will be some standard aspects of communication that need to be addressed: 'how much', 'how often', 'with whom' but there will also be some special problems associated with the organisations which will be important to investigate.

(ii) *How do demographic and employment factors influence internal communications?*

In order to answer this question, appropriate factors will need to be identified. There will inevitably be constraints on the numbers of items to be considered. So a subsidiary question will be *What factors are most likely to have major effects on communications?* Ways to measure communications will also need to be considered. These should include methods to identify, measure and rank groups for degree or standard of communications. It will be necessary to examine first the current methodologies for suitability for such an assessment. In the event that there are limitations to the instruments it will be necessary to make changes or improvements.

(iii) *Is there a demonstrable relationship between good communication and involvement with the organisation?*

A high level of communication on its own does not necessarily result in good participation, indeed there may be a distressing overload of communication messages. So it will be useful to establish whether there is a correlation between *good* communication and involvement with the organisation

(iv) *How can key areas and groups be successfully targeted for improvement.*

Having identified weaknesses and problem areas it will be necessary to determine how best to resolve the difficulties. It will be necessary to find practical and acceptable solutions which also address any problems of resistance to change.

To answer these questions it has been necessary to:

- Determine what management expects from the organisation and how it perceives the current situation.
- Evaluate both communications and underlying problems
- Identify key factors, strengths and weaknesses, opportunities and threats.
- Determine a suitable way to identify, measure and rank groups for degree or standard of communications.
- Identify information disadvantaged or 'isolated' groups.
- Facilitate the organisation to target improvements in appropriate areas.

6.2 Research methodology

There were four phases to the research:

(i) Literature survey

Review of communications and organisational theory, models, case studies and the NHS with particular reference to communication and changes.

(ii) Examination of organisation and management:

Informal discussions and semi-structured interviews, at Greenwich Healthcare and Dartford Borough Council. Visits to Greenwich Healthcare community sites.

(iii) Survey questionnaires

Pilot survey followed by full survey of all permanent staff at Greenwich Healthcare.

(vi) Analysis

Analysis and review of data. Computer software used included SPSS, NUD*IST and MS Excel.

6.3 Outcomes of the research

The main outcomes to the study were:

(i) Discovery of important deficiencies in communication in the organisations under study.

(ii) Improvements in some scales of measurement in a survey questionnaire to provide more easily understood categories.

(iii) Development of indices for assessment and comparison of elements of communication including:

- Overall communication satisfaction and level
- Frequency of communication
- Information overload
- Communication breakdown

(iv) Identification of a relationship between demographic and employment factors and the various elements of communication described above. This led to the identification of communication advantaged and disadvantaged groups.

(v) Identification of a positive relationship between good and satisfactory communication and involvement with the organisation.

7 Overview of the thesis

Chapter 2 gives some definitions of communication, describes relevant classical and modern theories of organisation and management of change, Various communication models are explained.

Chapter 3 describes some of the reasons for the importance of good communications in organisations and the ways people can communicate. Practical aspects of communications in organisations are discussed together with particular problem areas relevant to this study.

Chapter 4 documents methods of measuring and assessing communication. It details standard audit methods and the use of various scales to measure aspects of communication. Key previous exercises to measure communication in the NHS are reported. Methods used in this study are discussed.

Chapter 5 describes a small case study carried out with the assistance of Dartford Borough Council Management.

Chapters 6 describes the preliminary study of Greenwich Healthcare NHS Trust GHT) which was carried out mainly with senior management from the Trust.

Chapter 7 details the survey of all permanent staff carried out at GHT and provides an analysis of responses.

Chapter 8 sets out a method for comparing groups for elements of communication and details the results of analyses using this method.

Chapter 9 discusses the results of the studies on Greenwich Healthcare NHS Trust and Dartford Borough Council and compares the two organisations.

Chapter 10 describes the Trust's response to the survey and the mechanisms put in place for improvement.

Chapter 11 summarises the findings, recommends improvements and suggests future approaches.

CHAPTER 2

THEORIES OF COMMUNICATION, ORGANISATION AND MANAGEMENT OF CHANGE

1 Introduction

Some definitions of communication are given in this chapter and various communication models are explained. Classical and modern theories of organisation and management of change are described, particularly those aspects which are related to communication.

2 Definitions of communication

One cannot define communication without considering language and meaning. Indeed language is the central institution of any society. Pioneering studies were carried out by Ferdinand de Saussure, who in 1878 published a system of vowels in Indo-European languages. He also taught a renowned course in general linguistics at the University of Geneva over the period 1906-11, which was published in 1916 by his students. It included the concept of language as a system of mutually defining entities, (Baskin , 1959). Saussure rejected the concept of language as one of simple correspondence to the physical world and gave attention to the social interaction in language and codes of meaning.

Other key innovators in the field included Claude Lévi-Strauss a French social anthropologist, whose first major structionist[2] work was published in 1949. (see Lévi-Strauss, 1968). He realised that culture as well as language could be looked upon as a code of meaning in de Saussure's sense. Roland Barthes extended Saussure's and Lévi-Stauss's ideas on structuralism to a science of signs or semiology, see Barths, (1973).

More recent developments have been described by Cushman and Knovacic (1995), and have included such aspects as the co-ordinated management of meaning

[2] Structuralism in linguistics is an approach to the analysis of language where linguistic features can be described in terms of structures and systems. In social science and anthropology it is concerned with interdependence of different parts of a system., see Leach (1976) and Clarke (1981).

and constructionist theory which is concerned with understanding and interpretation.

Communication[3] can be defined as social interaction through messages, (Gerbner, 1967) and social interaction can be considered the very stuff of human life (Goldschmidt,1972). It is the transmission of information, ideas, attitudes or emotion from one person or group to another or others primarily through symbols (Theodorson and Theodorson , 1969).

Symbols and signs themselves are often the object of personal interpretation:

> *"When I use a word," Humpty Dumpty said in a rather scornful tone, " it means just what I choose it to mean - neither more or less".* Lewis Carroll (1872)

Evidently Aristotle thought that the world is identically perceived by all. In an analysis of speech and writing, De Interpetatione written in 350BC, he stated that:

> " *Sounds produced by the voice are symbols of mental impressions, and writing is a symbol of vocal sounds. And just as letters are not the same for all men, sounds are not the same either, although the mental impressions directly expressed by these indications are the same for everyone, as are the things of which these impressions are images".*

Sometimes there are difficulties in communication and understanding, perhaps because of some handicap. In other instances two people may not share the same range of communication possibilities for macrosocial reasons, for example, one person not speaking the other's language. Alternatively channels of communication may be more limited for circumstantial reasons such as physical separation, (Harris, 1996).

One cannot not communicate (Watzlawick et al, 1967). Even a deliberate effort not to engage in communication reveals itself as such, and hence communicates something (Krippendorff, 1994).

In organisational communication we are concerned with the exchange of information and transmission of meaning through an organisation, (Dessler, 1986). It can take the form of written policies, procedures and rules as well as oral communication. In some organisations communications are written and highly formalised, whereas in others they are spoken and informal.

---

[3] The word communicate comes from the Latin words communicare: to share and communis: common.

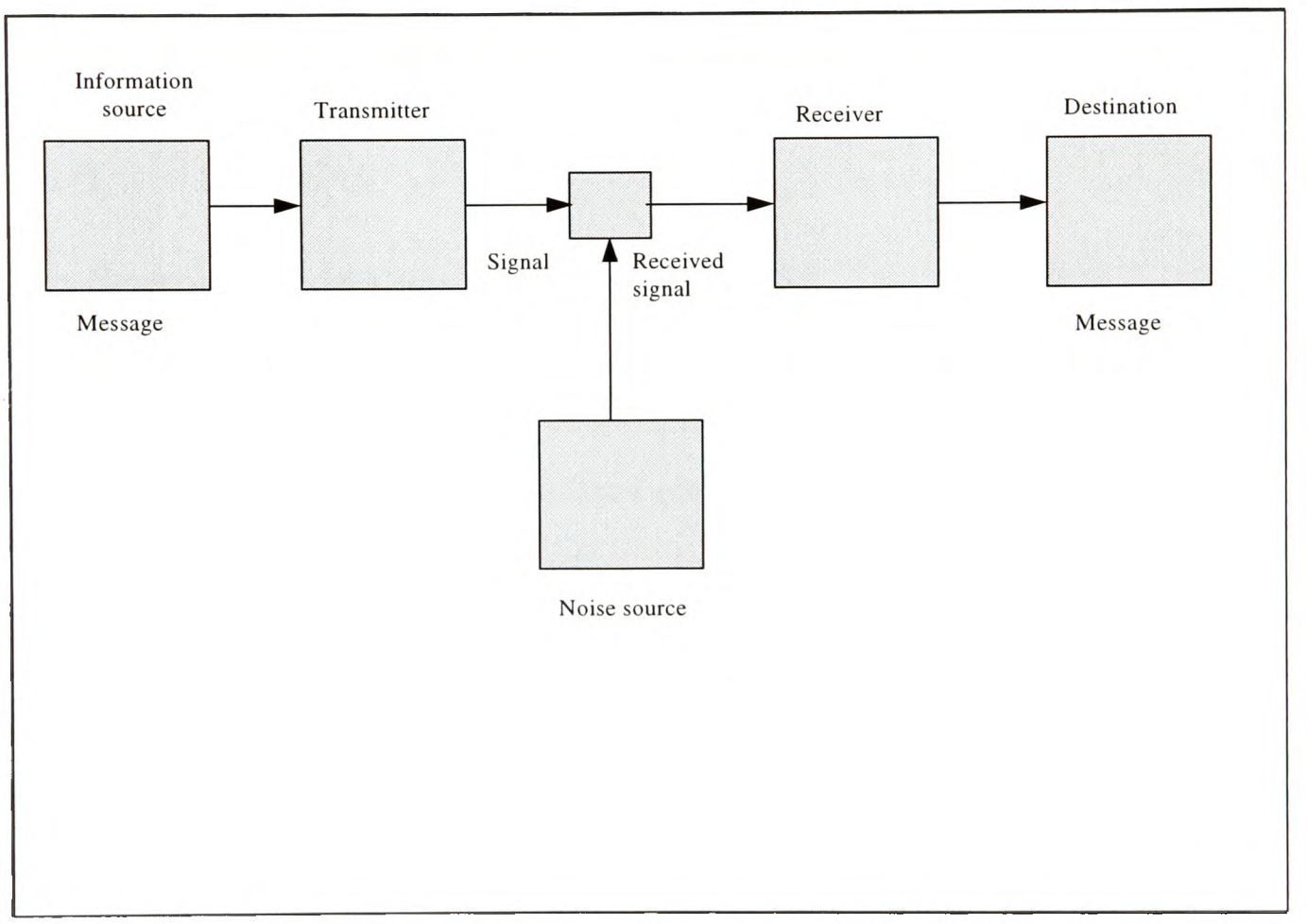
3 Communication models

McQuail and Windahl, (1993) have reviewed models for personal and mass communication. Some of these are described below.

3.1 The engineering theory diagram (Shannon and Weaver, 1949)

Figure 2.1, shows the elements of the act of communication considered as a process for the transmission of messages. A message is transferred from sender to receiver.

FIGURE 2.1: Engineering theory diagram
(Shannon and Weaver, 1949)

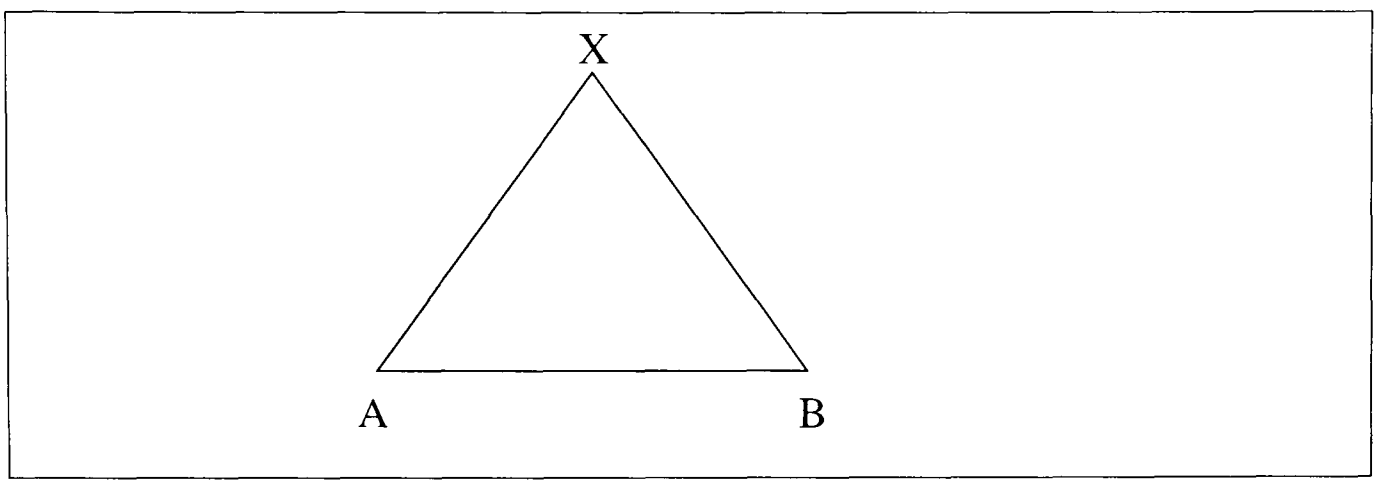


William Leiss (1994) has examined modifications to the basic diagram to take into account semantic coding and decoding and the effects of semantic noise on the signal. The Shannon and Weaver diagram has also been modified by others. See for example DeFleur (1970), whose modification takes account of feedback. He points out that in the communication process meaning is transferred into message. Then the transmitter transforms message into information which then passes through a channel. The receiver recognises the information as a message which in turn is

transformed at the destination into meaning. If the two meanings correspond there is communication. Correspondence is seldom perfect.

3.2 The ABX model (Newcomb, 1953)

FIGURE 2.2 ABX model



The Newcome model takes the form of a triangle. Two individuals A and B are oriented towards each other and an object 'X'. Communication is the process which supports the orientation structure, in the sense of maintaining or improving the symmetry of the relationship between the three elements and allowing adjustments to occur. The basic assumption is that tendency towards consistency of attitude and relationship will instigate communication. Newcome, (1959), later noted that communication is only likely to be activated under certain conditions:

(i) Where there is strong attraction between persons.

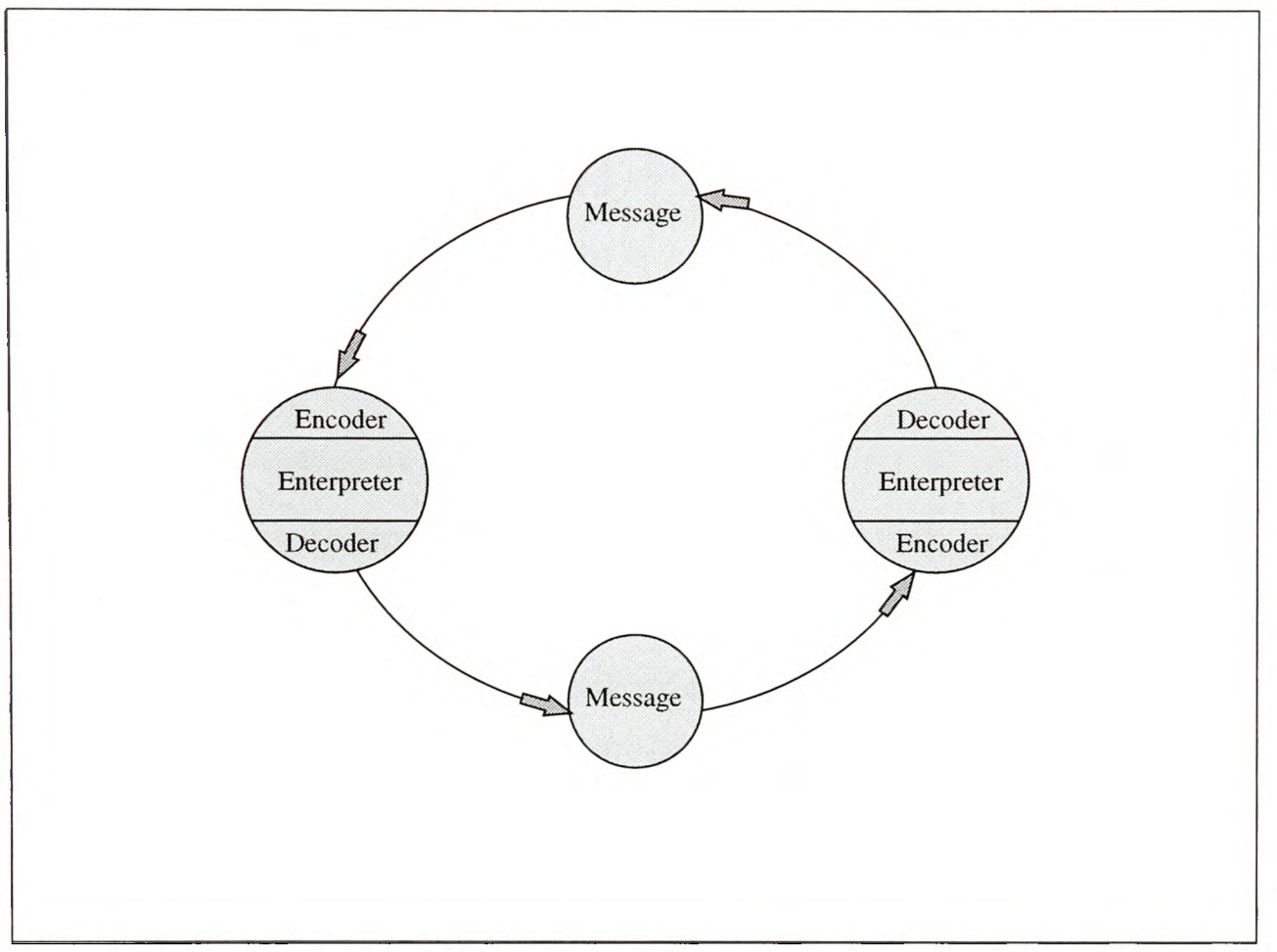
(ii) Where the object is important to at least one of the participants.

(iii) Where the object X has a joint relevance for both.

The Newcome approach supports the view that people are likely to attend to sources of information which are in line with their existing positions and look for information which supports and confirms their actual behaviour.

3.3 Osgood and Schramm circular model

FIGURE 2.3: Circular model



The circular model put forward by Schramm (1954) but originated with Osgood. In the above model, both parties in a conversation fulfil the same functions. However, the model does not deal with situations were there is little or no feedback.

Schramm comments that:

> *"It is misleading to think of the communication process as starting somewhere and ending somewhere. It is really endless. We are little switchboard centers handling and rerouting the great current of information".*

3.4 Helical model (Dance,1967)

The model takes into account the dynamic nature of communication and describes how different aspects of the process change over time. In a conversation the participants continually get more information about the topic, each other's point of view etc.

3.5 Lasswell model (1948)

The Lasswell approach for mass communication takes ication t
what, in which channel, to whom and with what effect. fect.

The model assumes that the communicator has some int has son
the receiver with messages having effects and hence that comnce that
treated mainly as a persuasive process. The model has contribıl has co
exaggerate the effects of especially mass communication. ıunicatic
interest at the time was political communication - well suited to vell suite

4 Organisation theory

4.1 Human Relations Management

Large-scale organisations have existed from Egyptiarom Eg
1920s, theories were concerned with organisational structure anl structu
tasks, (Dessler, 1986). There was little concept of motivation aımotivati
or finance. However, the rise of the science of human relationıman rel
early part of this century was to change attitudes considerably. nsiderab

Mary Parker Follett in her book 'Creative Experience' Experie
described the doctrine of integrative behaviour and how r and l
harmonised. Also how people respond to a variety of condition of conc
themselves as well as outside.

The famous Hawthorne studies, begun in 1927 at Westl927 at
that individuals tend to behave in an artificial way when theay whe
experiment. Indeed they can vastly exceed expectations wherctations
(Roethlisberger and Dickson, 1964). A few years later, Cheste later, C
an organisational theory, (Barnard, 1938). This included the orgluded th
as a communication system, the importance and variability of inciability
work and the effect of incentives on compliance. Barnance.
importance of communications in organisations. He also consHe also
informal organisational aspects and their role in aiding in aid
cohesiveness.

Herbert Simon, (1976) refined Barnard's ideas. He founeas. He
types of influence an organisation can use to ensure complianure com

which included establishing in the employee: attitudes, habits and a state of mind which would lead them to reach that decision which is advantageous to the organisation. He stated that:

> *"Decisions reached in the higher ranks of the organisation hierarchy will have no effect on the activities of operative employees unless they are communicated downward."*

4.2 The organisation as a system

In the period after World War 2, product diversification occurred in many organisations. This resulted in a climate of change and organisations could no longer be thought as being mostly isolated from their environments. They were becoming less centralised and there was more need for local decision making. By the 1960s theorists had become concerned with the organisation as a system and studied organisational behaviour. The concept of systems was developed by Bertalanffy in 1940 and described in his general systems theory published in 1968, (see Bertalanffy, 1973). Katz and Kahn (1966) considered organisations as open systems that responded and adapted to their environments.

4.3 Contingency theories

During the early 1960s there was a search for a unified organisational theory (Koontz, 1964). However, some recognised that there was no optimum type of management system and that internal states and processes in an organisation are contingent upon external requirements and member needs. Effects are interactive. Key authors on the topic include Galbraith (1977) and Lawrence and Lorsch (1967).

The contingency theory of management contends that there are many potential variables which will have influences on organisational performance. Wiio et al (1980) commented that:

> *"It is very likely that we will not find the underlying explanation for organizational communication behaviour".*
>
> *"organizational communication cannot be compared with other organizational variables: it makes all the other variables possible ... an interfacing variable".*

The theory of structural contingency has influenced organisational studies for many years.

5 Management of change

5.1 General

As the 21st century is approached, the pace and scale of the change demanded of organisations is enormous. Global competition and the inception of the Information age have caused organisations to move from traditional structures to ones where people can contribute their creativity energy and foresight in return for being nurtured, developed and enthused, (Jones et al, 1996). Life has become more unpredictable.

5.2 Agents of change

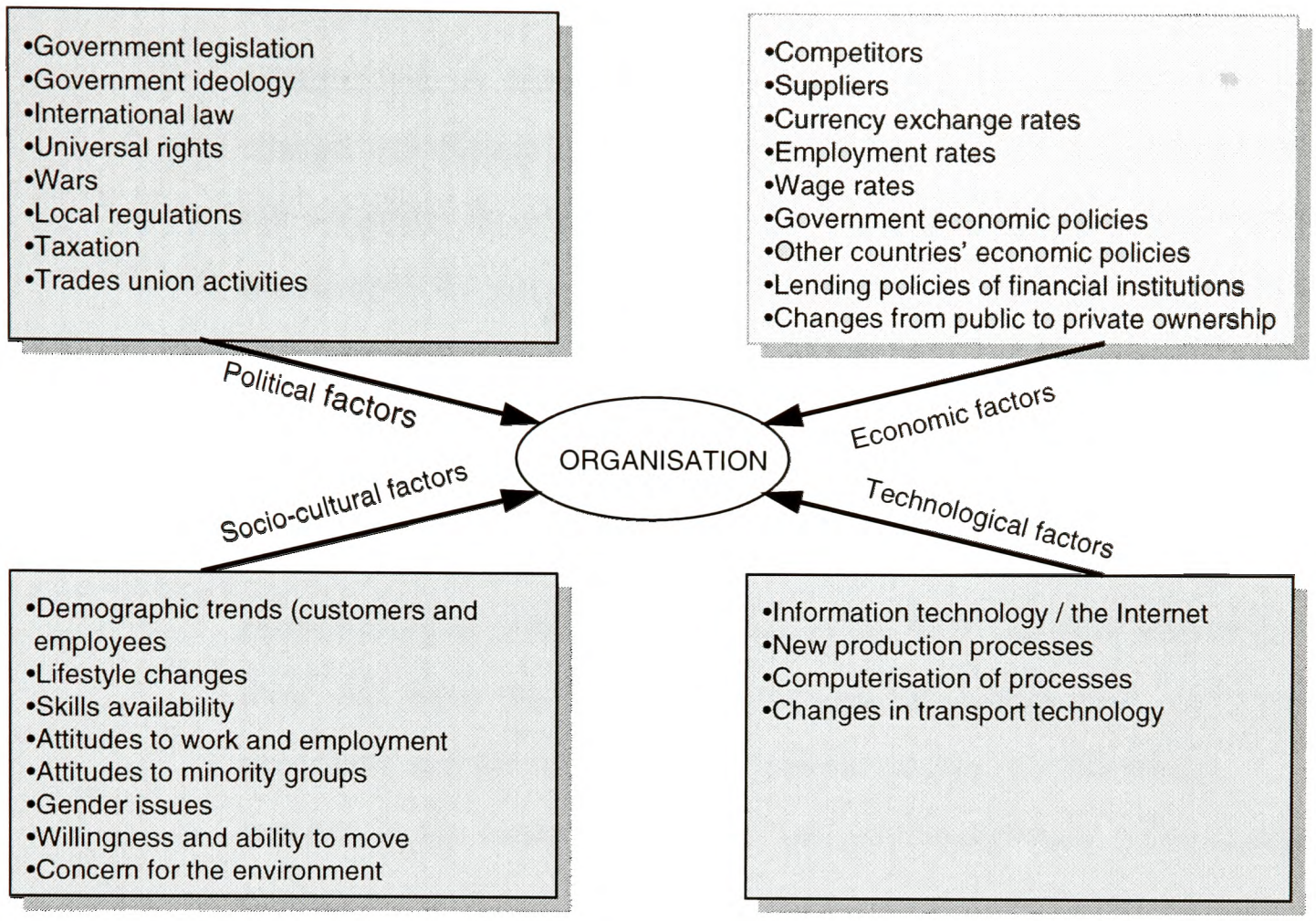
Three main triggers for change exist. These are the temporal aspects, the external environment and internal influences, (Senior, 1997).

Historically, temporal aspects have included the move from an agricultural economy to one based on machines. Currently major changes are occurring with the formation of an information based society. In many developed countries more people work at handling information than at agriculture and manufacturing combined (Senn, 1998).

The external environmental influences on change include the political, economic, technological and socio-cultural factors, known as the mnemonic PETS (Johnson and Scoles, 1993). These can influence organisations, their strategies, structures and means of operating. These will all interact, at some time or other, upon an organisation's systems as well as the products and services it offers. PETS factors are illustrated in Figure 2.4 (Senior 1997). Internal forces for change within an organisation, such as staff redundancies, are often the result of some external force. Internal contexts for change can include such aspects as ongoing strategy, culture, management and internal political processes, (Pettigrew et al, 1992).

FIGURE 2.4: PETS factors and organisational change

(source Senior 1997)



5.3 Theories and models of organisational change

Pettigrew et al (1992) have reviewed various models or mechanisms of change particularly appropriate to the NHS.

(i) Incrementalism

Change occurs by means of a continuous, evolving and consensus building approach, (Quinn, 1980).

(ii) Diffusion

Changes are introduced in one or a few organisations and diffuse outwards. This can be by means of interpersonal networks or a product champion, (Stocking, 1985). It may be more formally managed by means of some government policy initiative.

(iii) Cultural change

Attempts have been made to effect change by switching cultures. Some agent of change may be used such as the health service managers introduced as a result of the Griffiths Report (1983). Management must understand what culture currently exists in the organisation. A learning process is the key to managing both self change and change in organisations, (Plant, 1987). The change agent can act either as an promoter or an educator. Cultural change may be encouraged by means of a planned program such as Total Quality Management.[4]

(iv) Top down restructuring

A key feature of recent years has been the successive top down restructuring of public institutions. In the NHS the most important of these has been the introduction of general management, previously described, and the creation of an internal market in 1991 which resulted in the formation of NHS self governing trusts. The changes continue.

5.4 Structure of the organisation

Successful organisational structures[5] vary depending on whether they are operating in more stable environments which do not change much over time or in more unpredictable environments, subject to change at any time.

Pugh,(1973) described an organisation structure as containing the following dimensions:

(i) Structuring of activities - degree of regulation of employee behaviour.

(ii) Concentration of authority - degree of centralisation.

---

[4] TQM has been defined as an integrated, corporately-led programme of organisational change, designed to engender and sustain a culture of continuous improvement based on customer-oriented definitions of quality (Joss and Kogan,1995).

[5] An organisational structure can be defined as the established pattern of relationships between the component parts of an organisation, outlining communication, control and authority patterns. Structure distinguishes the parts of an organisation and delineates the relationship between them. (Wilson and Rosenfeld, 1990).

(iii) Line control of workflow - direct line management control or other procedures.

(iv) Support component - number of administration and other non workflow personnel.

Typical structures include:

- Bureaucratic where jobs are highly specialised, roles are hierarchically organised with a single chain of command and work is carried out and co-ordination of activities is in accordance with set rules (Weber,1947).
- Project or matrix organisation.
- Network organisation.

Contingency theory attempts to find relationships between the characteristics and structures of organisations and the operating environment. It has been argued there is no 'best way' but that the functional organisational structure is associated with the nature of the task being undertaken (Pettigrew et al, 1992). To meet new objectives an organisation may therefore need to change its structure (Fararce and Danawski, 1973). For example, bureaucratic management could work well in a mass production factory. However, if the workflows are highly uncertain then an organisation with good lateral communication together with developmental and learning capacity would be much more successful.

5.5 Organisational development as a tool for managing change

Organisational development (OD) is about people *and* organisations and people *in* organisations (French and Bell, 1995).

Harvey and Brown (1988) defined OD as an attempt to achieve corporate excellence by integrating the desires of individuals for growth and development with organisational goals. OD is all about change. The organisation members together with OD consultants need to work together to find effective ways to resolve problems. Oswick and Grant (1996) have explored the use of metaphors in describing facets of OD.

5.6 Knowledge management

Good knowledge management allows the workforce to be involved in the learning or change process. Kim and Mauborgne (1997) set out three key aspects:

(i) Engagement: involving individuals in decisions that affect them.

(ii) Explanation: ensuring everyone understands the reasons for decisions.

(iii) Expectation clarity: stating clearly the new rules of the game.

Rowland and Harris (1998), have described their research on the application of knowledge management in the NHS. They found the need for:

- Effective management of information using IT.
- A good network of relationships within the organisation is required otherwise information will remain within particular functions, groups or teams
- Training and development systems should be in place to facilitate cross-organisational learning.

A questionnaire distributed to various NHS organisations (including Greenwich Healthcare Trust), identified various development needs including the effective management of change and greater clarity of knowledge management.

6 Conclusions

These theoretical approaches have provided some explanation of communication, communication models, organisational behaviour and change management. Two modern management methods used in the management of change have been introduced - organisational development and knowledge management. The next chapter explores some practical aspects of organisational communication and looks at some examples particularly relevant to this study.

CHAPTER 3

COMMUNICATIONS IN ORGANISATIONS

1 Introduction

The reasons for the importance of good communications in organisations are explored in this chapter and the ways people can communicate are described. Some practical aspects of communications in organisations are discussed together with particular problem areas relevant to this study.

2 The importance of good communications in organisations

Communication is the social glue used to found an organisation in the first place and the glue that continues to keep the organisation held together (Roberts, 1984). However good communication is not a panacea for all problems.

Barnard (1938) pointed out that in any exhaustive theory of organisation, communication would occupy a central place because the structure, extensiveness and scope of the organisation are almost entirely determined by communications techniques.

Communication is a vital skill for management. In 1973 Mintzberg reported that supervisors spend as much as 80% of their work days engaged in some form of communication. Subscribers to the Harvard Business review rated the ability to communicate the most important factor in making an executive promotable, (see Adler, 1992).

Communication contributes to industrial competitiveness (White and Mazur, 1995). In the late 1970s there were developments in information and communication technology which allowed location of research and development or manufacturing anywhere in the world to gain competitive advantage. This was followed, in 1980 onwards, by growth of the multinational and expansion of world trade resulting in a volatile business climate characterised by rapidly changing technology, quick market saturation and unexpected competition. Companies need to stay close to customers and competitors and close co-ordination is required between design and manufacturing etc. This has required 'high speed management' and good organisational communication. Cushman et al (1995) argue that communication activities are at the core of organisational strategy. Speed of response has become

not only the primary source of competitive advantage but also a crucial means for obtaining any kind of competitive advantage. A firm's communication processes need to be subject to re-engineering[6] in order to achieve continuous improvement - thus increasing the speed to market of products and creating competitive edge.

Job satisfaction like other behaviours and attitudes may be partly dependent on the nature of the individual as well as related to a host of other factors such as working conditions, pay and security and so on. Some key factors have been found to include perceived quality of supervision and level of work and social stimulation (Greenberg and Baron, 1993). Wiio (1978) found little evidence of a relationship between communication and job satisfaction. However, a number of subsequent studies have demonstrated strong correlation between good communication practices and employee satisfaction and commitment. A survey reported by Foehrerbach and Goldforb (1990) showed that the better the managers' communication the more satisfied employees are with all aspects of their working life. A strong correlation between approaches to communication and corporate performance has also been observed (Perin, 1993).

3 Communication levels

Communication levels have been extensively described by Adler (1992). The content and nature of messages will be influence by the type of communication: upwards, downwards or to a colleague of similar status.

3.1 Downward messages

Messages are sent by management to subordinates and others. They might include such items as job instructions, procedures and practices, feedback to subordinates, indoctrination and motivation.

They often suffer problems of clarity or insufficient information. Some managers do not know how to communicate or the correct types and channels of communication to use. They also need to explain the reason why things are proposed. They may be guilty of supplying too much information to staff, causing

[6] Re-engineering - a concept promoted by Michael Hammer. It can be defined as the reshaping of business processes to remove barriers that prohibit an organisation from providing better products and services and capitalise on its strengths. It involves rethinking business practices, intoducing radical change to benefit both a business and its customers and focussing on business processes (Hammer and Champy, 1993; Senn, 1998).

overload. The message may pass through several managers before it reaches the recipient and the message may become over simplified, garbled or simply wrong. In some cases it does not even reach the people who need it.

3.2 Upward communication

Messages from subordinates to management might include: what staff are doing, unsolved work problems, suggestions for improvement, how subordinates feel about each other and the job.

Good upward communication provides a number of benefits including feedback on how accurately messages have been received, or how well management decisions have been received. This can diagnose and resolve existing problems and prevent new ones.

However, there can be difficulties. People may consider it risky to open up to their boss and may have to be encouraged positively. The degree of diffidence of the individual may depend on their perceived status. Staff are also less likely to communicate negative information. Subordinates feel they must highlight accomplishments and downplay mistakes if they are to be looked on favourably (Read, 1965). They fear rebuke or effects on their chances of promotion if they speak to supervisors (Glauser, 1984).

An early study reported by Walker and Guest(1952) showed that 70% of assembly line workers initiated communication less than once a month with their supervisors.

Among managers a study showed that less than 15% of their total communication was directed at their superiors (Luthans and Larsen, 1986).

In critical situations fatal accidents could occur through poor upward communication and an Air Florida accident in 1984 was attributed to the co-pilot's warning to the pilot being too subtle to avoid the crash (Foushee, 1984). Staff may need special training to avoid such problems.

3.3 Horizontal (lateral) communication

Horizontal communication occurs between people with equal power in the organisation. It is required for task co-ordination, problem solving, sharing information, conflict resolution and building rapport.

Factors inhibiting such communication will include rivalry, specialisation

(technical language problem), lack of motivation, information overload and physical barriers. People in another department may feel they are competing against each other for resources (Rogers and Rogers, 1976).

3.4 Social communication

Other communications that may occur both downwards and upwards include the many forms of social interaction and informal communication from a simple good morning to a free and easy conversation about the local football team. Informal communication has the following useful or not so useful functions: expanding, expediting, contradicting, circumventing, supplementary or confirming a formal message.

Andrew S Grove the Intel President stated that cultivating frank casual communication, common in a small company, is vital to keep a large corporation functioning smoothly, (Murrey, 1987).

4 Communication networks

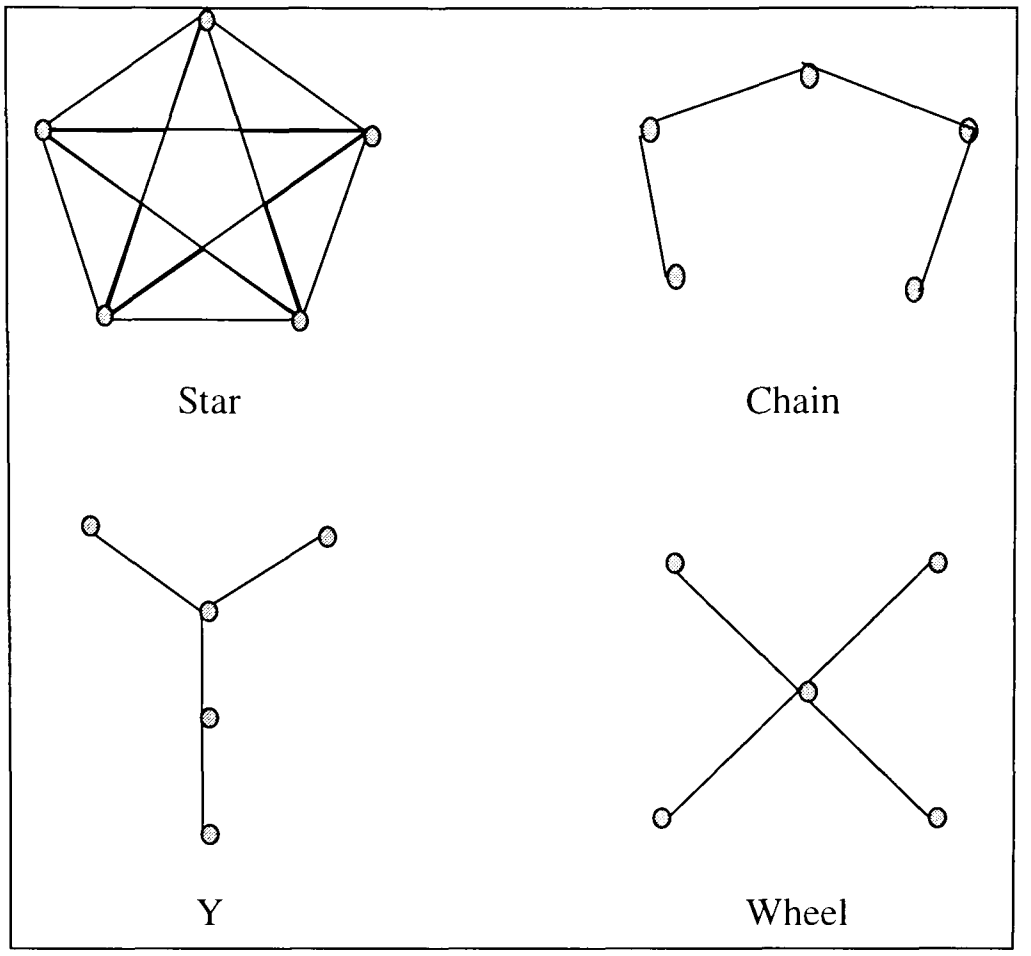
Lack of an integrated communications network has led to major problems in companies, (Werner, 1995). Also the organisation structure can restrict most communication to certain formally sanctioned routes, (Dessler, 1986). However, restricting communication to formal channels can lead to a lack of responsiveness.

4.1 Types of network

In a study by Leavitt (1972), 20 groups of five persons were each arranged in one of the four communication networks: star, chain, Y and wheel, see Figure 3.1. Each person was placed in a compartment in such a way that their communication was restricted. Subjects in the star network could communicate with any other subject, whereas people in the spokes of the wheel network could only communicate with the central subject, but they of course could communicate with any of the four other people in their network.

FIGURE 3.1: Types of network (Leavitt, 1972)

Each person can communicate only with the person or persons he is linked to directly.



The researchers found that the best communication pattern depended on the nature of the problem to be solved. If the problem was straightforward then the wheel structure was best. However, for complex problems the decentralised all channel star network was best.

Centralised structures are slower and subject to more errors for complex problems (Mears, 1975). There may be problems of overload for the hub member which can stop or slow all activity. There is less satisfaction for the other members.

Non-centralised structures are slower and more prone to errors for simple problems. Members are likely to spend a lot of time in discussion.

4.2 Social capital

Lin (1999), in a literature review, describes social capital as captured from embedded resources in social networks. It can be defined as resources embedded in a social structure which are accessed and/or mobilised in purposeful actions. It is an investment in social relations. A well networked individual will be more aware of opportunities and choices. The flow of information will be facilitated.

Within organisations, individuals with social capital will have access to resources through networks. Having one's personal worth recognised as both an individual and a member of a social group sharing similar interests and resources provides emotional support. However, it may also facilitate public acknowledgement of one's claim to certain resources. Improved networking may also make the organisation aware of the value of a hitherto unknown individual.

5 Communication in different types of organisation

Burns and Stalker (1961), have described two sorts of organisation: 'mechanistic' and 'organic'. The mechanistic system is based on the traditional hierarchical pattern, whereas the organic consists of flexible and informal teamwork which relies more on the skills than the status of the various participants.

The organisation type or culture[7] can have a dramatic effect on communication. The organic organisation is relatively unplanned and formal. Lateral rather than vertical communication occurs with people of different ranks consulting each other. Information and advice are communicated rather than instructions and decisions.

The mechanistic organisation is entirely different. Interaction between staff tends to be vertical i.e. between superior and subordinate. Employees' rights and obligations are precisely defined with, in many instances, formal procedures. Employees are encouraged to pursue their own narrow specialisation and refer questions to their immediate superiors.

Organisations like hospitals are bureaucratic without being highly centralised. The work is stable so that behaviour can be standardised, predetermined and predictable, but it is also complex. Professional bureaucracies of this nature rely on the skills and knowledge of their professionals to function, (Dessler, 1986).

A major problem for modern governments is to develop more organic or flexible forms of teamwork for tackling innovatory tasks than their traditional structures allow (Self, 1972).

[7] Culture is the collective programming of the human mind that distinguishes the members of one human group from that of another. Culture in this sense is a system of collectively held values (Hofsted, 1981).

6 Choice of media

The choice of communication media will depend on the degree of clarity or ambiguity of the message. Oral media such as telephone or face-to-face are better when messages are ambiguous and require explanation. Written media are more appropriate when messages are clear, (Daft et al, 1987). The more effective manager will appreciate the best channel to use for the particular circumstances.

Techniques such as business television are used a lot in the USA and to some extent in the UK as a vehicle for training and conveying marketing information and product launches. This can be live TV. Ford in the USA became one of the first companies to develop an in-house television network for Europe. At Ford in the UK, programmes are broadcast weekly to 250 sites for half hour slots covering different aspects and departments, (White and Mazur, 1995).

A MORI survey of members of the Industrial Society, reported by Blakstad and Cooper (1995), indicated that the most common/highly rated channel for communications was the team briefing. At that time electronic media such as e-mail and video came low. Even in 1998 the Industrial Society reported that of the 79% of the organisations surveyed that have practices in place to inform internal communications, 58% still used team briefing. However there has been a marked increase in the use of IT for internal communications. E-mails are now used by 64% and Intranets by 20%, (Industrial Society, 1998).

Poster, (1994) has pointed out communication theory needs to account for computer mediated communication (CMC). Electronic communication (like print) places a distance between addresser and addressee, but can also bring them together. It has been suggested that CMC works best when it supports face-to-face communication not when it supplants it (Cochrane, see Industrial Society, 1998).

The first large computer network ARPANET (start of Internet) was developed in the late 1960s and asynchronous CMC, e.g. e-mail, allows participants to communicate when they choose. Synchronous CMC e.g. teleconferences have developed less rapidly (Mantovani, 1996).

7 Communication in the management of change

Until recently research into organisational communication was conducted to find out how management could use communication to influence and secure co-

operation from employees rather than to contribute to organisational change or the quality of life of those working within organisations, (Grunig, 1992). However In the early 1990s change management was the hot topic in business schools and boardrooms. By the mid 1990s senior management were learning that communication is intrinsic to change management (Blakstad and Cooper,1995).

One aspect of change that has to be managed very carefully is corporate relocation. Much more than physical changes may result. Staff will want information to help them to cope with their new situation, (Baron and Greenberg, 1990). The organisation needs to avoid hidden messages by:

(i) Bringing certainty to the situation.

(ii) Keeping an eye on employee's feelings about relocation.

(iii) Making messages consistent.

(iv) Retaining some of the old while establishing the new (e.g. old systems).

Even if a move is local, employees can find the experience disorienting, (Webster, 1998). People can have an emotional attachment to the old site especially if they have worked there for years. Merrick, (1998) reports such an effect among staff when an NHS 83 year old psychiatric institution was closed.

A consequence of down-sizing and out-sourcing is that communication is becoming harder than ever. People laid off by their employers can often end up working as consultants and suppliers for the same companies on short term contracts and from their own premises often their own homes. Organisations needed to manage this and keep in contact with such staff.

8 Problems in organisational communication

8.1 Incompatibility of cognitive schemas

Every individual has their own way of interpreting the world based on their own experiences. Schemas, which in this context refer to the internal representation of the external world, tend to control the way people think, believe, talk and behave. There are numerous examples of failed employee communications programmes where the content of the message from senior management does not match the schemas of employees derived from experience on the shop floor, (Blakstad and

Cooper, 1995).

8.2 Physical environment

Office design, for example open plan or not, can influence communication. In the more effective companies physical supports such as white boards and open offices can encourage frequent informal interaction. However not all staff are comfortable in an open plan environment and may resist change.

8.3 Obtaining feedback

Communication is a two way process. It is not the message that is sent out that is important, it is how the message is understood, (Preston, 1993) or responded to. Feedback is important in assessing response and understanding.

However, feedback does not always occur spontaneously, there needs to be a formal mechanism to encourage it. Organisations may use a combination of surveys, suggestion schemes or in some cases 'corporate hotlines' to answer questions.

8.4 Gauging the flow of information - organisational intelligence

Information overload is a general problem for management in the world today. In an international survey, Reuters (1996) found that a third of managers receive enormous amounts of unsolicited information. Two thirds of managers in companies of all sizes claim to need very high amounts of information to perform effectively but 49% feel they are quite often or very frequently unable to handle the volume of information they receive.

In order to manage information, it may be necessary to employ a gatekeeper - a person whose job is to control the flow of information to potentially overloaded units, for example, the manager's PA. However it is better to encourage staff to target information appropriately.

Indeed there is a need to distinguish between information and intelligence (Goldhaber et al, 1979). Information overload can result from too much information and too little intelligence.

Power in an organisation will be more and more dependent on processing and dissemination (or withholding of information). Information is the foundation of organisational power.

There are various barriers to developing organisational intelligence. These include:

(i) The advent of the mobile manager whose original success was due to his development of organisational intelligence networks

(ii) Bureaupathic (term coined by Victor Thompson, 1961) - describes the aberrant behaviour line managers display when confronted with the need to acquiesce to the technical expertise of subordinates.

(iii) Groupthink (Janis, 1971) – the tremendous power of social conformity in rendering individual judgement impotent.

9 Practical approaches

A number of case studies have been described by Blakstad and Cooper (1995). For example: BT instituted 'Newline' a dial up news service for employees on an 0800 number. This was updated several times a week and a quarter of a million calls were received the first year. IBM has instituted a speak up system which allows employees the chance to conduct a debate with their bosses without having to reveal their identities - an electronic version of a suggestion box.

White and Mazur (1995) have listed a series of practical actions developed by Chevron to improve communications, which took place after consultancy studies on the perception among staff of the company's profile. These were:

(i) A communications plan as part of the business plan.

(ii) New approaches to presenting the business plan to staff.

(iii) Communications training for managers and supervisors.

(iv) Meetings between the MD and senior supervisors twice a year.

(v) Sessions where a department explains to other employees over lunch what it does.

(vi) An issues planning group to look at issues inside and outside the company.

10 Conclusions

Good communication is vital to the efficient running of organisations. However, there can be barriers to upward communication . The more mechanistic or hierarchical type of organisation that one might expect to encounter in public bodies can constrain communication channels. Organisations are still often using team

briefing to communicate general matters to staff. However the use of IT (e-mail and Intranet) is growing. Where there is significant change, good communication is even more important to inform staff and allay their fears.

The next chapter details ways of actually assessing or measuring communication and describes some examples of such measurements used in the NHS.

CHAPTER 4

MEASUREMENT OF COMMUNICATIONS

1 Introduction

This chapter describes the way communications can be measured or assessed. It details standard audit methods such as the ICA audit. The use of various scales to measure aspects of communication is considered. Key previous exercises to measure communication in the NHS are reported. The two major methods used in this study are discussed.

2 Origins of communication measurement

In order to evaluate both the current status of communication in the organisation and the effect of changes, it will be necessary to employ a one or several means of measurement. Techniques for measurement of communication are reviewed comprehensively by Goldhaber et al, (1979).

The first systematic measurement of organisational communication was described by Jacobson and Seashore in 1951. The name 'communication audit' was suggested by Odiorne in 1954. However, a standard procedure was required for assessing organisational communication. It was in response to this requirement that key methods of auditing communication were promoted in the 1970s. The communication audit has been described by Emmanuel (1985) as a study of communication, philosophy, concepts, structure, flow and practice within an organisation.

The ICA audit

A formal method of auditing communications was developed by the International Communication Association (ICA). It includes questions on various aspects of amount of information currently received and amount felt to be needed, attitudes to management and co-workers and perceptions of working relationships within the organisation, (Goldhaber, 1976). Five tools are employed:

(i) Questionnaire Survey

122 items and 12 demographic questions plus up to 34 questions of any type determined by the organisation. Respondents answer the

questionnaire anonymously in group sessions lasting about 45 minutes.

(ii) Interviews

Random or purposely selected members of the organisation are asked to participate in one-to-one interviews. The principal purpose of these are to corroborate and/or expand on other audit tools.

(iii) Network analysis

Respondents indicate extent to which they typically communicate with each individual in the unit.

(iv) Communication experiences

Respondents describe critical communication episodes which they consider representative of typically successful or unsuccessful incidents.

(v) Communications diary

Participant keeps a diary of specified communication activities over a one week period, using standard forms.

If used in its entirety the audit may take some time to implement. Goldhaber et al, (1979) estimate 3 months. It uses both computerised analysis and feedback procedures and allows comparisons between various organisations' communications systems. By 1979 the ICA communication audit had been implemented in 19 organisations in the USA and Canada with a sample of about 5000 people, (Goldhaber and Rogers, 1979).

3 The LTT audit

The LTT audit was developed by Wiio et al (1974). This is a simpler single instrument procedure for a quick analysis of the organisational and communication climates. It uses a standard questionnaire with 75 items. The average time to complete the questionnaire is 20-30 minutes. By 1976 this method had been used in

22 organisations in Finland. (Wiio, 1978).

4 Other techniques for measuring communication

There are a number of other techniques which have also been employed in measuring communication see Goldhaber, Dennis et al (1979). These include:

(i) Supervisory inventory

Eight item inventory which gives the manager personal feedback about his communication skills listening, speaking, writing.

(ii) Accuracy tests

Test employee understanding of major areas of concern in an organisation.

(iii) Credibility test

Perception of credibility of immediate supervisor.

(iv) Communication climate measures

Degree of supportedness, trust, confidence, openness and candour present in an organisation.

5 Application of measurement tools

It may be inferred from contingency theories (see Chapter 2, Section 3) that organisational processes vary widely depending on environmental conditions. Therefore mechanical administration of various measures across organisations may fail to assess important variables. It may be necessary to apply a custom mix of measurement tools for each organisation (Barnett et al, 1981).

6 What has been measured?

Aspects which have been examined in communications audits are many and have included demographics, communication activity, sources of information, access to information, job satisfaction, quality of information, improvements of communication and factors of organisational climate. as well as issues specific to the

organisation (Wiio, 1978; Goldhaber et al, 1979)

7 Measures and scales

As a basis for successful auditing of communication, it is necessary to consider the variables to be examined and the scales by which responses to questions can be ranged and assessed.

Stevens (1951) has classified variables into a number of types. The simplest is the nominal scale which classifies individuals into two or more groups with no order or gradation between the groups, e.g. home town. The ordinal scale ranks individuals but has no fixed interval between the scale positions. e.g. order of position in a company: worker, supervisor, manager. The interval type of scale has equal units of measurement but with no fixed origin or zero point, e.g. temperature. The 'highest' unit of measurement is the ratio scale which has the properties of an interval scale together with a fixed origin or zero point e.g. age.

Other methods of classifying variables have been summarised by Afifi and Clark, (1990). The term categorical is used by some authors to refer to nominal and ordinal variables where categories are used. A variable is called continuous if it can take on any value in a specified range e.g. height. A variable that is not continuous is called discrete: it can only take on certain specified values. For example a count can only be zero or a positive integer.

7.1 Types of scale

Moser and Kalton (1971) have described many types of scale but only those particularly relevant to use in communications audits will be mentioned here.

Likert scales were first developed in the 1930s, (Likert, 1932). The respondent is asked to choose between several response categories indicating various strengths of agreement and disagreement. Five categories are normally employed for each item.

Example: *strongly agree agree uncertain disagree strongly disagree.*

Scoring will be 1, 2, 3, 4, 5 or 5, 4, 3, 2, 1 depending on whether strongly agree indicates a favourable or unfavourable attitude.

The semantic differential technique was developed by Osgood et al, (1957) for their measurement studies in semantics. Respondents were asked to complete a

series of graphical rating scales on the concept under study such as 'father', 'socialism'. Seven point scales were employed such as:

good ____ ____ ____ ____ ____ *bad*

fast ____ ____ ____ ____ ____ *slow*

A scale needs to be reliable to the extent that repeat measurements made by it under constant conditions will give the same result. The scale must also be valid i.e. be successful in measuring what it sets out to measure. It should cover the range of possibilities in a balanced way. Importantly, it must be understood by the respondent!

7.2 Measures used in communications audits

Communications audits using standard tools and techniques allow comparison across organisations. Most of the standard auditing instruments rely on Likert type or semantic differential scales. This has been based on the premise that respondents cannot effectively understand or use more sophisticated measures. ICA audit scales are typically of the Likert type. For example respondents were asked about receiving information from others and asked to rate how much information received now on various topics on the scale:

very little little some great very great.

Barnett et al, (1981) have used a metric fractionation scale where 0 is none, 50 is average, 100 is twice average and so on. This is used, for example, to measure how much information is got on various subjects. The scale is a ratio variable with a true zero point and allows for more sophisticated mathematical treatment of responses but will require a higher level of understanding from the respondent.

The disadvantages of existing scales will be discussed further in Chapter 7 Section 5.

8 Measurement of communication in UK NHS organisations

A major study of communication within the NHS was carried out by Hargie and Tourish in the mid 1990s, see Tourish, (1996), Tourish and Hargie, (1996) Hargie and Tourish, (1996). Before that there had been comparatively little research into how the quality and quantity of communication between management and staff in the NHS could be assessed.

Fletcher (1973) has described a number of studies of communication in hospitals in the 1960s and early 1970s. Indices of freedom of communication upwards to the administration and downwards to the ward staff were found in fifteen hospitals to correlate inversely with the length of patients' stay.

The Burston-Marsteller, (1992) report of a consultancy study of senior NHS staff showed that NHS communications was very weak.

Tourish, (1996) in his DPhil thesis has reviewed the field of communications in the NHS and described communications audits on three areas in Northern Ireland: a community unit on the verge of becoming a trust, nurses working within a clinical directorate of a acute teaching hospital and senior managers at three main points of the NHS structure.

Tourish and Hargie, (1996) in a study on a unit in Northern Ireland, used a questionnaire based on the pattern used in the ICA audits but modified to make it more relevant to the needs of the NHS. In particular, key issues were identified that senior managers considered the organisation should be communicating about. A random sample of 54 staff representing about 10% of the overall population of the unit was used. Issues addressed included:

(i) Information received

(ii) Information sent

(iii) Working relationships

(iv) Crucial issues facing the unit

(v) Critical incidents and other comments

Staff felt they needed to receive significantly more information overall. This was particularly the case in relation to information about decisions that affect people's jobs, promotion opportunities and major management decisions. The main source of dissatisfaction was with the level of information needed from managers, especially middle managers. More face-to-face contact with managers was needed. There was a strong desire for more information to be delivered in the form of special talks by managers.

Respondents were most satisfied with the timing and amount of material received from the grapevine[8] and fellow workers.

It was found that almost all formal channels were under used. There was strong dissatisfaction with the amount of information received about all the new developments within the unit.

Conclusions from the study were:

(i) Insufficient information was being circulated on key issues affecting the unit.

(ii) A pattern of top down communication existed rather than two way.

(iii) Good working relationships were widespread but hostility existed towards the 'organisation'.

(iv) There was a positive correlation between levels of satisfaction with communication in the unit and amount of communication skills training received.

The paper supports part of the contention that one would expect to find, within the NHS, a creeping sensation of disempowerment, at virtually all levels. A facet of which would be increased evidence of people finding themselves underinformed and underinvolved.

Hargie and Tourish, (1996) also reported a communications audit focused on relationships between regional, district and local levels of management in the NHS.

Preston and Loan-Clark, (1997), reported on an organisational culture survey commissioned by a community healthcare Trust in the UK. This was held to determine the factors that might help or hinder the move towards an information led Trust. The results indicated a less than receptive audience, with less than 10 percent feeling that moral was high. However, 40 percent also said that they did not get enough information about what was going on in the Trust and 41 percent said they relied on the grapevine for information on the trust. Wording in the monthly team briefing and organisational newsletter were said to be patronising and difficult.

[8] The term grapevine originated during the US Civil War when makeshift telegraph lines strung among trees looked like grapevines.

Hepworth, (1997), described the use of communications audits as a complete assessment of the status and effectiveness of an organisation's communications and how they match the organisation's objectives. She suggested interviewing small groups of people (12-20) and pointed out:

> *"You need to know whether you are a disaster waiting to happen or an organisation in control...good communication requires careful thinking (rather than lots of money)".*

9 Methods used in this study

Two methods were used in the studies described in this thesis. The structured interview supplemented by informal discussions was used for both the Greenwich Healthcare NHS Trust (GHT) and the Dartford Borough Council investigations. A survey questionnaire was used to collect data from GHT. This section describes the advantages and disadvantages and the reasons for the particular choice of method.

9.1 The interview

Interviews can be structured, semi structured or completely informal. They are an ideal way of first exploring the organisation and issues.

Structured interviews use a fixed set of questions asked in a fixed order. There may be a fixed set of possible options or rating scales. Indeed the interview can be highly structured for example using a closed question questionnaire as described in the next section. In this case it is easy to analyse the responses and compare one interviewee with another. However, there will be little opportunity for unanticipated discoveries. People may feel frustrated because they are not asked about (to them) important issues.

The unstructured interview will cover a number of topics but the precise questions and their order is not fixed. Indeed they are allowed to develop in discussions with the respondent. This approach will require good note taking or tape-recording and there is more difficulty in interpreting the answers. Comparability is sacrificed, but the information will be more relevant to the interviewee. This method requires the researcher to have a good knowledge of the topic.

The semi-structured interview will have some fixed/closed questions but will also include some opportunities for free discussion with the respondent. This was

thought to be particularly appropriate for the first studies of both Dartford Borough Council (DBC) and Greenwich Healthcare NHS Trust (GHT). It was a good opportunity to meet with senior management and key players in the organisation. They provided good formal and informal information about communication and organisational aspects. In addition they could be informed about the study and their co-operation requested. They were therefore more likely to be helpful in the future.

Initial unstructured interviews were held at both GHT and DBC with a knowledgeable and experienced person in the organisation. This was to get some general information on organisational structure, meeting patterns, key players and the like. Similar semi-structured interviews were then used to interview key staff. This gave initial data plus a general appreciation of the problem areas in the organisations.

9.2 The survey questionnaire

A self-completion questionnaire is probably the commonest research tool in the social sciences (Fife-Schaw, 1995). It has the advantage of relatively low cost and can be used to gather data from a large number of people.

Responses can be of the open-ended or closed type. With the open ended format the respondent can chose their own words, for example they might be asked to make some suggestions about a topic. Closed questions on the other hand require the researcher to have a good idea of the likely responses to the items in advance.

Closed questions will reduce the number of vague or ambiguous answers that might be given. They are also quick to answer. Coding for analysis is simple - each of the alternative responses can be given a number.

Open questions allow people to give multiple responses. Respondents may find more difficulty answering this type of question. Also answers will require substantial interpretation and classification by the researcher. However, they may give some very interesting and useful information and topics may be raised about which the researcher was unaware.

The format adopted in our survey was to use mainly closed questions. A few open questions were however included, mainly to give an opportunity to respondents to air their views and offer suggestions.

Designing a questionnaire to suit everyone can be a problem, especially

where there is a wide cross section of respondents. It is essential to carry out a plot exercise to resolve any ambiguities and other difficulties.

The manner of administering the survey may also affect the results:

(i) The questions could be asked by an interviewer

Use of an interviewer could cause the respondent to modify their answers especially when a sensitive issue is being considered. On the other hand more questions are likely to be answered

(ii) Groups of staff could complete the survey under supervision

This would reduce the opportunities for staff to collaborate together. The method has been used to good effect by Tourish and Tourish (1996) for a communications audit in a public sector leisure centre. This will require the presence of an interviewer and the co-operation of management in getting groups of staff together. It could be a problem for staff with limited availability such as part-timers, night staff, or field workers.

(iii) Staff could be sent or issued with the survey and asked to complete it by a certain date.

This would be easier to arrange. It is particularly appropriate if large numbers of people are to be asked to take part. It gives staff the opportunity to complete the form anonymously, in the absence of management or researchers. However, there might be collaboration between respondents. Staff might be tempted to put the survey in the bin through 'lack of time' or 'lack of interest'.

The last method was adopted for the survey at GHT. It would have been difficult to organise groups of staff at GHT to meet together to complete the survey as inevitably certain categories of staff would have been unavailable. These were just the types of staff we were most anxious to include. and their absence would have limited the usefulness of the exercise. An initial pilot was used to test the survey form. Then a questionnaire was circulated to all staff with their payslips.

10 Conclusions

The communication audit has become a standard tool for measurement of communications in organisations. The use of communications audits in the NHS have been limited. However a major study carried out by Hargie and Tourish was reported in the mid 1990s (Tourish,1996; Tourish and Hargie,1996; Hargie and Tourish,1996).

Two audit tools have been used for the research described in this thesis: the interview and the survey questionnaire. Chapters 5, 6 and 7 detail the methodology and results.

CHAPTER 5

CASE STUDY: DARTFORD BOROUGH COUNCIL (DBC)

1 Introduction

Studies of the communications in two public organisations form the basis of the research in this thesis. The work with Dartford Borough Council was of limited scope and was intended to be used as a comparison with the preliminary study of Greenwich Healthcare NHS Trust described in Chapter 6.

This organisation although much smaller than Greenwich Healthcare has been subject to much change in recent years and formed a useful comparison for the first part of the larger study.

This chapter summarises the results of interviews with senior council officers.

2 Structure of DBC

Dartford Borough is situated 15 miles from central London in North West Kent. It covers an area or about 7000 hectares and has a population of about 84,000.

DBC employed 800 - 900 people in 1990. However in the succeeding years, following a management buy-out in 1993 and other changes, the staffing has been reduced to about 320. This includes a number of part-time staff and equates to 290 full time equivalents.

Most staff are located in a single building: the Civic Centre. The council chamber and committee rooms are also at the Civic Centre. This greatly helps liaison between councillors and council staff. A few staff are located at the Orchard Theatre, a local museum and a small cash office at one of the community centres.

Many of the council's operations have been contracted out and DBC does not run education or social services. The housing function is now managed by Hyde Housing. The council run housing services department is a small group responsible for contract management and planning strategy and policy. The budget requirement for 1995/96 was £2.11Million.[9]

[9] Most of the council tax collected by DBC goes to Kent County Council .

3 Mechanisms for assessment

In order to gain some insight into managerial attitudes and problems with communication in DBC, it was necessary to carry out a number of discussions and structured interviews with senior staff. The next sections summarise the findings from these interviews carried out during the period July - August 1997.

A number of documents were supplied by DBC by way of background to this study. These together with the job titles of the staff interviewed are listed in Appendix B.

The Head of Corporate Services, explained the organisational structure and key aspects of the work of DBC. Thereafter a standard set of questions was devised and used as a basis for discussions with other members of staff, (see Appendix B). In addition, further questions were posed and topics explored as appropriate. This semi-structured interview approach facilitated analysis and correlation of responses.

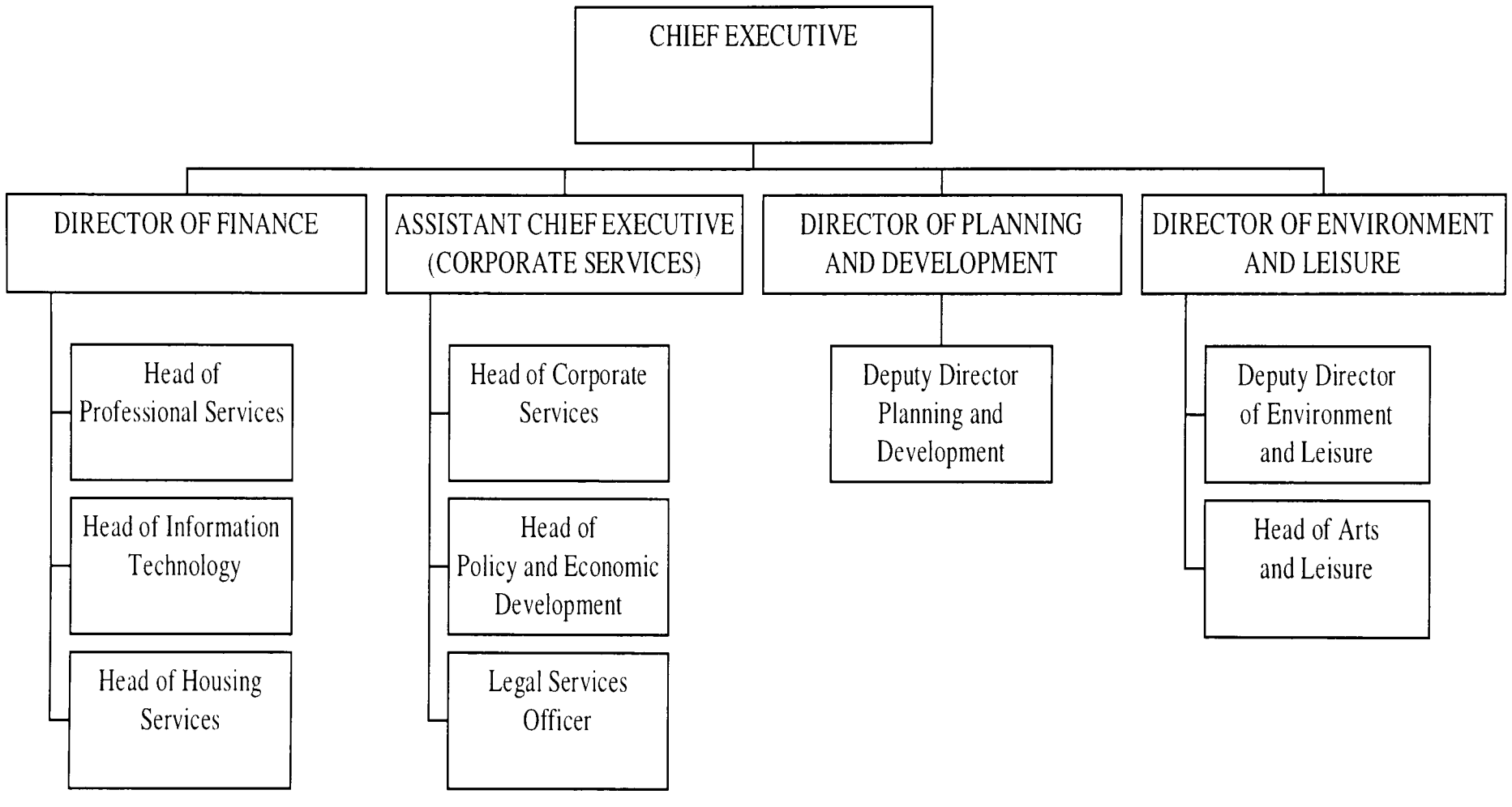
4 Organisation

A major change in the organisation occurred in April 1997 with the creation of two new directorates: 'Planning and Development' and 'Environment and Leisure'. The top-level management organisation structure in April 1997 is shown in Figure 5.1. The Chief Executive and Directors are formed into a management team. Staff are represented by a Staff Consultative Group.

The following Divisional Heads have specific responsibilities for aspects of communication:

Head of IT:	Telephone systems, reprographics, IT equipment.
Head of Corporate Services:	Building, personnel, reception/visitors, health and safety, security. council members
Policy and Economic Development:	public relations, pamphlets, newsletters, logo

FIGURE 5.1: Organisation structure of senior management at DBC, April 1997



5 Mechanisms for storing, retrieving and communicating information

IT is managed centrally. This includes all aspects of information technology i.e. telecommunications, fax, reprographics and computers. A mainframe is used for revenue and accounting systems. Computers used by staff are all networked apart from the stand alone Macs in the PR Department. PC use is growing but is proving more expensive than dumb terminals due to the requirement for multi-user software licences.

There is a central Chief Executive's filing system which is shared by other directors. However many departments have their own paper filing systems, which may or may not be in a form which makes them useful or available to other members of staff outside the department. An itemised central index is used by the IT department which facilitates access.

The word processing system used for corporate and committee matters is Office Power. However, some staff prefer the more user friendly MS Word, which is also used by the local Chamber of Commerce. This has caused some problems of incompatibility. The old version of Office Power is gradually being replaced by Office Power for Windows, which allows translation of Word documents. This is planned to be fully implemented by year end (1997).

Certain documents have to be kept for specific periods, for example, 6 years, and are physically stored. There are some off-site storage facilities but no basement storage at the Civic Centre.

Much information is held electronically and some documents have been microfilmed. Internal e-mail is available. However, this is not used personally by all managers and could be used much more. Indeed the culture is memo rather than e-mail. External e-mail is not available. DBC does not have a page on the World Wide Web.

6 Briefing of staff and feedback

Briefing is via the Industrial Society team briefing method with briefing notes and a cascading system of meetings. The management team meets on Tuesdays. This is typically followed by a series of meetings. The first of these is between directors and the senior managers within their directorate, (as shown on the

organisation chart Figure 5.1), to discuss issues raised by management team. The senior managers then brief their seniors and discuss issues. All this takes place over several days.

On major issues like local government reorganisation, a full meeting of all council staff has been held. A special briefing for front-line staff have been organised on Thames Gateway and there have also been staff briefings/visits to the new Bluewater retail centre. More normally, important items are cascaded via the briefing procedure to staff, or the director may talk to staff directly. Minor changes are circulated by memo. There is also a staff newspaper.

Feedback from staff is obtained from the team briefings but in some cases not much feedback results. Indeed in the previous administration staff have considered it dangerous to provide feedback. However, there have been improvements in some departments. For example, useful views were obtained from reception staff when the reception area was revamped. In general feedback is better at smaller meetings. In any case feedback is inevitably filtered, so it needs to be managed carefully.

The Staff Consultative Group also provides a forum for feedback. There is a staff suggestion scheme but this is little used.

7 Problems with departmental communication

The new organisation structure has resulted in some staff being on a learning curve. There have been problems with some departmental structures.

It is usually difficult to get all members of a directorate together for briefing. So briefing is normally managed using a hierarchical series of meetings, see previous section. Using this mechanism the briefing may not reach everyone. In some instances the message may get changed. There is also the problem of time lag, where gossip has delivered messages in advance of the briefing.

There has been a history of non-corporate thinking with planning not getting down to the work floor. Indeed groups may still be working on projects where finance may be unavailable or the project may not be extended.

8 Interdepartmental communication and networking

The Chief Executive and directors hold a weekly management team meeting. The meeting is organised so that strategic topics are discussed fortnightly and local

issues on the alternative weeks. This ensures time is given to both areas. The general view of those attending is that it is the most useful meeting for communication of information.

Directors attend other interdepartmental meetings as appropriate. There is a series of budget meetings held each year over the period September - January.

The Staff Consultative Group which includes representatives from each of the departments, (total of 12), meets once a month with the Head of Corporate Services, the management team or council members to discuss staff conditions, benefits etc.

Communication (outside meetings) between the respondents was analysed see Tables 5.1 - 5.3 The directors reported that they communicated orally with all the other directors and divisional heads at least once a month and in some cases much more frequently. The highest frequency of communication overall (oral and written) occurs between the Director Finance and the other respondents. Highest frequencies of written communications received are for Director Finance and Head of Corporate Services.

Social communication was also examined, see Table 5.4. There may be some problems in determining what is a social occasion, which has produced some inconsistencies in the responses. Overall, however, social communication between the directors themselves and between directors and Head of Corporate Services, Head of Policy and Economic Development and the Legal Services Officer is quite frequent, but less so with the other divisional heads. The Head of Policy and Economic development is much younger than the directors. and had little social interaction with them.

TABLE 5.1: Oral communication outside meetings

SPEAK TO:	Chief Executive	Director Finance	Assistant CE (Corp. Services	Director Planning & Developt	Director Environ-ment & Leisure	Head of IT	Head of Policy & Economic Dev.
Chief Executive	■	D	D	W	D/W	-	W
Director of Finance	D	■	D	D	D	W	W
Assistant Chief Executive	D	D	■	W	D	M	D
Dir. of Planning & Development	D	D/W	W	■	D	M	W
Dir. of Environment & Leisure	D	D/W	W	D	■	W/M	W
Head of Professional Services*	W	D	W	W		W	M
Head of Information Technology	M	W	W/M	M	W	■	M
Head of Housing Services	M	W	W/M	M	W	W	M
Dep. Dir. of Planning and Development	W	W/M	M	D	W	-	W
Dep. Dir. of Environment and Leisure	W/M	M	M	W	W	M	W
Head of Arts and Leisure	W/M	M	M	W	D	-	W
Head of Corporate Services	D	W	D	W	W	M	W
Head of Policy and Economic Development	D/W	W	D	W	W	-	■
Legal Services Officer	W	W/M	D	W	W	M	W

* Head of professional services has been sick so data for him is incomplete (applies to tables 5.1 - 5.4)

KEY D one or more times a day
W one or more times a week
M one or more times a month
- less than once a month / infrequent

TABLE 5.2: Written communication - sent to others

WRITE TO:	Chief Executive	Director Finance	Assistant CE (Corp. Services	Director Planning & Developt	Director Environ-ment & Leisure	Head of IT	Head of Policy & Economic Dev.
Chief Executive	■	W	W	W	M	-	W
Director of Finance	W	■	D/W	W	W	D	W
Assistant Chief Executive	W	W	■	W	W	-	W
Dir. of Planning & Development	W	D/W	W	■	M	M	W
Dir. of Environment & Leisure	W	W	W	M	■	M	W
Head of Professional Services	M	W	M	M		W	-
Head of Information Technology	M	W	M	-	W	■	-
Head of Housing Services	M	W	M	-	-	M	-
Dep. Dir. of Planning and Development	M	W	M	D	M	-	M
Dep. Dir. of Environment and Leisure	M	M	M	M	M	-	M
Head of Arts and Leisure	M	M	M	M	M	-	M
Head of Corporate Services	W	W	W	M	W	-	M
Head of Policy and Economic Development	M	M	M	W	-	-	■
Legal Services Officer	M	M	W	-	M	-	M

KEY as for Table 5.1

TABLE 5.3: Written communication - received

RECEIVED FROM:	Chief Executive	Director Finance	Assistant CE (Corp. Services	Director Planning & Developt	Director Environ-ment & Leisure	Head of IT	Head of Policy & Economic Dev.
Chief Executive	■	W	W/M	W	M	-	W
Director of Finance	W	■	W	W	W	D/W	M
Assistant Chief Executive	M	W	■	W/M	W	M	W
Dir. of Planning & Development	W	W	W	■	W	M	W
Dir. of Environment & Leisure	W/M	W	W	W/M	■	M	M
Head of Professional Services	M	W	W/M	M		M	-
Head of Information Technology	M	W	M	-	M	■	-
Head of Housing Services	M	W	M	M	-	M	-
Dep. Dir. of Planning and Development	W/M	M	M	W	M	M	M
Dep. Dir. of Environment and Leisure	M	M	M	-	W	M	W
Head of Arts and Leisure	M	M	M	M	W	M	M
Head of Corporate Services	D/W	W	D	W	W	M	W
Head of Policy and Economic Development	W	W/M	M	M	-	M	■
Legal Services Officer	W/M	M	M	M	W	M	M

KEY as for Table 5.1

TABLE 5.4: Social communication

Respondents asked: which of the other people on the following list do you talk to on a social occasion? Social occasions can include tea and lunch breaks, after work drink etc. KEY as for Table 5.1

COMMUNICATE SOCIALLY WITH:	Chief Executive	Director Finance	Assistant CE (Corp. Services	Director Planning & Developt	Director Environ-ment & Leisure	Head of IT	Head of Policy & Economic Dev.
Chief Executive	■	D	W	W/M	W	-	-
Director of Finance	D	■	W	W	W	W/M	-
Assistant Chief Executive	D	D	■	W	W	-	-
Dir. of Planning & Development	D	D	W	■	D	-	-
Dir. of Environment & Leisure	D	D	W	W	■	-	-
Head of Professional Services	W	D	-	M	-	W/M	-
Head of Information Technology	M	W	-	M	M	■	-
Head of Housing Services	W	W	-	M	M	-	-
Dep. Dir. of Planning and Development	-	M	-	D	W	-	-
Dep. Dir. of Environment and Leisure	W	M	-	W	W	-	-
Head of Arts and Leisure	W/M	M	-	W	W	-	-
Head of Corporate Services	D	W	W	W	W	-	-
Head of Policy and Economic Development	W	W	W	D	W	-	■
Legal Services Officer	W	W	W	W	W	-	-

Those most often cited for consultation on emergency and policy matters were the Chief Executive and directors (or division heads in their absence). Some concerns were expressed about the difficulties resulting from the absence of key people, especially in the holiday season.

Some respondents thought that too much information was received from other departments and that this information was not appropriately summarised. Information from finance was not always in a suitable format. Another respondent thought that he was not receiving quite enough or appropriate information. Solutions to these problems would have to take account of the need for all backing information to be available.

Timeliness of information is also important, especially where legal issues are involved. One person's priorities and targets may not be another's. There is some problem getting the message across about what are corporate responsibilities. Sometimes it is necessary to chase information from Finance. The Finance Directorate itself however has few problems with specifying and obtaining information from other directorates.

Some respondents require information about areas where they may not have direct involvement. For example they may be representing DBC at a function and will need to field questions intelligently and have a broad knowledge of council work.

Information may not necessarily be received in written form. For example where lower level staff are in daily communication with other departments they can provide the channel for feeding back information to management.

IT deficiencies are causing some problems. More training in the use of IT is needed.

9 Dealing with change

Top level organisational changes are normally instigated by the Chief Executive or directors in consultation and passed down to staff. Procedures are normally instigated or overseen by the appropriate director. Those of major importance, for example, standing orders, are reported to or discussed with the management team. Financial changes are the responsibility of the Director Finance.

An important element is forecasting and providing early warnings to the management team. Government intervention or other outside influences may also result in change.

In an emergency 'public relations' situation the Head of Policy and Economic Development may be asked to co-ordinate responses from management.

10 Communication strengths and weaknesses

Staff are predominantly housed in one building and numbers are relatively small. There is good dialogue between staff with fairly small communications links between the top and bottom.

There are mixed comments about what should be a strength: the team briefing. A director commented that there was:

"Need to look at better ways of communicating with staff"

The cascade system of briefing inevitably means there are delays. It is done this way to empower the managers. Some people are not perceived as working the system properly. There are also difficulties with the level of detail of information needed by staff. The staff side is represented by the Staff Consultative Group. This is weak and consultative rather than negotiative. It is difficult to get representatives to serve on it - possibly because no demands have been acceded to by management.

Non availability of staff (when off site etc.) for consultation can cause problems when emergency issues arise.

The directors are all located on the top floor. Not all senior staff are approachable and may need to walk the patch more. One senior manager remarked:

"The Management Team are not seen as being in touch with lower levels of staff."

A key problem expressed by several directors is that there is often no clear directive on policy. There is a tendency for individual directors to talk to individual council members and get an individual view of policy. A clear business plan is needed for implementation of strategy. Confusion at the top causes problems for staff. Possibly because of this some staff go off and do things on their own initiative and there is friendly rivalry in achieving different things. However there were plans to address this problem.

11 Conclusions

This small study of DBC has highlighted some problem areas:

(i) Corporate direction and communication of priorities to staff.

(ii) Dissemination of information in the right form

(iii) The team briefing system

(iv) Not enough feed back from staff

(v) IT could be used better, for example e-mail is not used by everyone.

(vi) Accessibility of management

This study will be compared with a similar exercise carried out with GHT which is described in the next chapter. The comparison of the two organisations is detailed in Chapter 9, Section 3.

CHAPTER 6

CASE STUDY: GREENWICH HEALTHCARE NHS TRUST(GHT)

1 Introduction

The main study on internal communications described in this thesis was carried out with the active collaboration of Greenwich Healthcare NHS Trust.

This chapter describes the preliminary study which was carried out mainly with senior management from the Trust.

The NHS is becoming more interested in improving communications, there is a growing sense of the importance of using communications to support the change process in the NHS. However, commitment to improved communication has to be "*more than lip service*" (Paul Lloyd, 1998). Greenwich Healthcare NHS Trust has such a commitment. A Communications Director was appointed in early 1997 and a formal communications strategy now exists for the Trust. The GHT management were enthusiastic about a collaborative study on internal communications.

Collaboration should mean just that. Staff should feel they have had some control over the exercise and want to know its conclusions and be stakeholders in resolving problems and putting improvements in place. The study therefore needed to be an exercise in communication in itself. It has been vital to involve as many of the staff as possible at all stages. This approach has encouraged staff to own the problems themselves. The process of co-operation with staff is detailed in Appendix C.

2 Structure of GHT

GHT is a large organisation employing about 3000 permanent staff. The Trust is currently responsible for 3 hospitals: Greenwich District Hospital, Memorial Hospital and Queen Elizabeth Hospital. It also controls numerous clinics and health centres and other primary and community care facilities currently located on 23 sites. It serves a local population of approximately 216,000 people. In the financial year

1997-8 it had an income in excess of £93 million, treated 168,824 outpatients, 36,613 inpatients, 9732 day patients and 97,842 A & E patients. The Trust has undergone major changes over the last few years. A fourth hospital, the Brook, closed at the end of 1995 and the Queen Elizabeth Hospital site is undergoing major redevelopment with planned completion in 2000. The Trust has also been working towards King's Fund Accreditation[10]. It was therefore a most interesting subject for study, offering many opportunities for observations.

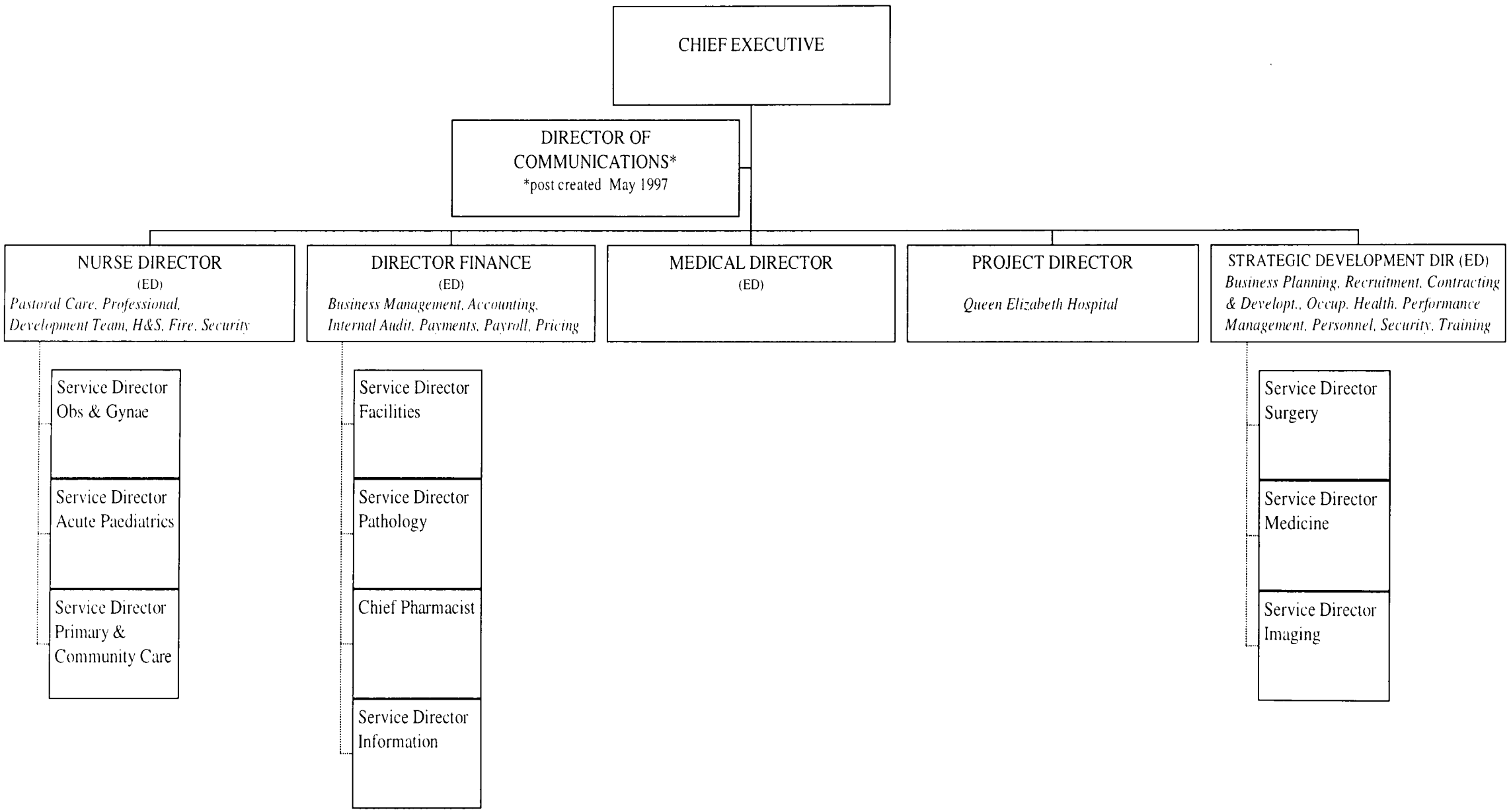
3 Mechanisms for assessment

As with Dartford Borough Council it was necessary to set the scene by interviewing a number of mainly senior staff in the organisation. Structured interviews were held over the period April - October 1997. Appendix D lists the job titles of the personnel interviewed and a standard set of questions used as a basis for the interviews. Further questions were posed and topics explored to develop knowledge of key issues and identify areas of concern. In addition discussions were held with other staff including the Trust Chairman and the Chief Executive and visits were made to a number of community sites. Figure 6.1 shows the senior management structure.

The summary described in the next sections refers to situations and attitudes existing in 1997.

[10] The King's Fund Accreditation scheme was launched across the Trust in May 1997. It allows the Trust to measure itself agreed nationally agreed standards of service provision and includes aspects of communication.

FIGURE 6.1: Organisation structure at GHT, January 1997 showing Executive (ED) and Service Director positions



4 Communication within individual directorates

The location of management and staff at different sites is seen as a significant problem. Good and instant communications only apply at individual sites. In some cases staff have to spend time at different locations and if they are not actually at their home site there may be difficulties contacting them as there are few mobile phones. Most respondents thought that things may improve with the centralisation of hospital services in the redeveloped Queen Elizabeth Hospital. However, there will still be a problem with the numerous community sites.

Primary and Community Care is the most spread out service in the Trust and employs over 600 people, but has the worst communications. There is an enormous variation in the standard of buildings, level of staffing and communications equipment. Some sites are very poor. Typical examples of the extremes are demonstrated by the Manor Brook Medical Centre, Kidbrook, which is a well staffed and equipped attractive little building opened in 1996. It also contains a separate GP section. Around 300 patients are seen each day. This contrasts with the Creek Road Clinic which is situated in a decrepit looking building, in a deprived area, at the extreme edge of the Trust in Deptford. It has little equipment and is staffed by a clerk and trainee health visitor who only saw 12 to 15 patients a day.

The community sites got fax machines only in the last few years and even now these are not at all locations. Some centres are still using ordinary typewriters. There is a problem with the telephone service on some sites in the evening: outside calls can be made, but no incoming calls are possible, as the switchboard is off from 5pm.

5 Information systems

Each directorate has its own system for handling information. Paper systems are still being used extensively. Some common tools such as Trendstar, used for financial and activity information and HISS (Hospital Information Support Systems) are being utilised. The clinical information system is fully integrated with the master patient database. It is used for scheduling, tracking etc. and the system links with departmental modules such as pathology and radiography. It allows for on-line review of patient information. Payroll and personnel aspects are also included.

However, it does not hold clinical records as the network is not currently capable of allowing this. It is hospital based only and not linked to community services or other outside systems.

There is an iterative and time consuming procedure to get documentation together involving sending disks through the post or faxing information.

6 Briefing of staff

Team briefings on the Industrial Society pattern are used but are frequently supplemented by other departmental meetings. It is difficult to get community staff together for a briefing as many of them are out all day seeing patients. Indeed there is a big general problem with field staff in learning about what is going on in the wider Trust.

Culturally the doctors have always had a separate communication system and there are still remnants of this. However, they are trying to improve general communications.

TABLE 6.1 Key interdepartmental meetings X = usually attend TEG = Trust Executive Group

		ATTENDEES						
Name of Meeting	**Frequency of meeting**	**Nurse Director**	**Director Finance**	**Medical Director**	**Strategic Development Director**	**Project Director**	**Service Director Primary & Comm. Care**	**Service Director Information**
NHS Trust Board	Monthly	X	X	X	X	every 3 months		
Audit Committee	2 monthly		X	Alternative meetings				
Project Control Committee	Twice/ month		X		X	X		
Quality Committee	2 monthly	X		X				
Resources Committee	2 monthly		X		X			
Executive	Weekly	X	X	X	X	X		
Strategic & Planning (TEG)	Monthly	X	X	X	X	Deputy does	X	X
Performance Management (TEG)	Monthly	X	X		X		X	X

TABLE 6.2 Oral communication between directors outside meetings

SPEAK TO:	Nurse Director	Director Finance	Medical Director	Project Director	Strategic Development Director
Chief Executive	W	D	D/W	D	D
Nurse Director (ED)	■	M	W/M	W	D
Director Finance (ED)	W	■	W/M	W	D
Medical Director (ED)	W	M	■	M	D/W
Project Director	W	D	W/M	■	D
Strategic Development Director (ED)	W	D	W	D	■
SD- Obs & Gynae	W	M	M	W	W
SD- Acute Paediatrics	W	M	M	W	M
SD- Primary & Community Care	W	M	M	W	W
SD- Facilities	W	W	-	W	M
Chief Pharmacist	W	M	M	M	M
SD- Pathology	W	M	-	M	M
SD- Information	W	W	-	W	M
SD- Surgery	W	M	M	W	W
SD- Medicine	W	M	M	W	W
SD- Imaging	W	M	-	M	W

KEY:
D one or more times a day
W one or more times a week
M one or more times a month
- less than once a month / infrequent

ED Executive Director
SD Service Director

TABLE 6.3 Written communication between directors - sent to others

SENT TO:	Nurse Director	Director Finance	Medical Director	Project Director	Strategic Development Director
Chief Executive	-	W	W	D	-
Nurse Director (ED)	■	M	M	M	-
Director Finance (ED)	-	■	M	W	-
Medical Director (ED)	-	M	■	M	-
Project Director	-	W	-	■	-
Strategic Development Director (ED)	-	W	M	W	■
SD- Obs & Gynae	M	M	-	W	-
SD- Acute Paediatrics	M	M	-	W	-
SD- Primary & Community Care	M	M	-	W	-
SD- Facilities	M	W	-	W	-
Chief Pharmacist	M	M	-	W	-
SD- Pathology	M	M	-	W	-
SD- Information	M	W	-	W	-
SD- Surgery	M	M	-	W	-
SD- Medicine	M	M	-	W	-
SD- Imaging	M	M	-	W	-

KEY: as for Table 6.2

TABLE 6.4: Written communication between directors - received

RECEIVED FROM:	Nurse Director	Director Finance	Medical Director	Project Director	Strategic Development Director
Chief Executive	W	W	W	D	M
Nurse Director (ED)	■	M	M	M	-
Director Finance (ED)	W	■	M	W	W
Medical Director (ED)	M	M	■	-	-
Project Director	M	D	M	■	-
Strategic Development Director (ED)	W	W	W	M	■
SD- Obs & Gynae	-	M	-	M	-
SD- Acute Paediatrics	-	M	-	M	-
SD- Primary & Community Care	-	M	-	M	-
SD- Facilities	-	W	-	W	-
Chief Pharmacist	-	M	-	M	-
SD- Pathology	-	M	-	M	-
SD- Information	-	W	-	M	-
SD- Surgery	-	M	-	M	-
SD- Medicine	-	M	-	M	-
SD- Imaging	-	M	-	M	-

KEY: as for Table 6.2

TABLE 6.5: Social communication between directors

Respondents asked: which of the other people on the following list do you talk to on a social occasion? Social occasions can include tea and lunch breaks, after work drink etc.

COMMUNICATE SOCIALLY WITH:	Nurse Director	Director Finance	Medical Director	Project Director	Strategic Development Director
Chief Executive	-	-	W	W	
Nurse Director (ED)	■	-	M	-	-
Director Finance (ED)	-	■	M	-	-
Medical Director (ED)	-	-	■	-	-
Project Director	-	-	M	■	W
Strategic Development Director (ED)	-	-	W	W	■
SD- Obs & Gynae	-	-	-	-	-
SD- Acute Paediatrics	-	-	-	-	-
SD- Primary & Community Care	-	-	-	-	-
SD- Facilities	-	-	-	-	-
Chief Pharmacist	-	-	-	-	-
SD- Pathology	-	-	-	-	-
SD- Information	-	-	D/W	W	M
SD- Surgery	-	-	-	W	-
SD- Medicine	-	-	W	-	-
SD- Imaging	-	-	-	-	-

KEY: as for Table 6.2

7 Interdepartmental meetings

Directors attend a number of 'top level' interdepartmental meetings as summarised in Table 6.1. In addition to these all attend a number of other interdepartmental meetings.

There was a common consensus, by those attending it, that the weekly executive meeting was the most useful for the communication of information, especially as it was a meeting of people with ability to make decisions. It was often the first sight of new issues. The board meeting was looked on as useful for communication of information to the non-executive directors. The 'strategic and planning' and 'performance management' meetings are used for communication of information to the Trust Executive Group (TEG), consisting of people of executive and service director rank.

The Greenwich Medical Committee (GMC), attended by the Medical Director, is a powerful group which has only relatively recently allowed managers to attend. The minutes are made available to both consultants and executive directors. The committee is very powerful at blocking rather than making things happen. However, it provides a means of getting to the consultant body.The frequency of different types of communication between director level staff is shown in Tables 6.2 - 6.5. All the members of the group communicated orally with all the other members at least once a month and in some cases much more frequently. The frequency was highest for the Chief Executive and the Strategic Development Director (includes personnel function). The Finance Director and Project Director were the most frequent senders of written information. The Strategic Development director prefers the telephone or face-to-face communication rather than memos.

People most frequently cited as key sources of information and usually talked to about emergency and policy issues were the Chief Executive and the Strategic Development Director.

Social communication between the directors is generally rather infrequent. This was attributed both to the disparate location of directors and to the 'NHS culture'. Indeed generally informal communication between staff is perceived as being somewhat limited and *"purposeful rather than social"*

8 Information overload

Information overload was generally reported. This originates from both inside and outside the Trust. The NHS generates a phenomenal amount of information. Too much information is generated and received. A comment was made that the provider may not know key issues relevant to the department. HISS is perceived as offering very little return to people at the bed-side compared with the effort of inputting the information.

9 Awareness of changes

The weekly executive meetings and the TEG meetings were frequently cited for news of all types of change. External sources of information were also mentioned such as networking with other Trusts and various other organisations/contacts.

Mechanisms for communication of changes to staff vary depending on the director. They mainly consist of briefing meetings or working through the organisational hierarchy.

10 Communication within the Trust organisation as a whole

The following summarises some key areas of concern expressed by management. Most of the issues listed below were brought up by more than one of the respondents.

In the past there has been centralism, distrust, and secrecy. The organisation has gone through enormous numbers of changes. People are frightened as a result of the relocation issues and cannot be offered certainty. Staff need reassurance in the period to come. Lots of human time went into the closure of the Brook Hospital including special meetings for the night staff. This approach helped address people's concerns.

Senior management should exhibit more visual leadership. The Chief Executive and Strategic Development Director are reported as having visibility but some people do not know who the other directors are.

"There ought to be more walking the patch".

Three directors mentioned the communications problems of middle management. This sector has a problem leading and debating issues with staff. This is partly confidence, partly lack of training, partly self-importance. A better culture

would be engendered if management were open and honest and prepared to consult on difficult issues. Interdepartmental communications also need to improve at the middle management level. One department often does not know what another department has been doing.

The organisation relies on a cascade structure which results in people at the bottom not being communicated with much. The six-monthly briefings were last done on a departmental basis with very patchy attendance - some departments had an almost full turn-out, others were very poor.

The Trust is responsible for both acute and community care:

"Two trusts under one banner. However, it feels like a trust running big hospitals".

There is an absence of strategy for community care and the delivery of healthcare across the board. There needs to be more visibility of what the community sector does. There is a generally expressed and ongoing problem in having groups on numerous different sites. There is also a difference in culture between staff in acute and community care.

The Trust has made valiant attempts to improve communications and these have improved. The breadth and complexity of communication and how to do this adequately is a difficulty. People only consider issues important if it relates to them. There is a need to organise communication for target audiences. It is thought that the government Private Finance Initiative (PFI) could make things harder - with yet another organisation involved in running the hospital. Communications in the public sector tends to be defensive rather than positive.

Problems are associated with speed of change and achievement of effective implementation. As one manager expressed their frustration:

"There are difficulties in getting enough time to think, reflect, debate and communicate"

11 Conclusions

This first study of GHT highlighted some key problem areas:

(i) Problems associated with the large number of sites, reflected in:

- Communication difficulties within the community care sector and interrelationships with the rest of the Trust.
- Poor interdepartmental communication

(ii) Visibility of senior management

(iii) Poor communication at the middle management level

A comparison of the findings with those for Dartford Borough Council is given in Chapter 9, Section 3. The next chapter shows how these first findings, together with further information from Trust staff, facilitated the next stage of the study: a survey of all permanent staff.

CHAPTER 7

SURVEY AT GREENWICH HEALTHCARE

1 Introduction

This chapter describes a survey of all permanent staff held at GHT. It includes the reasons why such a survey was appropriate. An analysis of responses includes relevant quotes from respondents.

Trust staff were involved in deciding key issues and themes to be addressed in the survey. Following this the survey questions were formulated and agreed with the Trust. It was necessary to run a small pilot in advance of the main survey and the need for this is explained. The method of administration and management of the main survey is outlined. The reliability of the survey is demonstrated and sources of errors discussed. A detailed analysis of responses is reported.

2 Reasons for the survey

The discussions with senior staff and visit to some community sites resulted in the identification of various problem areas as well as some strengths. The next stage in the investigation was to consult much more widely. An audit was needed to determine the current status of internal communications in the Trust.

A survey was thought to be the most appropriate way of gathering a large amount of information on communication across the Trust.

Sample size was considered. A minimum of 10% of staff would need to be surveyed. This would involve a survey population of about 300 and great care would be need to get a suitable sample. However, it was the view of Trust management that it would be desirable to survey all staff, since this would give everyone the opportunity of airing their views. It would also make staff aware of the commitment of management to improved communications in the Trust.

A communications survey to seek the views of all permanent staff working for Greenwich Healthcare was carried out during March - April 1998. It was anticipated that the findings would form the basis for follow up action and improvements and changes where necessary.

3 Staff involvement

In order to develop such a questionnaire to maximum effect it was considered vital to involve key staff from the start. Accordingly a Communications Working Group was set up with representatives from a wide range of areas in the Trust together with the author. The tasks of the Trust group were to identify topics and themes and agree the survey format. A brainstorming session resulted in a large number of themes and issues being identified. The author guided the group on the types of questions that might be asked. This assistance may have slightly biased the group but many excellent and appropriate ideas were generated which were incorporated into the survey. The author was responsible for turning the themes into suitable questions and designing the survey form.

4 Pilot survey

As a first step a pilot survey was carried out with a small number of staff to identify and correct any difficulties or ambiguities before surveying all staff. It was also necessary to determine the typical time taken to complete. A survey that took up too much of staff's time would be unpopular with management and staff alike.

20 people were selected by the Communications Working Group to receive the pilot survey. The selection was not random but included junior and senior personnel likely to provide useful feedback on the questions and design of the form. In addition to the survey questionnaire, staff were requested to fill in a sheet asking about any difficulties with instructions, layout, relevance and clarity of questions. They were also asked how long they took to complete the questionnaire.

18 questionnaires were returned. Staff took an average of 12 minutes to complete the survey. Further details of the pilot are given in Appendix E.

Following the pilot some modifications were made to the form which was then subjected to final review by the Communications Working Group.

5 Full survey content and format

5.1 Survey topics

The survey covered the following:

(i) Demographic and employment details

(ii) How often information was asked for from various sources

(iii) How much information was received

(iv) Duplication of information

(v) Timeliness of information

(vi) Information channels

(vii) Information given to others on various topics

(viii) Information received on special topics such as changes

(ix) How often certain statements were true

(x) Responsibility for communications

(xi) Change in quality of information

(xii) Practical ways of improving communication.

5.2 Scale categories to measure amount of information

Many of the aspects that needed to be addressed in the survey were concerned with amount of information. Hargie and Tourish, (1996), have carried out a number of audits on communication within the NHS. They used a 5 level Likert scale based on that used in previous ICA communication audits, for responses to this type of question, see Chapter 4 Section 8. As an example: the amount of information received on various topics was compared with the amount needing to be received on a scale *1=very little information, 2=little information, 3=some information, 4=great amount of information, 5=very great amount of information'*. The scale number for amount received can then be compared with that for amount need to be received. Total satisfaction scores could then be determined for each respondent by summing the individual's raw scores for all items to provide a measure of satisfaction with communication in the unit. However this method has the following disadvantages:

(i) It assumes a uniformity in the levels between this essentially ordinal scale. A Likert type scale is not an interval scale and no conclusions can be drawn about the meaning of differences between scale positions. A final score of a given magnitude could result from quite different patterns of response, (Moser and Kalton,1971).

(ii) It requires respondents to estimate amounts of information. The

success of this will depend a great deal on the experience and expectation of the individual. 10 documents a day may seem a great amount of information to someone who normally receives very few, whereas 50 documents may appear little to a clerk dealing with 100 or more.

(iii) It requires respondents to fill in two boxes for each question e.g. amount received and amount needed. This makes the questionnaire more complex and longer to complete.

(iv) There is no zero information category

It would be better to have a single scale. However this will need to provide the reliable and useful information. Crucially it must be comprehensible to a wide audience.

Our survey needed to determine aspects of communication from a very wide range of individuals of all levels of education and experience. It was a Trust wide exercise covering cleaners to clinicians. It was therefore essential to have a scale that was understandable to everyone. It was also desirable to use one scale rather than two to assess communication in order to minimise the time taken to complete the questionnaire.

5.3 A new scale to assess amount of information received or sent

The survey offered an opportunity to utilise a new four point scale with the categories: *none, little, enough, too much.* This scale has the advantage of simplicity. It would also aid analysis of various aspects of communication . A response of '*enough*' would indicate that a satisfactory amount of information was being received, whereas '*too much*' would be indicative of information overload. and '*none*' would indicate either communication breakdown or the complete absence of communication. These aspects are explored further in Chapter 8 Section 2. 21 questions in the main survey used these categories for the choice of responses. The reliability of this new scale was tested using Cronbach's alpha see Section 8 of this chapter.

5.4 Other scale categories

Other categories for responses used in the survey consisted of the following :

Question	Categories of responses
How often do you ask for information from (someone)?	*daily weekly monthly rarely never*
Is information coming to you at the right time from (someone)? How often are these statements true (statement)?	*never sometimes mostly (or most of the time) always*
How has the quality of information changed during the last year?	*got worse stayed the same got better*

5.5 Layout of survey form

The survey questionnaire consisted of a single folded A3 sheet, and included a letter from the Chief Executive of the Trust and the Director of Communications, instructions for completion and 50 questions. A sample form is shown in Appendix F. Most questions required the respondents to tick a box. A single scale was used to measure each response. A few questions required the respondent to write in an answer.

6 Logistics of full survey

The survey form was given to permanent staff with their March payslips. A return envelope was also supplied. Staff were asked to return the form by 17 April 1998.

The survey was anonymous but certain questions asked the respondents to give information about themselves including sex, age, directorate etc.

To promote a good response the members of the Communications Working Group were asked to encourage staff to complete the survey and return it promptly. The survey was also publicised in the staff magazine 'The Link' and via the team briefing system.

Other staff were involved in the mechanics of carrying out the survey. All staff who had a place in this activity were consulted in advance and by this means a number of difficulties were anticipated and dealt with. The survey itself went very

smoothly with very few logistical problems, and at minimum cost - a key consideration in an NHS Trust.

Approximately 3000 survey forms were distributed. 939 were returned. The total headcount for April 1998 was 2872, giving an overall percentage response of 32.7%.

7 Analysis of responses

32.7% of staff responded to the survey. This was not a random sample of staff, therefore the analysis can only be treated as statistically valid for those actually responding to the survey and not for all staff. All responses were coded and entered on to a computer in the form of a database.

The main software package used in the first analysis was SPSS[11] for Windows. This is a standard tool for statistical analysis. It was used for producing frequencies and other statistical information. In addition NUD*IST[12] was used to aid qualitative analysis of comments and suggestions.

Tables summarising frequency data have been used. These are displayed in Appendix G.

While it is fairly straightforward to analyse the data statistically, the results in themselves do not tell us the reasons for a particular situation, which are open to conjecture. However, the responses to the open questions 32, 33 and 50, which ask about existing and desired channels of communication and suggestions for improvements, have proved illuminating. Typical quotes from the responses are therefore included where appropriate in the following sections.

7.1 Response rate for questions.

The average response rate to all questions except the open questions 31, 32, and 50 was 94.4%. However, there was quite a wide variation in response rates to individual questions. As might be expected responses were lower for questions which required staff to write in an answer rather than tick a box. Question 7 asked for a job grade to be given, only 80.1% responded This may have been because some staff did not know what their job grade was. However, it was more likely to be because

[11] SPSS Statistical Package for the Social Sciences.
[12] NUD*IST Nonnumerical Unstructured Data Index Searching and Theory building

staff were sensitive that this information might help to pinpoint their identity in an otherwise anonymous survey.

TABLE 7.1: Percentage responses to individual questions

Question	% Response	Question	% Response
1	98.7	26	91.5
2	98.9	27	94.4
3	99.0	28	93.5
4	99.1	29	94.4
5	98.1	30	93.7
6	95.8	31	94.0
7	80.1	32	34.9
8	98.9	33	34.2
9	95.5	34	96.8
10	98.2	35	95.0
11	95.5	36	93.9
12	89.4	37	96.3
13	90.9	38	94.9
14	94.1	39	95.7
15	95.5	40	94.8
16	90.9	41	95.7
17	91.7	42	96.7
18	97.1	43	96.2
19	94.4	44	96.3
20	94.5	45	96.0
21	89.7	46	95.4
22	90.9	47	83.5
23	95.7	48	95.2
24	94.2	49	91.5
25	94.6	50	48.5

8 Reliability of survey

8.1 Definition of reliability

It is a requirement of a questionnaire developer to strive for the greatest accuracy of response possible. It is also necessary to determine details of the degree of accuracy that might be expected, when the questionnaire is used. Inevitably, however, there will be sources of error which can distort the results.

The reliability of a test is an indication of whether it measures anything at all, (Hammond, 1995), and is a measure of the similarity between the true and observed scores. Reliability can also be considered as the ratio of the true variance to the total test variance:

$$\text{Reliability} = \frac{\sigma^2 \text{true}}{\sigma^2 \text{observed}}$$

Thus reliability can also be thought of as the proportion of variance in test scores that is due to the variability of true scores.[13] The greater the reliability the less error and the greater the accuracy.

However there are some problems with this approach because in practice the 'true' value is not known. Psychologists have developed a method of assessing psychometric tests based on consistency. Effects due to randomness would be inconsistent. Therefore if consistency can be identified within the test then one can have the confidence of knowing that the results are not simply a function of random error.

8.2 Measurement of reliability

Essentially there are two types of measures of reliability or reliability coefficients, those based on longitudinal data, using, for example, parallel tests or test-retest and those based on cross-sectional data.

If the first type of measure is used, reliability could be assessed either by giving two parallel but similar tests to a group or giving the same test to the same sample of people at two different times. There would have practical difficulties with either of these approaches for our survey. It would be most difficult to formulate two suitable questionnaires even if this would have been acceptable to the recipients. A full retest was also undesirable as even in the pilot the responses were anonymous, and it would not have been acceptable to re-survey everyone. This second method also has its own problems, for example, differences might have been due to changing circumstances occurring between the two sets of tests.

For the second type of measure various half-split methods can be used to obtain a measure of reliability for a one-time administration of a questionnaire. In

[13] The simple correlation between true and observed is known as the reliability index while the squared correlation between true and observed is termed the reliability coefficient.

this approach, two scores are obtained for each person by dividing the test questions into equivalent halves. In practice, there will be difficulties with this approach, due to the numerous ways that the split can be made. A more practical method, based the administration of a single form, is to examine the overall internal consistency of the questions.

A commonly used method to determine internal consistency is that of Cronbach's Alpha[14] (Cronbach, 1951). This has become the usual measure for estimating the reliability of a multi-item scale. Providing the items are of sufficient quality the more items the greater the reliability. However if a scale is to be measured for reliability it is necessary to determine what is a 'good' or acceptable reliability coefficient. Essentially a test with a reliability of 0.7 means that 30% of its variance is irrelevant and it is generally accepted that alpha should be at least 0.7 if the instrument is to be used as a research tool. However, predictions for individuals require an alpha of greater than 0.9, (Hammond, 1995). Peterson, (1994) has carried out a wide ranging literature review from 1960 to 1992 of alpha coefficients. He found a mean alpha coefficient in psychology related journals of 0.77 and marketing related publications of 0.76. However only 14% of the observed alphas reached or exceeded 0.9.

Reliability for the standard ICA survey instrument described in Chapter 4, Section 3 has been assessed for coefficient alpha. Topics were measured by 14 sub-scales containing 4-13 items. Reliabilities range from 0.75-0.90 (Goldhaber et al 1978). Use of the fractionation scales described by Barnett et al (1981), shows similar values. Higher reliability is claimed for the LTT audit with a coefficient alpha of 0.97 for the 58 items which are not specific to the organisation, (Wiio, 1978).

The reliability of a test may also be expressed in terms of the standard error of measurement (SEM).

$$\text{SEM} = SD_t\sqrt{1\text{-}r_{tt}}$$

In which SD_t is the standard deviation of the test scores and r_{tt} is the reliability coefficient, both calculated on the same group of questions.

[14]Cronbach's alpha: If the items are standardised (have a standard deviation of 1), the reliability coefficient is based on the average correlation of items within a test. If the items are not standardised, it is based on the average covariance among items. Negative values for alpha occur when the average inter-item correlation is negative, which violates the reliability model.

8.3 GHT survey: measurement of alpha

Calculations of Cronbach's alpha can be made in order to evaluate the consistency of the survey. This could readily be done for those groups of questions with the same scales of measurement. It would also be useful to compare questions which might be expected to be related but which used different measures.

A major group of 21 questions were concerned with the amounts of information. They all used the same four point scale '*none, little, enough, too much'* This set of questions was analysed using SPSS for internal consistency. The results are summarised in Tables J1.1 and J1.2 in Appendix J and an alpha value of 0.87 obtained. This is sufficiently high for analysis of groups but should be treated with caution for any applications predicting the behaviour of individuals. The SEM was also calculated see Table 7.2. An average score of 2.51+/- 0.25 was obtained for the valid group of 706 respondents.

TABLE 7.2: Questions concerned with amounts of information

Q14-17, Q23-31, Q34-41

Score Interpretations	**Value**
Range of possible values	1 = none, 2 = little, 3 = enough, 4 = too much
Mean	2.51
Standard deviation	0.36
Valid cases (no blanks)	706
Alpha	0.87
Standard error of measurement	0.13
95% confidence level for true score	0.25

Other groups of questions in the survey were also evaluated for coefficient alpha. As expected with such small numbers of questions the alpha values are lower, see Table 7.3.

TABLE 7.3: Alpha for groups of questions

Question groups	Topic	Alpha
Q10-Q13	Frequency of communication	0.74
Q19-Q22	Timeliness of communication	0.70
Q42-Q46	How often statements true	0.75

See also supporting Tables J2.1- J4.2 in Appendix J.

The whole group of questions containing answers relating to communication i.e. frequency, timeliness, amount, etc. were recoded appropriately so that scales were in the same direction, (so that 1 = none/never/got worse). Open questions 31, 32 and 50 were excluded. Calculation of alpha for this group of 38 questions gave a value of 0.90, indication of a good level of overall consistency, despite some obvious heterogeneity between items.

8.4 Causes of errors

In some questions in the survey there is one unique correct answer. This will mainly apply to the demographic and employment questions where the respondent is asked to give their age group, sex etc. The questions in the communications section of the survey effectively ask for an estimate or assessment from the respondent, for example how much information is received from various sources etc. There are possibilities of errors in the responses to both these sorts of questions.

(i) Mistakes in recording

Misrecording of an answer, for example by ticking a box in the wrong row, is liable to be random. A computer simulation test showed that 10% random errors of this nature would have little effect on overall trends.

(ii) Respondent lacks knowledge

The respondent may give an answer other than the correct one because he lacks the knowledge to give the right one. In this survey it is clear that some staff do not know what directorate they are in! 59 people indicated that they belonged to the Nursing Directorate. However the directorate only contains 39 staff. Review of other details from the respondents, indicated that a large number of these were from nurses of lower grades who could not be members of the Nursing Directorate. It was likely that these were in fact from the Medical or Surgical Directorates. If this were the case, it would slightly ameliorate the comparatively low responses recorded for these directorates. However, no attempt has been made to 'reassign' these staff as this could lead to further inaccuracies.

(iii) Misunderstanding a question

The respondent may misunderstand the question. The pilot survey, carried out with a range of staff at various levels in the organisation highlighted some misunderstandings in both the questions and the response scales. These were addressed in the main survey. However, some questionnaires, particularly from Facilities Directorate, were completed in what appeared to be a random manner.

(iv) Misinterpreting the question

The respondent may misinterpret the question in a particular context. Such an error may have consistently occurred for question 9. Many staff answered 'no' to question 8*: 'are you a manager'* (as might be expected). However, 42 such respondents also answered 'not applicable' to question 9*: 'how many staff do you supervise'*. It is suspected that they should have ticked the box 'none'.

(v) Reluctance to give a particular response

The respondent may not wish for some reason to give the correct or appropriate response. He may be reluctant to give an unacceptable answer. In this survey this effect should be mitigated by the fact that the responses are anonymous.

(vi) Consensus with colleagues

The respondent may fill in the questionnaire in collaboration with colleagues. Due to the way the survey forms were collected by the internal postal service - in bundles from particular sites and departments, this was detected on a few occasions. It was, however, more evident that group discussion had occurred in some of the responses to the open questions.

(vii) Multi-responses

The respondent may tick more than one box, (when not required to). This results in a problem for encoding. Fortunately due to clear instructions, instances of this were rare.

(viii) Coding problems or mistakes in data entry

It was simple, using SPSS, to verify that all responses were within the valid range. A general cross-check was also carried out and very few errors found. In any case such errors are random so the effects should be small.

9 Responses to questions

9.1 Summary data tables

All data referred to in this section is summarised in Appendix G.

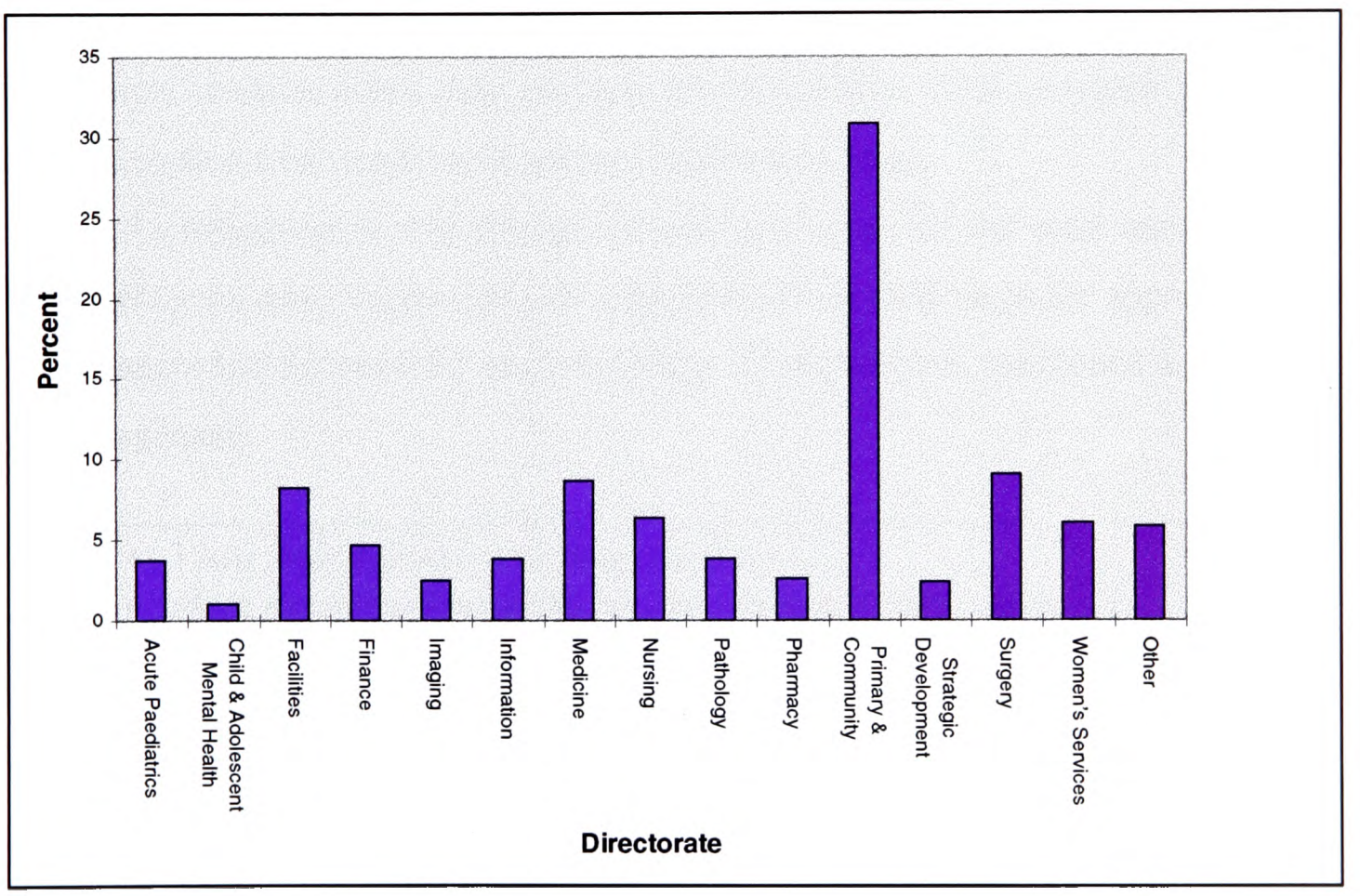
9.2 Personal And Employment Information

Questions 1-9 dealt with such aspects as gender, age and nature of employment etc. Details are given in Tables G.1-G.6 in Appendix G

82% of the respondents were female. About two thirds mainly worked in a hospital, one third mainly in the community and a small number equally in both. About one third worked part-time. More than half of the respondents supervised no staff.

Figure 7.1 shows the distribution of responses from the various directorates.

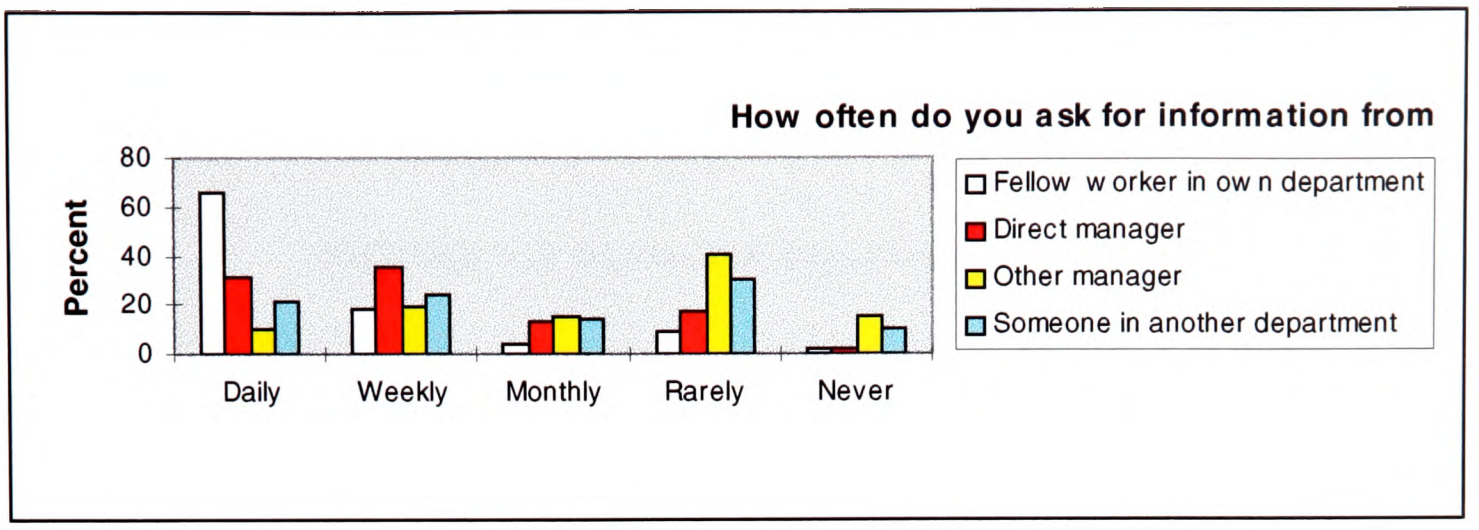
FIGURE 7.1: Distribution of responses from directorates



9.3 Asking for information

Questions 10-13. were concerned with how often staff asked for information from someone else., see Figure 7.2

FIGURE 7.2: How often information is asked for



66% of respondents asked for information from fellow workers in their own department on a daily basis whereas only 32% asked their direct manager daily. Managers other than the direct supervisor were asked much less often. A surprising 20% rarely or never asked their manager for information. 22% of respondents asked for information from someone in another department daily.

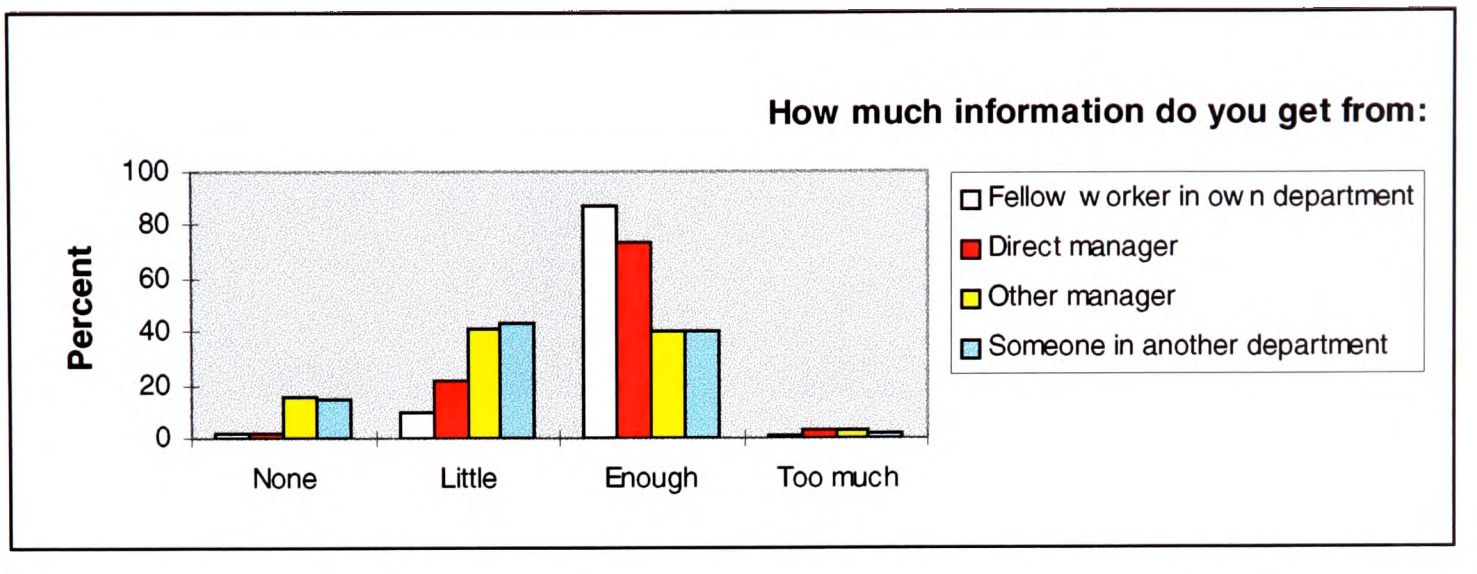
An indication of why the figures were low for direct and other managers may be given by the many comments and suggestions from staff about the approachability of managers and the need for more visibility: 22 respondents mentioned accessibility of management.

- *Visits from managers walking the floor.*
- *More contact with managers rather than see just a name.*
- *Whenever management have to communicate with lower ranks they could remember to speak to us as human beings.*
- *Since the previous management changeover I have not met the new manager.*
- *Managers should be approachable. However there is fear attached. Therefore I would be reluctant to approach managers.*
- *Listening sessions where the senior manager appears merely to threaten / bully are counter productive.*
- *Often it is difficult to make appointments (with managers) to discuss important issues.*

9.4 Receiving information

Questions 14 -17 were concerned with how much information was received.

FIGURE 7.3: Amount of information received



Most people got enough information from their fellow workers and direct managers, but only 40% got enough information from other managers or other departments.

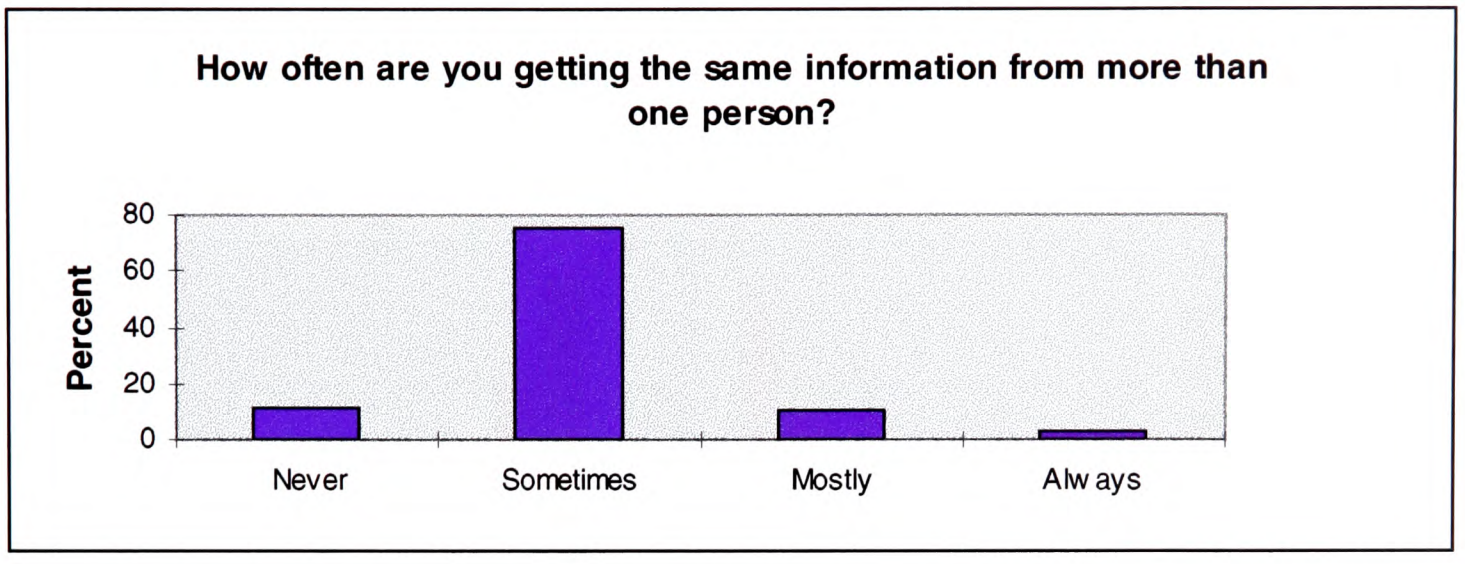
42 suggestions concerned team working, networking or social integration. It was evident that more interdepartmental liaison was needed.

- *Some social venue for different departments to integrate.*
- *Create social gatherings for Trust staff (parties, trips, dinners).*
- *More liaison between directorates.*
- *More contact with other departments in the Trust.*
- *More interaction between departments i.e. working parties.*
- *Stronger corporate lead - directorates are too isolated.*
- *Regular and more standard methods of imparting knowledge etc. between colleagues sites and departments.*

9.5 Duplication

Question 18 asked how often staff were getting the same information from more than one person.

FIGURE 7.4: Occurrence of duplication of information



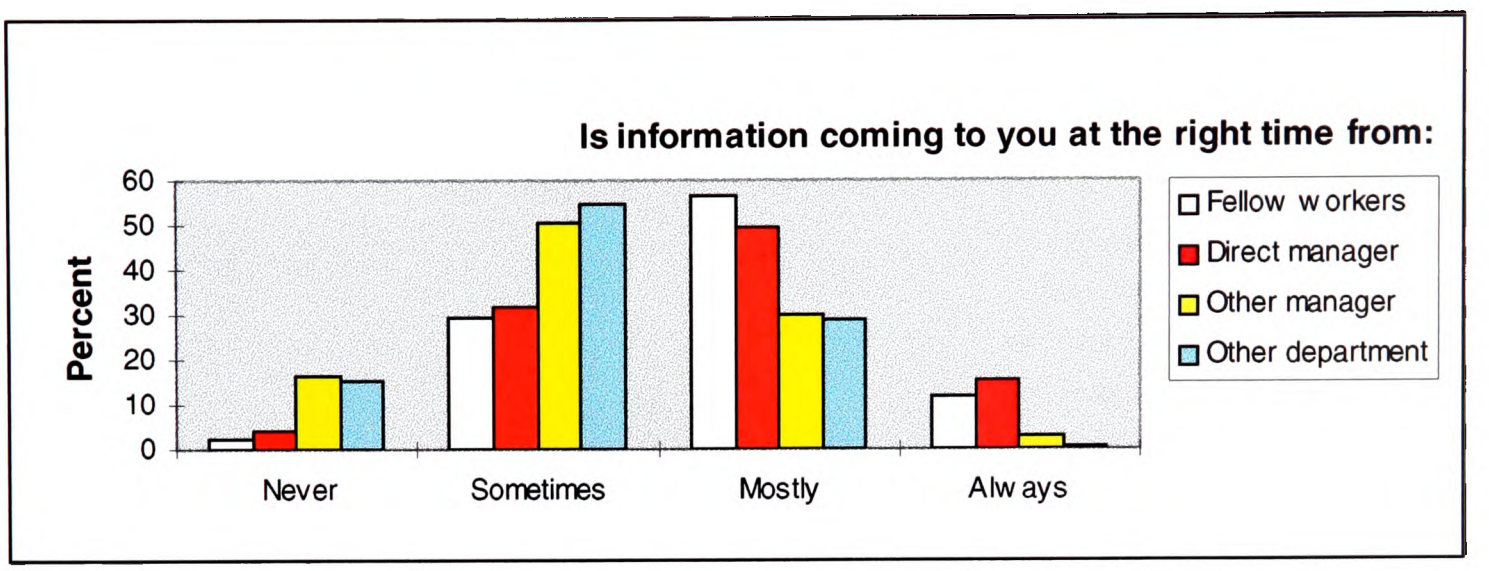
Most people were getting information from more than one person at least sometimes. Suggestions for improvement included:

- *Reduction in the duplication of written information sent out from various sources, this appears to be increasing not decreasing.*
- *Distribution channels need clarification to avoid receipt of some material more than once and other material not at all.*
- *Too much information from management in the directorate - often a lot of duplication - waste of our time, their time, paper etc.*

9.6 Timeliness of information

Questions 19-22 asked if information was coming to staff at the right time from various sources.

FIGURE 7.5: Timeliness of information



69% of respondents mostly or always got information at the right time from their fellow workers and direct managers but other managers and departments were much poorer in delivering timely information.

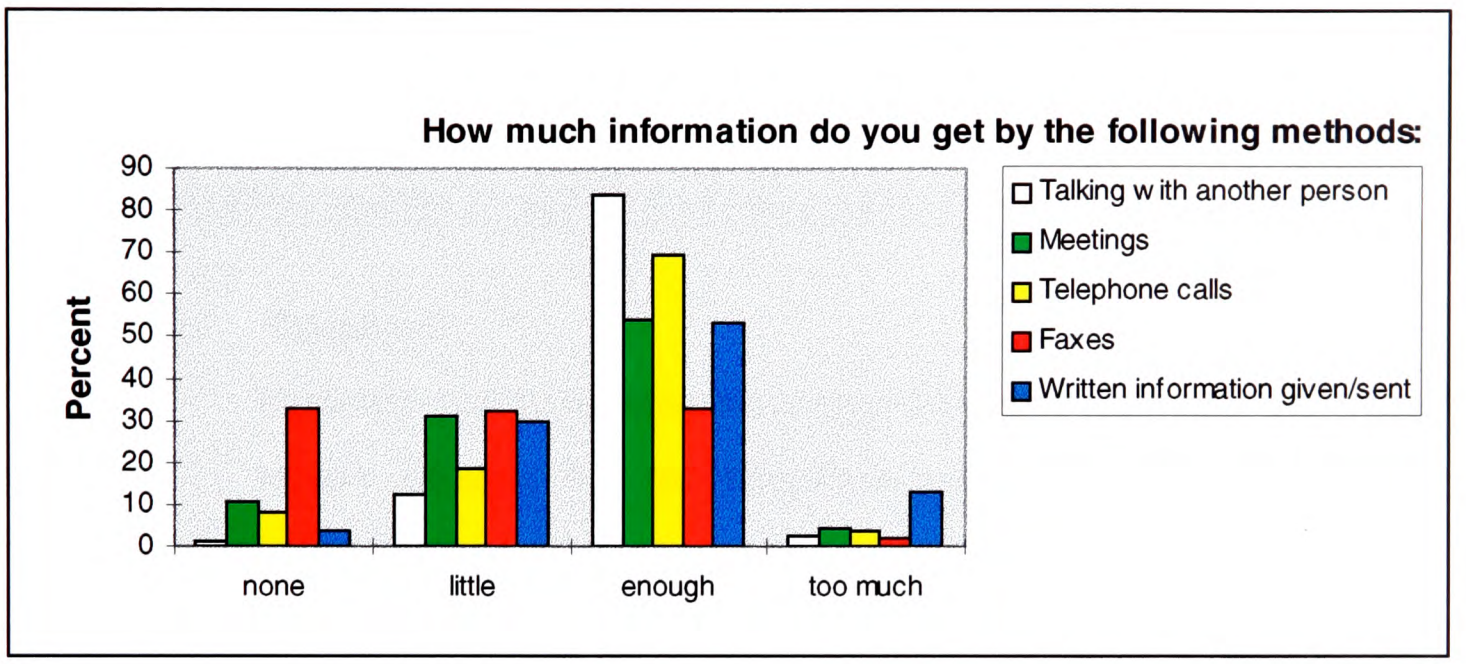
Timeliness or time to communicate was mentioned by 38 respondents as part of their response to question 50. Some typical comments are listed below.

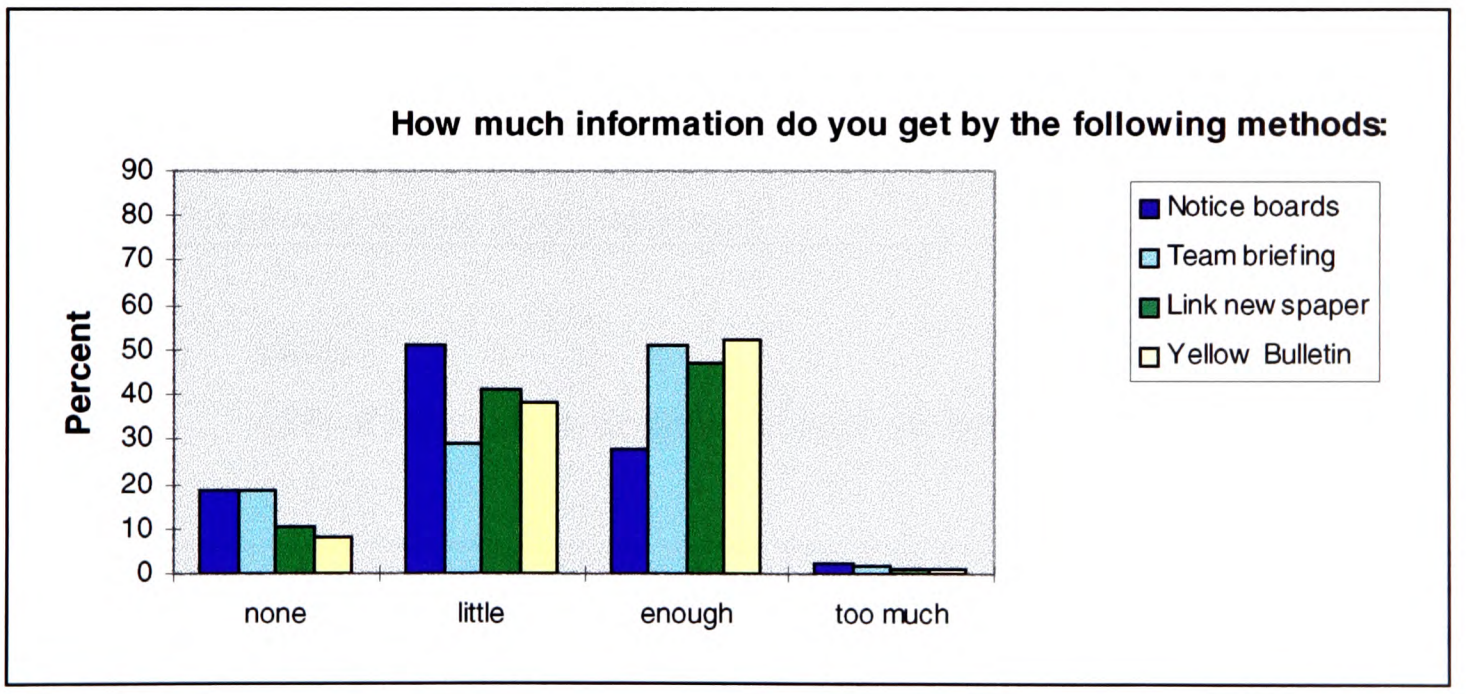
- *Tell us before decisions are taken.*
- *Information should be passed down more quickly from management to staff.*
- *It seems many issues are not reaching members of staff early enough. Quite often deadlines are missed or are notified much too late so that everything has to be dropped in order to attend the issue in question.*
- *The main problem is timing. The information is usually given too late to allow further discussion. Always given as a forgone conclusion, mainly between mid management and my direct supervisors - makes things very frustrating and staff lose morale.*
- *Documents often are circulated for comment by senior managers with very short time scale for return. Longer timeframes should be given*

9.7 Information channels

Questions 23-31 were concerned with how much information staff received via various channels. Due to the large number of channels examined, results are displayed in two sets of bar charts, see Figure 7.6.

FIGURE 7.6: Quantity of information received from various channels





(i) Talking with another person

64% of respondents got enough information by talking to someone.

(ii) Meetings

54% got enough information by this channel but a significant 42% got little or no information from meetings, possibly because they did not attend many. A number of people wanted more meetings. Some suggestions are listed below.

- *More staff meetings rather than hearing things second hand through the grapevine.*
- *To be involved more in staff meetings because of working part-time.*
- *Regular meetings between different departments that work together to ensure that jobs are done effectively and smoothly.*
- *Team meetings widespread in system.*
- *Regular updates by informal meetings held at locality bases.*

(iii) Telephone

Evidently a lot of information is passed by telephone and 70% of staff receive enough, but the telephone service could do with some improvements:

- *Sort out the awful internal telephone directory.*
- *Ensure all departments are notified of new numbers if offices move.*
- *Switchboard answer times speeded up for outside callers.*
- *More use of mobile phones.*
- *More direct dial phones needed to communicate with other health centres.*
- *All phones should have voice mail.*

(iv) Faxes

65% of respondents received little or no information by fax.

- *Fax machines for all departments in sites.*
- *Fax machines for different disciplines i.e. not locked in individual clinics available to key holders only, on different floors in multi-use clinics.*

(v) Written information

Of all the channels this had the highest percentage in the 'too much' category. Comments from respondents indicate that there should be more screening of information:

- *Reduce volume of paper circulating.*
- *Better screening and filtering of information circulated.*
- *Single method of staff information. Too much cover at present in Link, Yellow Bulletin, Team Brief. Memos arrive en masse daily to area and do not get read.*
- *Ensuring the relevant information reaches the right people instead of sending everything regardless.*

(vi) Notice boards

70% of respondents got little or no information from notice boards. Suggestions for improvement include:

- *Use more notice boards and inform people of their whereabouts.*
- *Better use of notice boards.*
- *People made aware of notices on boards, need to be updated regularly.*
- *More information could be posted around entrance areas of health centres - this would allow part-time staff to keep up with the changes.*
- *Information boards - like station.*

(vii) Team briefing

This is a problem area, as illustrated by the many comments and suggestions. 46 respondents mentioned briefing in their reply to question 50 and 23 mentioned briefing in their response to question 33. A little under half of respondents got little or no information from team briefing. It appears that some people are not actually getting a team brief.

- *Team briefing having a feedback loop.*
- *More relevant team briefing.*
- *Review team brief to make sure it is meaningful to front line staff.*
- *My manager never passes on team briefings.*
- *Team briefings actually happening.*

(viii) The Link newspaper

47% got enough information from the Link newspaper. Comments indicate that it is well received. However copies may not reach everyone.

- *More information in the Link.*
- *Better use of Link: less gossip, more solid information about Trust working, more information on performance of Trust and how it is interpreted.*
- *Expanding the Link magazine as this seems very popular.*
- *The Link is of an excellent standard and very relevant (but not always received). It avoids the cringe factor of the Elf (old staff newspaper).*

(ix) Yellow Bulletin

52% of respondents got enough information from the Yellow Bulletin[15] but again there may be a circulation problem:

- *Using Yellow Bulletin more - ensuring Yellow Bulletin is despatched promptly to all departments.*
- *More information in the Yellow Bulletin rather than team briefing.*

Some other types of bulletins were also suggested by staff:

- *Internal news bulletins to each office.*
- *Regular bulletins in wage slips, this way even bank staff are kept informed of changes in the Trust.*
- *Bulletin boards on computer system.*

9.8 Other ways staff get information

Question 32 asked staff to list any other ways that they got information, see Table G.12 in Appendix G. Inevitably many included ways already listed in the previous questions. However, gossip or talking to people informally was the most popular channel for getting information. This was followed by the media - mostly local newspapers.

[15] The Yellow Bulletin is a staff information document published fortnightly.

9.9 Ways staff would like to get information

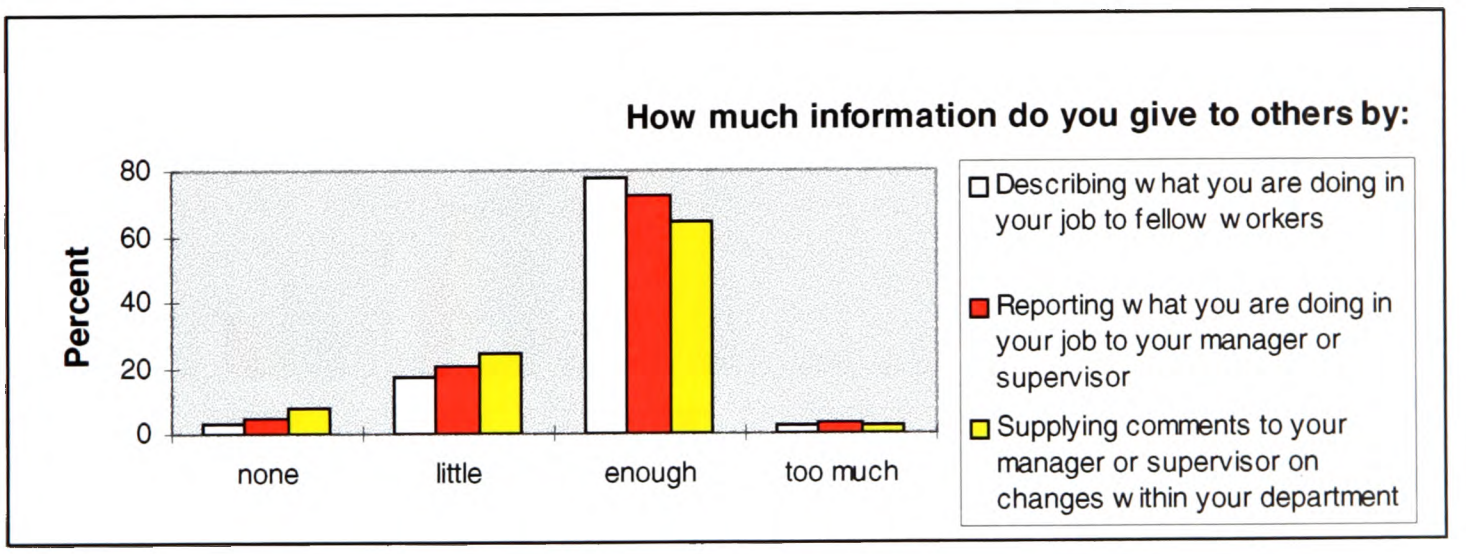
Question 33 asked staff to suggest any other ways that they would like to get information, see Table G.13. The most popular channel by a large margin was via information technology: e-mail, Internet/ Intranet or greater use of HISS. The next most popular suggestion was via meetings.

- *Departmental meetings with set agenda*
- *Meeting and sharing ideas with other healthcare professionals*

9.10 Passing information to others

Questions 34 - 36 were concerned with how much information the respondent passed to others, on some specific matters.

FIGURE 7.7: Quantity of information given to others



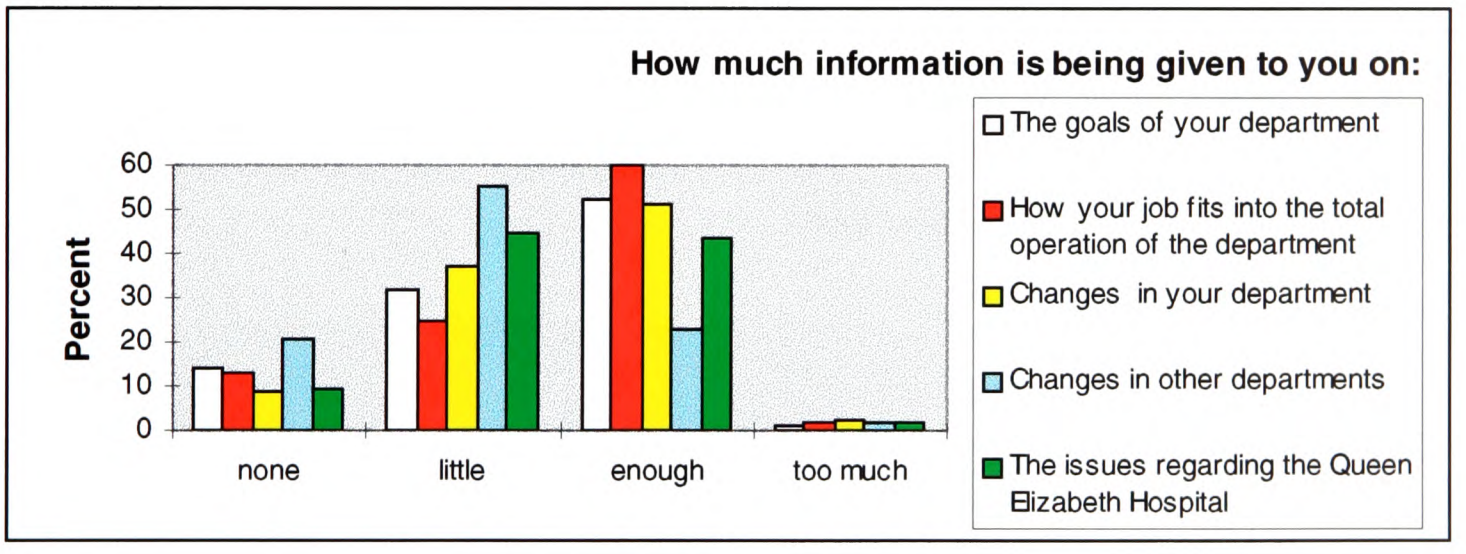
Most staff thought that they gave enough information about describing their job and reporting to their manager. About two thirds gave enough information by supplying comments on changes to their manager. Comments on exchange of views and feed-back are listed as follows.

- *Introduce meaningful upward communication with feedback.*
- *To have key staff who have an interest in better communication and liaison, cascading information to their local area and then feeding back comments and reactions as well as suggestions and ideas.*
- *Staff and management work together e.g. exchanging points of view and supplying comments to each other.*

9.11 Specific information

Questions 37-41. asked about some specific information topics.

FIGURE 7.8: Quantity of information received on specific topics



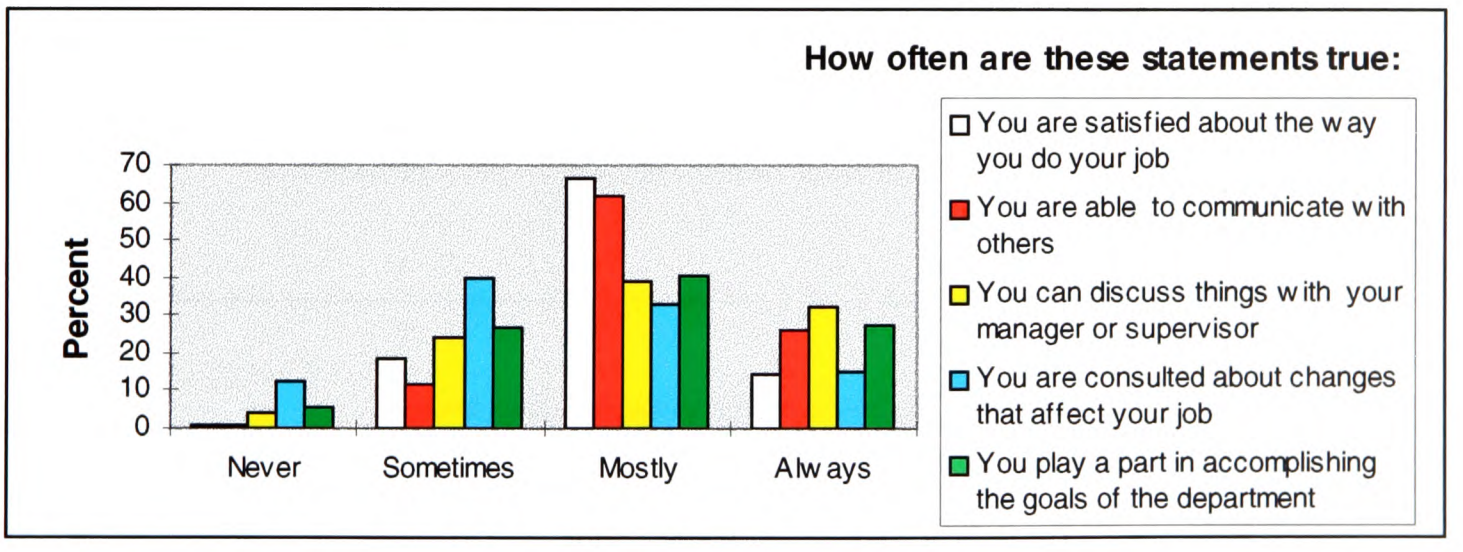
Overall the results are rather disappointing. The number of people who got enough information about changes in other departments was particularly poor (23%). Comments and suggestions from staff are listed as follows:

- *Staff in my department are not advised of the departments plans, goals or achievements.*
- *For managers to tell their staff what their direct goals are so that their staff can prioritise their work to meet their managers needs better.*
- *Everyone thinking carefully of how changes in their department might affect others and them informing them.*
- *Info sheets (in the department) whilst so much change and development is occurring.*
- *More communication regarding changes in the policy of hospital and the wards.*
- *We should be liased with more as to changes in the Trust affecting our department. If this means more individual staff meetings then so be it.*
- *More time to talk in my department especially things like QEH and team brief. I don't really know anything about QEH changes.*
- *More information filtered through via meeting/letters re: policy changes, general updates on QEH etc.*

9.12 Statements about the respondent

Questions 42-46: asked how often various statements were true.

FIGURE 7.9: Statements about respondents



The great majority of staff were mostly or always satisfied with the way they did their job.

88% of respondents were mostly or always able to communicate with others, whereas a smaller number (72%) were mostly or always able to discuss things with

their manager. This is reflected in the 22 replies to question 50, citing accessibility of management.

Less than half were consulted mostly or always about changes that affected their job. Staff made many comments on lack of information or discussion on changes, a few are listed below.

- *Discussions between all members of staff not just managers on the changes both in the ward and the hospital itself.*
- *When surgical and other managers would consult clinicians about changes they want to make before making them.*
- *Difficulty with shift work working different days or evenings - hold smaller meetings to discuss changes etc.*

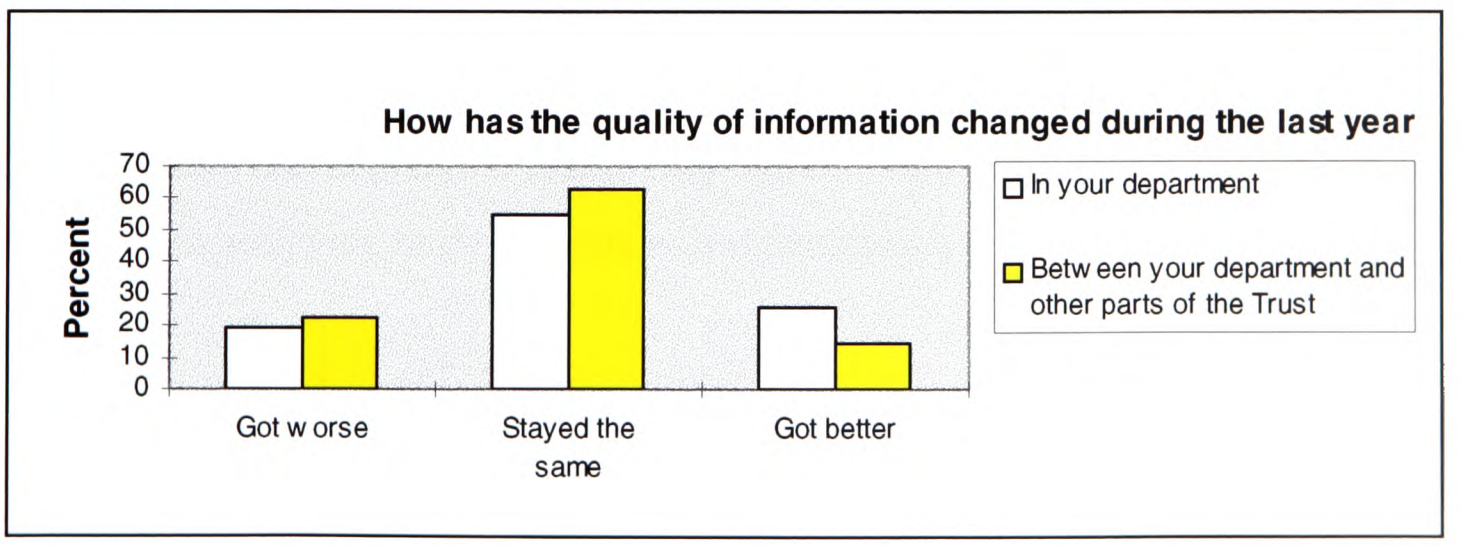
9.13 Responsibility for communications

Question 47 asked who staff thought was responsible for communications. 64% of respondents recognised that everyone was responsible for communications in the Trust though many of these also mentioned the role of management. Various levels of management were cited by most of the rest.

9.14 Quality of information

Questions 48-49 asked how has the quality of information had changed during the last year.

FIGURE 7.10: Change in the quality of information



For both questions the majority or respondents thought that there had not been a change during the last year. However, 26% thought that the quality of information within their department had got better and 20% thought it had got worse, whereas only 15% thought it had got better and 23% thought it had got worse between the department and other parts of the Trust.

Again it appears that interdepartmental communication is more of a problem than communication within departments.

9.15 Suggestions for improvements

Question 50 asked in what practical ways could communication be improved. About half of the respondents offered suggestions, many of which are quoted in the previous sections.

Analysis of such lists obviously depends on the categorisation. Table G.19 in Appendix G gives an indication of the numbers of suggestions and comments on certain themes. The four most frequently cited were: meetings, information sharing, IT and procedures.

10 Summary of frequency information

10.1 Personal communications

(i) 64% of respondents recognised that everybody was responsibility for communication in the Trust..

(ii) 88% of respondents were able to communicate with others mostly or always..

These are impressive results and should form an important basis for co-operation in achieving improvements in communication.

10.2 Communication between fellow workers in their own department.

Communication between fellow workers in their own department was generally good.

(i) 66% asked for information daily.

(ii) 68% mostly or always received information at the right time.

(iii) 87% received enough information.

(iv) 78% gave enough information by describing what they were doing.

10.3 Communication between staff and their direct manager or supervisor.

Lack of approachability and poor visibility of managers was highlighted in the comments and suggestions put forward by respondents.

(i) 32% asked for information daily.

(ii) 64% mostly or always received information at the right time.

(iii) 74% received enough information.

(iv) 72% gave enough information by reporting what they were doing in their job.

10.4 Communication between staff and another manager

Communication between staff and mangers other than their direct supervisor seems poor.

(i) 10% of staff asked for information daily.

(ii) 33% mostly or always received information at the right time.

(iii) 40% received enough information.

10.5 Communication between staff and someone in another department

Communication between departments is an area of concern and staff made many suggestions for better liaison and social integration.

(i) 22% of respondents asked for information daily from another department.

(ii) 30% mostly or always received information at the right time.

(iii) 40% received enough information.

10.6 Communication channels

Many suggestions were received on information channels. Key points are summarised below:

(i) Better IT including e-mail.

(ii) More meetings.

(iii) Improvements in telephone service and directory.

(iv) More fax machines.

(v) Better screening of documents to avoid information overload.

(vi) Team briefing should have a feedback loop. Everyone should get a team brief.

(vii) Ensure all get the Link newspaper and Yellow Bulletin.

10.7 Goals and job satisfaction

More information needs to be given to staff on the goals of the department.

(i) 81% of staff were mostly/always satisfied with the way they did their job.

(ii) 53% were given enough information about the goals of their department.

(iii) 68% mostly/always played a part in accomplishing the goals of the department.

10.8 Changes

Staff need to be told about changes in a timely way. They need more information on changes in other departments that affect their work.

(i) 65% of respondents gave enough information by supplying comments to their manager on changes within their department.

(ii) 51% were given enough information on changes in their department.

(iii) 23% were given enough information on changes in other departments.

10.9 Quality of information

More people thought that the quality of information had improved rather than got worse within their department over the last year. Unfortunately this was not so for communication with other parts of the Trust, which appears to have got rather

worse. This is another indicator for the need to improve interdepartmental communication

11 Conclusions

The survey showed that the majority of respondents recognised that everybody was responsible for communication in the Trust. There was also good communication between fellow workers in their own department. However problem areas identified These were:

(i) Deficiencies in the team briefing process.

(ii) Better and more timely communication was needed between departments.

(iii) Lack of approachability and visibility of management.

(iv) Staff wanted better IT including e-mail. They also wanted more meetings.

(v) Improvements were needed in the telephone service/directory and provision of fax machines.

It was also evident that some groups of staff might be communication disadvantaged but further analysis was required to identify these. This is described in the next chapter.

CHAPTER 8

COMPARISON OF GROUPS OF RESPONDENTS

1 Introduction

Staff at Greenwich Healthcare were asked to respond to 50 questions in the survey. It is possible to compare individuals or groups on a question by question basis but this can be tedious and time consuming. It would, however, be very useful to have some indication of how respondents compare with one another for specific groups of questions and for various aspects of communication. It may then be possible to determine if there are categories of staff who are substantially different from the average respondent in terms of quantity and quality of communications.

This chapter describes how the scale categories described in the previous chapter were utilised in the development of indices for various aspects of communication. The chapter goes on to show how these indices might be used to help identify communication advantaged or disadvantaged groups of staff.

2 Development of measures for aspects of communication

Chapter 7 Section 5 discusses the use of a new scale to assess amount of information received or sent.

The scale consists of the categories: *none* *little* *enough* *too much.*

The use of this scale particularly facilitates the interpretation of the resulting data. It would also aid analysis of various aspects of communication . A response of '*enough*' would indicate that a satisfactory amount of information was being received, whereas '*too much*' would be indicative of information overload. and '*none*' would indicate either communication breakdown or the complete absence of communication.

It is possible to develop a set of indicators for observable manifestations of a particular concept, (Bechhofer, 1974), in this instance an aspect of communication. These indicators can then be combined into an index. It would be desirable to be able to measure overall communication for individual respondents and groups and more specifically to assess:

(i) Level of satisfaction

(ii) Frequency of communication

(iii) Information overload

(iv) Communication breakdown

(v) Non responses to questions

2.1 Measure 1: Satcom index

It is possible to set one (or more) points on the scale to correspond to a 'desirable' level. 21 questions in the Greenwich Healthcare survey used the new four point scale '*none, little, enough, too much*', for which the desirable response would be 'enough'. Other desirable answers would indicate such aspects as a more frequent level of communication, or information is received in a timely manner. No attempt was made to assign a score to each response. However, it is possible to count the total number of desirable responses for each individual and therefore rank the respondents for a composite parameter of good overall communication which is a measure of communication frequency and satisfaction. Henceforth this total count is known as the *Satcom Index.* The maximum score achievable is 38 and the minimum 0. Groups may be compared by comparing the mean or average number of 'desirable' answers.

The desirable responses to the survey questionnaire are listed below. The 'desirable' answers to the questions 10-13 may vary with circumstances but have been set at the response given by at least 45% of all taking part in the survey. The answers to Questions 32, 33 and 50 were excluded from this analysis as they were of the nature of suggestions or comments. There are no 'best answers' for these.

Desirable answers to survey questions

	Questions	Desirable Answer
	How often do you ask for information from:	
10	A fellow worker in your own department	Daily
11	The manager or supervisor you directly report to	Daily/weekly
12	A manager other than your direct supervisor	Daily/weekly/ monthly
13	Someone in another department	Daily/weekly
14-17	How much information do you get from.....	Enough
18	How often are you getting the same information from more than one person?	Never/sometimes
19-22	Is information coming to you at the right time from....	Mostly/always
23-31	How much information do you get by the following methods...	Enough
34-36	How much information do you give to others by.....	Enough
37-41	How much information is being given to you on.....	Enough
42-46	How often are these statements true.....	Most of the time /always
47	Who do you think is responsible for communications?	All (or equivalent answer)
48-49	How has the quality of information changed during the last year.....	Got better

The responses from the whole survey population were analysed and the mean Satcom Index for all respondents was found to be 20.0.

2.2 Measure 1a: Satcom Average Deviation

The *percentages* of all respondents selecting the 'desirable' answer for each question can be determined. The responses for each member of the group under study can then be similarly analysed and the difference between the target group and the total population determined for each question (see example below). If a lower percentage of respondents from the group gives the desirable answer compared with than that obtained from the whole population then the difference is negative.

Example calculation:

Question: How much information do you get by telephone?

69.8% of all respondents ticked the 'enough' box

79.4% of Information Directorate ticked the 'enough' box

Positive deviation for Information Directorate is 9.6%

This measure allows the identification of major deviations from the average response for particular questions/groups of questions.

2.3 Measure 2: Frequcom Index

The count of desirable answers to questions 10-13 (which asks about how often information is sought from various sources) is included in the *Satcom Index.* However, it would be useful to be able also to calculate this separately as a *Frequcom Index*, a measure of frequency of communication. The mean Frequcom Index for all respondents is 2.1.

2.4 Measure 3: Overload Index

Receiving or having to impart too much information can be just as much a problem to staff as not getting enough information. It can waste time and cause worry to a busy person. Even worse, people can grow intolerant and reject or disregard information that may be important. It would be useful to assess information overload. Such a measure can be used and will be called the *Overload Index.*

21 survey questions gave respondents an option to chose 'too much' (information received or given) indicative of information overload. Summing all these will allow an Overload Index to be calculated for each respondent.

The mean Overload Index for all respondents was 0.54, indicating that information overload was not a problem for the majority of staff. However, a total of 255 people gave at least one 'too much' answer. The highest numbers of such responses were given for the questions listed as follows. 115 respondents received

too much written information.

Question no.	**No. of 'too much' responses**
27 Information got by written information given/sent	115
24 Information got by meetings	39
25 Information got by telephone	34

2.5 Measure 4: Blankcom Index

There are some instances where staff are not getting or sending information or communicating at all. For example: 5 respondents were unable to communicate with others and 38 were unable to discuss things with their manager.

A measure of communication failure has been developed called the *Blankcom Index*. 34 survey questions gave respondents the option of selecting 'none' or 'never' indicating communication or satisfaction failure (Question 18 has been excluded). Summing all these selections will allow a Blankcom Index to be calculated for each respondent.

Two thirds of the respondents (627) had a Blankcom Index of 1 or more. The mean for all respondents was 3.0.

2.6 Measure 5: Nonresponse Count

Sometimes a respondent does not choose to answer a particular question or indeed not return the survey form at all. There is usually no way of knowing the reason, though six staff have expressed dissatisfaction with the format or questions in the survey. The usual problem of apathy might explain the non-return of a form but not gaps left in responses.

It is clear that there is some sensitivity among respondents on answering questions about themselves, see Chapter 7 Section 7. However, there are also some interesting patterns of nonresponses by different groups to the communication questions.

Some forms had been rather randomly completed with a sprinkling of responses scattered around. This may indicate a problem of comprehension either of

the individual questions or of the overall requirements for completion - a failure in communication in itself on the part of the author!

The number of non-responses was counted for each respondent for all the 'tick box' communication questions plus question 47, (a maximum of 38). As before, the open questions 32, 33 and 50 were excluded. Staff who stated that a question was non-applicable to them were recorded as having responded. A total of 397 did not respond to at least one of the questions. The mean *Nonresponse Count* for all respondents was 2.3.

3 Bivariate analysis

It would be useful to establish the significance and strength of relationships between the various communication indices (dependent 'summary' variables) and the explanatory or independent variables relating to the characteristics of the respondent. It will also be necessary to consider any confounding factors which may also be influencing the results.

The relationship between the following variables and appropriate communications indices were explored:

(i) Sex

(ii) Age group

(iii) Work place - main place of work

(iv) Employment - part-time or full-time

(v) Supervision - numbers of staff supervised

(vi) Directorate

Classification of the variables under study is made according to Steven's system (1951) see Table 8.1

TABLE 8.1: Classification of Variables

Variable Type	Variable Name	Categories/values	Classification
Dependent	Satcom Index	0-38 (integer)	Ratio
Dependent	Frequcom Index	0-4 (integer)	Ratio
Dependent	Overload Index	0-21 (integer)	Ratio
Dependent	Blankcom Index	0-34 (integer)	Ratio
Dependent	Nonresponse Count	0-38 (integer)	Ratio
Independent	Sex	M, F	Nominal (dichotomous)
Independent	Age-group	<20, 20-29, 30-39, 40-49, 50-59, 60+	Ordinal
Independent	Work place	Hospital, Community, Both	Nominal
Independent	Employment	Full-time, Part-time,	Nominal (dichotomous)
Independent	Directorate	Finance etc. (14 Directorates + 'Other')	Nominal
Independent	Supervision	0, 1-5, 6-20, >20	Ordinal

There are some confounding factors and the independent variables are not independent of each other but are likely to be related in a complex way.

Examples of some interrelationships:

(i) Workplace: 83% of males give their workplace as 'hospital' compared with 66% of females.

(ii) 89% of males work full time compared with 64% females.

(iii) 48% of males supervise 1 or more compared with 39% females.

(iv) 51 % of full-time staff supervise no one, compared with 77 % of part-time staff.

(v) There is an older age group of staff working in the community than in the hospitals.

The classifications of the independent variables under study limit the typed of

valid analyses which can be made. Techniques of value include those of cross tabulation and examination of means.

Cross tabulation of the dependent variable and one of the independent variables together with analysis of statistical significance: the chi-square test, can be carried out. However the wide range of values for most of the indices makes it impractical without further data manipulation. A way of resolving this is to group the values of each index into four categories, corresponding to the range of values corresponding to the four quartiles of the responding population. This gives some significant results for those variables with a stronger relationship, but loses detail.

TABLE 8.2: Transformation of the Satcom Index values

Values of the Satcom Index	Transformed value
0-15	1
16-21	2
22-26	3
27-38	4

TABLE 8.3 Chi-square Analysis on transformed Satcom Index vs. independent variables

Independent Variable	Chi-Square (Pearson)	DF	Significance
Sex	5.69	3	.13
Age group	35.93	15	.0018
Work place	10.41	6	.11
Employment	31.86	3	.00000
Supervision	70.62	9	.00000

The variables 'employment', age-group' and 'supervision' have a statistical relationship with the transformed *Satcom Index* better than the .05 significance level.

An interesting way of analysing pairs of variables when the dependent variable is interval or ratio and the interdependent variable is either nominal, ordinal or dichotomous is by comparing means (Bryman and Cramer, 1997). The dependent variable is broken down in terms of the independent variable and the means and standard deviation of the dependent variable for each subgroup of the independent variable are calculated. So, for example, if we are looking at the effect of type of employment, we could examine the mean and standard deviation of the values of the *Satcom Index* for part-time and full time staff. This method is particularly appropriate if the ordinal or nominal variable has relatively few categories and the ratio variable has many values. Analysis of means and variance using SPSS allows the calculation of the F ratio which provides a test of statistical significance and eta squared which supplies a measure of the strength of the relationship between the variables.

4 Variation in mean values of the Satcom Index

The study shows there is a correlation between a number of the demographic/employment factors and the overall measure of communication level/satisfaction..

The order of strength of relationships as given by eta squared between the *Satcom Index* and the independent variables under study are shown in Table 8.4. The variable 'sex' has the least statistically strong relationship. Women appear to have a lower mean value for Satcom than men, but this effect may partly be explained by the higher proportion of female part-timers. The variable supervision has the strongest relationship with the Satcom Index but only about 8% of the variance of the Satcom Index can be attributed to level of supervision. It is likely that this index is dependent on other factors not tested in this survey. These may well be numerous and complex.

TABLE 8.4 : Significance and strengths of relationships between the independent variables and the Satcom Index

Variable	F	Significance	Eta squared
Sex	2.95	.086	.0032
Age group	2.59	.076	.0056
Work place	3.72	.0025	.020
Employment	33.34	.0000	.035
Directorate	4.68	.0000	.068
Supervision	26.45	.0000	.082

Figures 8.1 - 8.6 show the mean Satcom Indices for different groups. Source data for all graphs is given in Appendix I.

FIGURE 8.1: Mean *Satcom Index* by sex

FIGURE 8.2: Mean *Satcom Index* by age group

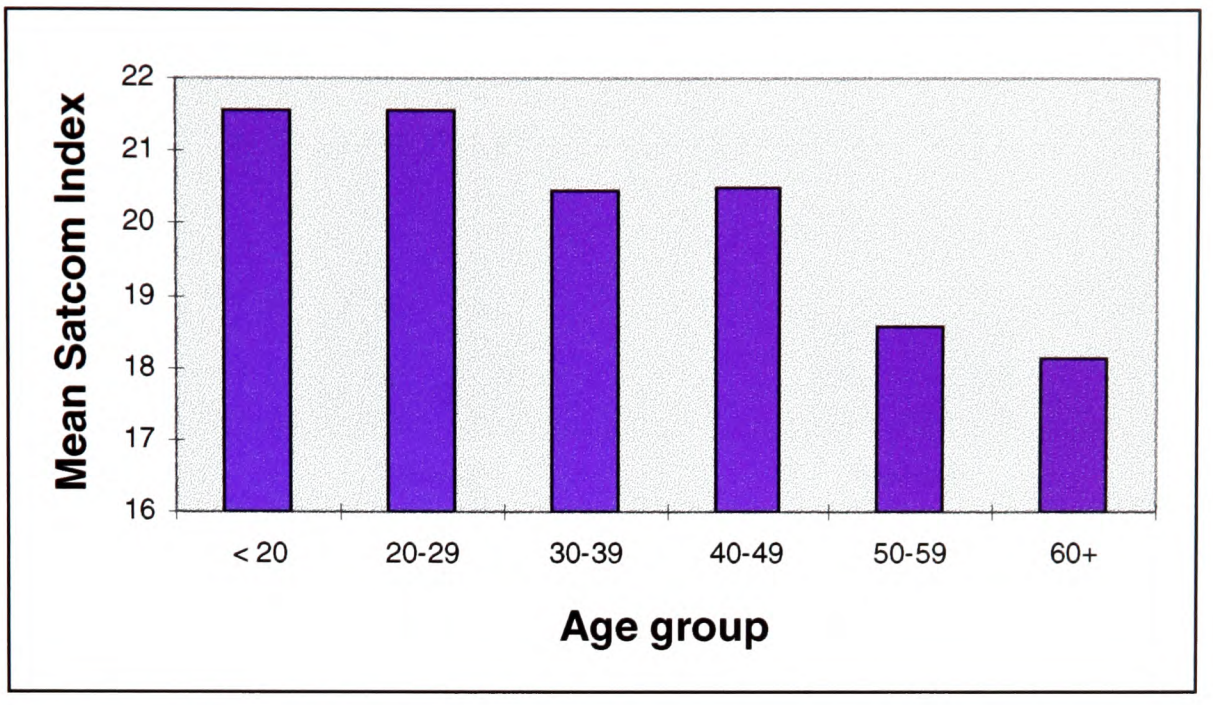


FIGURE 8.3: Mean *Satcom Index* by workplace

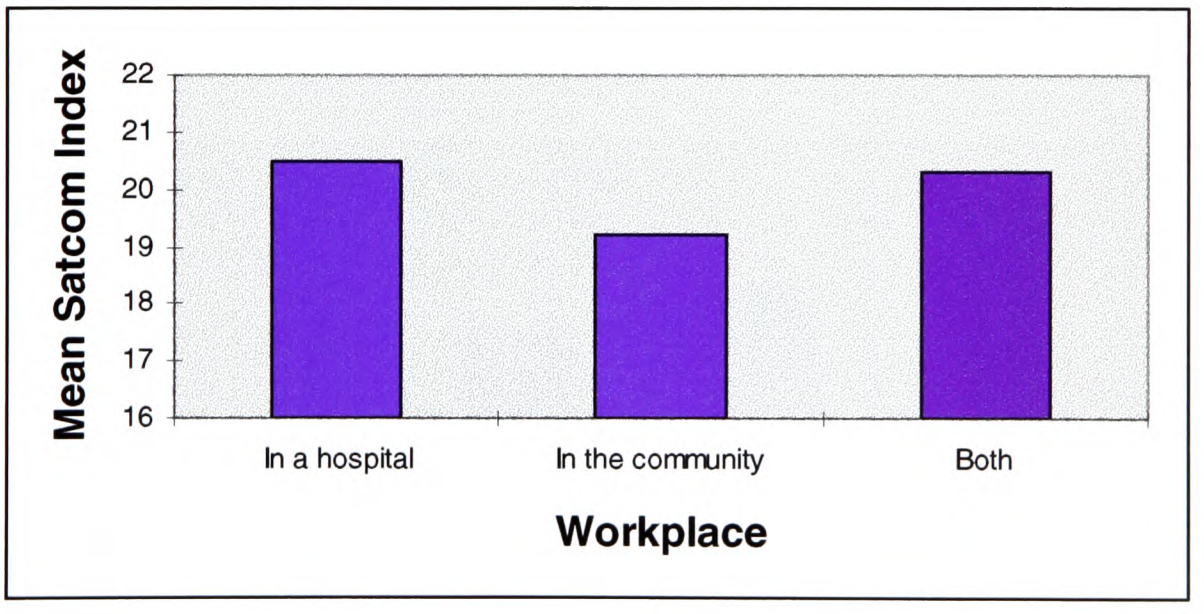


FIGURE 8.4: Mean *Satcom Index* by type of employment

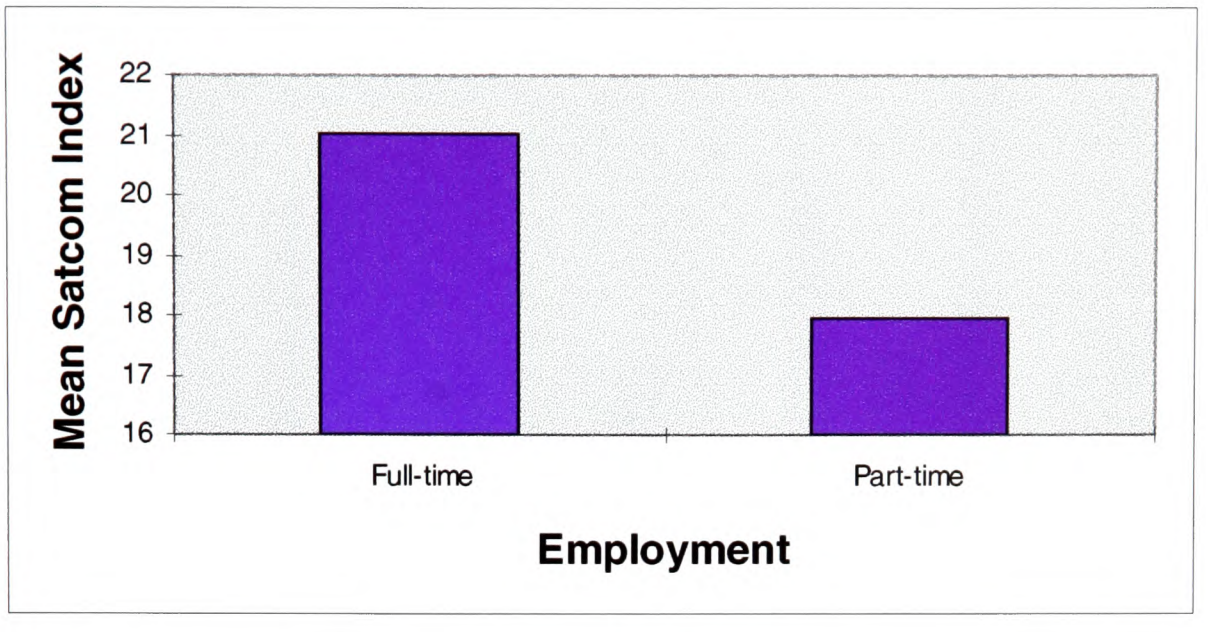


FIGURE 8.5: Mean *Satcom Index* by numbers of staff supervised

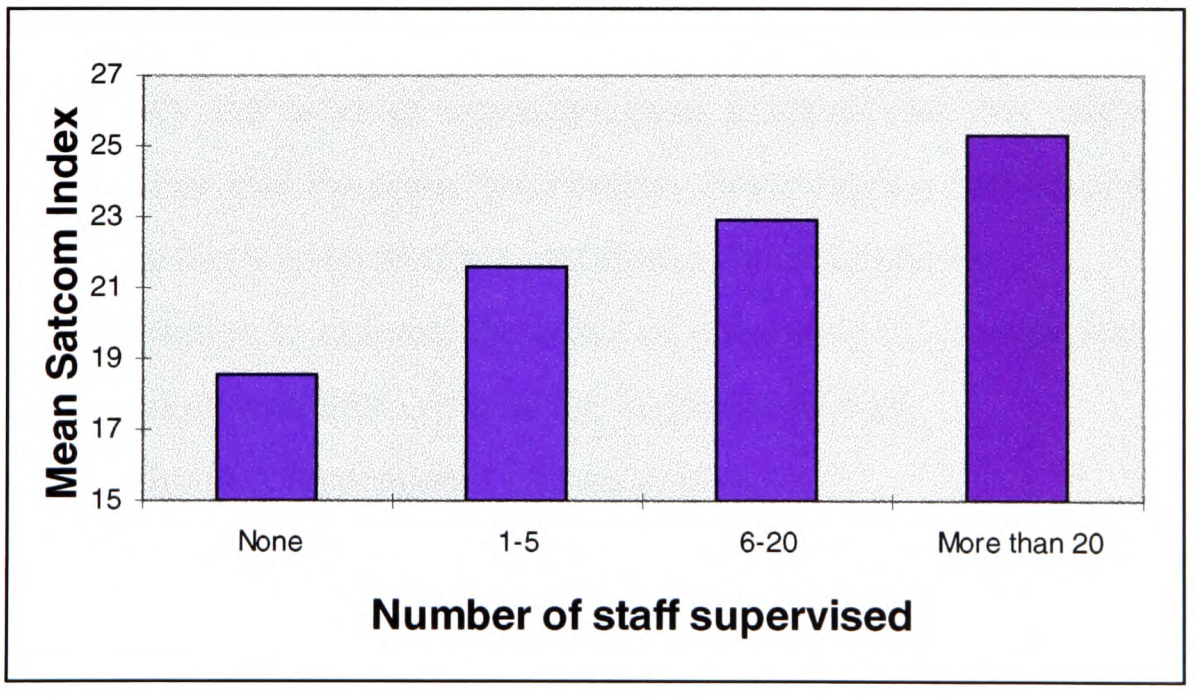
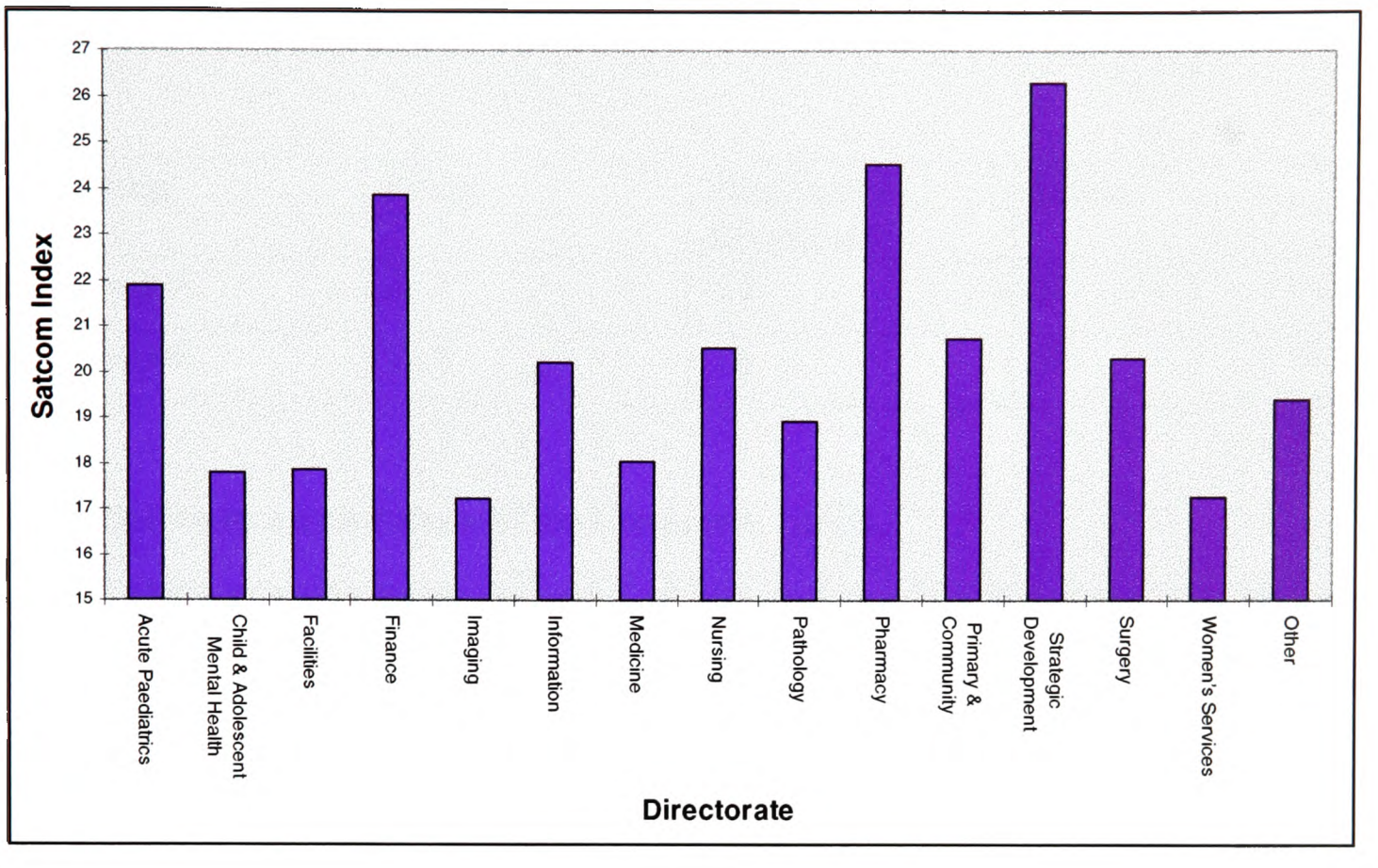


FIGURE 8.6: Mean *Satcom Index* by directorate



In comparing groups it should be noted that standard deviations for the mean Satcom indices are quite large. So the figures show a trend only and cannot be used to predict accurately the level of communication achieved for any one individual. However, it is clear that the more 'information disadvantaged individual tends to be older and is more likely to be working part-time in the community.

It is interesting to examine the effect of comparing those respondents with all the 'positive' factors with those with all the 'negative' factors.

(i) Group A respondents' characteristics:

Male, below 40 years of age working full- time in a hospital and supervising at least one member of staff.

(ii) Group B respondents' characteristics:

Female, at least 40 years old, working part-time in the community and supervising no one

As can be seen from Table 8.5, there is a very large difference between the two groups

TABLE 8.5: Mean values of the Satcom Index for Groups A and B

Group	Mean	Standard deviation	Cases
Group A	25.8	7.5	22
Group B	17.6	7.6	59

5 Variation in mean values of the Frequcom Index

There is a significant statistical relationship at much better than the .05 level between the Frequcom index for all the variables of sex, workplace, age group, employment, directorate and number of staff supervised. See Table 8.6.

TABLE 8.6: Significance and strengths of relationships between the independent variables and the Frequcom Index

Variable	F	Significance	Eta squared
Sex	16.56	.0001	.018
Work place	8.83	.0002	.019
Age group	11.20	.0000	.057
Employment	71.46	.0000	.071
Directorate	4.18	.0000	.061
Supervision	20.30	.0000	.064

Figures 8.7 - 8.12 show the mean Frequcom Indices for different groups. Source data for all graphs is given in Appendix I.

FIGURE 8.7: Mean *Frequcom Index* by sex

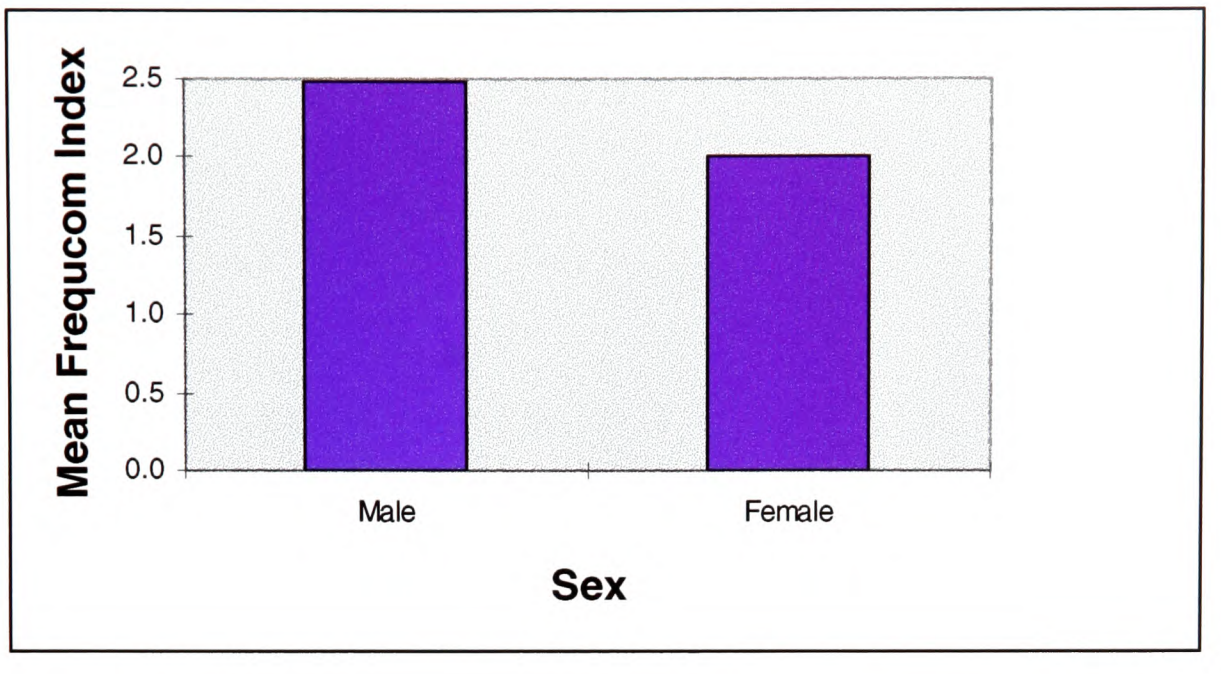


FIGURE 8.8: Mean *Frequcom Index* by age group

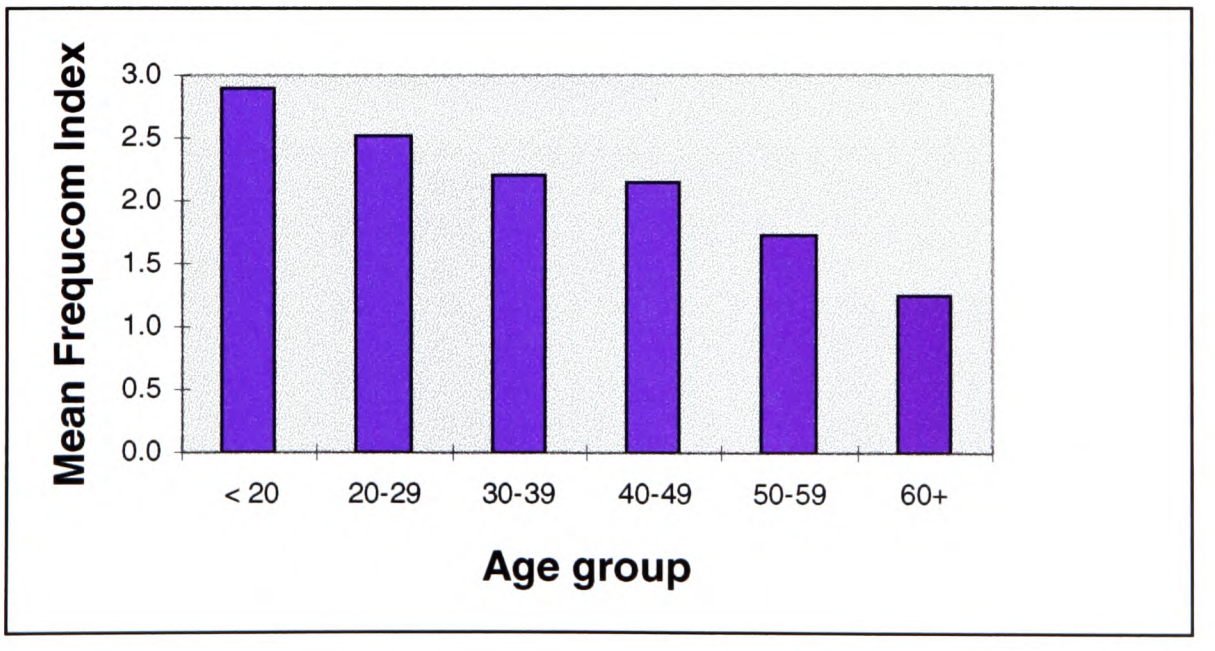


FIGURE 8.9: Mean *Frequcom Index* by workplace

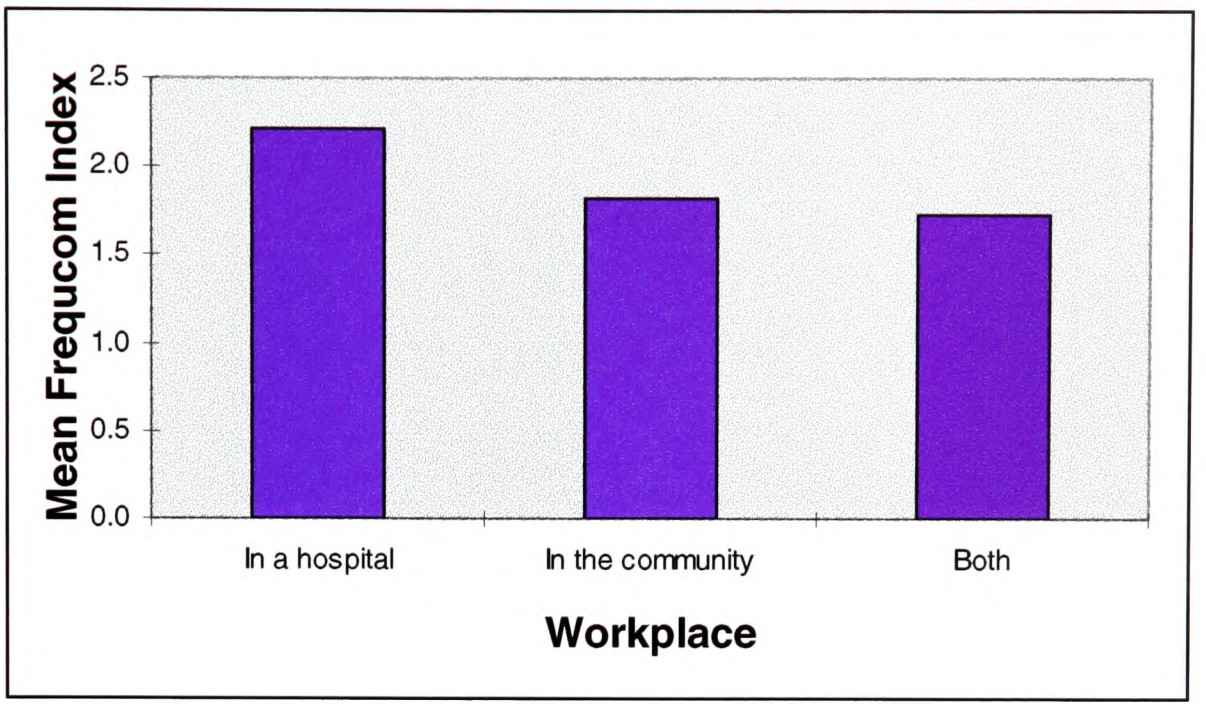


FIGURE 8.10: Mean *Frequcom Index* by type of employment

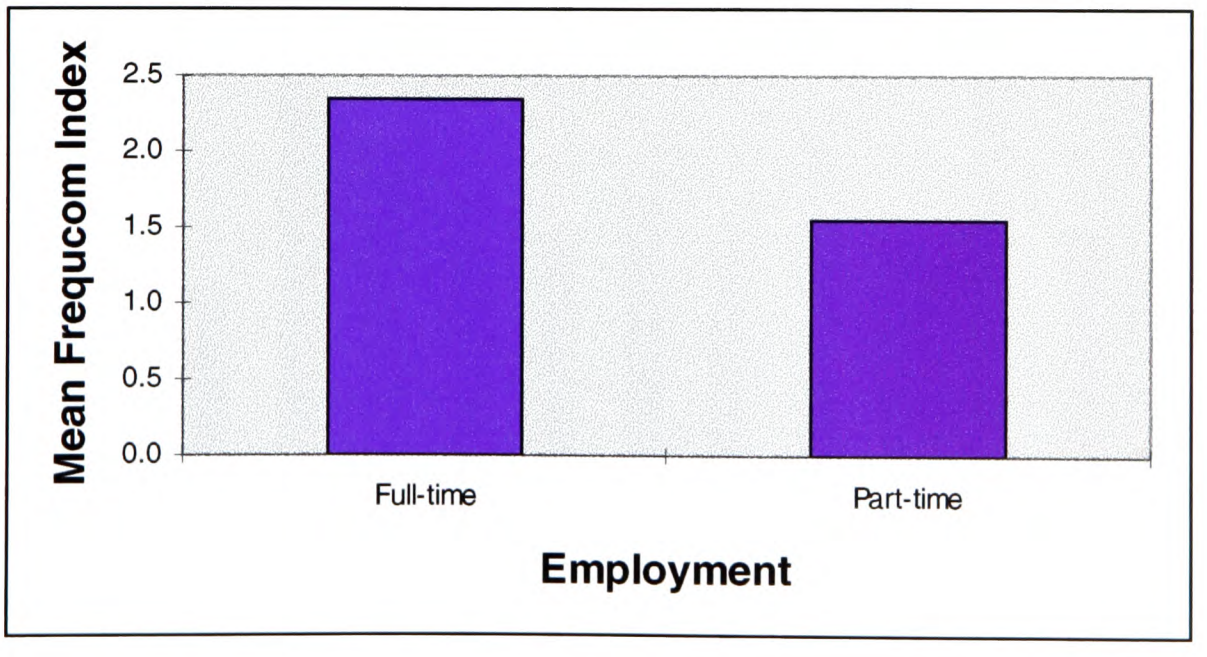


FIGURE 8.11: Mean *Frequcom Index* by numbers of staff supervised

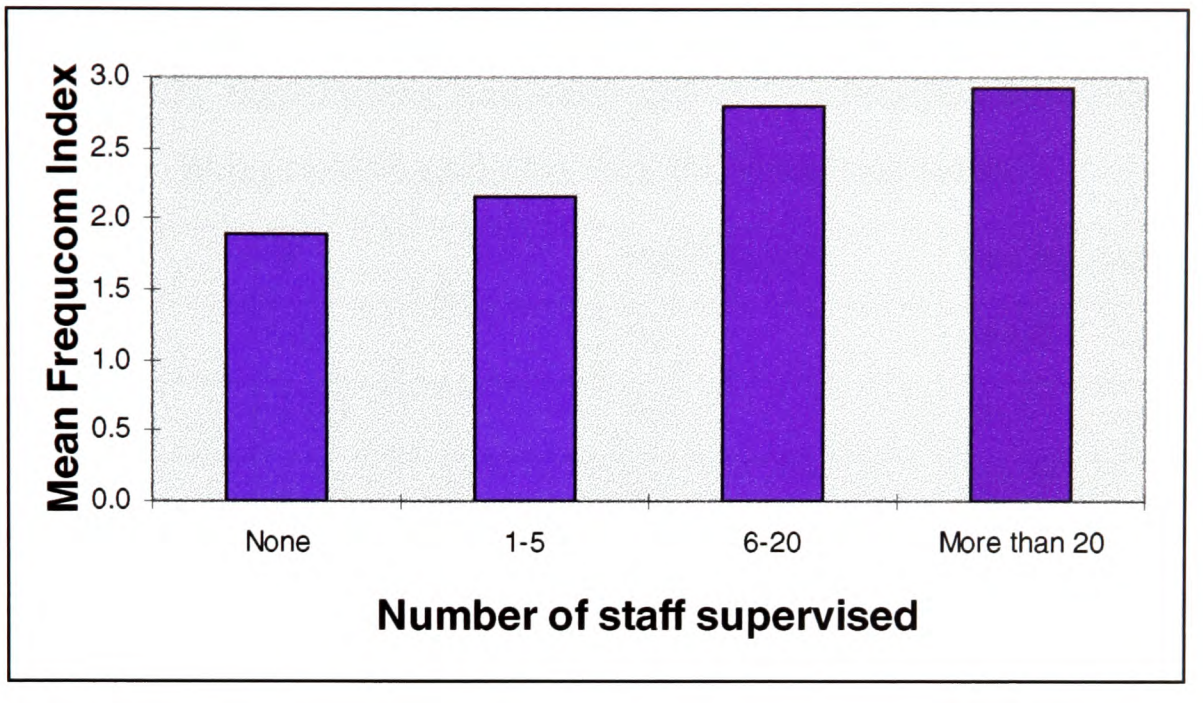
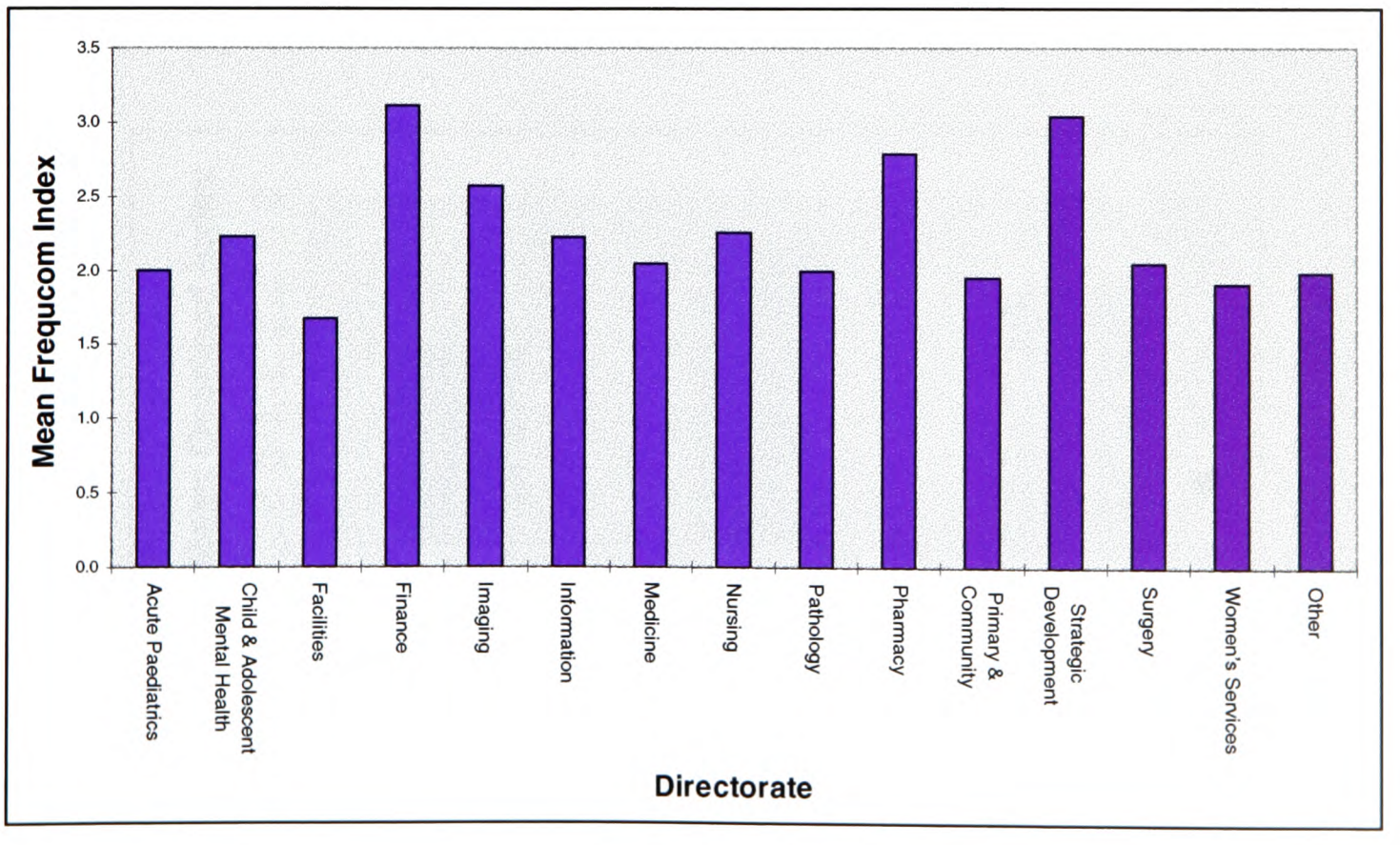


FIGURE 8.12: Mean *Frequcom Index* by directorate



6 Variation in mean values of the Overload Index

There was no statistically significant relationship between the mean Overload Index and employment and directorate. The index may be related to age group and sex, however standard deviations are wide. There is a clear correlation with workplace and level of supervision.

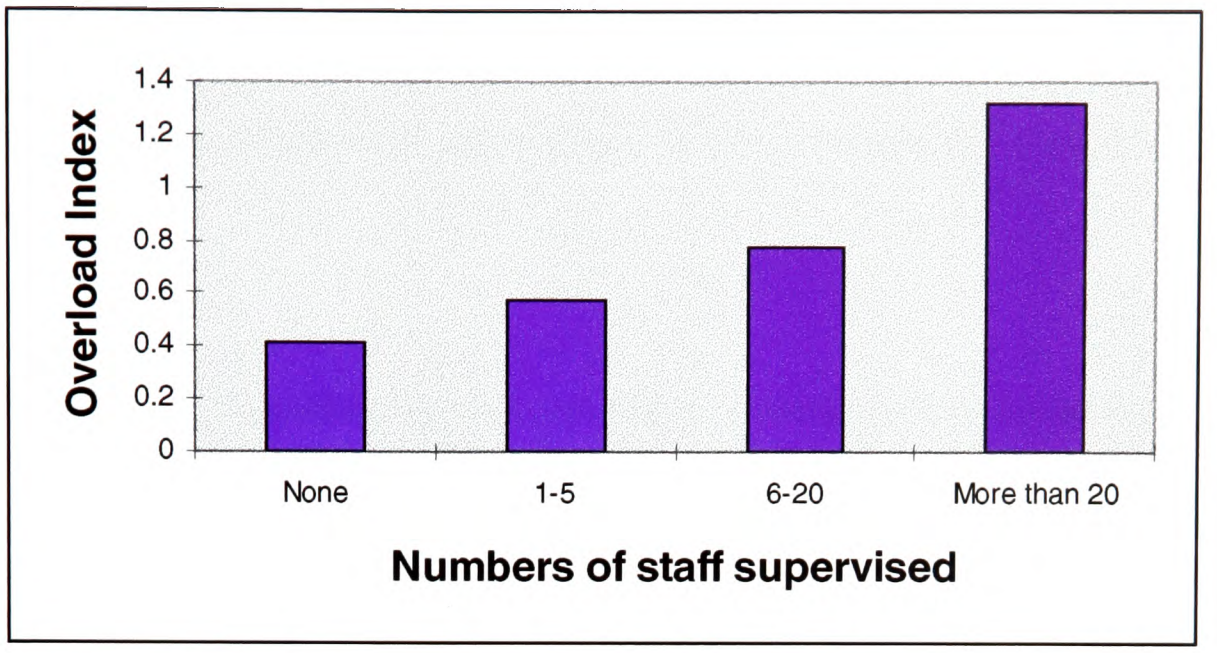
TABLE 8.7: Significance and strengths of relationships between the independent variables and the Overload Index

Variable	F	Significance	Eta squared
Employment	.23	.63	.0002
Directorate	1.00	.45	.015
Sex	2.52	.11	.0027
Age group	1.63	.15	.0088
Work place	3.80	.022	.0082
Supervision	12.13	.0000	.0392

Figures 8.13 - 8.14 show the mean Overload Indices for different categories of staff. Source data for all graphs is given in Appendix I.

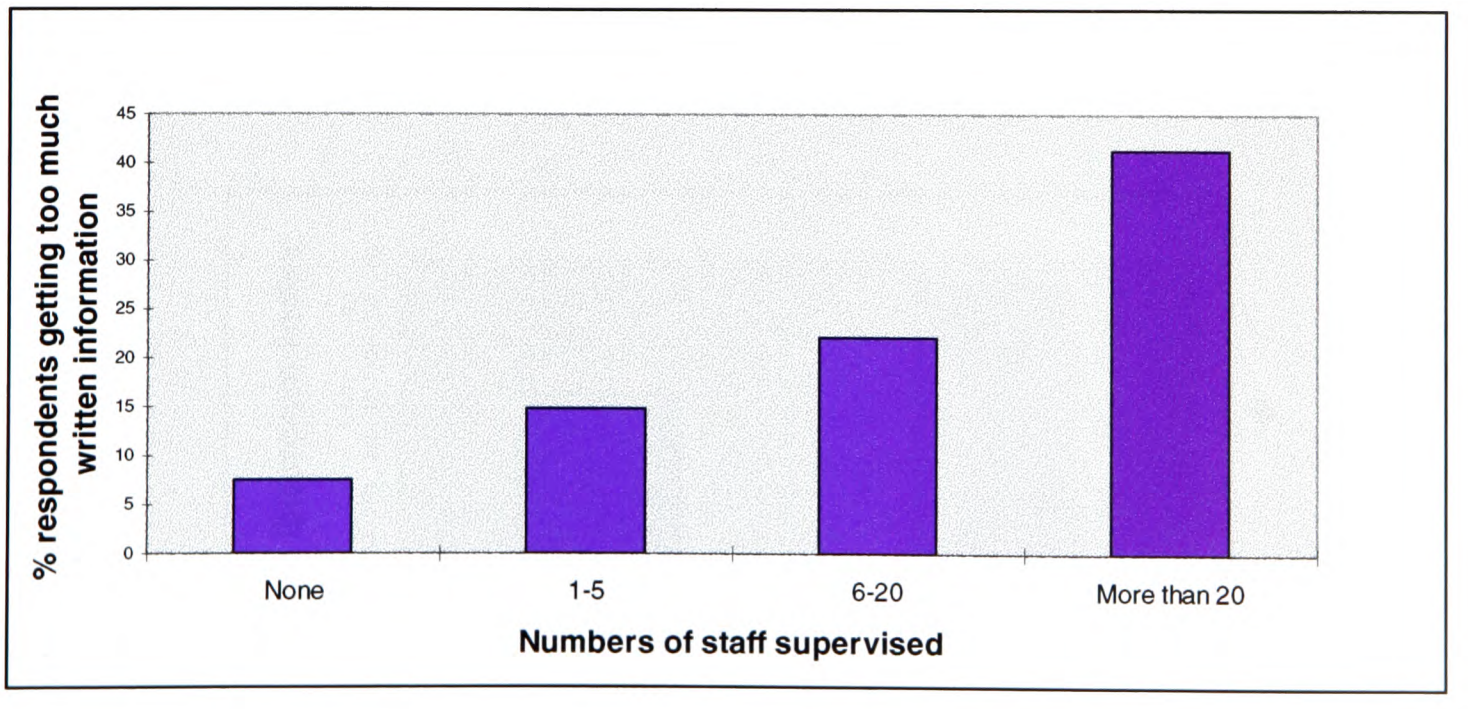
FIGURE 8.13: Mean *Overload Indices* by type of work place

FIGURE 8.14: Mean *Overload Indices* by numbers of staff supervised



Staff supervising higher numbers of staff seemed to suffer particularly from an overload of written information see Figure 8.15. Over 40 percent of respondents supervising more than 20 staff were affected.

FIGURE 8.15: Percentage of respondents getting too much written information vs. numbers of staff supervised



7 Variation in mean values of the Blankcom Index

There was no statistically significant relationship between the mean Blankcom index (a measure of communication failure) and sex, place of work and age. However there is a clear correlation with type of employment (part-time is higher), and an inverse correlation with level of supervision. There are noticeable variations between the directorates.

TABLE 8.8: Significance and strengths of relationships between the independent variables and the Blankcom Index

Variable	F	Significance	Eta squared
Sex	.27	.60	.0003
Work place	1.28	.28	.0028
Age group	1.91	.090	.010
Employment	17.14	.0000	.018
Directorate	2.77	.0005	.041
Supervision	19.91	.0000	.063

Figures 8.16 - 8.18 show the mean Blankcom Indices for different groups. Source data for all graphs is given in Appendix I.

FIGURE 8.16: Mean *Blankcom Index* by type of employment

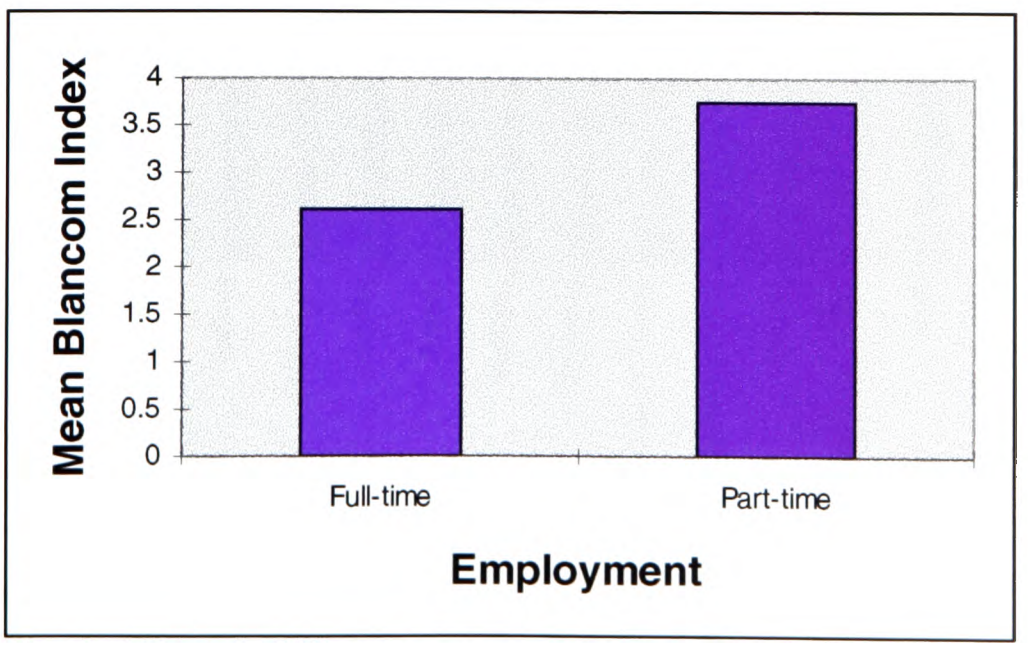


FIGURE 8.17: Mean *Blankcom Index* by numbers of staff supervised

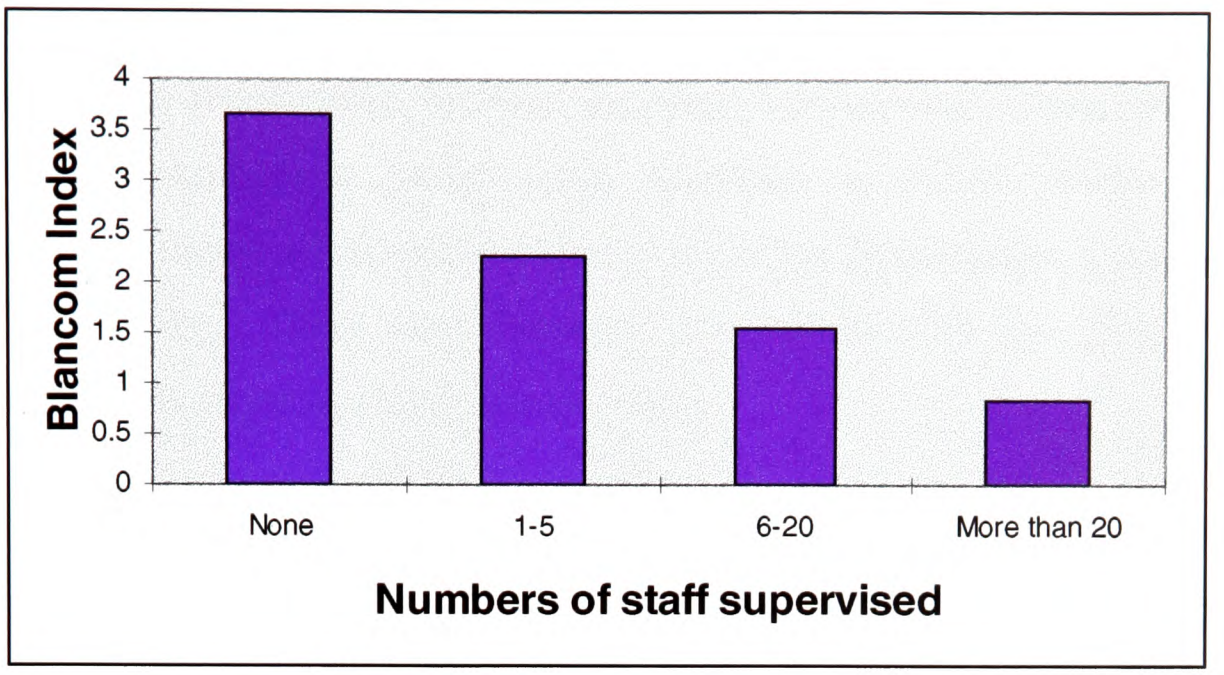
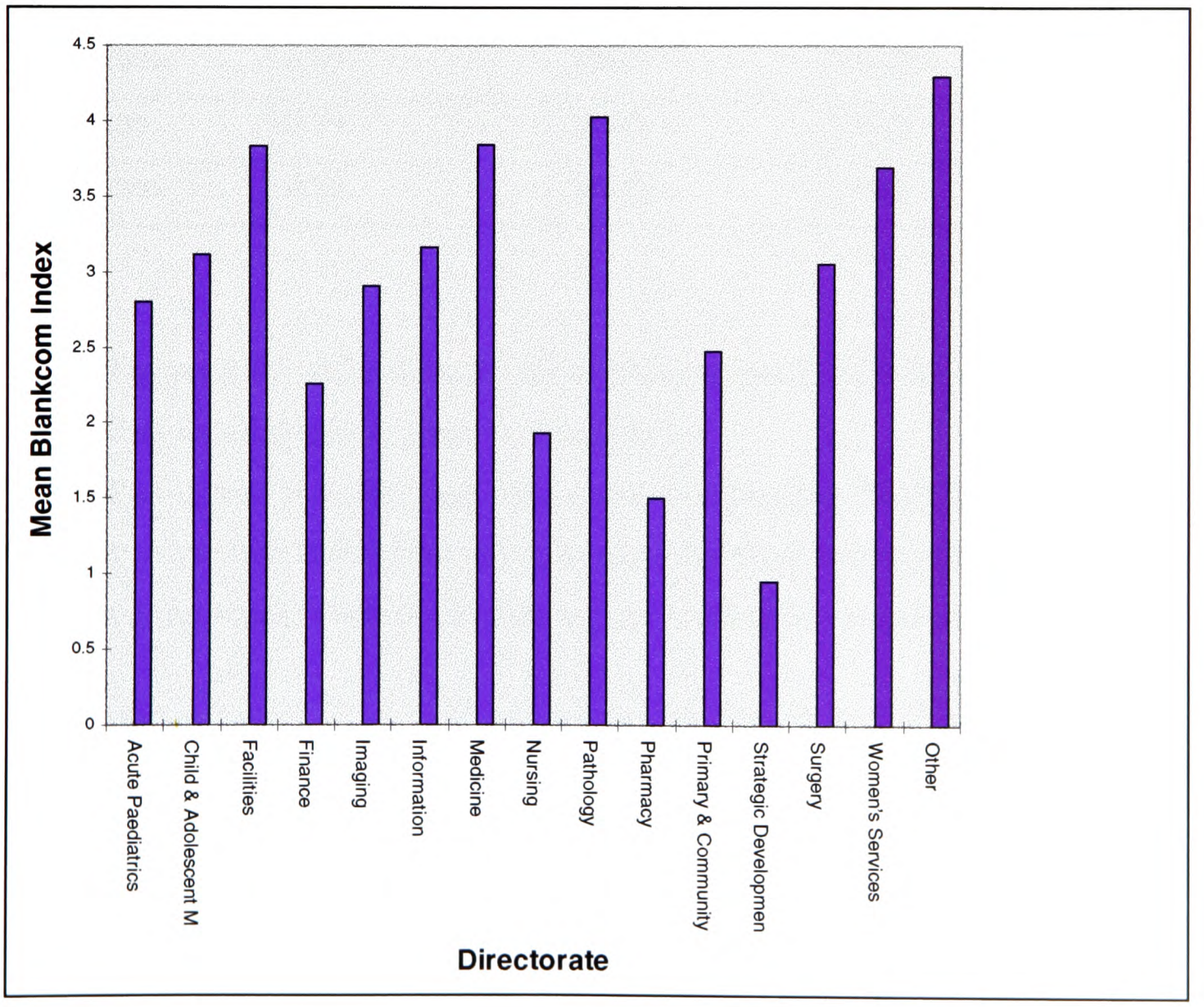


FIGURE 8.18: Mean *Blankcom Index* by directorate



8 Variation in mean values of the Nonresponse Count

Statistical relationships between the mean Nonresponse Count and different personal and employment factors were examined as before. There were no statistically significant relationships between the mean Nonresponse Count and sex and the workplace. There were, however, correlations with age group, type of employment, directorate and level of supervision.

TABLE 8.9: Significance and strengths of relationships between the independent variables and the Nonresponse Count

Variable	F	Significance	Eta squared
Work place	.018	.98	.0000
Sex	.16	.69	.0002
Employment	15.34	.0001	.016
Supervision	6.69	.0002	.022
Age group	5.79	.0000	.030
Directorate	4.23	.0000	.061

Figures 8.19 - 8.22 show the mean Nonresponse Counts for different groups. Source data for all graphs is given in Appendix I.

Part-timers and older staff were worse at responding. Staff supervising no-one were worse than supervisors of one or more and there were significant variations between directorates. Facilities had the highest level of non-responses.

FIGURE 8.19: Mean *Nonresponse Count* by age group

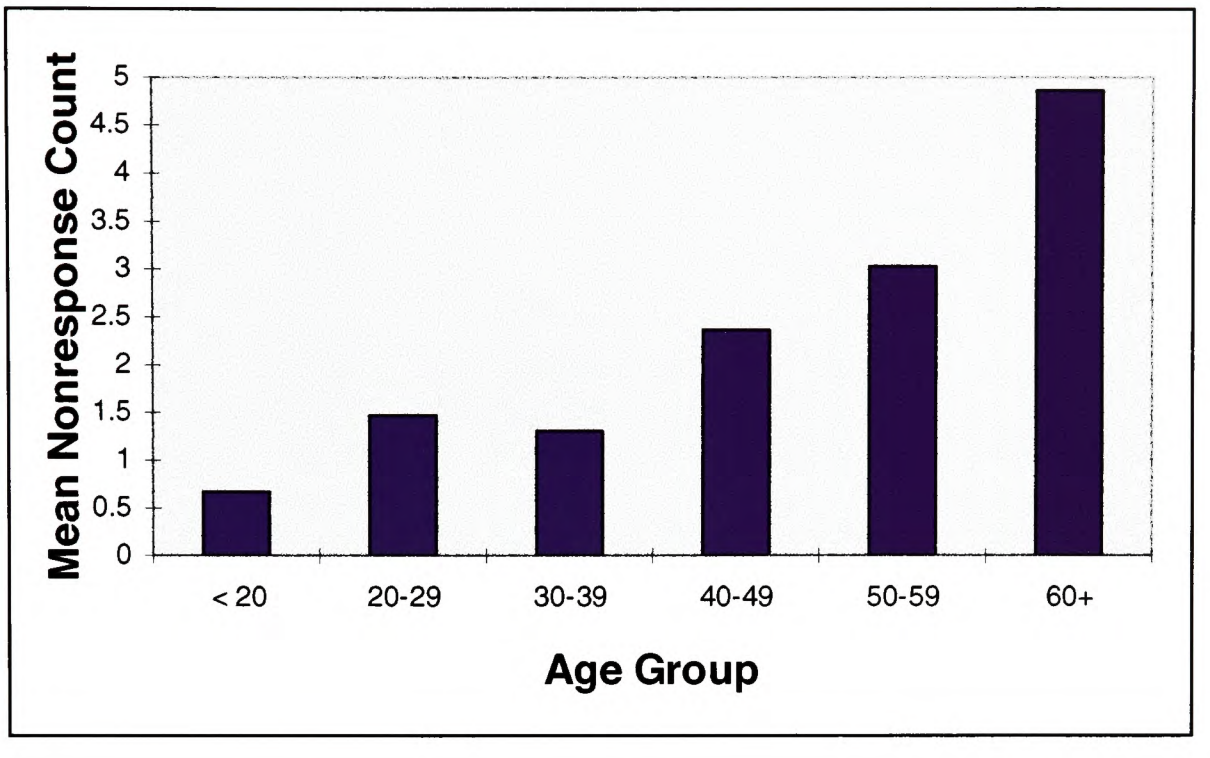


FIGURE 8.20: Mean *Nonresponse Count* by types of employment

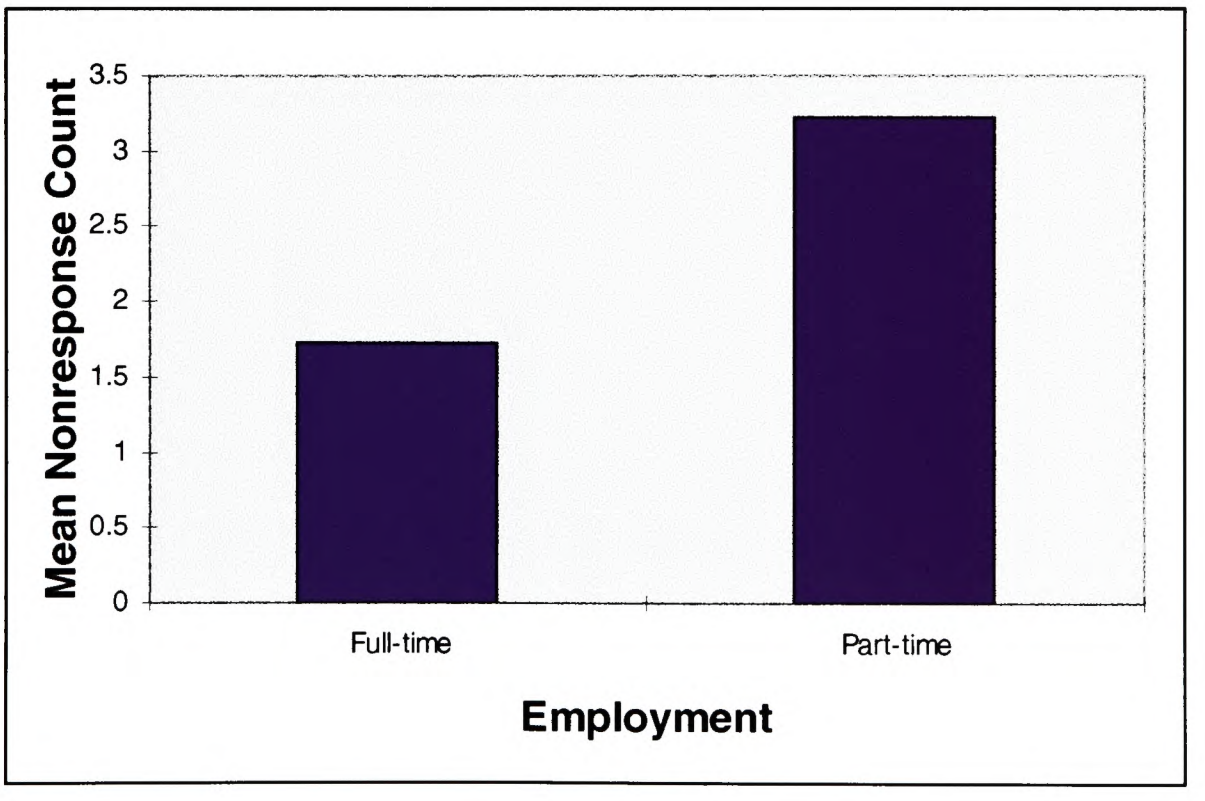


FIGURE 8.21: Mean *Nonresponse Count* by numbers of staff supervised

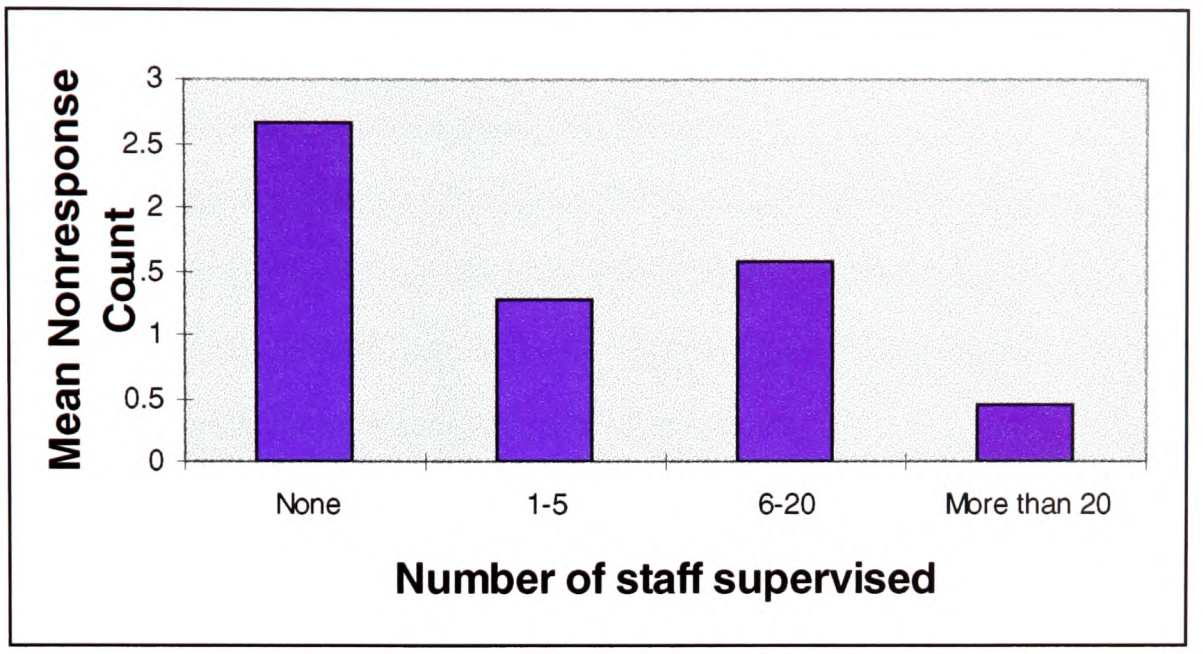
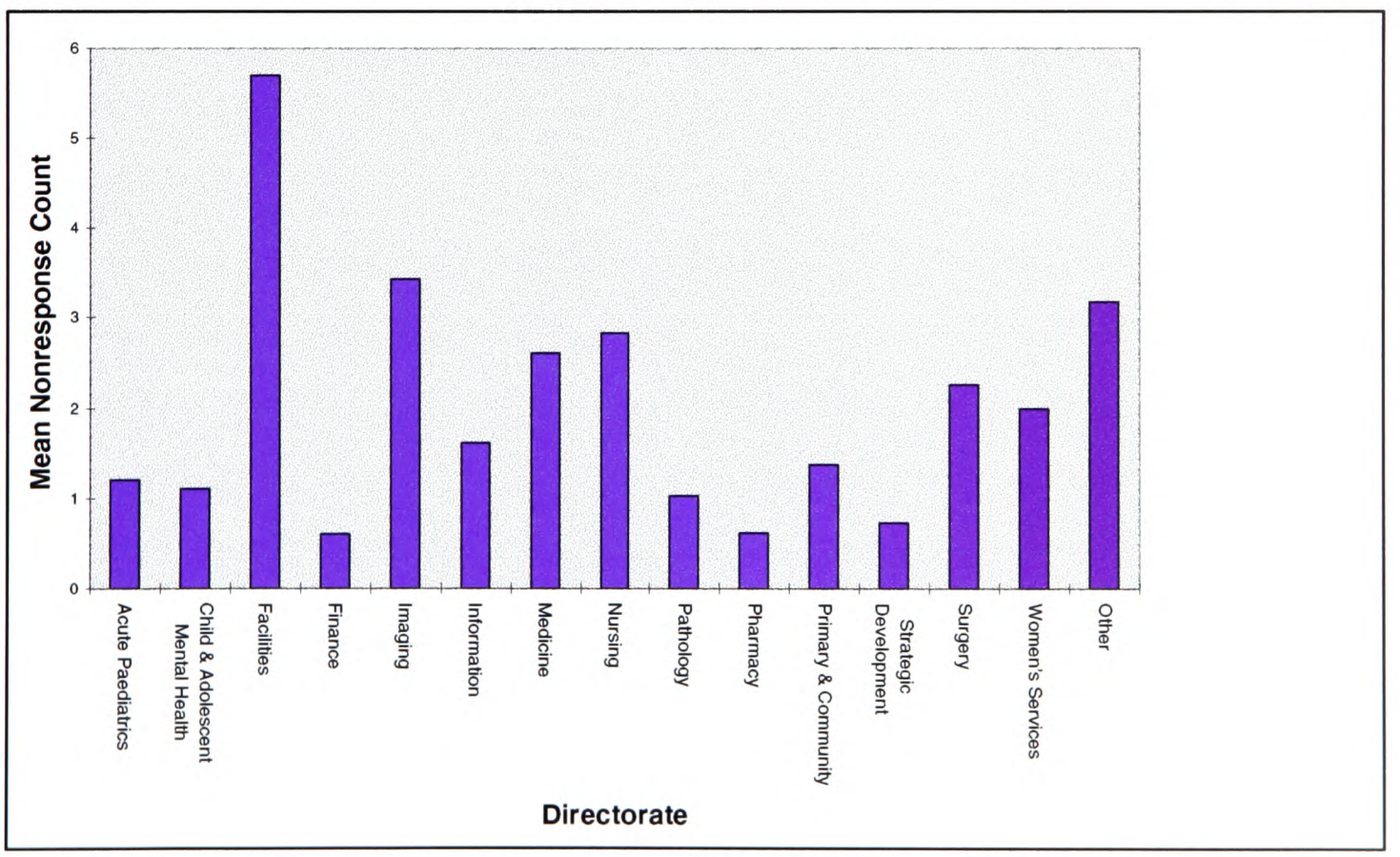


FIGURE 8.22: Mean *Nonresponse Count* by directorate



9 Conclusions

Indices have been developed to examine the effects of various demographic and employment variables on aspects of communication. Variables that affect the Satcom Index, a measure of overall communication level and satisfaction, include:

(i) Age: older lower values for Satcom.

(ii) Type of working: part-time lower values than for full-time.

(iii) Place of work: community lower values than for hospital.

(iv) Number of staff supervised: those supervising none lower values than for those supervising one or more.

(v) There are also noticeable directorate effects.

The number of staff supervised by respondents has a marked effect on their Overload Index a measure of information overload. (The more staff supervised the higher the Overload Index).

These effects are examined further in the next chapter where all the findings from the studies in this thesis are discussed.

CHAPTER 9

ASSESSMENT OF COMMUNICATIONS

1 Introduction

This chapter discusses the findings of the study. It describes the mechanisms of collaboration and feedback to Greenwich Heathcare NHS Trust (GHT) management and staff. The preliminary assessment of communications in GHT and Dartford Borough Council are compared. Groups of staff identified as 'communications disadvantaged' or 'communications advantaged' are examined for various aspects of communication, and the relationship between communication satisfaction and frequency and involvement with organisational goals is explored. Finally, some possible causes of communications problems are suggested.

2 Collaboration and communication

In an ideal world or organisation, people will receive and send just the information that they require in a timely way. It will not be unnecessarily duplicated. Staff will also feel involved and satisfied with their work. In the real organisation there are inevitable deficiencies. Management and staff need to be made aware of these and work together to improve the situation.

This study has been an interesting exercise in collaboration and communication in itself. The active participation of Greenwich Healthcare NHS Trust was motivated by a real desire on the part of the Trust to discover areas of strength and weakness and to put in place a mechanism to make improvements. This has involved the formation of a widely drawn group of Trust staff lead by the Director of Communications. This group worked with the author to develop a survey of internal communications for approximately 3000 permanent staff in the Trust. About a third of the questionnaires were returned, a good response for this type of survey.

Feedback is a key element of such an exercise. Following analysis of the survey results, two reports were produced for Trust management. A short report for all staff, highlighting key findings, was also given in the staff newspaper 'The Link'.

This collaborative study has enabled the discovery of strengths and

weaknesses in communication at GHT. The areas of weakness are being considered further and acted upon by the Communications Action Steering Group, again widely drawn from the Trust and containing some of the original Working Group staff. The members of the group were encouraged and motivated by an inaugural address by the Trust Chief Executive, emphasising the importance of their task. Details of the initial phases of this exercise are given in Chapter 10.

3 Comparison of two organisations

The preliminary assessment of communication in GHT and in the smaller DBC study highlighted some similarities and differences, see Table 9.1. The two organisations are very different in size and scale of operations. GHT is a medium sized Trust with approximately 3000 staff located on many sites with all the problems that imposes. DBC is a much smaller organisation of about 300 staff mostly located on one site. However, they share some common problems. Management of information relies on different departments having different systems with a mixture of paper and electronic methods. DBC does have a networked computer system, which allows for internal communication by e-mail. Unfortunately not every one uses it!

Director level staff in both organisations are kept well informed by regular meetings. Informing staff of general matters in both organisations is by the team briefing method. However, in both organisations the briefing does not get to everyone and feedback is a problem. It is known from other studies (Barber, 1998) that cascading messages can lose their power. Simon, (1976), stated that:

> *" Decisions reached in the highest ranks of the organisation hierarchy will have no effect on the activities of operative employees unless they are communicated downwards".*

There is a problem of visibility and availability of management. This is exacerbated in GHT by the separate sites and in DBC by the location of directors together on the 'top floor'. Staff from both organisations have suggested that there should be more 'walking the patch'. However Ansbary and Staples, (1991), have suggested that this may be interpreted as a form of snooping. It might therefore under certain circumstances be counterproductive. Nevertheless there is a clear need for more interaction with managers.

TABLE 9.1: Comparison of DBC and GHT(as of 1997)

	Greenwich Healthcare NHS Trust	**Dartford Borough Council**
Location	3000 people on many sites	300 people mostly on one site
Information Handling and Technology	Each directorate has own system - mixture of paper and electronic systems. Computers not generally networked. Common tools Trendstar and HISS. No e-mail (in 1997)	Departments mostly have their own paper filing system IT managed centrally. Computers mostly networked. Internal e-mail but not used by everyone
Executive liaison	Weekly meeting for CE and executive directors	Weekly Management Team meeting for Chief Executive and directors.
Staff Briefing	Team briefing system Occasional CE large meetings Staff newspaper	Team briefing system Special briefings Staff newspaper Staff Consultative Group monthly meeting
Social interaction	Little among directors	Some between directors/divisional heads
Problem areas	Lack of IT Visibility of management Information overload Middle management communication Interdepartmental communication Team briefing system not working at all levels	More training needed on IT Visibility of management Planning decisions not being communicated to work level Lack of direction of policy Weak Staff Consultative Group Team briefing system not working at all levels

GDH has difficulties of interdepartmental communication and DBC has problems where planning aspects are not getting down to the work floor, with the result that that staff may continue work on redundant projects.

Social interaction, at least between executive level staff, seems greater at DBC than GHT.

4 Particular strengths and weaknesses at Greenwich Healthcare

The survey at GHT highlighted the staff's awareness of the need for good communication. Almost two thirds of respondents recognised, unprompted, that communication was a personal responsibility for everyone. This is an important finding and should be utilised in building and improving communication in the Trust. The great majority of staff felt they were able to communicate with others. Communication was generally good between fellow workers in their own department.

However, the survey confirmed weaknesses in interdepartmental communication, the team briefing system and visibility and approachability of management. Information about changes also needs to be improved. as well as improvements to the internal post and telephone systems. Information was often obtained from the grapevine or local press. Respondents expressed a strong need for better information technology, particularly e-mail. and for more staff meetings.

5 Communication disadvantaged groups

In any but the most perfect organisation there will exist a number of people that are information or communications disadvantaged. The senior manager, usually well guarded by their secretary, who consider themselves too grand to have a computer on their desk - or never turn it on, have imposed their own barriers. The night cleaner with learning difficulties who is told nothing apart from simple job instructions, has the barriers ranged against them.

The disadvantaged may be isolates - individuals who are relatively unconnected to the system. They tend to withhold information rather than facilitate its flow. They perceive the communication system to be closed to them and are relatively dissatisfied with the system. (Goldhaber et al,1978).

A key aspect of this work has been the identification of certain groups or categories of staff who are communication disadvantaged (or advantaged). This can take various forms. The group may be receiving more or less information than they need or indeed none at all. It may be coming too late. They may frequently be getting the same or similar information from various official or unofficial sources. This wastes time and leads to confusion when there are inaccuracies. The disadvantaged individual may consequently feel particularly uninvolved, worried and dissatisfied.

In order to identify such groups four new communication indices have been developed (see Chapter 8), to provide overall measures of:

(i) Good communication: where communication is happening often enough and there is satisfaction: the *Satcom Index.*

(ii) Frequency of communication: the *Frequcom Index* (a subset of Satcom).

(iii) Too much information received or sent: the *Overload Index.*

(iv) Communication failure, where zero information is transmitted or received, or there is complete dissatisfaction: the *Blankcom Index.*

In addition the total *Nonresponse Count* for communication questions has also been measured

Analysis of the questionnaire has identified some disadvantaged categories. They include older staff, part-timers, staff who mainly work in the community and members of certain directorates. Females though forming the majority of respondents are also slightly disadvantaged compared to males but this may be due to such factors as more part-time working.

Review of the comments from respondents has also revealed further problem groups including include Bank staff [16] and night staff.

The Communications Action group identified some additional categories of more isolated staff working in or with the Trust. These included volunteers, students, social services, GPs and practice staff.

In this section certain categories of staff are examined in more detail.

[16] Bank staff are employed temporarily to fill vacancies or special requirements. These staff were not themselves surveyed for logistical reasons.

5.1 Older staff

Table 9.2 shows the clear correlation between increase in age group, with decreases in the Satcom and Frequcom Indices and increases in the Nonresponse Count. This is surprising as it might be anticipated that younger, less experienced employees would be communication disadvantaged. Indeed a study by Tourish (1996) on 62 nurses and their managers in a clinical directorate of a major hospital showed a lower percentage of younger staff under 30 were satisfied with communication compared with the over 40s. The lower Nonresponse Count for younger staff might reflect more familiarity with form filling and surveys, or less cynicism about the influence of such surveys.

Differences in the Blankcom and Overload indices are not statistically highly significant.

TABLE 9.2: A comparison of communication indices for staff of different age groups

Age Group	**>20**	**20-29**	**30-39**	**40-49**	**50-59**	**60+**
Percent (of total responses)	1%	16%	29%	27%	21%	6%
Mean Satcom Index	21.6	21.6	20.4	20.5	18.6	18.1
Mean Frequcom Index	2.9	2.5	2.2	2.2	1.7	1.6
Mean Nonresponse Count	0.7	1.5	1.3	2.4	3.0	4.9

5.2 Part-time staff

About 32% of the staff responding to the survey were employed part-time. Mean communication indices compared with full-time workers are shown in Table 9.3.

TABLE 9.3: A comparison of communication indices for part and full-time staff

Employment	Part-time	Full-time
Mean Satcom Index	18.0	21.0
Mean Frequcom Index	1.6	2.3
Mean Blankcom Index	3.7	2.6
Mean Nonresponse Count	3.2	1.7

Part-time working appears to be an important factor for all aspects of communication studied. In addition to having a lower overall level of communication (Satcom Index), Part-time staff ask for information from someone else less often (Frequcom Index). Instances of communication are more likely to occur (Blankcom Index). They also responded to less of the communication questions (Nonresponse Count). Information overload is not significantly different between the two groups and has not been included in the table.

5.3 Staff working in the community

About 29% of respondents gave their main place of work as the community, 69% work in a hospital and 2% in both. Mean communication indices for community compared with hospital staff are shown in Table 9.4

TABLE 9.4: A comparison of communication indices for community and hospital staff

Main Workplace	Community	Hospital
Mean Satcom Index	19.2	20.5
Mean Frequcom Index	1.8	2.2
Mean Overload Index	0.7	0.5

Community workers are somewhat disadvantaged. However the differences between community and hospital workers are smaller than those of part-time and full-time workers. Only differences in the Satcom, Frequcom and Overload Indices are statistically very significant. Surprisingly the mean Overload Index is higher for the community staff but the difference is relatively small.

5.4 Directorates

The percentages of respondents from each directorate are listed in Table 9.5 together with the mean communication indices. The differences between the mean Overload Indices are not statistically significant and are therefore not included

TABLE 9.5: A comparison of communication indices for the different directorates

Category (Directorate)	Percent (of responses)	Mean Satcom Index	Mean Frequcom Index	Mean Blankcom Index	Mean Nonresponse Count
All Respondents giving directorate	100%	20.1	2.1	3.0	2.1
Acute Paediatrics	3.8%	21.9	2.0	2.8	1.2
Child & Adolescent Mental Health	1.0%	17.8	2.2	3.1	1.1
Facilities	8.3%	17.9	1.7	3.8	5.7
Finance	4.7%	23.8	3.1	2.3	0.6
Imaging	2.5%	17.2	2.6	2.9	3.4
Information	3.9%	20.2	2.2	3.2	1.6
Medicine	8.7%	18.1	2.1	3.8	2.6
Nursing	6.4%	20.5	2.3	1.9	2.8
Pathology	3.9%	18.9	2.0	4.0	1.0
Pharmacy	2.6%	24.5	2.8	1.5	0.6
Primary & Community	30.8%	20.8	2.0	2.5	1.4
Strategic Development	2.4%	26.3	3.1	1.0	0.7
Surgery	9.1%	20.3	2.1	3.1	2.3
Women's Services	6.1%	17.3	1.9	3.7	2.0
Other	5.9%	19.4	2.0	4.3	3.2

The lowest average *Satcom Indices*, all less than 18, were given by Imaging,

Women's Services, Child and Adolescent Mental Health and Facilities. Highest were given by Finance, Pharmacy and Strategic Development.

The characteristics of the weakest directorates for overall communication level (Satcom Index) were examined to try and determine any contributory factors. To assist in this examination, and also determine any specific areas of strength or weakness, responses from all the directorates were analysed for *Satcom Average Deviation* as described in Chapter 8 Section 2. This measures deviations from the average response on a question by question basis. Tables 9.6 and 9.7 list questions for each directorate where the percent deviation was at least + 20% or – 20% respectively.

Imaging is quite a small directorate with a total headcount of 101. All respondents worked in a hospital and 78% of them worked full time. None of which were features that would specifically result in disadvantage. However, response rate to the survey was less than average (23%) and this directorate was weak on change information, briefing and information by telephone.

Child and Adolescent Mental Health was a very small directorate of 18. Response rate was good (50%). All respondents worked in the community and a high proportion were part-time, which may partly explain the low Satcom Index. It also appears that they have a problem with timeliness of information.

Women's Services is a medium sized directorate of 186. The response rate was about average at 30%. Half of the respondents were part-time and 71% worked in a hospital. Weaknesses included lack of information from meetings and interestingly 14 % said that they were giving too much information by reporting what they were doing in their job to their manager.

Facilities is a relatively large directorate of 302. The response rate was below average at 25%. Respondents from Facilities were older than average, with 75% over 40. The majority worked full-time in a hospital.

It is clear that demographic or employment aspects are only some of the factors influencing the Satcom Index. Further study is needed to determine other major influences.

TABLE 9.6: Strengths in directorates

Directorate	Question No	Question	% deviation from average, +ve
Acute Paediatrics		Is information coming to you at the right time from:	
	20	- The manager or supervisor you directly report to	23
	21	- Managers other than your direct supervisor	20
	47	Who do you think is responsible for communications	20
Finance		How often do you ask for information from:	
	10	- Fellow workers in your own department	21
	11	- The manager or supervisor you directly report to	21
	12	- Managers other than your direct supervisor	31
	13	- People in other departments	29
Imaging		How often do you ask for information from	21
	10	- A fellow worker in your own department	
Pharmacy	12, 21, 24, 28, 29, 37, 39, 41, 45, 48	Too many to list. Highest were information got by team briefing (deviation 31%) and information given on changes in own department (deviation 31%)	All 20+
Strategic Development	16, 17, 21, 22, 25, 30, 38, 40, 41, 45, 48, 49	Too many to list. Highest - consulted about changes that affect your job (deviation 37%)	All 20+

No great strengths were found for the following directorates: Child & Adolescent Mental Health, Facilities, Information, Medicine, Nursing, Pathology, Primary and Community Care, Surgery, Women's Services.

TABLE 9.7: Weaknesses in directorates

Directorate	Question No	Question	% deviation from average, -ve
Child & Adolescent Mental Health		How often do you ask for information from	
	13	- Someone in another department *No one asked daily*	-22
		Is information coming to you at the right time from:	
	19	- Fellow workers in your own department	-46
	20	- The manager or supervisor you directly report to	-20
	22	- People in other departments	-30
		How much information do you get by the following methods	
	30	- The Link Newspaper	-23
	31	- The Yellow Bulletin	-28
		How much information is being given to you on:	
	38	- How your job fits into the total operation of the department	-38
	39	- Changes in your department	-30
Imaging		Is information coming to you at the right time from:	
	19	- Fellow workers in your own department	-21
		How much information do you get by the following methods;	
	25	- Telephone calls *24% got no info. by telephone*	-32
	29	- Team briefing	-25
		How much information is being given to you on:	
	39	- Changes in your department	-27
		How often are these statements true:	
	45	- You are consulted about changes that effect your job	-29

TABLE 9.7(cont.): Weaknesses in directorates

Directorate	Question No	Question	% deviation from average, -ve
Facilities	47	Who do you think is responsible for communications	-30
Finance	47	Who do you think is responsible for communications	-23
Information	29	How much information do you get by the following methods; - Team briefing *49% got no information by team briefing*	-25
Pathology	20	Is information coming to you at the right time from: - The manager or supervisor you directly report to	-26
	25	How much information do you get by the following methods; - Telephone calls *23% got no information by telephone*	-24
Women's Services	24	How much information do you get by the following methods:- Meetings	-23
	35	How much information do you give to others by: - Reporting what you are doing in your job to your manager or supervisor. *14% answered 'too much'*	-21
	41	How much information is being given to you on: -The issues regarding the Queen Elizabeth Hospital	-27

No great weaknesses found for the following directorates: Acute Paediatrics, Medicine, Nursing, Pharmacy, Primary and Community Care, Strategic Development, Surgery.

Apart from 'Other'(which is anomalous)[17] Pathology, Medicine and Facilities have the highest mean *Blankcom Indices* a measure of communication failure. Strategic Development has the lowest. Table 9.8 lists some specific instances of communication failure where a directorate is more than 10% worse than average. Information, Nursing, Pharmacy, Primary and Community Care, Strategic Development and Surgery were not more than 10% worse than average for any question and are not included in the table.

TABLE 9.8: Specific instances of communications failure for directorates

Directorate	Response	
Acute Paediatrics	27%	never asked for information from a manager other than their direct supervisor
	20%	never asked for information from other departments
	53%	got no information by fax
Child & Adolescent Mental Health	22%	got no information by telephone
	25%	got no information from the Yellow Bulletin
	25%	given no information about issues regarding the QE Hospital
Facilities	26%	never asked for information from other departments
	28%	got no information from other departments
Finance	29%	got no information from meetings
Imaging	24%	got no information by telephone
	25%	got no information on how their job fitted into the total operation of the department
	25%	never consulted on changes that affect their job
	40%	given no information on changes in other departments
Medicine	22%	got no information from meetings
Pathology	23%	got no information by telephone
	20%	given no information about issues regarding the QE Hospital
	23%	never consulted on changes that affect their job
Women's Services	24%	given no information about issues regarding the QE Hospital

[17] 'Other' will include non executive directors who do not have the normal lines of communication It will also include staff who did not know which directorate they belonged to!

Facilities had a particularly high *Nonresponse Count* of 5.7. Only 40% from this directorate answered all the communication questions (tick-box). This compares with an average of 58% for all respondents. It was noticed that some staff only marked up a small seemingly random selection of the tick boxes, possibly indicating a lack of understanding of the questions.

6 Communication advantaged staff

Some groups of staff were found to be particularly 'communication advantaged' these include full-time workers in a hospital who supervise at least one other staff member and, not surprisingly, Trust Managers.

There were relatively strong correlations between the numbers of staff supervised and the all the communication indices. However, it was also interesting to note the increase of information overload with increasing numbers supervised. This is particularly noticeable with staff supervising more than 20. See also Chapter 8 Section 6.

TABLE 9.9: A comparison of communication indices for different numbers of staff supervised.

Number of Staff supervised	None*	1-5	6-20	>20
Percent of all giving supervision level	59.1%	24.1%	8.4%	8.4%
Mean Satcom Index	18.6	21.6	23.0	25.2
Mean Frequcom Index	1.9	2.2	2.8	2.9
Mean Overload Index	.4	.6	.8	1.3
Mean Blankcom Index	3.7	2.3	1.6	0.9
Mean Nonresponse Count	2.7	1.3	1.6	0.5

*Respondents replying 'non applicable' were counted as supervising none

The respondents from the Finance and Strategic Development[18] directorates also had good average Index scores, see Table 9.5. It should be noted that the type of work

[18] The Strategic Development directorate includes the personnel function, see Figure 6.1.

that these directorates handle is likely to require a higher than average level of communication. Good scores were also achieved by Pharmacy, which was strong in most areas, particularly team briefing and information on changes. Respondents from this directorate were comparatively young (71% under 40) and 65% supervised one or more staff.

7 Involvement

If individuals feel they are achieving and involved they are more likely to be satisfied with their jobs and be able to contribute to the goals of the department However some staff require reassurance. Clearly they need good communication with their manager and feedback on their performance.

The survey questions 42 - 46 asked how often various statements were true, topics covered were:

(i) Satisfaction with the way job is done.

(ii) Communication with others.

(iii) Discussions with the manager.

(iv) Consultation about changes that affect the respondent's job.

(v) Playing a part in the accomplishment of goals of the department.

These are all aspects that might be expected to influence the respondent's degree of involvement with the organisation.

Figures 9.1 - 9.5 illustrate the relationship between the categories of response on these aspects and the mean *Satcom index* for all staff giving that particular response

The results appear to confirm the hypothesis that there is a positive correlation between good communication (as measured by the Satcom Index) and staff's involvement with the organisation.

FIGURE 9.1: How often true respondents satisfied about the way they do their job

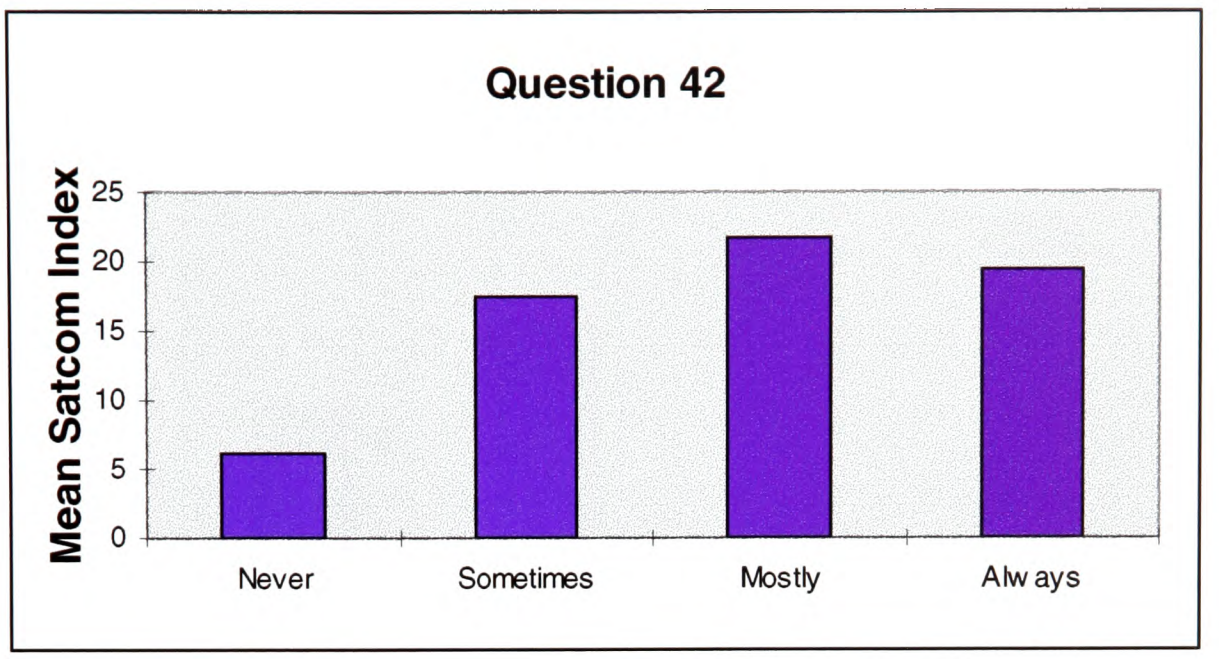


FIGURE 9.2: How often true respondents are able to communicate with others.

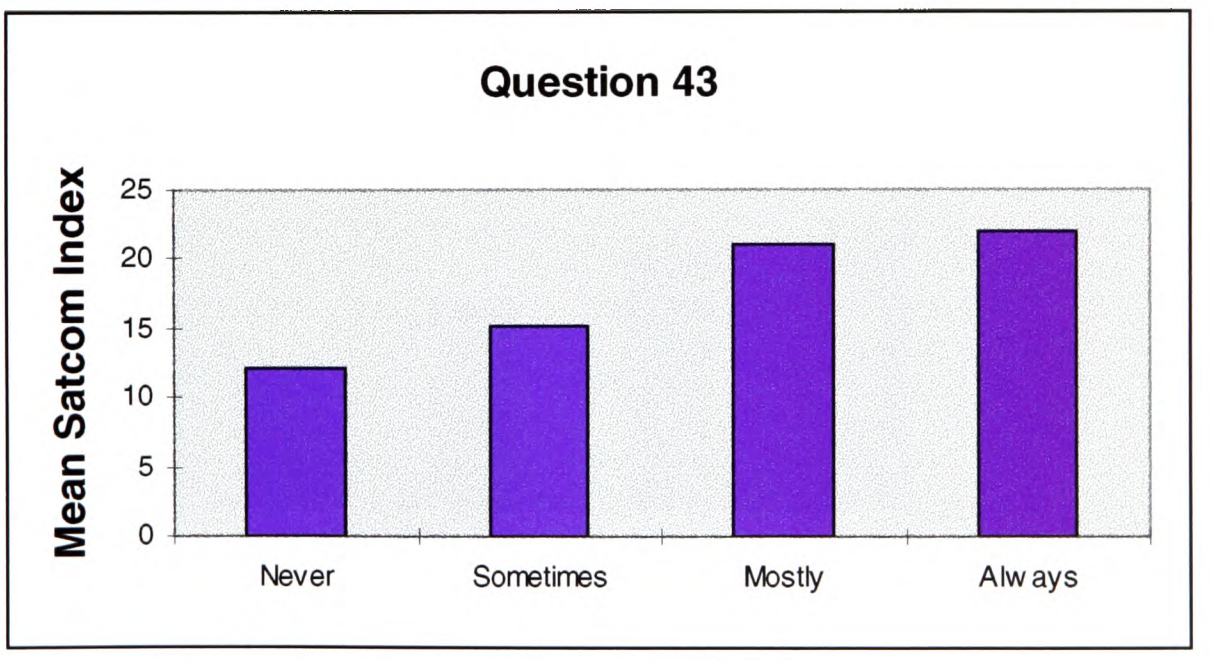


FIGURE 9.3: How often true respondents can discuss things with their manager or supervisor

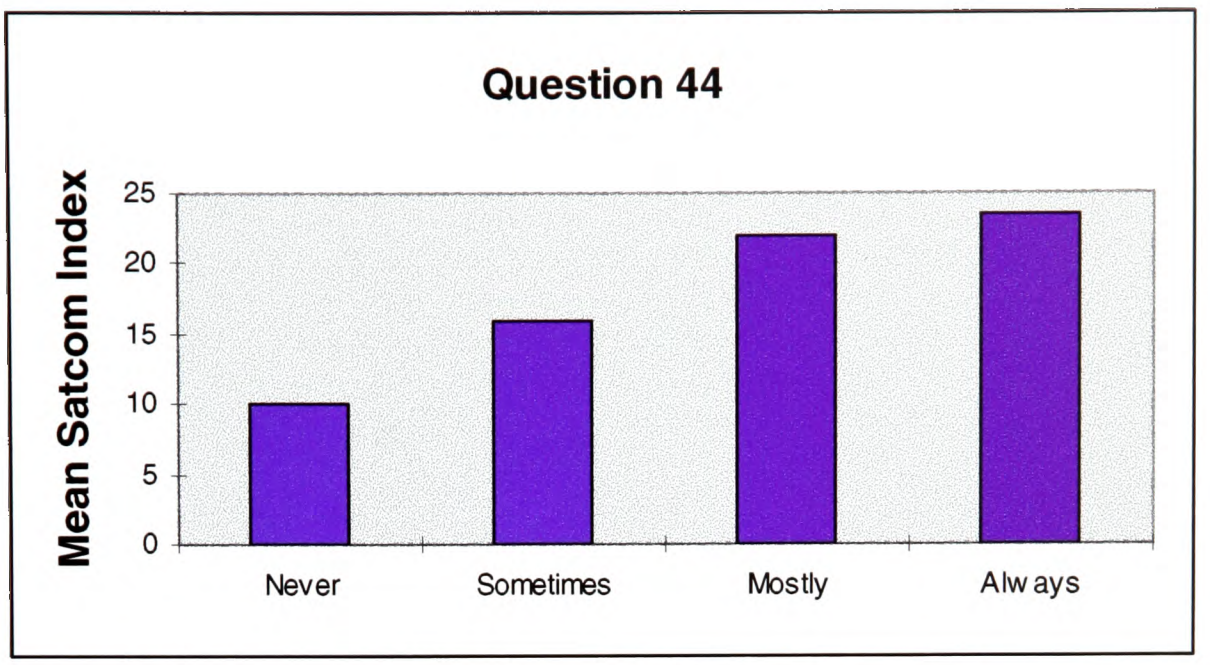


FIGURE 9.4: How often true respondents are consulted about changes that affect their job

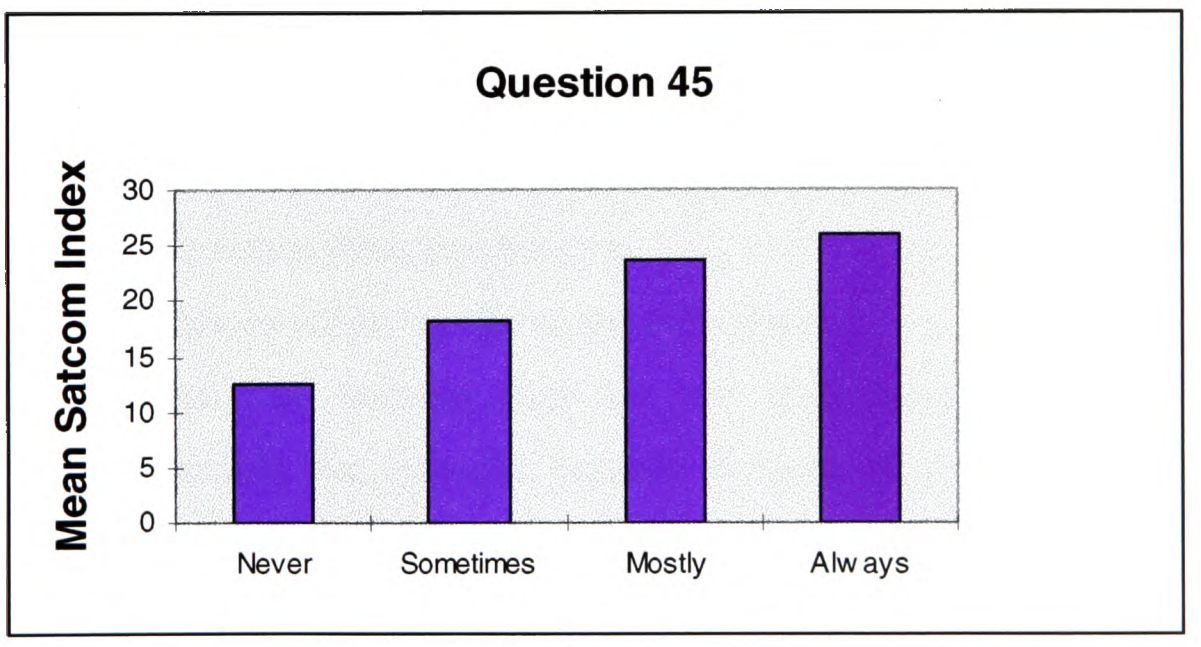
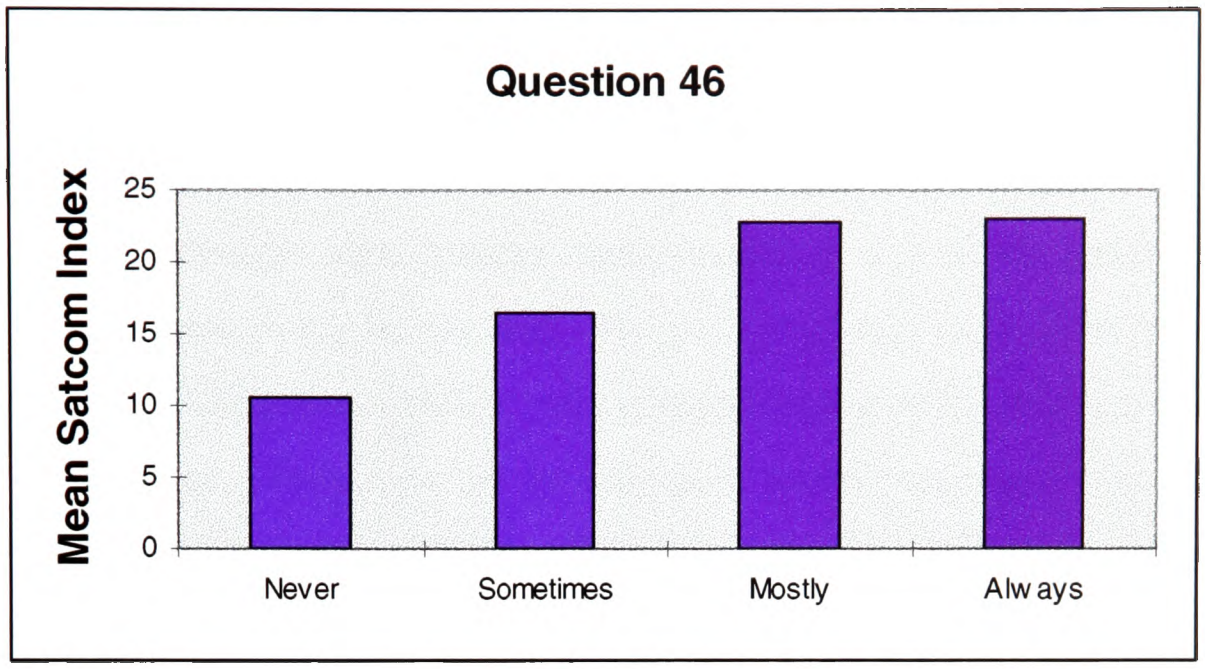


FIGURE 9.5: How often true respondents plays a part in accomplishing the goals of the departments



8 Causes of the communications problems

There are many factors which might cause someone to be communication disadvantaged or indeed lead to general problems in communication within the organisation. Some of these are listed below. The disadvantaged person will be even worse off in an organisation undergoing significant change than in a more stable environment. Many of the possible causes described below are being addressed by GHT Communications Action Steering Group

(i) Messages do not always get to the individuals.

This may be because they are not there when information is disseminated, for example, because of mode of working: part-time, shift, community workers etc. They may be junior in the organisation and messages are not filtering down to them, for example the team brief. Perhaps an appropriate channel does not exist, for example the paucity of fax machines at community sites. Channels may not be being managed very well, for example the location and use of notice-boards. Poor departmental or interdepartmental procedures may result in gaps in communication. People may not be aware of who actually needs the information.

(ii) The messages are apparently not relevant

This appears to be a problem with the team briefing which may need to be formulated in a form more appropriate to all staff.

(iii) The information is in an incomprehensible or unusable form

The message may contain inappropriate or too much jargon, The document could be too long. The individual may have some problem such as defective vision or poor comprehension of English as a second language. They may not be trained to receive messages and handle information appropriately. They may be technophobic - even the telephone may be a problem for some.

(iv) Information is arriving too late

Some staff are not getting messages in sufficient time to take appropriate action or to provide useful feedback. Gossip may occur in advance of accurate information, leading to unrest.

(v) The information is not trusted

This may apply where the situation is changing rapidly and information can become rapidly out of date. Alternatively the manager may be suspected of having his own agenda.

(vi) There is too much information

The Reuters (1996) survey showed the general problem of information overload for managers. At GHT the situation is no different, great quantities of information can arrive without due consideration of who needs it. Summaries would be useful. Messages may be being repeated too many times. They may also be being delivered in slightly contradictory forms from different sources.

(vii) Feedback is discouraged

Questioning of information, feedback or indeed any form of upward

communication may not be sufficiently encouraged. This may be linked to approachability and visibility of management.

9 Conclusions

The comparison of DBC and GHT has shown some interesting similarities particularly in the areas of visibility and accessibility of management and problems with the staff team briefing process. Clearly they are both quite formal and hierarchical or 'mechanistic' organisations (Burns and Stalker, 1961) see Chapter 3 Section 5.

The survey results reinforced by discussions with GHT staff have indicated the poor level of communication achieved with other departments and managers other than direct supervisors. There are also limited opportunities for feedback, indeed staff may be wary of feeding back unwelcome information. In a safety critical organisation however good feedback is vital. See Chapter 3 Section 3 for a description of some of the typical organisational problems of upward communication.

Groups of communications disadvantaged staff have been examined further including older staff, part-time workers, community workers staff from certain directorates have been examined further for communication problems. There is a positive correlation between good communication (as measured by the Satcom Index) and staff's involvement with the organisation. Some of the possible causes of communication problems have been discussed.

The next chapter describes the method of feed back of results of the study to GHT and the first follow-up actions put in place by the Trust.

CHAPTER 10

FOLLOW UP ACTIONS AT GHT

1 Introduction

This chapter describes how the author fed back her results to the Trust and the mechanisms that were put in place to investigate further where necessary and put improvements in place.

2 Need for follow up action

The study at GHT revealed many useful findings. However it was important that it have practical applications. The first step would be for management to accept and trust the findings of the survey and other investigations. Over the course of the research three reports were supplied to GHT Management. These covered the initial interviews, an analysis of frequencies of responses to the various questions in the survey and a breakdown of responses by directorate. The findings were accepted by the Trust management.

The survey and other investigations have high-lighted some weaker areas in communication. However, there was a need to identify priorities and to examine other influences and impacts such as cost, before implementing change in communication practices. There was also a need to encourage management not only to implement and adapt to change but also help other staff to manage change.

French and Bell (1995) emphasised the need for a survey feedback or organisational development approach, where data are fed to the top executive team and then down through the hierarchy in functional teams. Clearly this might be the best method for involvement of many or all people in an organisation. This approach would be extremely time consuming and costly to manage even if the end results could justify the expense. A compromise was needed. The management decided to form a Communications Action Group.

3 Formation of a Communications Action Steering Group

A Communications Action Steering Group drawn from all parts of the Trust. was set up by the Director of Communications. The remit of the group was to look at the findings of the survey with the assistance of the author, make further investigations where necessary and implement improvements in communication.

Each member of the Steering Group had the responsibility to:

(i) Act as a communication representative for their department or directorate.

(ii) Seek the views of colleagues informally or via questionnaires and feed back information, impression and opinion to the Steering Group.

(iii) Contribute to creative ways of devising ways of practical solutions to communication problems.

(iv) Develop and upgrade patient information and encourage feedback. Be responsible for communications in practical ways to help fellow colleagues not in the group to access and distribute information.

The responsibility of the author was to:

(i) Provide further interpretation and explanation of her findings.

(ii) Draw on knowledge of published work of other researchers in the field.

(iii) Offer practical suggestions.

(iv) Attend Steering Group meetings.

The group met regularly, initially once a month, to report and discuss progress. In addition members worked in subgroups to carry out initiatives and further investigations. They were encouraged to involve other members of staff. Four sub-groups were established. The rationales for these were as follows:

(i) Group A: Staff briefing systems and feedback systems

Staff briefing is a significant problem as illustrated by the responses given in the survey: a little under half of respondents got little or no information from team briefing. It appears that some people are not actually getting a team brief.

(ii) Group B: Interdepartmental Information sharing

Improvements in interdepartmental communications and the breaking down of barriers are required.

(iii) Group C: Disadvantaged / Isolated staff groups

Some people receive less useful or timely information than the majority of staff. These could include staff in isolated locations or subject to different patterns of working. They may also have some special requirements for information which are not currently being addressed.

(iv) Group D: External communication

External communication had not been included in the 1998 communications survey (which was concerned with internal staff communications). However, a uniform approach to all communications in the Trust was necessary. It was therefore appropriate to integrate the aims of the Steering Group with those of a group, previously formed by the Director of Communications, which was responsible for the task of monitoring and improving external communications.

Greenwich Healthcare needs to disseminate information, clearly and accurately, in its most appropriate form for its intended audience. (This may include the people whose first language is not English). In all communications the Trust's corporate identity must be upheld.

Networks of communication need to be developed with external organisations, agencies, authorities and trusts, enhancing the understanding of Greenwich Healthcare.

4 Steering Group actions

The Steering Group may continue investigations and actions for some years. It is therefore appropriate in this thesis just to review the approaches and progress that the four sub-groups have made by June 1999.

4.1 Group A: Staff Briefing Systems and Feedback Systems

The group thought there was need for further information on:

(i) The current state - the perceived strengths and weaknesses of the current process.

(ii) How the organisation would like to see staff briefing systems developed.

(iii) The mechanisms for putting new systems in place also need to be established.

In order to help gather this information, the group decided to carry out a set of structured interviews of 36 members of staff selected randomly with the aid of the Human Resources Department. These included representatives from each staffing category.

4.2 Group B: Interdepartmental information sharing

The group has carried out a small survey by means of a questionnaire. 49 surveys were returned from 66 distributed. The survey results identified a need for up-to-date information on changes to staff, roles, responsibilities, phone/fax etc. There also needs to be a formal, central mechanism to notify changes. This should reduce paperwork and avoid duplications on circulation. The majority of respondents wanted to see changes highlighted in the 'Yellow Bulletin'. The group has proposed the following actions.

(i) Staff changes

Launch of a new page in the 'Yellow Bulletin', called 'Joiners, Leavers and Movers'.

(ii) Telephone usage

Place article in 'The Link' to try and raise awareness of how effective telephones can be and that internal and external callers are equally important.

(iii) Interdepartmental liaison

Service directors have been sent a questionnaire asking them to respond on aspects of interdepartmental meetings, job shadowing by someone from another department and open door days when managers will be available for discussions.

(iv) Social Aspects

The annual Trust ball and concert events were well supported. A quiz tournament is being promoted. The group proposed forming a social events subgroup. This will require additional volunteers.

4.3 Group C: Isolated staff groups

The group has identified the isolated groups and put them into seven categories:

(i) GPs and practice staff

(ii) Night workers, part-timers

(iii) Community staff

(iv) Volunteers

(v) Students

(vi) Sub-contracted staff

(vii) Social services staff

Main recommendations are listed below. A detailed action plan has been developed, with individuals designated to investigate further or put actions in place.

(i) Circulation lists

Introduce comprehensive, centrally held circulation lists to improve distribution of information across the Trust.

(ii) Fax machines and telephones

More Fax machines are needed at community sites but the compatibility of telephones with Greenwich District Hospital switchboard needs to be investigated. The use of voicemail needs to be improved and an explanatory article in the staff newspaper 'The Link' is proposed.

(iii) E-mail

Develop and promote access to e-mail at community sites and elsewhere.

(iv) General Practitioners

Liaise with GPs about information required from Greenwich Healthcare and tailor Greenwich Heathcare Trust's Service Directory to meet needs of GPs

4.4 Group D: External communications

A sequence of actions has been proposed, (a time scale was also given but is not shown below).

(i) Survey current information e.g. letters confirming out-patient appointments /admission.

(ii) Set some minimum standards for documentation.

(iii) Sample letters to be drafted by team based on minimum standards.

(iv) Market test sample documentation.

(v) Make recommendations based on market test findings.

(vi) Consultation period for recommendations.

(vii) Draft project plan for implementing recommendations.

(viii) Establish a regular random audit of documentation to ensure compliance with agreed standards.

4.5 General comments on proposed actions of groups.

Group A is undertaking a further round of information gathering and has not yet put forward any actions to improve the staff briefing system. Group B has some firm proposals with the means to take these forward. However, other suggestions need further work before actions can be proposed. Group C is the only group to have both a time scale and designated individuals to take actions forward. Group D has a program of actions with time scale.

5 Conclusions

The four sub-groups have made a good start to their work. Some overlap between the proposals of the four groups has been noted. The groups were reminded of the need for appropriate liaison in these areas.

The next chapter lists the conclusions for this study and makes some suggestions for further work.

CHAPTER 11

CONCLUSIONS

1 Introduction

This chapter describes the outcomes from the study on organisational communication. Some suggestions for improvements are put forward together with some ideas for further work

2 Outcomes

2.1 Strengths and weaknesses

This study has identified both strengths and weaknesses in communications in Greenwich Healthcare Trust. Some of the weaknesses are also exhibited in the DBC organisation.

Strengths:

(i) Recognition that communication is everybody's responsibility.

(ii) Ability to communicate with others, particularly fellow workers in the home department.

Weaknesses:

(i) Interdepartmental communication.

(ii) Visibility and approachability of management.

(iii) Methods of informing and discussing key matters with staff:

- team briefing. system
- staff meetings (more requested)
- details of changes

(iv) Information arriving first via the grapevine or local press.

(v) Deficiencies in the internal post and telephone systems.

(vi) Lack of information technology.

2.2 New categories for responses

The survey questionnaire employed some new categories for responses. This facilitated the development and evaluation of indices used to measure specific aspects of communication:

Satcom Index: measure of overall good communication (satisfaction and level).

Frequcom Index: measure of frequency of communication.

Overload Index: measure of information overload.

Blankcom Index: measure of non-occurrence or breakdown of communication.

Nonresponse Count: total non-responses to communication questions.

2.3 Relationships between communication and demographic and employment variables

Relationships have been established between these one or more of the indices listed above and certain demographic and employment variables. These relationships are explained more fully in Chapters 8 and 9. Variables include:

(i) Age.

(ii) Type of employment (part-time or full time).

(iii) Place of work (community or hospital).

(iv) Number of staff supervised.

(v) Directorate.

(vi) Number of staff supervised.

2.4 Identification of communication disadvantaged and advantaged staff

These measures have also facilitated the identification of categories of staff at GHT that are either communication advantaged or disadvantaged compared to the average member of staff. Disadvantaged groups include older staff, part-time workers, community staff and some directorates. Supervisors and managers are, not surprisingly, advantaged though they are more prone to suffer from information overload.

2.5 Organisational involvement

The hypothesis has been confirmed that respondents who are mostly or always both satisfied with the way they do their job and play a part in accomplishing the goals of the department, have a significantly better communication level and satisfaction than the rest. One could say, therefore, that a good communicating worker in GHT is more involved in the organisation. Fortunately, these form the majority of respondents. It is, therefore, essential to address the problems of the communication disadvantaged. There is a particular danger in times of great change that these individuals may be left behind.

3 The way forward

3.1 Adapting to change

Organisations are considered by Katz and Kahn (1966) as open systems that adapt to their environment. The NHS may be resistant to change but is continually having change thrust upon it, often by government. It has been subject to organisational, managerial and service change processes, (Pettigrew et al, 1992). GHT has been subject to much change over recent years and management will need to ensure that staff are kept informed and involved. An incremental approach where staff work together to bring about and adapt to change by means of a continuous, evolving and consensus building approach is needed. Everyone should be a stakeholder in the process. Good communications are essential to make this work.

3.2 Making sure everyone gets the message

Often people are not aware of the requirements, problems, and changes in other departments. Sometimes duplicate information is being sent out from various sources. The confusion needs to be sorted out.

GHT needs to ensure that important messages are getting to everyone - particularly about changes. The initiative to improve briefing and feedback, will need to address the problem of those who are not getting a briefing at all at the moment. The new procedures being put in place by the Communications Action Steering Group to inform about staff movements (joiners, movers and leavers) will be helpful.

3.3 Working together to communicate better

Staff need to feel they are involved and that their opinion matters. They need to be encouraged to be more friendly and open particularly between different levels.

Some staff are fearful about expressing their views to management. Training of middle management is needed to encourage them to be approachable, communicate with staff better in a non-adversarial way and encourage upward communication. This may help to eliminate some of the concerns of more junior staff.

GHT has a problem of lack of social integration. At present like many NHS organisations it is very hierarchical. The opportunities for more social events are being investigated by the Communications Action Steering Group.

3.4 IT will help - the future strategy

The move into the information age is influencing events at GHT. The current channels of communication do not make use of the latest developments in information technology, for example e-mail is not available for most staff. However, GHT was one of the pioneers of HISS (Hospital Information Support System) and staff are not averse to IT. Indeed many staff expressed a need for e-mail and Internet access in the survey. A major strategy to improve IT has been put in place. This will not only take account of the internal needs of the Trust but will also include links with other organisations such as GP practices.

Improved communication between staff will be achieved by means of e-mail to be made available in both the hospital and community care sites. It will be essential, as with any new system however potentially advantageous, to ensure that all staff are trained and familiarised with the technology. This will be particularly important for the community staff. Any problems will need to be resolved before replacing existing channels or procedures. In addition a repository for information of interest to staff, provided by means of an Intranet, is also being planned. This will need to be maintained and updated regularly if it is to be useful.

Significant new business and information systems are also being considered but discussion of these is outside the scope of this thesis.

4 Future studies:

It would be most important at an appropriate stage to carry out a new survey on a sample of staff at GHT to audit progress in improvements in communication.

For practical reasons the 1998 communications survey contained only 50 questions. The information gathered about the respondents themselves was therefore inevitably limited in scope. It would be useful in a future survey to enlarge this section in order to clarify causes of communication disadvantage. Questions could be asked about such aspects as patterns of working, numbers of other staff worked with and so on. It would also be helpful to ask more about attitudes to management.

The use of the set of measures developed in this study: the *Satcom Index* etc., could be tested in other organisations and could be utilised to examine other categories of staff than the ones studied here.

It would also be useful to format and test survey questions and indices for such aspects as:

Information confusion (conflicting messages)

Information comprehension (understanding messages)

Information receptivity (wanted messages)

It may be possible and illuminating to study patterns of the various elements of communication by means of maps or diagrams.

APPENDIX A: KEY EVENTS IN THE NHS

1 Overview

Ill heath is always with us, especially among the poorer sections of the community. Dealing with it is expensive and increasing use of technology requires sophisticated equipment and highly skilled and trained staff.

Organised public healthcare goes back to Elizabethan times (Pater, 1981) when care was paid for out of local rates.

The voluntary hospitals were established by philanthropy or public subscription. Many were created in the eighteenth and nineteenth centuries (Baggott, 1998). In Victorian times local care provision was via a system of relief known as the poor law and poor law infirmaries were designed to keep costs low. Some of those old buildings still exist today.

The National Health Insurance Bill of 1911 provided a minimum medical care service. It included the provision of sickness benefit, free GP services and free drugs for employed workers. Of course this did not cover the unemployed.

In the late 1930s two thirds of patients were being treated in local authority municipal hospitals. War was imminent and it was anticipated that there would be a need for facilities for massive numbers of casualties. Planning began to draw together the existing hospital system. By 1939 the hospital system was nationally co-ordinated and a hospital building programme had commenced in country areas. The structures actually created before World War 2 were formalised in 1948 with the formation of the National Heath Service, (Kelly, 1997).

The creation of the NHS by Bevan was opposed by Herbert Morrison who argued against the nationalisation of the municipal hospitals. It was also fiercely opposed by the medical profession. Many concessions were made to them in the new organisation. GPs remained as independent contractors and hospital consultants given generous salaries and allowed to combine private practice with their NHS work

Managerism has characterised the NHS from 1948-1990. Since 1990 the service has moved to market oriented consumerism. The pace of change has quickened in recent years, (Kelly and Glover, 1996) .

Nowadays the picture is very variable across the country. There are some

centres of excellence, especially in London, linked to universities. Sites are being rationalised and some new hospitals being built mainly under the Private Finance Initiative.

TABLE A1: Key dates in the history of the NHS

DATE	EVENT
1948	NHS established in UK
1956	Guillebaud enquiry report, Cmd9663 - strengthened case for more NHS expenditure
1972	'Reorganisation' White Paper, Cmnd 5055 (under Heath Government)
1973	NHS Reorganisation Act (took effect 1974); 3 tiers of health service management below the DHSS[19] at regional, area and district level.
1974-79	Attempt to redistribute resources under the Resource Allocation Working Party.
1976	New planning process - with priorities e.g. elderly, mentally ill. Introduction of cash limits.
1979	Royal Commission report, Cmnd 7615 - set out seven key objectives including equality of access to services, and. service free at time of use. It successfully argued for abolition of a tier of management below the regional level.
1982	Commencement of next phase of reorganisation - abolition of area tier, simplification of consultative machinery, introduction of unit management.
1983	Griffiths Report (see next section of this Appendix for details).
1987	White Paper 'Promoting Better Health', links financial efficiency with consumerist aspects also individual responsibility for health by public.

[19] DHSS: Department of Health and Social Security.

TABLE A1 (cont): Key dates in the history of the NHS

DATE	EVENT
1988	De-merging of the Department of Health and Social Security with formation of Department of Health.
1989	White Paper 'Working for Patients', offering better healthcare, more choice, delegation of power to local levels, proposed setting up self governing hospital trusts. Creation of a new Policy Board and the NHS Management Executive.
1994	Banks Report (The Review of the Wider Department of Health, DoH) - recommended department be organised into groups each focusing on public health, social care and health care. Abolition of 14 Regional Health Authorities. Reorganisation of NHSME to include 8 regional offices.
1991	Creation of internal market for provision of hospital and community health services - creation of Trusts and Directly Managed Units (DMUs). The DMUs were directly managed by the local health authority and were mostly being prepared for trust status.
1995	Health Authorities Act - created 100 integrated health authorities in England.
1997	NHS White Paper Cm 3807 (under Labour Government) - proposals to strengthen health authority planning role and devolve commissioning functions to local primary care groups.

2 Summary of Griffiths report recommendations

Spurgeon and Barwell, (1991, pages 3-5), have reviewed the Griffiths Report. Key features are:

(i) The establishment of a National Health Service Management Board to provide a central management function.

(ii) The creation of a general management function throughout all levels of the service with individual general managers being appointed at District and Unit Level who are accountable for the service provided. It was noted that these managers should be drawn from any discipline within the NHS or indeed from managers outside the service.

(iii) That as far as possible day-to-day management decisions should be devolved to the unit of operation.

(iv) That the service should seek to involve clinicians more closely in the management process.

(v) The service should endeavour to be more aware and more sensitive to the needs of the consumer.

(vi) The management structures within each District should have greater flexibility and attempt to incorporate the varying patterns of needs within different populations.

APPENDIX B: INTERVIEWS WITH DBC OFFICERS

1 Interviews

Interviews were held with the following DBC staff:

Chief Executive

Director of Finance

Assistant Chief Executive (Corporate. Services)

Director of Planning and Development

Director of Environment and Leisure

Head of Information Technology

Head of Corporate Services

Head of Policy and Economic Development

2 Questions used in discussions /interviews with officers

NETWORKING

1. Organisation structure?
2. Formal and informal networks?
3. Where are the various departments located?
4. Are there any communication problems associated with department location?

INFORMATION GATEKEEPERS

5 Which people have specific responsibilities for communication?

6. Which people do you consider as providing key sources of information?

MECHANISMS FOR STORING, RETRIEVING AND PASSING INFORMATION

7. What general systems exist for storing, retrieving and passing information?
8. What mechanisms exist for dissemination of information to staff: e.g. team briefings?
9. How is this dissemination managed ?

INTERDEPARTMENTAL MEETINGS

10. List key meetings

MEETING	FREQUENCY	ATTENDEES

11. Who else sees the minutes of the above meetings ?

LIAISON BETWEEN COUNCILLORS AND COUNCIL STAFF

12. What mechanisms exist for liaison with Councillors?

13. Key persons responsible for liaison?

MEETINGS WITH COUNCILLORS

14. List key meetings

MEETING	FREQUENCY	ATTENDEES

15. Who else sees the minutes of the above meetings?

COMMUNICATION WITH THE LOCAL COMMUNITY

16. Mechanisms for communicating with individual members of the public?

17. Mechanisms for communicating with key groups?

MEETINGS WITH KEY GROUPS

18. List key meetings

MEETING	FREQUENCY	ATTENDEES

19. Who else sees the minutes?

3 Bibliography

The following papers supplied by Dartford Borough Council and the Dartford Chamber of Commerce provided background reading.

1. Taking the Council to the People; DBC agenda item A5, Report to Policy Committee, 27 November 1995
2. Minutes of the Meeting of the Town Centre Forum, 21 March 1996
3. Dartford Profile, Spring 1996
4. Dartford Borough News, June to July 1996
5. Dartford's Annual Report 1995/6, September 1996
6. Dartford Borough Council Strategy Consultation Document, October 1996
7. Dartford Borough News, Annual Report Supplement for the Financial Year 95/96, October 1996
8. Dartford Borough News, December 1996 to January 1997
9. The Borough of Dartford Local Plan Review, February 1997
10. Dartford Borough News, June to July 1997
11. Dartford Chamber of Commerce (pamphlet)
12. Business News Dartford and District Chamber of Commerce, Vol.3, Issue 6,July/August 1997
13. DBC Organisation Chart, April 1997
14. Team Briefing, Nos.54 – 57, (March - May 1997)
15. Dartford Borough Council Summons and Agenda, 15 July 1997

APPENDIX C: TIMETABLE OF EVENTS AT GHT

TABLE C1: Key events and actions in the collaborative study with GHT

DATE	ACTION
Dec 96	Letter to David Astley Chief Executive of Greenwich Healthcare proposing study on 'communications in the management of change'.
Jan 97	Meet with Chief Executive of Greenwich Healthcare to discuss possible collaboration.
Feb 97	Meet with Executive Directors to discuss scope and requirements.
Mar 97	Meet with PA to CE to discuss organisational aspects and identify key players.
Mar 97	Meet with Chairman of Greenwich Healthcare Trust Board.
April 97	Structured interviews with Executive Directors.
May 97	**Report**
May 97	Meet and discuss progress with new Communications Director.
June-Oct 97	Interview other key staff.
June 97	Visit some community sites.
Oct 97	Communications Working Group (CWG) formed.
Dec 97	First meeting with CWG to discuss problems and themes for survey.
Dec 97	Draft survey circulated for comment.
Jan 98	Pilot survey sent out to 20 staff.
Feb 98	Results of pilot analysed.
Feb 98	Survey questions rewritten and circulated to CWG.
Mar 98	Second meeting of CWG to discuss and agree final list of survey questions.
Mar 98	Final format and logistics of survey discussed and agreed with staff from Reprographics, Payroll and Postal Services.
Mar 98	Survey form/ return envelope published in final form.
Mar 98	Advance publicity for survey in Link (in-house newsletter).
Mar 98	Survey form / envelope circulated with payslips.
April 98	Survey forms returned.
May - June 98	Coding and first analysis of survey.
July 98	**Report**
Aug 98	Presentation to Executive: further information requested.
Oct 98	**Report on directorates**
Dec 98	Communications Action Steering Group formed.
Mar 99	First meeting of CAG : Subgroups formed .
June 99	Subgroups' reports and action plans passed to Executive Directors.

APPENDIX D: INTERVIEWS WITH STAFF FROM GHT

1 Interviews

Interviews were held with the following GHT staff:

Nurse Director, (Executive Director)

Director Finance, (Executive Director)

Medical Director, (Executive Director)

Strategic Development, (Executive Director)

Project Director

Service Director Primary and Community Care

Service Director Information

2 Questions asked in interviews

COMMUNICATION WITHIN DIRECTORATE

1. What systems or mechanisms exist in your directorate for storing, retrieving and communicating information?
2. Where are your staff located?
3. Are there any communication problems associated with location? Give details.
4. What are the main problems of communication in your directorate?

INTERDEPARTMENTAL COMMUNICATION

5. Which of the following meetings do you usually attend.

MEETING	FREQUENCY	USUALLY ATTEND
NHS Trust Board	Monthly	
Audit Committee	2 monthly	
Project Control Committee	2 times a month	
Quality Committee	2 monthly	
Resources Committee	2 monthly	
Executive	Weekly	
Strategic and Planning	Monthly	
Performance Management	Monthly	

6. Do you attend any other regular interdepartmental meetings apart from the list above?
7. Which of your interdepartmental meetings do you perceive as being most useful for the communication of information? Give reasons.
8. Apart from the above meetings which other directors / directorates do you communicate with orally using either official or unofficial lines of communication?

TITLE	FREQUENCY OF CONTACT one or more times per:		
	DAY	WEEK	MONTH
Chief Executive			
Nurse Director / Executive Director			
Director Finance / Executive Director			
Medical Director / Executive Director			
Project Director			
Strategic Development / Executive Director			
Service Director Obs & Gynae			
Service Director Acute Paediatrics			
Service Director Primary & Comm.			
Service Director Facilities			
Chief Pharmacist			
Service Director Pathology			
Service Director Information			
Service Director Surgery			
Service Director Medicine			
Service Director Imaging			

9. Which other directors / directorates do you send written communications to? (list as above)
10. Which other directors /directorates do you receive written communications from? (list as above)
11. Which people do you consider to be key sources of information?
12. Who do you usually talk to about emergency or policy issues?
13. As far as you are aware are you being sent appropriate information from other departments? Give details of deficiencies or excesses.

14. Have you had any problems obtaining information from other departments? Give details.

SOCIALISING

15. Which of the other people on the following list do you talk to on a social occasion? Social occasions can include tea and lunch breaks, after work drink etc., (see list as of question 8).

AWARENESS OF CHANGES

16. How do you normally first become aware of the changes to the following?:
    - 16.1 Organisation
    - 16.2 Procedures
    - 16.3 Location
    - 16.4 Finance/funding
    - 16.5 Other
17. How do you communicate the above changes to members of your directorate?
18. How do you handle feedback?

COMMUNICATION WITHIN THE TRUST ORGANISATION

19. What are the main problems

APPENDIX E: PILOT SURVEY

It was important to test the survey questionnaire out on a suitable cross section of staff in order to identify inconsistencies, ambiguities or other problems. A selection of staff were nominated by the Communications Working Group to receive the questionnaire, see Figure E1. Recipients were asked to complete the survey form then fill in 'Supplementary Form A', see Figure E2, which asked questions about the survey.

20 sets of forms were sent out. 18 were returned. Comments chiefly referred to measures, job title, understanding and applicability of specific questions to the individual. However, respondents generally thought the survey was a good idea. The following changes made to the final version:

(i) The Trust logo and a letter from the Chief Executive and Director of Communications was included on the front page. This, it was hoped, would give authority to the survey.

(ii) The instructions were modified. Staff were asked to put NA next to a question if it did not apply to them. This would indicate that the respondent had considered the question rather than ignoring it or choosing not to answer.

(iii) Job titles were considered too vague. In the final version staff were asked for their job grade, their directorate, and whether they were a manager. Staff who are Trust Managers (a specific position) do not have a job grade.

(iv) Some blocks of questions were rearranged into a more logical order

(v) Some people had a problem with understanding the question '*How much information do you get by face to face contact.* Two questions were used instead '*....talking with another person*' and '*....meetings*'.

An extra question about faxes was also included.

(vi) Measures were changed. The use of *'great amount'* gave problems of assessment and was omitted. The measure *'less than once a month'* was changed to *'rarely'*.

(vii) The question about the Annual Report was omitted.

(viii) The revised form had less room at the end for people to write comments, but it was hoped that this would be less intimidating.

FIGURE E1: Pilot survey form

Pages of form shown less than full size

☐☐☐☐

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY

HOW TO FILL IN THIS SURVEY FORM

Most of the questions ask you to choose from a list by ticking boxes. Please tick only one box in each row of boxes

Example if you are 31 years old you would tick the box headed 30 to 39

	Less than 20	20 to 29	30 to 39	40 to 49	50 to 59	60 or more
What is your age group?	☐	☐	☑	☐	☐	☐

A small number of the questions ask you to write in an answer.

You do not have to answer all the questions but please try and answer as many questions as possible.

PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT YOURSELF:
Tick the appropriate boxes. Only tick one box in each row

				Official use only
1.	**Sex :**	Male ☐	Female ☐	☐
2.	**What is your age group?**	Less than 20 ☐ / 20 to 29 ☐ / 30 to 39 ☐ / 40 to 49 ☐ / 50 to 59 ☐ / 60 or more ☐		☐
3.	**Please state job title :**			☐☐
4.	**Please state job grade :**			☐☐
5.	**Where is your main place of work?**	In a hospital ☐	In the community ☐	☐
6.	**How are you employed ?**	Full-Time ☐	Part-time ☐	☐
7.	**How many staff do you supervise?**	None ☐ / 1 to 5 ☐ / 6 to 20 ☐	More than 20 ☐	☐

NOW PLEASE TURN TO THE NEXT PAGE

fig cont.

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY

Tick the appropriate boxes. Only tick one box in each row

	How much information is being given to you on:	None	Little	Enough	Great Amount	Too Much	Official use only
8.	The goals of your department	☐	☐	☐	☐	☐	☐
9.	How your job fits into the total operation of the department	☐	☐	☐	☐	☐	☐
10.	Changes in your department	☐	☐	☐	☐	☐	☐
11.	Changes in other departments	☐	☐	☐	☐	☐	☐
12.	The issues regarding the Queen Elizabeth Hospital	☐	☐	☐	☐	☐	☐

	How often do you ask for information from:	Daily	Weekly	Monthly	Less than Monthly	Never	
13.	A fellow worker in your own department	☐	☐	☐	☐	☐	☐
14.	The manager or supervisor you directly report to	☐	☐	* ☐	☐	☐	☐
15.	A manager other than your direct supervisor	☐	☐	☐	☐	☐	☐
16.	Someone in another department	☐	☐	☐	☐	☐	☐

	How much information do you get from :	None	Little	Enough	Great Amount	Too Much	
17.	Fellow workers in your own department	☐	☐	☐	☐	☐	☐
18.	The manager or supervisor you directly report to	☐	☐	☐	☐	☐	☐
19.	Managers other than your direct supervisor	☐	☐	☐	☐	☐	☐
20.	People in other departments	☐	☐	☐	☐	☐	☐

		Never	Some times	Mostly	Always	
21.	**How often are you getting the same information from more than one person?**	☐	☐	☐	☐	☐

	Is information coming to you at the right time from:	Never	Some times	Mostly	Always	
22.	Fellow workers in your own department	☐	☐	☐	☐	☐
23.	The manager or supervisor you directly report to	☐	☐	☐	☐	☐
24.	Managers other than your direct supervisor	☐	☐	☐	☐	☐
25.	People in other departments	☐	☐	☐	☐	☐

fig cont.

Tick the appropriate boxes. Only tick one box in each row

	How much information do you get by the following methods:	None	Little	Enough	Great Amount	Too Much	Official use only
26.	Face to face contact	☐	☐	☐	☐	☐	☐
27.	Telephone calls	☐	☐	☐	☐	☐	☐
28.	Written information given /sent to you	☐	☐	☐	☐	☐	☐
29.	Notice boards	☐	☐	☐	☐	☐	☐
30.	Team briefing	☐	☐	☐	☐	☐	☐
31.	The Link Newsletter	☐	☐	☐	☐	☐	☐
32.	The Yellow Bulletin	☐	☐	☐	☐	☐	☐
33.	Greenwich Healthcare's Annual Report	☐	☐	☐	☐	☐	☐

34. **List any other ways that you get information.** .....

.....

☐☐
☐☐

35. **Suggest any other ways that you would <u>like</u> to get information.** .....

.....

☐☐
☐☐

	How much information do you give to others by:	None	Little	Enough	Great amount	Too much	
36.	Describing what you are doing in your job to fellow workers	☐	☐	☐	☐	☐	☐
37.	Reporting what you are doing in your job to your manager or supervisor	☐	☐	☐	☐	☐	☐
38.	Supplying comments to your manager or supervisor on changes within your department	☐	☐	☐	☐	☐	☐

	How often are these statements true	Never	Some times	Most of the time	Always	
39.	You are satisfied about the way you do your job	☐	☐	☐	☐	☐
40.	You are able to communicate with others	☐	☐	☐	☐	☐
41.	You can discuss things with your manager or supervisor	☐	☐	☐	☐	☐
42.	You are consulted about changes that affect your job	☐	☐	☐	☐	☐
43.	You play a part in accomplishing the goals of the department	☐	☐	☐	☐	☐

44. **Who do you think is responsible for communications?** .....

☐☐
☐☐

	How has the quality of information changed during the last year:	Got worse	Stayed the same	Got better	
45.	In your department	☐	☐	☐	☐
46.	Between your department and other parts of the Trust	☐	☐	☐	☐

NOW PLEASE TURN TO THE NEXT PAGE

fig cont.

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY

47. **In what practical ways could communications be improved?**

Official use only

THANK YOU FOR YOUR HELP WITH THIS SURVEY. PLEASE RETURN IT IN THE ENVELOPE PROVIDED BY **27 JANUARY 1998** TO: LINDA MARSH, DIRECTOR OF COMMUNICATIONS, GREENWICH DISTRICT HOSPITAL

FIGURE E2: Form used to gather views about the pilot survey (shown slightly smaller than actual size)

SUPPLEMENTARY FORM A ☐☐☐☐

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY
QUESTIONS ABOUT THE SURVEY FORM

Thank you for taking part in this pilot. It is most important that the questionnaire is understandable by all and that any ambiguities are dealt with. We are therefore asking for some further help from you in assessing the questionnaire and highlighting any problem areas. We should very much appreciate your comments. If the space on this form is not big enough please write on a separate sheet of paper and attach it to this form.

Please fill in the Greenwich Healthcare Communications Survey form <u>first</u> before answering the following questions about it.

Name.....Department.....

1. Were the instructions clear on how to fill in the form? Yes ☐ No ☐
2. Describe any difficulties with the instructions.
3. Was the layout of the form clear and easy to work with? Yes ☐ No ☐
4. Describe any difficulties with the layout.
5. Were any of the questions not relevant to you? Yes ☐ No ☐
6. List the numbers of any irrelevant questions. If possible explain why they were not relevant to you.
7. Were there any questions that you did not understand or could interpret in more than one way? Yes ☐ No ☐
8. List the numbers of any such questions. If possible explain in what way they were ambiguous or not understandable.
9. Approximately how long did it take you to complete the questionnaire?
10. Please list any other concerns or comments that you have about the survey.

Please return this form with the Greenwich Healthcare Communications Survey questionnaire to Linda Marsh, Director of Communications, GDH

APPENDIX F: SURVEY FORM

FIGURE F1: Full survey questionnaire

Form shown less than full-size

Greenwich
HEALTHCARE

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY

Dear Colleague

Good communication is vital for the smooth running of any organisation. It is particularly important for Greenwich Healthcare because our staff are spread across so many sites. We need to know **your views**.

To find out how well our communications are working between members of staff now, a joint working group from the Trust and a PhD student from the University of Greenwich have developed this questionnaire.

The survey form is anonymous and the analysis of responses will be carried out by the University of Greenwich and at no cost to the Trust.

Please take the time to fill in this form, **we really value and need your input**. We shall also use the input you provide to improve our communications.

If you have any difficulties, you can ring our Helpline on 0181-312-6156 for assistance.

Please return this Communications Survey form in the envelope provided, to me, Linda Marsh, Director of Communications, Greenwich District Hospital, **by Friday 17 April 1998.**

May we thank you in advance for your help. We shall be feeding back to you the results.

David Astley
Chief Executive

Linda Marsh
Director of Communications

HOW TO FILL IN THIS SURVEY FORM

Most of the questions ask you to chose from a list by ticking a box.

Example: if you are 31 years old you would tick the box headed 30 - 39

	Less than 20	20 - 29	30 - 39	40 - 49	50 - 59	60 or more
What is your age group?	☐	☐	☑	☐	☐	☐

A small number of the questions ask you to write in an answer, please print this clearly.

If a question does not apply to you please write NA next to that question.

NOW PLEASE TURN TO THE NEXT PAGE

fig cont.

GREENWICH HEALTHCARE COMMUNICATIONS SURVEY ☐☐☐☐

PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT YOURSELF:
Please tick the appropriate boxes.

Official use only

1. **Sex:** Male ☐ Female ☐ ☐

2. **What is your age group?** Less than 20 ☐ 20 - 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 50 - 59 ☐ 60 or more ☐ ☐

3. **Where does your main work take place?** In a hospital ☐ In the community ☐ ☐

4. **How are you employed ?** Full-time ☐ Part-time ☐ ☐

5. **What is your directorate?** (tick one box only)
Acute Paediatrics ☐ Child and Adolescent Mental Health ☐ Facilities ☐ Finance ☐
Imaging ☐ Information ☐ Medicine ☐ Nursing ☐
Pathology ☐ Pharmacy ☐ Primary and Community Care ☐ Strategic Development ☐
Surgery ☐ Women's Services ☐ Other ☐ ☐☐

6. **Do you have a job grade?** No ☐ Yes ☐ ☐

7. **If the answer to question 6 is yes, what is your job grade?** ..... ☐☐
(For example Nurse Grade G, please print your answer).

8. **Are you a manager?** No ☐ Yes ☐ ☐

9. **How many staff do you supervise?** None ☐ 1 - 5 ☐ 6 - 20 ☐ More than 20 ☐ ☐

fig cont.

THE NEXT QUESTIONS ARE ABOUT COMMUNICATION

Please tick only one box in each row

Official use only

	How often do you ask for information from:	Daily	Weekly	Monthly	Rarely	Never
10.	A fellow worker in your own department	☐	☐	☐	☐	☐
11.	The manager or supervisor you directly report to	☐	☐	☐	☐	☐
12.	A manager other than your direct supervisor	☐	☐	☐	☐	☐
13.	Someone in another department	☐	☐	☐	☐	☐

	How much information do you get from:	None	Little	Enough	Too much
14.	Fellow workers in your own department	☐	☐	☐	☐
15.	The manager or supervisor you directly report to	☐	☐	☐	☐
16.	Managers other than your direct supervisor	☐	☐	☐	☐
17.	People in other departments	☐	☐	☐	☐

		Never	Some times	Mostly	Always
18.	**How often are you getting the same information from more than one person?**	☐	☐	☐	☐

	Is information coming to you at the right time from:	Never	Some times	Mostly	Always
19.	Fellow workers in your own department	☐	☐	☐	☐
20.	The manager or supervisor you directly report to	☐	☐	☐	☐
21.	Managers other than your direct supervisor	☐	☐	☐	☐
22.	People in other departments	☐	☐	☐	☐

	How much information do you get by the following methods:	None	Little	Enough	Too much
23.	Talking with another person	☐	☐	☐	☐
24.	Meetings	☐	☐	☐	☐
25.	Telephone calls	☐	☐	☐	☐
26.	Faxes	☐	☐	☐	☐
27.	Written information given / sent to you	☐	☐	☐	☐
28.	Notice boards	☐	☐	☐	☐
29.	Team briefing	☐	☐	☐	☐
30.	The Link Newsletter	☐	☐	☐	☐
31.	The Yellow Bulletin	☐	☐	☐	☐

32. **List any other ways that you get information.** .....

33. **Suggest any other ways that you would like to get information.** .....

PLEASE TURN TO THE NEXT PAGE

fig cont.

Please tick only one box in each row

Official use only

	How much information do you give to others by:	None	Little	Enough	Too much	
34.	Describing what you are doing in your job to fellow workers	☐	☐	☐	☐	☐
35.	Reporting what you are doing in your job to your manager or supervisor	☐	☐	☐	☐	☐
36.	Supplying comments to your manager or supervisor on changes within your department	☐	☐	☐	☐	☐

	How much information is being given to you on:	None	Little	Enough	Too much	
37.	The goals of your department	☐	☐	☐	☐	☐
38.	How your job fits into the total operation of the department	☐	☐	☐	☐	☐
39.	Changes in your department	☐	☐	☐	☐	☐
40.	Changes in other departments	☐	☐	☐	☐	☐
41.	The issues regarding the Queen Elizabeth Hospital	☐	☐	☐	☐	☐

	How often are these statements true:	Never	Some times	Most of the time	Always	
42.	You are satisfied about the way you do your job	☐	☐	☐	☐	☐
43.	You are able to communicate with others	☐	☐	☐	☐	☐
44.	You can discuss things with your manager or supervisor	☐	☐	☐	☐	☐
45.	You are consulted about changes that affect your job	☐	☐	☐	☐	☐
46.	You play a part in accomplishing the goals of the department	☐	☐	☐	☐	☐

47. **Who do you think is responsible for communications?** .....

	How has the quality of information changed during the last year:	Got worse	Stayed the same	Got better	
48.	In your department	☐	☐	☐	☐
49.	Between your department and other parts of the Trust	☐	☐	☐	☐

50. **In what practical ways could communications be improved?**

If there is not enough space for all your suggestions, please write them on a sheet of paper and attach it to this form.

THANK YOU FOR YOUR HELP WITH THIS SURVEY. PLEASE RETURN IT IN THE ENVELOPE PROVIDED BY **FRIDAY APRIL 17 1998** TO: LINDA MARSH, DIRECTOR OF COMMUNICATIONS, GREENWICH DISTRICT HOSPITAL.

APPENDIX G: SURVEY SUMMARY TABLES

Tables G1 - G11and G14 - G18 show the percentage responses for all answers to a particular question. Questions marked NA (non-applicable) by the respondents are treated as a nil response in these tables unless otherwise stated. Tables G12, G13 and G19 summarise the number of times a topic or theme is mentioned by a respondent.

1 Demographic questions

1.1 Gender

TABLE G.1: Question 1 Sex

Gender	Percent
Male	17.9
Female	82.1

1.2 Age group

TABLE G.2: Question 2 What is your age group?

Age Group	Percent
Less than 20	1.0
20-29	16.1
30-39	29.3
40-49	26.6
50-59	21
60 or more	6

2 Employment questions

2.1 Work place

TABLE G.3: Question 3 Where does your main work take place?

Work place	Percent
Hospital	68.5
Community	29.2
Both hospital and community	2.4

2.2 Employment

TABLE G.4: Question 4 How are you employed?

Employment	Percent
Full time	68.3
Part time	31.7

2.3 Directorate

TABLE G.5: Question 5 What is your directorate?

Directorate	Percent
Acute Paediatrics	3.8
Child & Adolescent Mental Health	1.0
Facilities	8.3
Finance	4.7
Imaging	2.5
Information	3.9
Medicine	8.7
Nursing	6.4
Pathology	3.9
Pharmacy	2.6
Primary & Community Care	30.8
Strategic Development	2.4
Surgery	9.1
Women's Services	6.1
Other	5.9

2.4 Job grade

Question 6 Do you have a job grade?

Question 7 If the answer to question 6 is yes, what is your job grade?

Question 8 Are you a manager?

These questions were all concerned with job grades or the equivalent. A large number of non-responses (187) occurred for question 7. This was possibly because people thought that the information might reveal their identity. There are many different job grades, It is not appropriate to report them here.

2.5 Supervise

TABLE G.6: Question 9 How many staff do you supervise?

Staff supervised	Percent
None	57.5
1-5	25.1
6-20	8.7
More than 20	8.7

In addition 42 respondents reported that this question was not applicable. It is suspected that they should have ticked the 'none' box

3 Communications questions

3.1 asking for information

TABLE G.7: Questions 10-13: How often do you ask for information from:

How often do you ask for information from:	Daily	Weekly	Monthly	Rarely	Never
	Percent				
Fellow worker in own department	66.0	18.6	4.3	9.3	1.8
Direct manager	31.5	35.6	13.0	17.5	2.3
Other manager	10.1	19.0	15.5	40.5	14.9
Someone in another department	21.5	24.8	13.8	30.1	9.7

3.2 Receiving information

TABLE G.8: Questions 14 -17: How much information do you get from:

How much information do you get from:	None	Little	Enough	Too much
	Percent			
Fellow worker in own department	1.9	9.6	87.4	1.0
Direct manager	2.3	21.3	73.9	2.5
Other manager	16.1	41.0	40.0	2.9
Someone in another department	14.3	43.0	40.3	2.3

3.3 Duplication

TABLE G.9: Question 18: How often are you getting the same information from more than one person?

Never	Sometimes	Mostly	Always
Percent			
11.7	75.5	10.3	2.4

3.4 Timeliness of information

TABLE G.10: Questions 19-22: Is information coming to you at the right time from:

Is information coming to you at the right time from:	Never	Sometimes	Mostly	Always
	Percent			
Fellow worker in own department	2.3	29.3	56.7	11.8
Direct manager	3.9	31.7	49.2	15.2
Other manager	16.2	50.8	30.2	2.7
Someone in another dept.	15.4	54.8	29.1	.7

3.5 Information channels

TABLE G.11: Questions 23-31: How much information do you get by the following methods:

How much information do you get by the following methods:	none	little	enough	too much
	Percent			
Talking with another person	1.1	12.6	84.0	2.3
Meetings	10.4	31.3	53.8	4.4
Telephone calls	7.8	18.8	69.6	3.8
Faxes	32.7	32.5	32.9	1.9
Written information given/sent	3.6	30.1	53.3	13
Notice boards	18.6	51.1	27.9	2.4
Team briefing	18.4	28.8	51.3	1.5
Link newspaper	10.7	41.2	47.2	.9
Yellow Bulletin	8.3	38.3	52.4	1.0

3.6 Other ways of getting information

TABLE G.12: Question 32: List any other ways that you get information

Count is defined as the number of respondents mentioning the topic

Category	Count
Gossip and Talking	101
Media	56
Information Technology	36
Books and Journals	30
Documentation	25
External Sources	22
Training	19
Clients and Public	17
Research	14
Mail	10
Departmental Newspaper	9
Professional Bodies	9
Union Rep	2
Payslips	2
Other	12

3.7 Ways staff would like to get information

TABLE G.13: Question 33: Suggest any other ways that you would like to get information (Count is defined as the number of respondents mentioning the topic).

Category	Count
Information Technology	110
Meetings	46
Manager	32
Direct	30
Documentation	26
Briefing	23
Timely	14
Newsletter	14
Any and improved	10
Training	8
Payslip	6
Fax	5
Telephone	4
Change	3
Chief Executive and High Level	3
Notice-boards	2
Other	15

3.8 Passing information to others

TABLE G.14: Questions 34 - 36: How much information do you give to others by:

How much information do you give to others by:	none	little	enough	too much
	Percent			
Describing what you are doing in your job to fellow workers	3.2	17.1	77.7	2.0
Reporting what you are doing in your job to your manager or supervisor	4.4	20.3	72.2	3.0
Supplying comments to your manager or supervisor on changes within your department	8.1	24.6	64.6	2.7

3.9 Specific information

TABLE G.15: Questions 37-41: How much information is being given to you on:

How much information is being given to you on:	none	little	enough	too much
	Percent			
The goals of your department	14.1	32.0	52.6	1.3
How your job fits into the total operation of the department	13.1	24.9	60.0	2.0
Changes in your department	9.0	37.2	51.4	2.3
Changes in other departments	20.4	55.2	22.8	1.6
The issues regarding the Queen Elizabeth Hospital	9.5	45.0	43.5	2.0

3.10 Statements about the respondent

TABLE G.16: Questions 42-46: How often are these statements true:

How often are these statements true:	Never	Some times	Mostly	Always
	Percent			
You are satisfied about the way you do your job	.9	18.5	66.3	14.3
You are able to communicate with others	.6	11.4	61.7	26.4
You can discuss things with your manager or supervisor	4.2	24.0	39.4	32.4
You are consulted about changes that affect your job	12.1	39.7	33.0	15.2
You play a part in accomplishing the goals of the department	5.6	26.5	40.3	27.6

3.11 Responsibility for communications

TABLE G.17: Question 47: Who do you think is responsible for communications?

Responsible for communications	Percent
All	64.3
Management	23.8
Heads of Departments	3.3
Director of Communications	2.9
Chief Executive/Executive Team/Trust Board	1.8
Directorate	1.2
Senior staff / higher management	0.9
Post room/switchboard	.4
Information source	.3
Other	1.1

3.12 Quality of information

TABLE G.18: Questions 48-49: How has the quality of information changed during the last year:

How has the quality of information changed during the last year:	Got worse	Stayed the same	Got better
	Percent		
In your department	19.5	55.0	25.6
Between your department and other parts of the Trust	22.9	62.6	14.5

3.13 Improving communications

TABLE G.19: Question 50: In what practical ways could communications be improved?

Count is defined as the number of respondents mentioning the topic

Topic	Count
Meetings, discussions	85
Information sharing	79
IT: e-mail, Internet, HISS, computers	67
Procedures, protocols, documentation, work organisation	50
Changes	47
Team Brief, other briefings	46
Networking, social integration, team working	41
Timelines of information, time allowed to communicate	38
Screening, information overload, reduction of paperwork	34
Telephone: service, problems, voice mail	33
Bulletins, newsletters	26
Rumour control	25
Format: plain talking, face to face, tailored to user	23
Accessibility of management	22
Training, workshops	21
Feedback	18
Notice boards	14
Openness, truthfulness	13
Mail service	13
Duplication	12
Information Disadvantaged groups: e.g. shift working, part-time working, Bank staff, disabled	9
Fax	7
Critical (of survey)	6
Strategy	6
Location	4
Help facilities: surgery, mediator	4
Other	34

APPENDIX H: RESPONSES BY DIRECTORATES

(demographic and employment questions)

Responses to all questions have been analysed by directorate, (a requirement for GHT). However only demographic and employment questions are included in this appendix as Tables H1 - H6. The following comments apply to these tables.

(i) Respondents for the Child and Adolescent Mental Health directorate were all female. Facilities had the highest male percentage response: 46%.

(ii) Facilities had the highest percentage of respondents aged 40 or more (75%). Pharmacy had the lowest (29%).

(iii) For all responses from the Finance, Imaging and Information Directorates the main workplace was a hospital. The main workplace for Child and Adolescent Mental Health was in the community only.

(iv) Pathology had the highest number of full time workers (90%). Child and Adolescent Mental Health had the lowest (33%).

(v) Acute paediatrics had the highest percentage of respondents supervising 1 or more staff (59%). The lowest was Information (29%).

TABLE H1: Question 1 Sex

	Male		Female	
Directorate	**Count**	**Percent**	**Count**	**Percent**
Acute P	2	5.7	33	94.3
Child & A	0	0	9	100.0
Facilities	35	46.1	41	53.9
Finance	13	30.2	30	69.8
Imaging	7	30.4	16	69.6
Information	7	19.4	29	80.6
Medicine	12	15.0	68	85.0
Nursing	9	15.8	48	84.2
Pathology	12	34.3	23	65.7
Pharmacy	4	16.7	20	83.3
Prim & Com	19	6.7	263	93.3
Strategic	4	18.2	18	81.8
Surgery	19	22.9	64	77.1
Women	8	14.3	48	85.7
Other	13	24.5	40	75.5
All directorates	164	17.9	750	82.1

TABLE H2: Question 2 What is your age group?

	Age group											
	< 20		20-29		30-39		40-49		50-59		60+	
Directorate	**Ct.**	**%**	**Ct.**	**%**	**Ct.**	**%**	**Ct.**	**%**	**Ct.**	**%**	**Ct.**	**%**
Acute P			9	25.7	11	31.4	7	20.0	8	22.9		
Child & A					3	33.3	4	44.4	2	22.2		
Facilities			5	6.6	14	18.4	25	32.9	22	28.9	10	13.2
Finance	1	2.3	10	23.3	10	23.3	11	25.6	7	16.3	4	9.3
Imaging			3	13.0	4	17.4	6	26.1	6	26.1	4	17.4
Information	1	2.8	6	16.7	8	22.2	6	16.7	14	38.9	1	2.8
Medicine	1	1.3	14	17.7	32	40.5	19	24.1	10	12.7	3	3.8
Nursing	1	1.7	6	10.3	23	39.7	16	27.6	7	12.1	5	8.6
Pathology			6	16.7	8	22.2	12	33.3	9	25.0	1	2.8
Pharmacy			9	37.5	8	33.3	4	16.7	2	8.3	1	4.2
Prim & Com	2	0.7	50	17.7	82	29.0	80	28.3	56	19.8	13	4.6
Strategic	1	4.5	4	18.2	4	18.2	11	50.0	2	9.1		
Surgery	2	2.4	11	13.3	25	30.1	21	25.3	19	22.9	5	6.0
Women			7	12.7	25	45.5	10	18.2	12	21.8	1	1.8
Other			8	14.8	13	24.1	8	14.8	17	31.5	8	14.8
All directorates	9	1.0	148	16.2	270	29.5	240	26.2	193	21.1	56	6.1

TABLE H3: Question 3 Where does your main work take place?

	Hospital		Community		Both	
Directorate	**Count**	**%**	**Count**	**%**	**Count**	**%**
Acute P	32	91.4	2	5.7	1	2.9
Child & A			9	100.0		
Facilities	56	74.7	16	21.3	3	4.0
Finance	41	100.0				
Imaging	23	100.0				
Information	35	100.0				
Medicine	78	98.7	1	1.3		
Nursing	48	81.4	9	15.3	2	3.4
Pathology	35	97.2	1	2.8		
Pharmacy	22	91.7	1	4.2	1	4.2
Prim & Com	67	23.8	204	72.3	11	3.9
Strategic	21	95.5	1	4.5		
Surgery	84	100.0				
Women	40	71.4	15	26.8	1	1.8
Other	42	79.2	8	15.1	3	5.7
All directorates	624	68.3	267	29.2	22	2.4

TABLE H 4: Question 4 How are you employed?

	Full-time		Part-time	
Directorate	**Count**	**%**	**Count**	**%**
Acute P	29	82.9	6	17.1
Child & A	3	33.3	6	66.7
Facilities	52	69.3	23	30.7
Finance	31	72.1	12	27.9
Imaging	18	78.3	5	21.7
Information	27	77.1	8	22.9
Medicine	57	71.3	23	28.8
Nursing	44	74.6	15	25.4
Pathology	32	88.9	4	11.1
Pharmacy	21	87.5	3	12.5
Prim & Com	175	61.8	108	38.2
Strategic	18	81.8	4	18.2
Surgery	64	76.2	20	23.8
Women	28	50.0	28	50.0
Other	30	55.6	24	44.4
All directorates	629	68.5	289	31.5

TABLE H5: Question 8 Are you a manager?

	No		Yes	
Directorate	**Count**	**%**	**Count**	**%**
Acute P	29	82.9	6	17.1
Child & A	7	77.8	2	22.2
Facilities	56	74.7	19	25.3
Finance	30	69.8	13	30.2
Imaging	18	78.3	5	21.7
Information	29	80.6	7	19.4
Medicine	61	77.2	18	22.8
Nursing	48	81.4	11	18.6
Pathology	29	80.6	7	19.4
Pharmacy	13	54.2	11	45.8
Prim & Com	230	81.3	53	18.7
Strategic	14	63.6	8	36.4
Surgery	72	85.7	12	14.3
Women	50	89.3	6	10.7
Other	43	81.1	10	18.9
All directorates	729	79.5	188	20.5

TABLE H 6: Question 9 How many staff do you supervise?

	None		1-5		6-20		> 20	
Directorate	**Count**	**%**	**Count**	**%**	**Count**	**%**	**Count**	**%**
Acute P	14	41.2	10	29.4	6	17.6	4	11.8
Child & A	4	57.1	2	28.6			1	14.3
Facilities	40	56.3	8	11.3	9	12.7	14	19.7
Finance	24	60.0	9	22.5	3	7.5	4	10.0
Imaging	9	47.4	4	21.1	4	21.1	2	10.5
Information	24	70.6	6	17.6	2	5.9	2	5.9
Medicine	39	53.4	22	30.1	4	5.5	8	11.0
Nursing	30	55.6	16	29.6	4	7.4	4	7.4
Pathology	17	48.6	12	34.3	2	5.7	4	11.4
Pharmacy	7	35.0	9	45.0	3	15.0	1	5.0
Prim & Com	155	58.7	75	28.4	17	6.4	17	6.4
Strategic	12	54.5	7	31.8	2	9.1	1	4.5
Surgery	39	53.4	15	20.5	11	15.1	8	11.0
Women	38	70.4	9	16.7	4	7.4	3	5.6
Other	32	64.0	12	24.0	4	8.0	2	4.0
All directorates	484	56.9	216	25.4	75	8.8	75	8.8

APPENDIX I: COMMUNICATION INDICES DATA

The following tables summarise the mean and standard deviations of the various Communication Indices for different groups or categories of staff. Only data which show statistically significant differences between the categories have been included.

1 Satcom Index

TABLE I 1.1: Mean Satcom Index by sex

Category (Sex)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving gender	20.07	7.70	927
Male	20.99	8.25	166
Female	19.86	7.56	761

TABLE I 1.2: Mean Satcom Index by age group

Category (age group)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving age	20.11	7.69	929
>20	21.56	6.62	9
20-29	21.55	7.07	150
30-39	20.44	7.63	272
40-49	20.48	7.77	247
50-59	18.56	7.91	195
60+	18.13	7.57	56

TABLE I 1.3: Mean Satcom Index by workplace

Category (Workplace)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving workplace	20.10	7.69	926
Hospital	20.47	7.75	634
Community	19.21	7.49	270
Both	20.32	7.85	22

TABLE I 1.4: Mean Satcom Index by employment

Category (Employment)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving employment	20.06	7.70	931
Full-time	21.04	7.44	636
Part-time	17.96	7.83	295

TABLE I 1.5: Mean Satcom Index by numbers of staff supervised

Category (Supervision)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving supervision	20.23	7.64	897
None *	18.59	7.68	531
1-5 staff	21.56	7.30	216
6-20 staff	22.95	6.72	75
>20 staff	25.28	5.24	75

* Respondents replying 'non applicable' were counted as supervising none

TABLE I 1.6: Mean Satcom Index by directorate

Category (Directorate)	Mean Satcom Index	Standard Deviation	Cases
All Respondents giving directorate	20.14	7.67	921
Acute Paediatrics	21.89	5.23	35
Child & Adolescent Mental Health	17.78	6.94	9
Facilities	17.86	9.12	76
Finance	23.84	7.55	43
Imaging	17.22	6.69	23
Information	20.22	7.32	36
Medicine	18.05	7.41	80
Nursing	20.54	7.20	59
Pathology	18.94	7.34	36
Pharmacy	24.54	6.93	24
Primary & Community	20.75	7.29	284
Strategic Development	26.32	4.94	22
Surgery	20.32	7.42	84
Women's Services	17.27	7.48	56
Other	19.39	8.79	54

2 Frequcom Index

TABLE I 2.1: Mean Frequcom Index by sex

Category (Sex)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving gender	2.09	1.39	927
Male	2.48	1.39	166
Female	2.00	1.38	761

TABLE I 2.2: Mean Frequcom Index by age group

Category (age group)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving age	2.09	1.39	929
>20	2.89	0.78	9
20-29	2.53	1.22	150
30-39	2.21	1.35	272
40-49	2.15	1.42	247
50-59	1.74	1.40	195
60+	1.25	1.35	56

TABLE I 2.3: Mean Frequcom Index by workplace

Category (Workplace)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving workplace	2.09	1.39	926
Hospital	2.22	1.39	634
Community	1.82	1.33	270
Both	1.73	1.35	22

TABLE I 2.4: Mean Frequcom Index by type of employment

Category (Employment)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving employment	2.09	1.39	931
Full-time	2.34	1.36	636
Part-time	1.55	1.30	295

TABLE I 2.5: Mean Frequcom Index by numbers of staff supervised

Category (Supervision)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving supervision	2.11	1.39	897
None *	1.89	1.35	531
1-5 staff	2.15	1.43	216
6-20 staff	2.79	1.27	75
>20 staff	2.92	1.16	75

* Respondents replying 'non applicable' were counted as supervising none

TABLE I 2.6: Mean Frequcom Index by directorate

Category (Directorate)	Mean Frequcom Index	Standard Deviation	Cases
All Respondents giving directorate	2.10	1.38	921
Acute Paediatrics	2.00	1.50	35
Child & Adolescent Mental Health	2.22	0.83	9
Facilities	1.67	1.43	76
Finance	3.12	1.18	43
Imaging	2.57	1.04	23
Information	2.22	1.50	36
Medicine	2.05	1.48	80
Nursing	2.25	1.33	59
Pathology	2.00	1.31	36
Pharmacy	2.79	1.47	24
Primary & Community	1.95	1.33	284
Strategic Development	3.05	1.05	22
Surgery	2.05	1.22	84
Women's Services	1.91	1.39	56
Other	1.98	1.52	54

3 Overload Index

TABLE I 3.1: Mean Overload Indices by types of work place

Category (Main work place)	Mean Overload Index	Standard Deviation	Cases
All Respondents giving workplace	0.53	1.25	926
Hospital	0.46	0.98	634
Community	0.70	1.72	270
Both Hospital and Community	0.59	1.01	22

TABLE I 3.2: Mean Overload Indices by numbers of staff supervised

Category (Supervision)	Mean Overload Index	Standard Deviation	Cases
All Respondents giving supervision	0.56	1.29	897
None *	0.41	1.25	531
1-5 staff	0.57	1.13	216
6-20 staff	0.77	1.34	75
>20 staff	1.32	1.65	75

* Respondents replying 'non applicable' were counted as supervising none

4 Blankcom Index

TABLE I 4.1: Mean Blankcom Index by type of employment

Category (Employment)	Mean Blankcom Index	Standard Deviation	Cases
All Respondents giving employment	2.97	3.92	931
Full-time	2.61	3.69	636
Part-time	3.74	4.28	295

TABLE I 4.2: Mean Blankcom Index by number of staff supervised

Category (Supervision)	Mean Blankcom Index	Standard Deviation	Cases
All Respondents giving supervision	2.92	3.88	897
None *	3.67	4.2	531
1-5 staff	2.27	3.37	216
6-20 staff	1.56	2.96	75
>20 staff	0.85	1.25	75

* Respondents replying 'non applicable' were counted as supervising none

TABLE I 4.3: Mean Blankcom Index by directorate

Category (Directorate)	Mean Blankcom Index	Standard Deviation	Cases
All Respondents giving directorate	2.95	3.92	921
Acute Paediatrics	2.8	3.06	35
Child & Adolescent M	3.11	2.09	9
Facilities	3.83	5.06	76
Finance	2.26	4.09	43
Imaging	2.91	2.59	23
Information	3.17	3.60	36
Medicine	3.84	4.26	80
Nursing	1.93	2.36	59
Pathology	4.03	4.53	36
Pharmacy	1.50	2.86	24
Primary & Community	2.47	3.79	284
Strategic Development	0.95	1.33	22
Surgery	3.06	3.33	84
Women's Services	3.70	3.93	56
Other	4.30	5.21	54

5 Nonresponse Count

TABLE I 5.1: Mean Nonresponse Count by age group

Category (age group)	Mean Nonresponse count	Standard Deviation	Cases
All Respondents giving age	2.19	5.49	929
>20	0.67	0.71	9
20-29	1.46	4.66	150
30-39	1.32	3.60	272
40-49	2.36	5.98	247
50-59	3.03	6.38	195
60+	4.86	8.23	56

TABLE I 5.2: Mean Nonresponse Count by types of employment

Category (Employment)	Mean Nonresponse Count	Standard Deviation	Cases
All Respondents giving employment	2.19	5.50	931
Full-time	1.72	4.72	636
Part-time	3.22	6.78	295

TABLE I 5.3: Mean Nonresponse count by levels of supervision

Category (Supervision)	Mean Nonresponse Count	Standard Deviation	Cases
All Respondents giving supervision	2.05	5.19	897
None *	2.66	6.16	531
1-5 staff	1.28	3.32	216
6-20 staff	1.57	3.72	75
>20 staff	0.45	1.33	75

* Respondents replying 'non applicable' were counted as supervising none

TABLE I 5.4: Mean Nonresponse Count by directorate

Category (Directorate)	Mean Nonresponse Count	Standard Deviation	Cases
All Respondents giving directorate	2.12	5.27	921
Acute Paediatrics	1.20	2.01	35
Child & Adolescent Mental Health	1.11	2.26	9
Facilities	5.70	9.36	76
Finance	0.60	1.26	43
Imaging	3.43	7.15	23
Information	1.61	3.49	36
Medicine	2.61	5.67	80
Nursing	2.83	6.04	59
Pathology	1.03	2.82	36
Pharmacy	0.63	0.82	24
Primary & Community	1.38	3.99	284
Strategic Development	0.73	1.58	22
Surgery	2.26	5.94	84
Women's Services	2.00	4.07	56
Other	3.19	6.59	54

APPENDIX J: SURVEY RELIABILITY CALCULATIONS

Results of calculations for reliability analysis - scale alpha are given in Tables J1-J4 for groups of survey questions.

In addition to the matrix showing inter-item correlations the following have been calculated as described by Coakes and Steed(1996) using SPSS:

(i) Scale mean if item deleted - this column gives the average score for the scale if the item had been excluded from the scale.

(ii) Scale variance if item deleted - this gives the scale variance if the item were eliminated

(iii) Corrected item-total correlation - this column gives the Pearson correlation coefficient between the score on the individual item and the some of the scores on the remaining items.

(iv) Squared multiple correlation - this column gives the result or a multiple regression equation with the item of interest as the dependent variable and all the other items as independent variables

(v) Alpha if item deleted - this gives the alpha coefficient that would result if the item was removed from the scale.

TABLE J1.1 Correlation Matrix for all questions about amount of information

	Q14	Q15	Q16	Q17	Q23	Q24	Q25	Q26	Q27	Q28
Q14	1									
Q15	0.22	1								
Q16	0.22	0.38	1							
Q17	0.26	0.20	0.49	1						
Q23	0.37	0.19	0.18	0.22	1					
Q24	0.21	0.29	0.32	0.23	0.33	1				
Q25	0.21	0.24	0.34	0.36	0.39	0.30	1			
Q26	0.19	0.15	0.28	0.30	0.24	0.28	0.42	1		
Q27	0.20	0.25	0.37	0.35	0.22	0.35	0.37	0.32	1	
Q28	0.18	0.17	0.15	0.11	0.19	0.17	0.12	0.05	0.20	1
Q29	0.20	0.28	0.26	0.14	0.18	0.39	0.15	0.16	0.27	0.33
Q30	0.12	0.20	0.27	0.14	0.15	0.23	0.22	0.20	0.34	0.36
Q31	0.11	0.14	0.22	0.10	0.13	0.17	0.18	0.19	0.28	0.32
Q34	0.20	0.05	0.03	0.12	0.24	0.11	0.20	0.09	0.16	0.14
Q35	0.14	0.16	0.13	0.13	0.22	0.21	0.19	0.14	0.18	0.21
Q36	0.18	0.22	0.18	0.17	0.22	0.25	0.21	0.19	0.21	0.19
Q37	0.21	0.39	0.29	0.23	0.24	0.36	0.24	0.17	0.24	0.28
Q38	0.21	0.34	0.28	0.23	0.18	0.35	0.22	0.11	0.25	0.28
Q39	0.25	0.37	0.24	0.20	0.23	0.30	0.19	0.13	0.25	0.23
Q40	0.17	0.27	0.28	0.26	0.15	0.26	0.19	0.20	0.25	0.21
Q41	0.16	0.23	0.32	0.25	0.14	0.33	0.17	0.25	0.35	0.15
	Q29	**Q30**	**Q31**	**Q34**	**Q35**	**Q36**	**Q37**	**Q38**	**Q39**	**Q40**
Q29	1									
Q30	0.46	1								
Q31	0.41	0.77	1							
Q34	0.06	0.07	0.12	1						
Q35	0.15	0.13	0.13	0.39	1					
Q36	0.23	0.19	0.19	0.34	0.57	1				
Q37	0.38	0.26	0.20	0.15	0.30	0.32	1			
Q38	0.33	0.22	0.16	0.15	0.29	0.29	0.65	1		
Q39	0.30	0.22	0.14	0.07	0.21	0.25	0.61	0.60	1	
Q40	0.25	0.21	0.15	0.07	0.17	0.26	0.48	0.48	0.58	1
Q41	0.34	0.29	0.26	0.00	0.16	0.22	0.37	0.33	0.42	0.51
	Q41									
Q41	1									

Number of valid cases = 706

Statistics for scale:

Mean 52.67, variance 55.61, standard deviation 7.46, number of variables 21

TABLE J1.2: Item total statistics for all questions about amount of information

Question no	Mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Alpha if item deleted
Q14	49.79	53.31	0.36	0.22	0.87
Q15	49.90	51.90	0.45	0.28	0.87
Q16	50.36	49.66	0.50	0.39	0.86
Q17	50.36	50.72	0.42	0.34	0.87
Q23	49.78	53.10	0.40	0.30	0.87
Q24	50.12	49.79	0.52	0.34	0.86
Q25	49.95	50.93	0.46	0.36	0.86
Q26	50.60	50.29	0.38	0.27	0.87
Q27	49.90	49.85	0.52	0.33	0.86
Q28	50.53	51.18	0.37	0.23	0.87
Q29	50.29	49.47	0.50	0.38	0.86
Q30	50.27	50.41	0.49	0.64	0.86
Q31	50.21	51.18	0.42	0.61	0.87
Q34	49.86	53.61	0.24	0.25	0.87
Q35	49.93	52.13	0.38	0.39	0.87
Q36	50.06	50.84	0.45	0.39	0.87
Q37	50.25	48.71	0.61	0.56	0.86
Q38	50.16	49.11	0.57	0.53	0.86
Q39	50.19	49.83	0.56	0.55	0.86
Q40	50.60	49.93	0.52	0.46	0.86
Q41	50.26	50.26	0.51	0.39	0.86

Reliability Coefficients 21 items Alpha = 0.87

TABLE J2.1 Correlation Matrix for all questions about frequency of communication

	Q10	Q11	Q12	Q13
Q10	1			
Q11	0.43	1		
Q12	0.29	0.43	1	
Q13	0.41	0.35	0.56	1

Number of Cases = 813

Statistics for scale:

Mean 10.33, variance 10.44, standard deviation 3.23, number of variables 4

TABLE J2.2: Item total statistics for all questions about frequency of communication

Question no	Mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Alpha if item deleted
Q10	6.90	7.05	0.48	0.26	0.71
Q11	7.53	6.46	0.51	0.29	0.69
Q12	8.49	6.29	0.57	0.38	0.66
Q13	8.06	5.74	0.57	0.38	0.65

Reliability Coefficients 4 items: Alpha = 0.74

TABLE J3.1 Correlation Matrix for all questions about timeliness of communication

	Q19	Q20	Q21	Q22
Q19	1			
Q20	0.48	1		
Q21	0.28	0.41	1	
Q22	0.31	0.22	0.49	1

Number of Cases =815

Statistics for scale:

Mean 9.87, variance 4.10, standard deviation 2.03, number of variables 4

TABLE J3.2: Item total statistics for all questions about timeliness of communication

Question no	Mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Alpha if item deleted
Q19	7.08	2.66	0.47	0.27	0.64
Q20	7.12	2.42	0.49	0.32	0.63
Q21	7.68	2.39	0.53	0.33	0.60
Q22	7.72	2.70	0.44	0.27	0.66

Reliability Coefficients 4 items, Alpha = 0.70

TABLE J4.1 Correlation Matrix for all questions about truth of statements

	Q42	Q43	Q44	Q45	Q46
Q42	1				
Q43	0.39	1			
Q44	0.24	0.43	1		
Q45	0.20	0.28	0.57	1	
Q46	0.36	0.36	0.41	0.51	1

Number of Cases = 875

Statistics for scale:

Mean 14.50, variance 7.55, standard deviation 2.75, number of variables 5

TABLE J4.2: Item total statistics for all questions about truth of statements

Question no	Mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Alpha if item deleted
Q42	11.56	6.09	0.38	0.21	0.75
Q43	11.36	5.74	0.49	0.29	0.72
Q44	11.51	4.62	0.59	0.41	0.68
Q45	11.99	4.56	0.57	0.42	0.69
Q46	11.59	4.65	0.57	0.35	0.68

Reliability Coefficients 5 items, Alpha = 0.75

REFERENCES

Adler R B, (1992). *Notes on Communicating at Work* (4th edn.), McGraw Hill

Afifi A A, Clark V, (1990). *Computer-Aided Multivariate Analysis* (2nd edn.), New York, Chapman and Hall, p17

Alford R R, (1975). *Health Care Politics*, Chicago, London, University of Chicago Press

Ansbary J, Staples P, (1991). *Improving administrator/nurse communications: a case study of management by wandering about*, Journal of Business Communication, 28, p101-112

Aristotle(350BC), *De Interpretatione*, Translation from the Latin, (1962). On Interpretation, Milwaukee, Marquette University Press

Arnott M, (1987). *Effective Employee Communication*, in Hart N A (ed.), Effective Corporate Relations, London, McGraw-Hill p 67

Baggott R, (1998). *Heath and Healthcare in Britain*, (2nd edn.), Basingstoke, Macmillan

Barber J, (1998). *Words of Wisdom*, Healthcare Today, no 57, June, p16-18

Barnard C, (1938). *The Functions of the Executive*, Cambridge Mass. Harvard University Press

Barnett G A, Hamlin D A, Danowski J A, (1981). *The Use of Fractionation Scales for Communication Audits*, Communication Yearbook, 5, p 455-471

Baron R A, Greenberg J, (1990). *Behaviour in Organisations*, (3rd edn.), Boston, London, Allyn and Bacon

Barrett M, (1995). *Practical and Ethical Issues in Planning Research*, in Breakwell G M, Hammond S, Fife-Schaw C (eds.), Research Methods in Psychology, London, Sage p16-33

Barthes R, (1973). *Elements of Semiology*, New York, Hill and Wang

Baskin W, (1959). translator of Saussurian's course of 1916 as *Course in General Linguistics*, New York

Bechhofer F, (1974). *Current Approaches to Empirical Research: Some Central Ideas*, in Rex J (ed.), Approaches to Sociology, London, Routledge and Kegan Paul, p 70-91

Bertsch B, Williams R, (1994). *How Multinational CEOs Make Change Programmes Stick*, Long Range Planning, 27, p12-24

Bertalanffy L von (1973). *General Systems Theory: Foundations, Development, Applications,* Harmondsworth, Penguin

Blakstad M, Cooper A, (1995). *The Communicating Organisation*, London, Institute of Personal Development

Bryman A, Cramer D, (1997). *Quantitative Data Analysis with SPSS for Windows,* London & New York, Routledge

Burns T, Stalker G M, (1961). *The Management of Innovation*, London, Tavistock

Burson-Marsteller, (1992). *Maintaining the Momentum of the National Communications Programme*, Private report to the NHS Executive, London.

Carroll L (Dodgeson C), (1872). *Through the Looking Glass*, London, Macmillan, p128

Clampitt P, Downs C, (1993). *Employee Perceptions of The Relationship Between Communication and Productivity*, Journal of Business Communication, 30, p 5-28

Clarke S, (1981). *Foundations of Structuralism*, Sussex, Harvester Press p 1-5

Coakes S J, Steed L G, (1996). *SPSS for Windows, Analysis without Anguish,* Brisbane, John Wiley and Sons p 116

Cronbach LJ, (1951). *Coefficient Alpha and the Internal Structure of Tests,* Psychometrika, 16 (September), p 297-334

Cushman D P, Knovacic B, (1995). *Watershed Research Traditions In Human Communication Theory*, State University of New York

Daft R L, Lengel R H, Trevina L K, (1987). *Message Quivocality, Media Selection and Manager Performance - Implications for Information Systems*, MIS Quarterly 11 p 355-366

Dance F E X, (1967). *A Helical Model of Communication,* in Dance F E X (ed.), Human Communication Theory, New York, Holt, Rinehart and Winston

DeCotilis T, Summers T, (1987). *A Path Analysis of a Model of the Antecedents and Consequences of Organisable Commitment*, Human Relations, 40, p 445-470

DeFleur M L, (1970). *Theories of Mass Communication*, New York, David McKay

Dessler G, (1986). *Organization Theory: Integrating Structure and Behaviour*, New Jersey, Prentice-Hall

Duncan S, Fiske D W, (1977). *Face to Face Interaction*, New Jersey, Lawrence Erlbaum Associates

Emmanuel M, (1985). *Auditing Communication Practices*, in Reuss C, DiSilvas R (eds.), Inside Organisational Communication, (2nd edn), New York, Longman, p 50

Fife-Schaw C, (1995). *Questionnaire Design*, in Breakwell G M, Hammond S, Fife-Schaw C (eds.), Research Methods in Psychology, London, Sage, p174-193

Fletcher C M, (1973). *Communication in Medicine*, The Nuffield Provincial Hospitals Trust

Foehrenbach, Goldforb, (1990). *Employee Communication in the 90s: Greater Expectations*, ABC Communication World, International Association of Business Communicators May-June

Follett M P, (1924). *Creative Experience*, New York, Longmans,

Foushee H C, (1984). *Diads and Triads at 35000 Feet*, Factors Affecting Group Processes and Aircrew Performance. American Psychologist, 39, p 885-893

French W L, Bell C H, (1995). *Organisation Development* (5th edn.), London, Prentice Hall

Galbraith J R(1977). *Organisational Design*, Reading Mass., London, Addion-Wesley,

Gerbner G, (1967). *Mass Media and Human Communication Theory,* in Dance F E X (ed.), Human Communication Theory, New York, Rinehart and Winston

Glauser M J, (1984). *Upward Information Flow In Organisations*, Review and Conceptual Analysis, Human Relations, 37, p 613-643

Goldhaber G M, (1976). *The ICA Communication Audit: Rational and Development*, Communication Association of the Pacific Meeting, Kobe, Japan

Goldhaber G M, Dennis H, Richetto G M, Wiio O A, (1979). *Information Strategies - New Pathways to Corporate Power*; New Jersey, Prentice Hall

Goldhaber G M, Yates M P, Porter D T, Lesniak R, (1978). *Organizational Communication:* 1978, Human Communications Research, 5, no 1

Goldhaber G, Rogers D, (1979). *Auditing Organizational Communication Systems,* The ICA Communication Audit, Dubuque, Kendall Hunt

Goldschmidt W, (1972). *An Ethnography of Encounters, a Methodology for the Enquiry into the Relation Between the Original and Society*, Current Anthropology, 13, p 59-78

Greenberg J, Baron R A, (1993). *Behaviour in Organisations* (4th Edn.) Boston, Allyn and Bacon

Griffiths Report, (1983). *NHS Management Enquiry,* (The Griffiths Management Report), London, DHSS

Grunig J E (ed.) (1992). *Excellence in Public Relations and Communications Management*, L Erlbaum

Hammer M, Champy J, (1993). *Re-engineering the Corporation: A Manifesto for Business Revolution*, London, Nicholas Brearly

Hammond S, (1995). *Using Psychometric Tests*, in Breakwell G M, Hammond S, Fife-Schaw C (eds.), Research Methods in Psychology, London, Sage p194-212

Hargie O D W, Tourish D, (1996). *Auditing Senior Management Communication Practices in the NHS: a Regional Study*, Health Services Management Research, 9, p 209-222

Harris R, (1996). *Signs Language and Communication*, London, Routledge

Harrison S, (1988). *The Workforce and the New Managerialism*, In Maxwell R, (ed) Reshaping the National Health Service, Berksire, Policy Journals p 141-152

Harvey D, Brown D, (1988). *An Experimental Approach to Organization Development* (3rd edn.), New Jersey, Prentice Hall, p 3

Hepworth V, (1997). *Communication Chords*, Health Services Journal, 29 May, p30-31

Hofsted G, (1981). *Culture and Organisations*, International Studies of Management and Organizations, 10, no 4, p 15-41

Jacobson E W, Seashore S E, (1951). *Communication Practices in Complex Organisations*, Journal of Social Issues, 7 p 28-40

Janis I, (1971). *Groupthink*, Psychology Today, November p 43-76

Johnson G, Scoles K, (1993). *Exploring Corporate Strategy, Text and Cases* (3rd edn.), London, Prentice Hall, p 37-8

Jones P, Palmer J, Osterweil C, Whitehead D, (1996). *Delivering exceptional performance: Aligning the Potential of Organisations, Teams and Individuals,* London, Pitman

Joss R, Kogan M, (1995). *Advancing Total Quality: Total Quality Management in the National Health Service*, Buckingham, Open University Press

Katz D. Kahn R, (1966). *The Social Psychology of Organisation*, New York, John Wiley

Kelly M, (1997). *Private Discussions*, University of Greenwich

Kelly M, Glover I, (1996). *In Search of Health and Efficiency: the NHS 1948-1994,* in Leopold J, Glover I, Hughes M (eds), Beyond Reason, The National Health Service and the Limits of Management, Aldershot, Avebury

Kennedy D, (1996). *Trust Chairman Forced out by Doctors' Resignation*, The Times, 15 August, p2; also Hospital Revolt, The Times 28 August, p 6

Kim W C, Mauborgne R, (1997). *Fair Process: Managing the Knowledge Economy,* Harvard Business Review, July-August, p 65-75

Koontz H (ed), (1964). *Toward a Unified Theory of Management*, New York, McGraw-Hill

Krippendorff K (1994). *A Recursive Theory of Communication* in D Crowley, D Mitchell (eds), Communication Theory Today, Cambridge, Polity Press

Lasswell H D, (1948). *The Structure and Function of Communication in Society*, in Bryson (ed) The Communication Of Ideas, New York: Harper and Brothers

Lawrence P P, Lorsch J W, (1967). *Differentiation and Integration in Complex Organisations*, Administrative Science Quarterly, 12, p 1-47

Leach E, (1976). *Culture and Communication*, Cambridge, Cambridge University Press, p 3-7

Leavitt H, (1972). *Some Effects of Certain Communication Patterns on a Group Performance*, Journal of Abnormal and Social Psychology, 46, p 38-50

Leiss W, (1994). *Risk Communication and Public Knowledge*, in Crowley D, Mitchell D (eds), Communication Theory Today, Cambridge, Polity Press

Lévi-Stauss C, (1968). *Structural Anthropology*, Translated from the French by Jacobson C and Schoef B G, London, Allen Lane the Penguin Press

Likert R, (1932). *A Technique for the Measurement of Attitudes*, (Archives of Psychology no 140), New York, Columbia University Press

Lin N, (1999). *Building a Theory of Social Capital*, Connections, 22, issue 1, p 28-51

Lloyd P, (1998). *More than Lip Service - a Survey of Communication Practice in the NHS,* London, Office for Public Management

Lloyd P, (1998a). *Off message*, Health Service Journal 108, 7 May, p 26-29

Luthans F, Larsen J K, (1986). *How Managers Really Communicate*, Human Relations, 39, p 161-175

Mantovani G, (1996). *New Communication Environments from Everyday to Virtual*, London,Taylor and Francis

McQuail D, Windahl S, (1993). *Communication Models for the Study of Mass Communication* (2nd edn.), London and New York, Longman

Mears P, (1975). *Structuring Communication in a Working Group*, The Journal of Communication 24, no 1, p 71-79

Merrick N, (1998). *Grievous Procedure*, People Management 30 April p 38-40

Mintzberg H, (1973). *The Nature of Managerial Work*, New York, London, Harper and Row

Mintzberg H, (1990). *Mintzberg on Management*, London, Free Press

Moser C A, Kalton G, (1971). *Survey methods in Social Investigation*, (2nd edn.), Aldershot, Gower

Murrey T J, (1987). *How to Stay Lean and Mean*, Business Month, August, p 29-32

Newcome T, (1953). *An Approach to the Study of Communicative Acts,* Phsycological Review, 60, p 393-404

Newcome T, (1959). *The Study of Consensus,* in Merton R K, Broom L, Cottrell S (eds), Sociology Today, New York, Basic Books

NHS Confederation ,(1997). *Directors Guide: Better communications for NHS Trusts*

NHS Executive, (1996). *Communication Standards in the NHS*, April

Odiorne G, (1954). *An Application of the Communication Audit*, Personnel Psychology, 1, p 235-43

Osgood C E, Suci G J, Tannenbaum P H, (1957). *The Measurement of Meaning*, Urbana, University of Illinois Press

Oswick C, Grant D (Eds.), (1996). *Organisation Development: Metaphorical Explorations*, London, Pitman, p 1-3

Pater J E, (1981), *The Making of the National Health Service*, King's Fund Historical Series 1, London, King's Fund

Perin T, (1993). *Improving Business Performance Through People, Investing in People - the Benefits of Being an Investor*, Department of Employment

Peterson R A, (1994). *A Meta-analysis of Cronbach's Coefficient Alpha*, J. of Consumer Research, 21, September, p 381-391

Pettigrew A, Ferle E, McKee L, (1992). *Shaping Strategic Change*, London, Sage

Pettigrew A, Ferle E, McKee L, (1992a). *Shaping Strategic Change - the case of the NHS in the 1980s*, Public Money and Management, July – Sept 1992, p 27-31

Plant R, (1987). *Managing Change and Making it Stick*, London, Fontana

Poster M, (1994).*The mode of information and post-modernity*, in: Crowley D, Mitchell D (eds.) . Communication Theory Today, Cambridge, Polity Press

Preston D, (1993). *Learning the Organisation: Confusions and Contradictions for New Managers,* Human Resource Management Journal, 4, no 1, p 24-33

Preston D, Loan-Clark J, (1997). *The Importance of Being Ernest: Reflections On An Attempt to Create an Information-led Organisational Culture in the NHS*, Health Manpower Management, 23, no 4, p120-122

Pugh D S, (1973). *The Measurement of Organisational Structures: Does Context Determine Form?*, Organisational Dynamics, Spring, p19-34

Quinn J B, (1980). *Stratagies for Change: Local Incrementalism*. Homewood Il., Irwin

Read W, (1962). *Upward Communication in Industrial Hierarchies*, Human Relations, 15, p 3-16

Reuters, (1996). *Dying for Information, an Investigation into the Effects of Information Overload in the UK and World Wide*, London, Reuters Business Information

Roberts K H, (1984). *Communicating in Organisations*, Science Research Association, p 4

Roethlisberger F J, Dickson W J, (1964). *Management and the Worker*, New York, John Wiley

Rogers E M, Rogers A, (1976). *Communication in Organisations*, New York, Free Press

Rowland H, Harris L,(1998). *Doctor Know*, People Management, 4, 5 March p50-52

Saussure F de, (1916). *Cours de Linguistique* Générale, Payot, Paris

Scammell B, (1990). *Communication Skills: Essentials of Nursing Management,* London, Macmillan

Schramm W, (1954*). How Communication Works*, in Schramm W (ed.), The Process and Effects of Mass Communication, Urbana, University of Illinois Press

Self P, (1972). *Administrative Theories and Politics*, London, Allen & Unwin,

Senior B, (1997). *Organisational Change*, London, Pitman, p 7-19

Senn J A, (1998). *Information Technology in Business, Principles, Practices and Opportunities* (2nd edn.), New Jersey, Prentice-Hall, p 7

Shannon C E, Weaver W, (1949). *The mathematical theory of communication,* Urbana, University of Illinois Press

Simon H A, (1976). *Administrative Behaviour*, New York, Free Press

Smeltzer L, (1991). *An Analysis of Strategies for Announcing Organisation Wide Change,* Group and Organisation Studies, 16, p 5-24

Spurgeon P, Barwell F, (1991). *Implementing Change in the NHS*, London, Chapman and Hall p7-8

Steers K D, Porter L W, (1991). *Motivation and Work Behaviour* (5th edn.), NewYork, London, McGraw Hill

Stevens S S, (1951). *Mathematics, Measurement, and Psychophysics*, in Stevens S S (ed), Handbook of Experimental Psychology, New York, Wiley

Stocking B, (1985). *Innovation and Inertia in the NHS*, London, Nuffield Provincial Hospitals Trust

Strong P, Robinson J, (1990). *The NHS: Under New Management*, Buckingham, Open University Press

Theodorson S A, Theodorson A G, (1969). *A Modern Dictionary of Sociology*, New York, Cassell

Thompson V, (1961). *Modern Organizations*, New York, Knopf

Tourish D, (1996). *Internal Communication and the NHS: The Results of a Fieldwork Analysis and implications for Corporate Practice*, DPhil Thesis, University of Ulster, Jordanstown

Tourish D, Hargie O, (1996). *Communication Audits and the Management of Change: a Case study from an NHS Unit of Management*, Health Services Management Research, 9, p 125-135

Tourish D, Turish B, (1996). *Assessing Staff-management Relationships in Local Authority Leisure Facilities: the Communication Audit Approach,* Managing Leisure: an International Journal, 1, p 91-104

Walker C R, Guest R H, (1952). *The man on the Assembly Line*, Harvard University Press

Watzlawick P, Beavin J H, Jackson D D, (1967). *Pregmatics of Human Communication*, New York, W W Norton, p 48-51

Weber M (1947). *The Theory of Social and Economic Organisations,* in Pugh D, Organisational Theory Selected Readings (3rd edn.), Harmodsworth, Penguin, 1990

Webster G (1998). *Changing Places*, Management Today, August, p 62-66

Webster P, Sherman J, (1999). *Blair Scarred by Stubborn Public Sector*, The Times, 7th July , p 1

Werner D, (1995). *Managing Company Wide Communication*, Chapman and Hall

White J, Mazur L, (1995). *Strategic Communication Management* - Making Public Relations Work, Wokingham, Addison-Wesley p163

Wiio O A, (1974). *Auditing Communication in Organisations, a Standard Survey* LTT Communication Audit, Presented to the ICA meeting, New Orleans

Wiio O A, (1978). *Organizational Communication Studies: the LTT and OCD procedures,* International Communication Association, Annual Meeting in Chicago, April, p1-24

Wiio O A, Goldhaber G M, Yates M P, (1980). *Organizational Communication Research: Time for Reflection*, Communication Yearbook 4, p 83-97

Wilson D C, Rosenfeld R H, (1990). *Managing Organisations, Text Readings and Cases*, Maidenhead, McGraw-Hill

Wylie I, (1997). *Making Communications Matter for Trusts*, Health Director, no 35, February, p 4