Human Resources, Organisational Development and Workforce Development in the NHS: A Review of Recent Research

Human Resource Management, Organisational and Workforce Development in the NHS
From current thinking to future models
Human Resources, Organisational Development and Workforce Development in the NHS:
A Review of Recent Research

Authors
Linda Miller
Andrea Broughton
Penny Tamkin
Peter Reilly
Jo Regan

The Institute for Employment Studies
The Institute for Employment Studies is an independent, apolitical, international centre of research and consultancy in human resource issues. It works closely with employers in the manufacturing, service and public sectors, government departments, agencies, and professional and employee bodies. For over 35 years the Institute has been a focus of knowledge and practical experience in employment and training policy, the operation of labour markets and human resource planning and development. IES is a not-for-profit organisation which has over 60 multidisciplinary staff and international associates. IES expertise is available to all organisations through research, consultancy, publications and the Internet.

IES aims to help bring about sustainable improvements in employment policy and human resource management. IES achieves this by increasing the understanding and improving the practice of key decision makers in policy bodies and employing organisations.

Other titles from IES
A catalogue of over 100 other titles is available from IES, or on the IES Website, www.employment-studies.co.uk

The authors would like to thank the following for their help:
• Liz Brown at the NHS Institute for Innovation and Improvement for her enthusiasm and support during the project,
• the research institutes who kindly provided reports during the literature search phase, and
• last but not least, our colleagues Gwen Leeming and Natalie Gonnella for their help in producing the report.
## Contents

**Executive Summary**

1. **Introduction**
   1.1 Approach
   1.1.1 Aims and objectives
   1.2 Methodology
   1.2.1 Scoping
   1.2.2 Structure of the final report

2. **Structure and Role of HR**
   Key points from the literature are:
   2.1 Structure of HR
   2.2 HR roles
   2.3 Technology
   2.4 Outsourcing
   2.5 Current trends in organising training and development

3. **Impact of People Management on Organisational Performance**
   Key points from the literature are:
   3.1 High performance work practices
   3.1.1 How do high performance work practices bring benefits?
   3.2 Developing employee commitment and engagement
   3.2.1 Benefits of employee commitment and engagement
   3.3 How does people management practice impact on organisational performance?
   3.4 Universal good practice or a contingent view?
   3.5 The benefits of ‘good’ functional HR
4 Evidence from the Health Care Setting
   Key points from the literature are:
   4.1 Applying HR research findings within the NHS
      4.1.1 Types of measures used
      4.1.2 Outcome measures specific to the Health Service
   4.2 Evidence from people management in the health setting
      4.2.1 High performance HR management/bundles
      4.2.2 Management and leadership
      4.2.3 Appraisal
      4.2.4 Team working/high reliability teams
      4.2.5 The working environment/worklife characteristics
      4.2.6 Staff ratios
      4.2.7 Skill mix
      4.2.8 Reward systems
      4.2.9 Training and development
      4.2.10 Shift work
      4.2.11 Organisational trust, empowerment and involvement

5 Conclusions: Implications and Recommendations for the Role of HR Within the Health Sector
   Key points from the literature are:
   5.1 How should HR be structured in the health sector?
   5.2 What is the relationship between HR and learning and development, workforce planning and OD?
   5.3 The evolving relationship between the line and HR
   5.4 People management practices
      5.4.1 Training and support practices
      5.4.2 Practices aimed at improving working conditions
      5.4.3 Increasing employee involvement and engagement
   5.5 Implications for HR activity
      5.5.1 Training and support practices
      5.5.2 Practices aimed at improving working conditions
      5.5.3 Increasing employee involvement and engagement
   5.6 Concluding comments

6 Bibliography
Executive Summary

The NHS plan (2002) proposed reforms that aim to improve the working lives and careers of NHS employees. Human Resource (HR) and Organisational Development (OD) practitioners within the NHS are seen as being key players within this agenda. The NHS Institute for Innovation and Improvement (NHS Institute) commissioned IES to review and summarise existing research findings regarding the role of HR/OD in workforce development and to put forward suggestions for the further development of roles and activities of HR and OD practitioners in the NHS. This report is the outcome of that work.

There were four main requirements for the report. The NHS Institute asked for the report to outline:

1. The people management models that are in use within the UK and internationally.
2. The available evidence that implementation progressive HR policies leads to enhanced productivity, efficiency and service improvement.
3. The evidence of their successful use within the NHS and other health services (eg in other countries) and for the functional impact of particular HR initiatives in achieving sustainable service improvement and transformation in the healthcare sector.
4. To make recommendations for the sorts of good practice people management examples the NHS should bear in mind when considering making organisational changes and service reforms.

The structure and role of HR

The first substantive chapter of the report (Chapter 2) outlines current thinking and developments regarding the structure and role of HR in the UK and internationally. The various suggestions that have been made for the ways in which HR could be organised and HR roles and responsibilities distributed are outlined.

In general, the key points from the literature in this area are as follows:

- The ‘three legged stool’ model suggests that there should be three main components of contemporary HR practice: shared service centres, business partners and centres of expertise. However, some writers have suggested that the model is mainly suitable for application within large and complex organisations.
- David Ulrich has argued against a single generic model for HR structure on the grounds that structure should follow strategy rather than lead it. He also suggests that the form adopted should take account of how the business itself is organised. He believes that HR should take one of three generic forms to satisfy the needs of different businesses. These are:
  - An HR ‘functional’ organisation model, in which specialists provide both theory and practice aligned to a single business.
  - An HR ‘shared services’ organisation model, providing both transaction and transformational work aligned to a diversified business.
  - The ‘embedded HR’ model, that is, a model in which HR personnel act as generalists, business partners and account managers aligned to a business unit of a holding company as dedicated HR.
There is further debate regarding the nature of the various roles in HR. Ulrich has proposed and subsequently refined a model of HR roles. Whereas the model he suggested in 1997 advocated four HR roles (strategic partner; administrative expert; employee champion; and change agent), a later, revised framework, based on a new synthesis of HR roles, suggested that the following roles are required within the HR function as a whole:

- employee advocate
- functional expert
- human capital developer
- strategic partner; and
- HR leader.

Debate continues regarding the benefits of technology (see section 2.3, main report). While there is evidence that automation can free up time for HR practitioners, other organisational factors may intervene to prevent HR professionals from subsequently using those time savings strategically. Nonetheless, the overall consensus appears to be that technology brings time savings.

There is also continuing uncertainty regarding outsourcing of HR functions (see section 2.4, main report). While the usual reason for introducing outsourcing is to reduce costs, organisations typically do so in an expectation that there will also be improvements to service delivery. Where such improvements do not happen, this is often the prompt for services to be brought in-house once again. For most organisations, outsourcing is usually viewed as an option that is best applied selectively to specific HR services.

An increasingly holistic approach is being taken to people management. As a result, the majority view is that training and development should be integrated with HR where possible, and this is based on the creation of an overall employment ‘proposition’. Precise reporting lines for practitioners tend to be determined by the types of training and development activity undertaken (in other words, whether the activity is largely generic, technical or management development) and the extent to which the role is concerned with design and evaluation or involves advice and facilitation.
Impact of people management on organisational behaviour

Chapter 3 considers the evidence available within the literature for the impact of people management on organisational behaviour and identifies the benefits that research suggests that progressive people management approaches can bring to organisations. The literature reviewed here is from general research into people management practices and is largely drawn from sectors other than healthcare.

However, there are competing ideas of quite what constitutes a ‘progressive people management approach’, and the chapter is therefore sectioned to reflect the two broad types of approach that are to be found in the recent literature. It focuses on two key areas of study: first, it considers the literature relating to the development and impact of high performance work practices (HPWP; see section 3.1, main report). After this, it looks at the literature relating to the development of employee commitment and engagement (see section 3.2, main report).

Section 3.3 attempts to bring together these two approaches and suggests a general model that indicates the impact that the various different components of progressive people management practices may have on different aspects of individual and organisational performance. Sections 3.4 and 3.5 consider the extent to which it is possible to identify ‘universal’ good practice, that will work in all types of organisation, and the benefits that good HR may bring.

Key points from these areas of the literature are as follows:

- The factors discussed in this section all fall under the broad term of ‘progressive’ people management practices; these aim to increase the knowledge and skills of employees, while also developing individuals’ citizenship behaviours and encouraging superior performance.

- However, the review notes that, within the literature, there is a lack of consensus regarding precisely which practices constitute ‘high performance work practices’ (HPWPs). Many researchers have suggested different groups, types or bundles of practices and a description offered by the CIPD (Chartered Institute of Personnel and Development) sets out their main attributes: typically, HPWPs are taken to include those that aim to customise the service, develop leadership, devolve decision-making, develop staff capabilities (particularly those associated with self-management and team capabilities) and improve systems to provide fair treatment and build trust, enthusiasm and commitment amongst staff. Within these five broad categories, researchers have identified up to 33 separate HR practices.

- While much of the HPWP literature is concerned with developing employee commitment and engagement, this topic – that is, the various ways in which organisations can develop commitment and engagement – has grown as an area of research on its own, outside of the HPWP literature. In recent years engagement has received particular attention because of the benefits it may bring in terms of improved organisational performance, along with reduced staff turnover, decreased absence and lateness, and increased organisational altruism amongst employees. Job satisfaction is also viewed as an outcome, although there is debate over whether job satisfaction causes greater engagement or greater engagement causes job satisfaction.
A range of factors is associated with increased engagement, including: feeling valued and involved, good relationships with managers and colleagues, a sense of organisational justice, trust in the organisation, promotion, work-life balance and job satisfaction. However, these may vary somewhat by sector and occupation. These factors are set out in section 3.3 in the main report.

There is some debate regarding whether or not ‘good’ HR practices are beneficial in all situations. The idea that good practice remains good practice and is beneficial irrespective of context is often referred to as the ‘universalist’ view. Set against that, many practitioners believe that, to be effective, HR practices need to be aligned with the business strategy of the organisation. This is the ‘internal contingency’ viewpoint. These contrasting views are set out in section 3.4 of the main report.

In addition to the benefits that arise through the implementation of HPWP and/or increased employee engagement, there is some emerging evidence of the value of good quality HR in and of itself, that is, over and above the benefits brought about through these intermediary mechanisms (such as commitment). However, at present the evidence for this direct value of HR is neither strong nor widespread.

**Evidence from the health care setting**

Chapter 4 provides a review of evidence from healthcare settings within the UK and elsewhere. The review starts by considering the types of measures typically used in HR impact research (see section 4.1.1 in main report) and then goes on to consider what might constitute appropriate indicators by which to gauge performance in the health sector (see section 4.1.2. in main report). Section 4.2 provides an overview of the impact of various different components of contemporary HR practice. The first section considers the evidence for the impact of high performance HR (section 4.2.1); the chapter continues with a summary of the evidence for the impact of:

- management and leadership (section 4.2.2)
- appraisal (section 4.2.3)
- team working and high reliability teams (section 4.2.4)
- the working environment (section 4.2.5)
- staff ratios (section 4.2.6); skill mix (section 4.2.7)
- reward systems (section 4.2.8)
- training and development (section 4.2.9)
- shift work (section 4.2.10)
- and, lastly, organisational trust, empowerment and involvement (section 4.2.11)
The key points from this body of literature are that:

- The finding, reported in non-healthcare sectors, that individual HR practices on their own may have little impact, and that particular ‘bundles’ of HPWPs may need to be implemented in order for some organisational change to be detected, is found to be as true in the health sector as in other sectors.

- While bundles of HR activity are generally needed, broad initiatives aimed at some specific areas of improvement nonetheless do show some impact. The single area that appears to be most related to improvements in performance within the health sector is appraisal – improved appraisal processes are associated with decreases in mortality rates of up to 8 per cent. Management and leadership are also viewed as particularly important and appear to impact on unit performance and job satisfaction.

- Teams that work effectively can significantly increase the health outcomes of patients and also lead to reductions in staff stress levels. However, it should be noted that this effect is largely limited to teams that have clear objectives, are truly participative and in which the team members are committed to quality and innovation.

- Stress and burnout in staff appear to impact on patient mortality. Skill mix within the staff team also has implications for patient outcomes. For example, a richer mix of skills in the nursing team is associated with improved patient outcomes.

- While pay typically has not been identified as the primary motivator of NHS staff, nonetheless it remains a reasonably important factor in people’s assessments of their jobs. Research suggests that moves to increase skill levels and areas of responsibility of staff should be adequately rewarded, to avoid resentment arising where staff feel that rewards have not been adequately aligned with increased responsibilities. There has been some successful experimentation with team reward, but individual performance-related pay schemes are more contentious.

- Shiftworking will clearly remain a necessity in order to provide 24-hour cover for patients, but the costs of shiftwork – in terms of its impact on individuals’ cognitive functioning and ability to remain focused and alert – are well-known. However, research suggests that where individuals are allowed some flexibility in determining shift patterns, detrimental impact might be reduced.

- Increased autonomy and decision-making latitude and empowerment among nurses, along with higher levels of nurse/physician collaboration, are associated with lower patient mortality rates and improved performance.

- HR practitioners may wish to consider their particular context to ensure that they select the appropriate types of measures to demonstrate success. The literature reveals several outcome measures specific to the Health Service that potentially constitute useful metrics for providing robust analysis of impact in specific NHS contexts. HR practitioners will need to consider which measures constitute the best gauge of organisational performance and change in their part of the NHS.

- Positive outcomes will be obtained only if employees are open to, and positive about, the developments and policies. The literature suggests that programmes of organisational change and development are most likely to be successful when performed in a way that creates a positive working environment for employees, while enabling changes in behaviour to take place. Finally, for these practices to bring about an increase in performance within the NHS, line managers and those involved in HR will need to show their full support, play an active role in, and have the capacity to implement change programmes.
Implications and recommendations for the role of HR within the health sector

Chapter 5 summarises the findings of the HR research within the health service and outlines its implications for future developments within the sector.

- **Section 5.1** considers how HR could be structured within the health sector. The research suggests that there are various options regarding how HR might be structured in future within the health sector. What is seen as the optimal structure is likely to vary with size and level of organisation. Different options are suggested at individual trust level and at SHA or NHS level.

- Following that, the current status of the relationships between HR, learning and development, workforce planning and OD is considered, and suggestions are made for what might be the best way to move forward in organising these functions (section 5.2 in main report). The conclusion is that there is probably more value in bringing them together than organising them as separate functions.

- Next, the relationship between HR and line management, and the division of responsibilities for people management between them is addressed (section 5.3 in main report). Some of the discussion on the potential devolution of HR functions has overlooked the difference between the more strategic HR tasks, typically the province of HR professionals, and the more ‘hands on’ activities often shared with, or indeed undertaken solely by, line management. Where line managers undertake people management activities, it is suggested that HR should ensure that line managers have sufficient capability and support to undertake this role appropriately.

- Following these sections we provide a summary of the main findings from the research into people management practices, identifying the issues for HR. These findings are grouped into three broad category of activity: those concerned with training and support practices (see section 5.4.1 in main report); those focussed on improving working conditions (section 5.4.2 in the main report); and those aimed at increasing employee involvement and engagement (section 5.4.3 in the main report). This summary reveals that, while there is quite strong evidence for the impact of good HR practices in some areas (such as appraisal and leadership) the evidence for impact of other areas, at present, is not so strong. Nonetheless there is sufficient evidence to suggest that each of the areas identified will be important for HR practitioners to consider in the future.

- **Section 5.5** follows the same outline structure as that followed in section 5.4 and, for each of the people management practices identified in section 5.4, implications for future HR developments of the impact findings are outlined, along with the types of HR competence that will be needed. The report concludes that it is likely that HR professionals will need to use an increasingly wide range of skills and move HR professionals into areas of activity with which they have not previously been engaged. In particular, the report points to an increasing need to assess and take stock ahead of initiating interventions and for assessing any impact subsequent to changes being made.

- Taking stock of the value of interventions will provide HR practitioners with valuable evidence for use in persuading key stakeholders of the value of further changes.
Conclusions

The report concludes that it is likely that HR professionals will need to use an increasingly wide range of skills in the future. Many of the suggested changes would move HR professionals into areas of activity with which they have not previously been engaged, in particular, assessing the situation ahead of initiating interventions and assessing subsequent impacts of organisational change.

While some HR professionals may routinely do this at present, it is likely that more HR practitioners will need to do so in future, and, furthermore, that many will need to become more skilled in evaluating the impact of HR activities. The increasing focus on demonstrating the value of HR/OD activities and how, where and in what ways, strategic changes are expected to have their impact, is likely to drive these developments.

Taking stock of the value of interventions will provide HR practitioners with valuable evidence for use in persuading key stakeholders of the value of further changes. Work identifying the sorts of links (such as those typically examined in the HPWP and commitment literatures) is increasingly likely to take centre stage. In the NHS this is likely to include the need for HR professionals to be able to demonstrate how changes to working arrangements, developing leadership capacity, increasing or decreasing staff levels or modifying shiftwork patterns impact variously on indicators such as bed occupancy rates, mortality rates or rates of hospital acquired infections.

Irrespective of how the HR function is organised or where it is located, HR practitioners are likely to need to be able to account for the reasoning behind any structural changes made in working arrangements, explain the expected patient benefits and (perhaps most importantly) be able to point to relevant evidence to support the value of such changes. This in turn implies some role extension for HR professionals, to build their own capacity to plan, model and evaluate OD interventions.
1 Introduction

The NHS plan (2002) sets out an agenda for action to improve the use of human resources. Its proposed reforms centre on improving the working lives and careers of NHS employees and on the capability of their employers to maximise their contribution. The NHS Institute for Innovation and Improvement (NHS Institute) is concerned with this vital business priority, namely building innovation and improvement capability in the NHS workforce and, within its work stream Building capability for a self-improving NHS, commissioned IES to pull together and build upon previous research findings regarding workforce development.

The aim of this work is to help identify areas of development within the areas of human resources/organisational development (HR/OD) and workforce development for the NHS Institute and its stakeholders. Such activities clearly have a key role in developing a flexible, adaptable workforce that is capable of sustaining continuous service improvement. This may be as critical as the development of effective and efficient healthcare in large measure relies upon the contribution of employees. Each organisation in the NHS must be able to recruit the right people, effectively deploy them, continuously develop them and then motivate them to perform to deliver effective services.
1.1 Approach

1.1.1 Aims and objectives
The objectives of the study were to:

- Consider and consolidate previous research on workforce development in the NHS, especially to review the functional contribution of HR/OD and workforce professionals to learning, performance and service improvement.
- Propose recommendations for the further development of the HR/OD and workforce professionals in terms of roles, structures and activities so that the function is both efficient and effective in delivering its future mission.
- Describe the role of the HR/OD function and workforce professionals in bringing about sustainable service improvement and transformation.

Our intention is to take an evaluative approach to produce a critically examined and concise reference document. The emphasis will be on those interventions that have been tested and show evidence of learning or service improvement.

The synthesis of theory and practice is intended to address a number of issues, namely:

- The functional impact in achieving sustainable service improvement and transformation in the healthcare sector.
- The people management models in the UK and internationally, irrespective of sector, to achieve enhanced productivity, efficiency and service improvement.
- The evidence of the successful use of these models in the NHS.
- The sort of good practice people management examples the NHS should consider for organisational change and service reform.

In essence the project aims to embody what is known about the operation of HR and workforce development in the NHS, together with what is known about good practice externally. This is both an exploration of how organisations deliver effective learning, performance and service improvement and the ways in which they structure themselves to help them to do so.

1.2 Methodology

The project had three stages of execution: scoping, interim report and production of this, the final report. The interim report (Reilly et al., 2007) was presented to the NHS Institute in April 2007, and set out the main areas for investigation that are expanded upon in this report.
1.2.1 Scoping
Identification of the main body of literature to be drawn upon in this review commenced with an examination of the work of the Department of Health and NHS bodies, along with work emerging from funding streams such as the Service Delivery and Organisation (SDO) strand. It identified research in the health context that had been undertaken by research centres such as:

- The School for Health & Related Research (ScHARR) and the Medical Care Research Unit (MCRU), University of Sheffield
- Work and Organisational Psychology Group, Aston Business School
- Centre for Performance-led HR, Lancaster University Management School
- The Judge Institute, University of Cambridge
- The Centre for Health Economics, York University.

In addition, research reports from the Chartered Institute for Personnel and Development (CIPD) were included in the review. An electronic search was also conducted for relevant literature on both the general HR function and for literature located within the health sector. Existing recent studies and reviews conducted by IES on topics such as people management and business performance were also examined for information of relevance to the current review.

1.2.2 Structure of the final report
This report describes the main findings to emerge from this body of literature. Key themes, commonalities and differences are identified, and the final chapter considers the implications of the research for functional (HR/OD and Workforce) development. The structure is therefore as follows:

- **Chapter 2:** Structure and organisation of the HR/OD function, including issues of purpose and positioning, relationships to stakeholders, content areas and where HR/OD can have most business impact.
- **Chapter 3:** The Impact of People Management on Organisational Performance, including analyses of High Performance Work Practices, approaches to developing employee commitment and engagement and how HR practice impacts on organisational performance.
- **Chapter 4:** Evidence from the Healthcare Setting, which includes a discussion of the application of HR research findings to the NHS, the types of measures used and issues concerning outcome measures specific to the healthcare sector.
- **Chapter 5:** Sets out our conclusions and draws out the likely implications for the National Health Service. The chapter considers the contribution that the HR/OD/workforce function can have on service delivery (and how it has its impact), relative to that of line managers and service professionals. It also discusses the implications for HR role development within the NHS and how the HR/OD/workforce function can help improve service delivery.
2 Structure and Role of HR

In this chapter we start by considering research regarding the role and structure of HR, the impact of technology and the state of outsourcing. The specific issue of the organisational location of training and development is also considered.

**Key points from the literature are:**
- The ‘three legged stool’ model suggests that there should be three main components of contemporary HR practice: shared service centres, business partners and centres of expertise. However, some writers have suggested that the model is mainly suitable for application within large and complex organisations. Other influences on optimal HR structure include the way the organisation is configured and the stage of business development.
- David Ulrich has argued against a single generic model for HR structure on the grounds that structure should follow strategy rather than lead it. He also suggests that the form adopted should take account of how the business itself is organised. He believes that HR should take one of three generic forms to satisfy the needs of different businesses. These are: the HR ‘functional’ organisation model; the HR ‘shared services’ organisation model; and, the ‘embedded HR’ model.
- There is further debate regarding the nature of the various roles in HR. Ulrich has recently suggested that the following roles are required within the HR function as a whole: employee advocate; functional expert; human capital developer; strategic partner; and HR leader. Although some writers have mistakenly believed that the roles are synonymous with specific jobs, Ulrich suggested these roles could be undertaken by one or several individuals.
- Debate continues regarding the benefits of technology. While automation can free up time, other organisational factors may prevent HR professionals from using their time strategically. Nonetheless, the overall consensus appears to be that technology brings time savings.
- There is also continuing uncertainty regarding outsourcing. While the usual reason for introducing outsourcing is to reduce costs, typically there is also an expectation of improvements to service delivery. Where such improvements do not happen, this has often been one of the prompts for services to be taken in-house once again. Outsourcing has remained for most organisations an option to be applied selectively to specific HR services.
- An increasingly holistic approach is being taken to people management that suggests that training and development should be integrated with HR. This is based on the creation of an overall employment ‘proposition’. Precise reporting lines tend to be determined by the types of training and development activity undertaken.
2.1 Structure of HR

The structure of HR has been subject to a number of changes in recent years. There have been moves to outsource functions and to use shared services, primarily as ways of cutting costs. However, there is little evidence to date that either outsourcing or the use of shared services provide sustained benefits beyond any initial cost reduction. Lawler and Mohrman (2003) have concluded that, for example, structural changes to the HR function have not led to it becoming more strategic in its contribution to organisational performance. Indeed, a number of criticisms have emerged, centring on issues such as the segmentation of the HR service into many operating parts and questioning the extent to which such changes facilitate customer focus and operational integrity. Segmentation leads to the creation of many interfaces between service units and, therefore, to the risk of issues or information being lost between units or communication generally not being as good as it could be (Reilly and Williams, 2006). Furthermore, while in principle this model may look as though it can be tailored to meet the needs of the particular organisation, in practice organisations may find it is less tailored or flexible than they may wish.

The so-called ‘three-legged stool’ model of HR, often attributed to American business guru Dave Ulrich, (in fact, Ulrich was not the originator of this model and its origins appear unclear) has generally been held to be best practice for large or complex organisations. As its name suggests, this model has three components: shared service centres, business partners and centres of expertise. David Ulrich has argued against a single generic model for HR structure on the grounds that structure should follow strategy rather than lead it and should take account of how the business itself is organised. He believes that HR should take one of three generic forms to satisfy the needs of different businesses. These are:

1. An HR ‘functional’ organisation model, in which specialists provide both theory and practice aligned to a single business.
2. An HR ‘shared services’ organisation model, providing both transaction and transformational work aligned to a diversified business.
3. The ‘embedded HR’ model, that is, a model in which HR personnel act as generalists, business partners and account managers aligned to a business unit of a holding company as dedicated HR.

This approach seems to blend a number of different factors in the alignment of HR structure with the operation of the business. These factors include the structure of the organisation, the business strategy and an organisation’s stage of development. A body of work has examined the alignment of HR strategy with:

- **Business strategy**: Some researchers have explored the extent to which the HR structure is aligned with business strategy improves performance. Mostly, studies have failed to find support for this argument (Huselid, 1995; Huselid and Becker 1995, 1996). While Delery and Doty (1996) found a relationship between the adoption of a range of high performance work practices and firm performance (in US banks), there was only weak support for this relationship being contingent on the company’s business strategy.
• **Structure**: The structure of the organisation – whether it is centralised or decentralised, a holding company etc., has been suggested by some to influence the type of HR function that is appropriate.

• **Stage of development**: Depending on whether the organisation is a start up company, mature, in decline etc., has implications for the types of activity in which an HR function needs to be involved and therefore it is suggested that this too has a bearing on which HR structure will be optimal.

We now turn to consider the different roles that practitioners can play within the HR function.

### 2.2 HR roles

Much of the recent debate has focussed on the different roles that HR practitioners can play and this debate has mostly been conducted within the framework of Ulrich’s various models of HR roles. His 1997 model (Ulrich, 1997) advocated four HR roles: strategic partner; administrative expert; employee champion; and change agent. In 2005, Ulrich proposed a revised framework based on a synthesis of HR roles, which were as follows:

• **employee advocate** (ensuring employer-employee relationships are of reciprocal value)
• **functional expert** (designing and delivering HR practices)
• **human capital developer** (building future workforce)
• **strategic partner** (help line managers reach their goals); and
• **HR leader** (credible to own function and others).

Source: Ulrich and Brockbank (2005)

There has been much debate about these various models proposed by Ulrich. According to Ashton and Lambert (2005), while Ulrich’s original four roles have been influential, whether and how they are put into practice varies: the change agent and strategic partner have proved attractive, the employee champion much less so. Often these roles have been used as labels without much understanding of what they stand for. Ashton and Lambert have argued that Ulrich’s model ‘should arguably never have been taken as a blueprint for the HR functional structure’. In fact, Ulrich never intended that they should be. He was not describing a set of roles to mean jobs, but a set of activities that potentially could be performed either by one individual or by a number of people.
2.3 Technology

Technology has a significant impact on both the structure of HR and the skills necessary for its implementation. Process improvement has been an integral part of structural change for many organisations (Reilly and Williams, 2003). The first phase of this is process reengineering (such as streamlining processing or cutting out duplication of tasks). The second phase concerns e-HR, including manager self-service (where managers can directly authorise and execute decisions, eg on the payment of overtime), employee self-service (where staff directly update their computer records) and a range of e-applications such as e-recruitment, e-learning, and e-performance management. E-HR can bring a number of practical benefits, such as the elimination of repetitive paperwork, the streamlining of organisational processes and a reduction in transaction costs. There is also evidence that e-HR has facilitated a reduction in HR numbers and freed up time to allow those remaining to engage in ‘higher value added’ tasks. Research undertaken in the US by American Cedar claims an average 37 per cent reduction in HR staffing can be attained just through the introduction of self-service (American Cedar, 2003). Cycle times in HR processes (ie, the time taken to complete a process) were cut on average by 62 per cent and cost per HR transaction was down by 43 per cent. However, the extent of improvement through e-HR is likely to vary according to sector, size of organisation and the financial resources available for implementation. Shortage of funds or the inability to successfully argue the business case for them has driven a few organisations towards outsourcing. Under such circumstances, third party service providers may be able to deliver e-HR improvements quicker and more thoroughly.

Furthermore, not all agree that technology has delivered on its promises. According to the CIPD’s 2003 survey, HR professionals believe that time spent on administration continues to limit their ability to be more strategic (CIPD, 2003). However, whether the blame for this can be laid at technology’s door is debateable: as Hewitt Associates have commented, ‘HR’s ineffective use of technology, that is to say, not fully understanding the benefits of existing technology or inappropriately using technology to do the wrong things faster’ can be a major obstacle to effective service delivery (Hewitt Associates, 2007). Even where automation does free up time, Lawler and Mohrman (2003) have concluded that this does not, on its own, guarantee that the time saved will be spent in the ‘right’ areas. Lawler and Mohrman’s views have subsequently been backed up by research by Collison (2005), who found that the use of technology had not led to HR staff being able to spend more time on strategic resource planning and leading the organisation (Collison, 2005, cited in Weatherly, 2005a).
2.4 Outsourcing

The practice of outsourcing has also prompted significant debate in recent years. Cost saving is usually the primary driver for outsourcing; for example the 2004 WERS survey found that over half of its respondents contracted out to save money (see also CIPD, 2003). However, the desire to improve service delivery, obtain access to skills, or, more recently, to facilitate investment in technology have also been prominent in such decisions (Kersley et al., 2006). However, reliable evidence on the outcome of outsourcing is in short supply. Beside those satisfied with their results, problems have been reported with the quality of the outsourced services, the fragmentation of HR and, sometimes, difficulties in establishing a good relationship between provider and client. Weatherly (2005b) cites a study by Deloitte Consulting of the general outsourcing market, which claims that vendor complacency, employee turnover, unsatisfactory delivery and unbalanced contracts have prompted organisations to increase demand for vendor accountability and/or to bring operations back in-house. A recent survey of the experience of major UK companies bears this out. It shows that nearly two-thirds of outsourcing deals have had to be renegotiated and almost one in four have been brought back in-house, despite the difficulties of so doing (Birchall, 2006).

An overview of the extent of HR outsourcing can also be gained from WERS 2004 (Kersley et al., 2006), which suggests that outsourcing is specific to certain activities and limited in extent. The main outsourced functions were: training (just over a third of organisations); payroll (around a quarter of organisations); resourcing of temporary positions (around a quarter of respondents); and recruitment (14 per cent).

In 2003 a CIPD survey of HR practitioners concluded that the outsourcing market overall was broadly static and there no evidence that it has picked up since, despite some high profile deals. For example, a more recent CIPD survey of learning and training (CIPD, 2006) reported that only a third of respondents said that they had made greater use of external training provision in the last few years, with nearly half reporting no change.

In terms of the success of outsourcing, the picture is less clear. Some surveys (eg Towers Perrin, 2005) report a very high success rate in reducing costs, which supports previous commentary. Further, The Conference Board (2004) reported that 90 per cent of their sample planned to continue outsourcing HR activities despite any difficulties they had faced. However, other surveys have reported problems (for example see eg Lonsdale and Cox, 1998; Wigham, 2005; Kersley et al., 2006; Booz Allen Hamilton, 2004), particularly in the area of service quality, and there is little evidence that outsourcing enables HR to refocus on higher value-added activities. In particular, Lawler and Mohrman (2003) found no association between outsourcing and HR becoming more strategic.

There are also warnings about the ‘division’ of the HR role (Tyson and York, 2000), which can result in the fragmentation of HR both through outsourcing and increasing specialisation within the function. The danger is that such splitting reduces influence and coherence in the function and ultimately diminishes impact.
2.5 Current trends in organising training and development

How training and development is organised within organisations varies. In some organisations it is integrated into HR; in others it is quite separate; whereas in a third model technical training has been separated from management development with the latter in HR. IES research (Carter et al., 2002) suggested that, in a large majority of organisations, the training and development function reports to the HR director, but under a whole range of different organisational structures, from centralised to devolved, from largely in-house to largely outsourced. Key factors determining the reporting line are: the content of the training and development work, the extent to which in-house staff are involved in training delivery, whether the training is generic or technical, the extent to which the role is concerned with design and evaluation, and the extent of involvement in advice or facilitation.

There appears to be a continuing trend towards the greater integration of HR and training and development. This may be because an increasingly holistic approach is being taken to people management where functional barriers are being broken down. The notion of creating an employment ‘proposition’ to attract employees and finding the way to engage them once hired implies that all people management practices should be effectively combined. The ASTD (the American Society of Training and Development) has shifted its activities away from technical training and towards the strategic impact of learning and development (linked with other people management functions) on business performance. It is influenced by the fact that learning and development functions in leading companies are spending an increasing proportion of their time on such things as organisational effectiveness, OD and performance improvement. The CIPD in the UK is taking a similar stance.
3 Impact of People Management on Organisational Performance

This chapter identifies the benefits that progressive people management approaches can bring to organisations, as suggested by research. However, there are competing ideas of what constitutes a ‘progressive people management approach’, and therefore the chapter is sectioned to reflect the two broad types of approach that are to be found in the recent literature. We start by reviewing the literature relating to high performance work practices, and then move on to consider the body of research that has focused on encouraging employee engagement and commitment. The last section of the chapter attempts to bring together these two approaches and sets out a general model that indicates the impact that different components of progressive people management practices have on different aspects of individual and organisational performance.

Key points from the literature are:

- All of the factors identified in the literature and discussed in this section fall under the broad term of ‘progressive’ people management practices; these aim to increase the knowledge and skills of employees, while also developing individuals’ citizenship behaviours and encouraging superior performance.
- However, within the literature there is a lack of consensus regarding precisely which practices constitute ‘high performance work practices’ (HPWPs). Many researchers have suggested different groups, types or bundles of practices. A description offered by the CIPD sets out their main attributes: HPWPs are usually taken to include those that aim to customise the service, develop leadership, devolve decision-making, develop staff capabilities (particularly those associated with self-management and team capabilities) and improve systems to provide fair treatment and build trust, enthusiasm and commitment amongst staff. Within these broad categories researchers have identified up to 33 separate HR practices.
- While much of the HPWP literature includes a concern to develop employee commitment and engagement, ways to develop commitment and engagement has grown as an area of research on its own, that is, outside of the HPWP literature. In recent years engagement has received particular attention because of the perceived benefits to organisational performance, along with reduced staff turnover, decreased absence and lateness, and increased organisational altruism. Job satisfaction is also viewed as an outcome, although there is debate over whether job satisfaction causes greater engagement or greater engagement causes job satisfaction.
- A range of factors is associated with increased engagement, although these may vary somewhat by sector and occupation: feeling valued and involved, good relationships with managers and colleagues, a sense of organisational justice, trust in the organisation, promotion, work-life balance and job satisfaction.
- There is some emerging evidence of the value of good quality HR over and above the benefits brought about through intermediary mechanisms (such as commitment), but at present this evidence is neither strong nor widespread.
3.1 High performance work practices

The CIPD (2001, revised 2007) has defined the component parts of high performance working as:

- A vision based on increasing customer value by differentiating an organisation’s products or services and moving towards customising its offering to the needs of individual customers.
- Leadership from the top and throughout the organisation to create momentum.
- Decentralised, devolved decision-making by those closest to the customer to constantly renew and improve the offer to customers; development of people capabilities at all levels with emphasis on self-management, team capabilities and project-based activity.
- Support systems and culture, which include performance operations and people management processes, aligned to organisational objectives to build trust, enthusiasm and commitment to the direction taken by the organisation.
- Fair treatment for those who leave the organisation and engagement with the needs of the community outside the organisation — an important component of trust and commitment-based relationships both within and outside the organisation.

However, it is fair to say that high performance working can be considered to be an emerging organisational model and there is a lively debate in the literature about how it operates in practice. For example, Guest (2000), in work for the CIPD, identified 18 key practices associated with high performance or high commitment HR management. These are:

- realistic job previews
- use of psychometric tests for selection
- well-developed induction training
- provision of extensive training for experienced employees
- regular appraisals
- regular multi-source feedback on performance
- individual incentive pay
- profit related bonuses
- flexible job descriptions
- multi-skilling
- presence of work-improvement teams
- presence of problem-solving groups
- information provided on the business plan
- information provided on the firm’s performance targets
- no compulsory redundancies
- avoidance of voluntary redundancies;
- commitment to single status\(^1\)
- and harmonised holiday entitlement.

\(^1\) This refers to the harmonisation of terms & conditions across grade groups. It is particularly used in local government with manual and clerical staff.
The impact of high performance work practices (HPWP) on organisational performance appears generally to be positive. For example, Wood et al. (2001), using data from the UK Workplace Employee Relations Survey (WERS), found that the implementation of high involvement management raised the rate of productivity growth. Patterson et al. (1998) found that nearly one-fifth of variations in productivity and profitability were associated with differences in HR practices. A series of studies by Ichniowski and his colleagues (Ichniowski, 1990; Ichniowski & Shaw, 1999; Ichniowski, Shaw & Prennushi, 1997) has shown links between HR management systems and company value, quality of product and productivity. The general consensus in the literature is that high performance HR systems have economic benefits for organisations' financial performance.

There is some evidence to suggest that it is not the practices per se that make a difference but the degree to which they align with each other to create meaningful ‘bundles’ of practice (eg Huselid, Jackson and Schuler, 1997; Den Hartog and Verburg, 2004). Buchan (2004) has suggested that single or uncoordinated HR management interventions are less likely to have success than are ‘bundles’ of linked and coordinated activities. Practices need to be ‘bundled’ into meaningful groups in order for any impact on organisational performance to be seen and these ‘bundles’ need to be ‘designed to fit the characteristics, context and priorities of the organisation itself if sustained improvements are to be seen’ (Buchan, 2004:7). This idea - that HR practices need to be designed to fit with organisational characteristics, context and priorities - is sometimes referred to as the ‘contingency’ approach to HR management, but, rather than seeing this as a separate approach, Buchan suggests this needs to be used in conjunction with the ‘bundles’ approach to bring about change.

However, one of the criticisms of the high performance concept is the lack of agreement regarding quite what constitutes the relevant groups or bundles of practices. For example, work by Thompson in the aerospace industry (Thompson, 2000) has identified over 30 practices, which fall into three clusters:

1. High involvement practices that aim to create opportunities for engagement (eg semi-autonomous teams, problem-solving teams, continuous-improvement teams, responsibility for own work quality, job rotation within and/or between teams, team briefings, staff suggestion schemes, attitude surveys).
2. Human resource practices to build skill levels, motivation and ability (eg formal recruitment interviews, performance or competency tests, psychometric tests, share ownership schemes, personal development plans, training, competence-based pay, team rewards, performance-related pay).
3. Employee relations practices that help build trust, loyalty and identity with the organisation (eg single status, formal grievance procedures, formal salary reviews, social gatherings).
An alternative grouping is provided by Tamkin (2005b), who suggests that these practices generally focus on (and can therefore be grouped under) high skill requirements, discretion at work, team working and incentives enhancing organisational commitment. On the other hand, recent work by Sung and Ashton (2005) has identified three distinct ‘bundles’ of practices:

1. **High employee involvement practices**: those encouraging trust and communication and accompanied by empowerment and discretion.

2. **Human resource management practices**: those designed to encourage human capital investment and skills formation.

3. **Reward and commitment practices**: such as profit sharing to increase stake holding in the organisation, egalitarian terms and conditions and flexible working opportunities.

They found there was differential uptake of practices by sector, with uptake of a wider range of practices being seen in manufacturing and business services than in financial services and wholesale and retail. Furthermore, they found that the three bundles were associated to different extents with various outcomes. For some outcomes, each of these three bundles appeared to be equally effective in bringing about positive results. Thus, all three bundles served to improve staff satisfaction, provide leadership quality and create effective teamwork, employee involvement and innovation. However, other outcomes were associated with specific pairings of these bundles, or in some instances, with just one. For instance, Sung and Ashton report that while the ability of the organisation to meet its goals was associated in the main with the human resource and reward and commitment bundles, the employee involvement and human resource bundles together tended to lead to an improved sense of job security. Employee involvement on its own was the only bundle thought to significantly impact on staff turnover.

Critiques of such studies have made the point that association does not prove causality and it may simply be the case that better organisations tend both to exhibit better performance and to have bundled HR practices. However, the few studies that have included a longitudinal element have also tended to support the view that the practices impact on performance rather than the other way round. These studies are reviewed in the following section.
3.1.1 How do high performance work practices bring benefits?
As indicated in the previous section, across a range of organisations and sectors, progressive HR activity has been shown to increase productivity, improve employee satisfaction and decrease staff turnover, and is associated with improved leadership, employee commitment and a variety of other organisational outcomes. These are hypothesised to occur through both direct and indirect routes: for example through increasing the skills and knowledge of employees, enabling them to use those skills and their knowledge, and by bringing about changes that render it more likely that they will have a positive attitude towards their work (Penna, 2002, 2003; Watson Wyatt, 2002).

A recent study published by the CIPD (Purcell et al., 2003) examines the ways in which HR practices may impact on performance. The authors seek to move the debate on, from whether HR practices do have an impact, to understanding how they have an impact. The researchers assert that for people to perform above minimal requirements they must:
• have the ability, ie the requisite knowledge and skills
• be motivated to work well
• be given the opportunity to deploy their skills and contribute.

HR practices serve to turn these three elements into action, and managers have a central role in implementing policy and practice. A key factor in the Purcell model is the extent to which HR practices motivate employees to engage in ‘discretionary behaviours’, that is, behaviours that are not necessarily specified within a job description or person specification but, when performed, contribute towards enhanced individual, team or unit performance.
3.2 Developing employee commitment and engagement

Alongside the growing literature on HPWPs there is also a growing body of literature on commitment and engagement. A range of factors build commitment and engagement, including good relationships with managers and colleagues, a sense of organisational justice and trust, opportunities for promotion, work-life balance and job satisfaction. While similar factors to those involved in developing engagement have been identified as being involved in building employee commitment, it should be noted that, in recent years, HR practitioners have tended to focus more on employee engagement than on employee commitment. This is because ‘committed’ individuals may include those who are committed to the organisation for the ‘wrong’ reason: more from a lack of any realistic alternative than from any positive affiliation (Allen and Meyer, 1990). The concept of employee engagement is seen as not suffering from this problem as it involves alignment with the goals of the organisation and being prepared to ‘go the extra mile’ on behalf of the organisation.

Many studies imply that high performance workplace practices are associated with higher levels of employee commitment and engagement. There is a growing recognition that commitment and engagement are important factors in improving organisational performance and it may be that this is the main route through which HPWPs have their impact. It should be noted however that the literature on commitment and engagement does not exclusively derive from studies of HPWP. The research is summarised below.

- **Being valued and involved:** Analysis of NHS case study information by Robinson, Perryman and Hayday (2004) indicates that the strongest driver of engagement is the sense of being valued and involved. They suggest that, in turn, several factors contribute to the development of a sense of being valued and involved: involvement in organisational decision-making; being able to voice their ideas (and the extent to which those ideas are listened to and valued); the opportunities employees have to develop their jobs; and the extent to which the organisation is concerned for employees’ well-being.

- **Relationships with managers:** Quality of the relationship between managers and their employees is related to the development of commitment. Those employees who have good relationships with their immediate managers have greater commitment (Green et al. 1996; Nystrom, 1990; Settoon et al. 1996). Indeed, the CIPD (2001) concluded that a good relationship between line managers and employees is one of the most important factors affecting motivation at work. In particular, day-to-day contact and communication with the line manager is a key factor in the maintenance of commitment.

- **Relationships with colleagues:** Emotional attachment to colleagues is another important factor in the development of commitment. Emotional attachment is maintained through frequent and rewarding contact with peers (Baumeister and Leary, 1995), which promote feelings of belonging that can bind employees to the organisation.
• **Organisational justice:** Organisational justice appears to be a key determinant of outcomes such as satisfaction and commitment (Folger and Konovsky, 1989; Moorman, 1991). Employees evaluate their experiences at work in terms of whether or not they are fair and indicate a concern on the part of the organisation for the well-being of the employees (Meyer, 1997). Research findings (eg McFarlin and Sweeney, 1992) suggest that employees’ commitment to the organisation might be shaped, in part, by their perception of how fairly they are treated by the organisation. It is suggested in the literature that, by treating employees fairly, organisations communicate their commitment to employees. This suggests that organisations wanting to foster greater commitment from their employees must first provide evidence of their commitment to employees.

• **Trust:** O’Malley (2000) identified four factors that can influence an employees’ sense of trust in the employer. These are: opportunities for personal growth, working arrangements that facilitate work-life balance, accommodation of the organisation to the individual’s needs, and attention to health and safety. Regarding personal growth, O’Malley suggests that, as most employees want to be more proficient in their job, a good way to instil trust is for organisations to attend to employees’ development needs. Similarly, as most employees would like greater work-life balance, organisations may find that allowing employees greater flexibility in working arrangements when needed is a second area that may repay attention (see also section below on this point). Acts of organisational flexibility or benevolence toward employees may also be viewed positively and result in increased trust. Lastly, O’Malley suggests that organisations that are committed to protecting employees’ health and safety are more likely to be trusted.

• **Promotion:** Policies and practices concerning promotion can also affect commitment. For example, Schwarzwald et al. (1992) found that commitment was higher among employees who had been promoted, and was also related to employees’ perceptions that the organisation had a preference for recruiting from their internal labour market.

• **Work-life balance:** A key issue emphasised by research, especially in recent years, is the extent to which employees perceive that they are able to achieve the right balance between home and work. Organisations are beginning to recognise this, and are making more concerted efforts to introduce a host of programmes intended to facilitate this. These include initiatives such as: flexible work arrangements; child care; time off policies; elder care; healthcare; information and counselling; and convenience services (such as concierge services1) to name but a few. A major study by the Families and Work Institute (1998) found that employer support of this type was related to increased employee commitment.

• **Job satisfaction:** Job satisfaction plays a key role in employee behaviour and commitment. A satisfying job typically has three properties: it has intrinsically enjoyable features (such as the variety of tasks involved and the interest and challenge the job generates); it provides an opportunity for growth and development; and it makes employees feel effective in their roles (that they can positively influence organisational outcomes). Reviews by Mathieu and Zajac (1990) and Randall (1990) have found that the strongest correlation with commitment was obtained for job characteristics, particularly job scope (enrichment).

1 This refers to household-help benefits – help with laundry, ironing, shopping etc.
3.2.1 Benefits of employee commitment and engagement

Commitment is thought to bring benefits to the organisation through a ‘three step process’ that leads to employee engagement. The stages that have been suggested are as follows:
• first, the employee is happy with their job and enjoys what they are doing
• as a result, they become committed to the organisation
• finally, they engage with the organisation and want to stay there.

At this last stage, the theory suggests that they will work to make the organisation better, to improve not only their own performance but that of their team and the organisation more widely, making suggestions for improvement, and ‘going the extra mile’; in other words, going beyond what an employee would strictly be required to do.

This has been labelled the ‘Say, Stay, Strive’, model of engagement and has largely been promoted by Hewitt Associates (http://www.hewittassociates.com). However, while this model sees engagement as a final stage and an outcome of job satisfaction, other authors have suggested that increased job satisfaction is an outcome of engagement. This might imply on the one hand that the causality is uncertain (Vandenberg and Lance, 1992) or, alternatively, that once engagement is established, a ‘virtuous circle’ is set up, whereby satisfaction leads to engagement and engagement leads to higher levels of job satisfaction.

Some of the other key benefits of increased employee engagement (aside from job satisfaction) that have been identified in the literature include:
• **Increased job performance:** Mathieu and Zajac (1990) have reported that organisational commitment is related to job performance, although since then Riketta (2002) has suggested that the correlation is somewhat stronger for white-collar workers than for blue-collar workers. In addition, she suggests the relationship is stronger when performance is assessed through means such as the use of self ratings rather than through supervisor ratings or objective indicators of performance.

• **Decreased employee turnover and intention to leave:** In general, highly committed and engaged individuals are more likely to stay with their employer than are those who are less engaged. However, while Cohen (1991) found some data to support this idea, he found that the strength of the association varied with the way in which commitment was assessed; he also found that the relationship weakened with increasing gap between the time at which commitment was measured and the departure. Unsurprisingly, reduced intention to leave – and specifically, decreased turnover intentions – has been reported in more highly engaged employees by Balfour and Wechsler (1996) and, more recently, by Schaufeli and Bakker (2004), while Cohen (1993) has reported decreased intention to search for alternative employers amongst more engaged employees.

• **Decreased lateness:** Commitment is associated with reductions in lateness and
absenteeism (Clegg, 1983; Cotton and Tuttle, 1986). Becker et al. (1995) found that those employees with higher levels of organisational commitment (measured by use of the Organizational Commitment Questionnaire (Mowday et al., 1982)) were significantly less likely to be late than other colleagues. This study, which was conducted in a fast-food chain in the USA, revealed that some 23.7 per cent of variance in lateness over a two-month period was accounted for by organisational commitment.

**Increased organisational altruism:** The Becker (1995) study also revealed that organisational commitment was positively related to ‘organisational altruism’. Organisational altruism is defined as ‘behaviour that is directly and intentionally aimed at helping specific persons in face-to-face situations’ (Becker, Randall and Reigel, 1995), which includes activities such as volunteering for tasks that are not compulsory, making innovative suggestions and helping to orient new employees. The analyses indicated that commitment accounted for 33 per cent of the variance in altruistic behaviour in the workplace (with altruism being assessed over a two-month period by the employees’ managers). Others (eg, Organ, 1988) have linked commitment to increased conscientiousness.

**Decreased absenteeism:** Studies have demonstrated that increased employee commitment is positively related to decreased absenteeism (Cohen, 1993; Barber et al. 1999). Harter, Schmidt and Hayes, (2002), found that both employee satisfaction and engagement are related to objectively measurable business outcomes. Their research involved 36 organisations, from a variety of public and private sector areas, and sought to examine the relationship between employee satisfaction, engagement and business unit outcomes. These included customer satisfaction, engagement and business unit outcomes. These included customer satisfaction, productivity, profit, employee turnover, and workplace accidents.

**Increased sales, profitability and total return to shareholders:** There is evidence of impact of commitment on shareholder return (Walker Information Inc, 2000) while Guest (2000) has identified a link between high commitment practices and financial performance. The majority of studies find positive links to performance but there are a few that do not: for example, in a later study Guest et al. (2003) failed to find a link with profitability once the previous year’s profit was controlled for. Research in the UK retail sector showed that employee commitment had a direct impact on sales (Barber et al., 1999). As well as the direct link, commitment was also found to influence sales through improved customer loyalty and improved employee attendance. While previously this may have been of less concern to healthcare providers, the increasing focus on cost control within a competitive, pluralistic marketplace for healthcare means that the relationship with sales and profit is likely to be of increasing interest to health sector HR.

---

1 Note that some researchers (eg Hannam and Jimmieson, (2002) view conscientiousness as an individual trait that feeds into the development of affective commitment and organisational citizenship. However, in effect this merely serves to emphasise the ‘virtuous circle’ notion.
3.3 How does people management practice impact on organisational performance?

One of the first tasks in conducting research is to decide the particular focus and scope of the study. For this reason researchers in the studies reported above have tended to explore specific links within the context of people management and organisational performance. In this section we attempt to pull together the various different components examined by researchers, so that the implicit pathways examined in this research are made explicit in the model. An outline of the Purcell model was described above. Here, we present a model that sets out those factors that have been demonstrated by research to have an impact on performance, and the route through which this occurs.
Figure 3.1: The relationship between people management practices, employee commitment and organisational impact

Perceptions of fair treatment

Organisational flexibility / concern for wellbeing

Work-life balance

Opportunities for personal growth / development

Employer concern for health & safety

Involvement in decision making

Job characteristics, especially job scope (enrichment)

Good relationships with managers and colleagues

Perceptions of organisational justice / commitment to employees

Trust in employer

Feeling of being valued and involved

Opportunities for promotion

Job satisfaction

Employee’s organisational commitment

Increased job performance

Reduced lateness

Decreased turnover / intention to leave

Reduced absenteeism

Increased altruism

Increased conscientiousness

Source: IES, 2007
3.4 Universal good practice or a contingent view?

In the background to the research described here there is a fundamental and continuing debate regarding whether it is possible to make an argument for one particular model being ‘best practice’ or not (see Guest et al., 2004). The ‘universalist’ perspective argues that a number of people management practices, if adopted, will always (i.e., ‘universally’) result in superior organisational performance, whatever the context. On the other hand, the contingency model argues that a distinct combination will work only under specified conditions or with specific groups of staff (i.e., the environment in which the HR service operates itself influences the likely success of any approach).

There are various different positions between these two poles of the argument: some have concluded that it is the intensity with which HR practices are adopted that has greater effect on performance than organisational fit (Becker et al., 1997), while there is also evidence in support of the contingency view (i.e., that it is not practices per se that make the difference, but the degree to which they align with each other to create meaningful ‘bundles’ of practice (e.g., Huselid, Jackson and Schuler, 1997). This is sometimes referred to in the literature as ‘internal contingency’ (Tamkin, 2005a).
3.5 The benefits of ‘good’ functional HR

One question that has been only occasionally addressed is whether there is some additional benefit that accrues to ‘good’ functional HR in and of its own right - that is, over and above any benefit that arises through HR's impact via intermediary processes such as commitment. However, Reilly and Williams (2006) have suggested that there is some confusion over the attributions used in evaluating HR functional performance. Often, people management measures (rather than HR measures) are used to assess the HR function, when in reality they are measures of line management performance. Furthermore, a report by IRS (Industrial Relations Services 2006) confirms that most measurement within HR is confined to assessing operational efficiency rather than the impact of the HR function itself on business performance.

One piece of research that did attempt to investigate the role of HR itself was undertaken by Becker and Huselid (1999). They examined five leading US companies with a reputation for strategic human resource management and concluded that:

- the foundation of a value-added HR function is a business strategy that relies on people as a source of competitive advantage and a management culture that embraces that belief
- a value-added HR function will be characterised by operational excellence, a focus on client service for individual employees and managers, and delivery of these services at the lowest possible cost, and
- a value-added HR function requires HR managers who understand the human capital implications of business problems and can access or modify the HR system to solve those problems.

Thus it is a combination of what HR managers can do as individuals, ie, their own capability, what their function can achieve in terms of service, and how HR can drive cultural change within the wider organisation.

Ehrlich (1997), taking a somewhat narrower and prescriptive approach, outlined the following six principles to support the HR function in creating value as part of its shift to being a strategic business partner:

- **HR strategy must be anchored to the business strategy** - the HR function needs to understand the business strategy and the economic realities that support it. HR professionals need to be able to speak the language of the business and their activities must reflect the priorities of the business.
- **HR management is not about programmes, but about relationships** - the primary role of HR is to create an environment in which employees are committed to the success of the business. It should seek to develop forms of attachment with people that make them want to work and contribute.
- **The HR department must be known as an organisation that anticipates change and understands what is necessary to implement it** - this involves working closely with managers to implement change as well as being advocates of changes and new ideas that will contribute to future success.
• HR should be an outspoken advocate of employee interests, yet it must understand that business decisions have to balance a range of factors that often conflict with one another - this involves providing a ‘thoughtful, objective and realistic assessment’ of the HR aspects of impending business decisions. HR's role is not to win arguments but to ensure that HR issues are given the attention they deserve.
• The effectiveness of HR depends on it staying focused on issues rather than personalities - this involves, for example, countering recommendations that have a negative impact on HR with proposals that achieve the same objective, though it is important that HR professionals keep an open mind because there is usually more than one good solution to a business issue.
• HR executives must accept that constant learning and skill enhancement are essential to their being a contributor to the business.

This second piece of research adds to that of Becker and Huselid by emphasising the role of HR within the organisation and the management processes within which it works. The role aspects (change agent, business partner and employee advocate) contained within this model echo the recommendations made by Ulrich.
4 Evidence from the Health Care Setting

This chapter provides an overview of research within the health sector that has examined the use of different types of approach to people management. Is there a need for the NHS to seek its own set of people management practices in order to deliver success in the healthcare environment or is it appropriate to adopt ‘universal’ practices to deliver higher organisational performance? This is a point we will review now in the light of the literature on the effectiveness of people management practices in the health environment.

Key points from the literature are:

- Individual HR practices on their own may have little impact and, in order to detect some organisational change, particular ‘bundles’ of HPWPs may need to be implemented. Recent evidence from the health service shows that this is as true in the health sector as in other sectors.
- While noting that caveat, broad initiatives aimed at some specific areas of improvement nonetheless do show some impact. The one area that appears to be most related to improvements in performance within the health sector is appraisal. Improved appraisal processes are associated with decreased mortality rates of up to eight per cent. Management and leadership are also viewed as important and appear to impact on unit performance and job satisfaction.
- Teams that work effectively can significantly increase the health outcomes of patients and also lead to reductions in staff stress levels. However, this is largely limited to teams that have clear objectives, are truly participative and in which the team members are committed to quality and innovation.
- Stress and burnout in staff appear to impact on patient mortality. Skill mix within the staff team also has implications for patient outcomes. A richer mix of skills in the nursing team is associated with improved patient outcomes.
- While pay typically has not been identified as the primary motivator of NHS staff, nonetheless it is a reasonably important factor. Research suggests that moves to increase skill levels and areas of responsibility should be adequately rewarded. Resentment can occur where individuals feel that their skill and workload levels have increased with no tangible increase in reward. There has been some successful experimentation with team reward, but individual performance-related pay schemes are more contentious.
- Shiftworking will clearly remain a necessity in order to provide 24-hour cover for patients, but the costs of shiftwork – in terms of its impact on individuals’ cognitive functioning and ability to remain focused and alert – are well-known. However, research suggests that where individuals are allowed some flexibility in determining shift patterns, detrimental impact might be reduced.
- Research suggests that increased levels of autonomy, decision-making and empowerment among nurses, along with higher levels of nurse/physician collaboration, are associated with lower patient mortality rates and improved performance.
• HR practitioners may wish to consider their particular context to ensure that they select the appropriate types of measures to demonstrate success. The literature reveals several outcome measures specific to the Health Service that potentially constitute useful metrics for providing robust analysis of impact in specific NHS contexts. HR practitioners will need to consider which measures constitute the best gauge of organisational performance and change in their part of the NHS.
• Positive outcomes will be obtained only if employees are open to, and positive about, the developments and policies. The literature suggests that programmes are most likely to be successful when performed in a way that creates a positive working environment for employees, while enabling changes in behaviour to occur. Finally, for these practices to bring about an increase in performance within the NHS line managers and those involved in HR will need to show their full support, play an active role in, and have the capacity to implement change programmes.

4.1 Applying HR research findings within the NHS

The NHS is Europe’s largest employer, with over 1.2 million individuals, around half of whom are professionally trained, often working in labour-intensive roles. Budgetary constraints and the changing role of the health service (to one which offers patients increasing choice over their healthcare through greater use of markets) make it necessary for HR to investigate ways of increasing efficiency and improving patient outcome.

The NHS Plan set out a vision for a new NHS, within which it was acknowledged that ‘... improving the working lives of staff contributes directly to better patient care through improved recruitment and retention’ (Department of Health, 2000, p53). The NHS Plan also set out to build the management skills of the workforce. The standards set out in Improving Working Lives (IWL), described by the Department of Health as ‘a tool for the measurement of human resource management’, aimed to entitle every NHS employee to work in a ‘model employer’ organisation that effectively addresses issues such as training, harassment at work and reducing accidents. IWL also proposed undertaking a yearly staff attitude survey within NHS organisations, to better understand and increase morale levels. Together, these indicated an acknowledgement by the Department of Health that HR practices can have an effect on the quality of the services that NHS patients receive. Buchan, too, in a review of health sector and HR reforms, adds his voice to this argument, saying: ‘The importance of the management of human resources to the success or failure of health sector reform has often been overlooked’ (Buchan, 2000:319).
However, as was set out in the previous chapter, there are different schools of thought regarding quite what constitutes progressive people management and how this is related to business performance. It is useful to refer here to the summary of viewpoints given by Buchan in his 2004 review:

- **‘Best practice’** – a set of HR processes can be identified that, when implemented, will improve business performance.
- **‘Contingency’** – business performance will be improved when the ‘best fit’ between business strategy and HR practices is achieved.
- **‘Bundles’** – specific bundles of HR practices can be identified that will generate higher performance in organisations; the most effective composition of these ‘bundles’ will vary in different organisational contexts.

As is the case in the wider HR constituency, the view that positive outcomes can be gained when such ‘good’ or ‘progressive’ HR practices are performed is also gaining support within the NHS (Hyde et al., 2006). Nonetheless, there are some factors that need to be considered in adopting progressive practices within the NHS. First, the NHS, as a public sector organisation, can be more susceptible to political influence and scrutiny than are private sector organisations, which means that HR directors may need to make clear the value of the changes they implement. In this respect the evidence presented here should provide some backing for the introduction of initiatives aimed at improving practice. Second, working in a partial market environment, often with sub-contractors, means that HR initiatives may need to be carefully designed to fit with these various different contracting arrangements.

In healthcare, patients are currently less likely than other types of ‘customer’ to switch their custom, should services not meet their requirements. This can lead to poor performance being concealed, to some extent at least. While at present the majority of patients may appear unwilling or unable to move to another provider, increasing plurality of healthcare provision and the drive to increase patient choice may cause this situation to change quite rapidly.

Taken together, these points may mean that the true costs of poor performance (or conversely, of improvements to performance) can be obscured in some measures (mainly the more subjective ones). However, it also means that HR professionals in the health service will need to consider the most appropriate measures of performance given their context. While a ‘bottom line’ analysis based entirely on pure ‘profit and loss’ calculations may be viewed as inappropriate, nonetheless the increasing focus on cost management within the NHS means that there is a real need to consider the costs of poor performance and/or the value of any changes made. Indicators specific to the health sector – mortality, infection rates, bed occupancy, recovery times – appear to constitute a sound basis for calculating organisational performance.
The Department of Health (2006) has summarised this situation by saying: ‘Performance decline and failure in the public sector is typically more complex and subjective than in the for-profit sector, where a different set of performance measures, largely concerned with financial/market success, operate. Currently, public sector organisations do not operate in such a competitive, open marketplace, with the resultant effect that the cost of failure may be lower than in the for-profit sector, where failed organisations usually exit from the marketplace. However, the development of public services reform agenda and the introduction of a NHS failure regime are likely to make the costs of decline and failure in healthcare more serious in the future’ (DoH, 2006:9).

Clearly then, a key task for the HR function within the health service will be to identify the appropriate indicators to use in calculating the returns to HR developments. However, this does not mean that it is inappropriate for parallels to be drawn with other sectors of the economy, and indeed many writers within the sector have commented on, and drawn parallels with, other complex and high-risk industries such as aviation (Firth-Cozens, 2004, Provonost et al., 2003, and Wilson et al. 2005), nuclear power (Wilson et al., 2005), and the Navy (Firth-Cozens 2001). Hyde and her colleagues have argued that ‘…while the NHS is clearly different from other types of organisation, this doesn’t imply that a new theory of the relationship between HRM and performance is needed. Rather, great care must be taken when using approaches or practices that haven’t already been successfully applied in this context’ (Hyde et al., 2005).

Therefore, HR within the NHS needs both to consider what lessons have already been learnt from HR practice in other complex sectors and the impact of HR activities on (ultimately) the health outcomes for patients. However, there is no reason to consider sector-specific factors (such as the number of patients treated, length of recovery time or mortality rates) as being in any way inferior as measures by which to gauge performance than are outcomes such as profitability, production rates or sales volume. HR practitioners in the NHS should strive to identify the indicators that will best serve evaluation attempts within their sector.
4.1.1 Types of measures used

Hyde et al. (2006) conducted a systematic review and meta-analysis of research to explore the elements of HR management that lead to high performance. Their review (of research across HR in general, not just that conducted within the health sector) identified some 31 different HR management practice or policy measures, with the ten most frequently-occurring being:

- Training and development
- Pay/incentives
- Involvement/voice
- Selection/recruitment
- Teamworking
- Information sharing/communication
- Performance appraisal
- HR systems/strategy
- HR index/bundle
- Pay for performance

Source: Hyde et al. (2006)

These can be considered to be ‘input’ variables in the suggested model of causality. Similarly, Hyde and her colleagues found an extensive list of ‘output’ or performance variables – some thirty-five different forms of performance measure had been used in the 97 papers that were included in the review. The most frequently used were:

- Overall financial performance
- Productivity
- Sales
- Product/service quality
- Profitability
- Market performance
- Employee performance
- Customer satisfaction
- Labour efficiency
- Return on investment/capital

Source: Hyde et al. (2006)

While many of these may well be of interest irrespective of sector – service quality, employee performance and customer (patient) satisfaction, for example – many might be deemed inappropriate to the health setting (such as sales or return on investment). Hyde et al. (2006) note that Buchan (2004) has commented on the unique nature of many of the indicators of interest to the health service: measures of clinical activity and workload (e.g. staff per occupied bed), output (e.g. number of patients treated) or outcome (e.g. mortality). Buchan (2004) also notes that, while a wide range of clinical outcome indicators have been used to assess the impact of HR management in the health sector (he lists 24), some of these are likely only to be used (and reported) in health systems with ‘a relatively sophisticated information infrastructure’ (Buchan, 2004:6). This restricted use and/or reporting will obviously impose limits on any attempts made to model the impact of HR management on health outcomes.

For various reasons (possibly including the above), research on the impact of reforms to the HR function has tended to be based on ‘snapshot’ studies often relating to the issues of pay determination and employee relations policies. Buchan suggests that these studies have therefore often under-estimated the impact of ‘less high profile and more incremental’ developments that have occurred as a result of factors such as staffing changes and workforce re-profiling (Buchan, 2000).
4.1.2 Outcome measures specific to the Health Service

Of particular interest for the NHS (and other parts of the health sector) is the question of the costs of poor practice in terms of increased recovery times, increased numbers of hospital acquired infections and numbers of avoidable deaths. These issues do not often form the focus of reviews of HR practice in other sectors.

The National Audit Office estimates the prevalence of, and the costs, of hospital acquired infections (HAIs):

‘In February 2000 our report The Management and Control of Hospital Acquired Infection in NHS Trusts in England (HC 230 Session 1999-00) noted that at any one time, 9 per cent of patients had an infection that had been acquired during their hospital stay. The effects varied from extended length of stay and discomfort to prolonged or permanent disability and, in at least 5,000 patients a year, death. These infections were costing the NHS as much as £1 billion a year and around 15 per cent could be prevented by better application of good practice, releasing resources of £150 million for alternative NHS use.’ (NAO, 2004)

HAIs are just one sub-group of a range of adverse conditions that can arise in patients as the result of treatment by healthcare professionals\(^1\). The term ‘treatment’ used in this context covers a range of actions from prescription of incorrect drugs (or multiple drugs which, taken together, cause an adverse reaction) through incorrect radiation dosages to surgical removal of the wrong body part. In the United States, the Institute of Medicine (1999) reported that medical errors caused as many as 98,000 deaths each year. Based on this, the editor of the British Medical Journal has calculated that 30,000 people in the UK die as a result of medical errors every year (Smith, 2000).

Other outcome measures specific to the health service include recovery rates and times, remissions and bed occupancy rates. These do not bear any realistic similarities to the types of outcomes more usually assessed in studies of HR efficiency gains.

\(^1\) Often referred to as ‘iatrogenic’ conditions
4.2 Evidence from people management in the health setting

As indicated above, issues regarding the contextualisation of HR management inputs and outcomes – and in particular the indicators used to track improvements – mean that comparisons across health settings should be carefully considered in light of the different activities and therefore the types of outcomes that will be appropriate. It should also not necessarily be assumed that, where outcomes appear similar in different health settings, these outcomes have been arrived at through the same causal route. Therefore, while Buchan (2004) concludes on the basis of ten studies conducted in the health sector, that there is a loose association between higher staffing levels and/or staffing mix and better ‘outcomes’, the particular route by which such changes have had their impact may not be entirely clear, nor indeed may any generic ‘benefit’ be readily identified, since the input and outcome measures vary in each of the ten cases cited. This caveat therefore needs to be borne in mind in interpreting the results reported in the following sections.

4.2.1 High performance HR management/bundles

One of the most significant recent pieces of research looking at the impact of HR management practices in the NHS has come from West and his team in Aston. West et al. (2006) investigated the relationship between high performance HR management and healthcare outcomes in 52 English hospitals. Rather than focus on individual HR management practices, they focussed on a ‘high performance bundle or system’ of HR practices and the effects that this had on patient mortality. They collected information from each hospital on a range of HR-related areas, such as: assessment of training needs; sophistication of training policy; appraisals; contribution of staff views; staff involvement in decision-making; centralisation of decision-making; employment security; and Investors in People status. The scores for each hospital were then combined to provide a single rating which indicated their position on a continuum from a ‘high performance’ hospital to one with a more traditional approach.

After controlling for influential factors (such as the prior mortality rates at each hospital), the authors found that the HR system variables accounted for almost eight per cent of the variance in mortality rates. They also looked at the contribution of each of the elements of the HR system, and found that the most influential individual HR practices were: the presence of a sophisticated appraisal system, employment security and Investors in People status. They concluded that: ‘… the strong relationship between the overall scale measure of the high performance HRM system and patient mortality, suggests that it is the combination of a ‘bundle’ of high performance HR practices that is necessary. Such practices are likely to be mutually reinforcing and coherent as an interconnected system, and therefore produce the behaviours described above that lead to the provision of high quality healthcare and, as a consequence, lower patient mortality’ (West et al., 2006:996).
In a similar study in the US, Preuss (2003) examined high performance work systems in healthcare, using survey data from registered nurses and nursing assistants in 50 acute-care hospital units. His research examined the relationship between high performance working and information quality, and the mediating role that information quality has on performance quality. Overall he concluded that: ‘...information quality is an important factor linking high performance work systems and organisational performance quality’ (Preuss, 2003:600).

Further information relating to the individual elements of high performance HR management is detailed in the following sections.

4.2.2 Management and leadership
Work by Borrill, West and Dawson (2003a) suggests that more effective supervisors and line managers are associated with improved staff perceptions of well-being and job satisfaction and reduced intentions to leave. There was a weaker association between staff perceptions of leadership in top level managers and job satisfaction. Higher leadership ratings of top management were associated with higher star ratings, higher clinical governance review ratings and lower numbers of patient complaints. Their analyses also suggest that more positive perceptions of both senior and immediate line managers are associated with higher proportions of staff having well-structured appraisals; that more positive perceptions of senior managers were associated with increased likelihood of having a personal development plan and (in acute/specialist, mental health and primary care trusts only) with better work-life balance (Borrill et al., 2003b). It should be noted though that in such studies based entirely on ratings of perceptions, quite what is ‘cause’ and what is ‘effect’ may be unclear.

Recent work by Bailey and Burr (2005) suggests that Trust Chief Executives and senior development staff believe that leadership accounts for around 60 per cent of variance in unit performance. However, these respondents were not asked about the level of leadership/management that had the most impact. Bailey and Burr suggest that further information will be needed regarding the levels of leadership that have the most substantive impact in order for development work to be undertaken to increase leadership capability. Earlier work by Alimo-Metcalfe and Alban-Metcalfe (2000) aimed to identify the essential qualities of a good leader within healthcare. Their survey of 2,000 NHS managers revealed that they believed the most important characteristic to be concern for others, followed by an ability to communicate and inspire (Alimo-Metcalfe and Alban-Metcalfe 2000, cited in Firth-Cozens, 2001).

Research has also emphasised the importance of strong nursing leadership. Laschinger and Leiter (2006), in their examination of the relationship between nursing work environment and patient safety outcomes, concluded that strong nursing leadership had a fundamental role in the quality of nurses’ worklife and ‘... highlights the importance of developing effective staff nurse leaders to ensure that nurses feel confident and satisfied with their work and that patients receive the quality of care they deserve’ (Laschinger and Leiter, 2006: 266).
Firth-Cozens and Mowbray contend that the impact of good leadership can be seen throughout organisations, from the highest levels down, through staff teams, to patients:

‘…one important way in which leaders affect patient care and satisfaction is through their management of teams and its effect upon the levels of stress experienced by the team members. Although most evidence comes from the team level, it is likely that this is also true for whole organisations and their chief executives. It implies again that there are important ways of assessing leaders other than by meeting assigned objectives. Rather, we can judge by the wellbeing of their staff in terms of absence, turnover, and disruptive behaviours’ (Firth-Cozens and Mowbray, 2001:6).

4.2.3 Appraisal
As detailed above, the recent analyses conducted by West et al. (2006) provide evidence that appraisal is a key aspect of HR impacting on patient mortality. Earlier work by this research team had already started to point to the centrality of effective appraisal systems. In 2003 Borrill and West reported a ‘…strong association between the sophistication and extensiveness of staff management practices in NHS hospitals and lower patient mortality’ (Borrill and West, 2003:3). In this work they found a number of key HR management practices had an effect on patient mortality, including:

• having an appraisal system in place
• training (the more extensive the training, the lower the mortality)
• the percentage of staff working within a team
• the HR director being a voting member of the hospital board.

Of all of these factors, having an appraisal system in place was found to have the single strongest effect upon patient mortality. They concluded that:

‘…a hospital which appraises around 20 per cent more staff, and trains around 20 per cent more appraisers, is likely to have 1,090 fewer deaths per 100,000 admissions’ (Borrill and West, 2003:6).

Similarly, Pearson, Reilly and Robinson (2004) reported research into the provision of appraisals for NHS staff, and the benefits this can bring:

‘An important way for employees to feel that the organisation (NHS) cares about them as individuals is to ensure that everyone has an annual appraisal and performance development plan. A comparison between 2000 and 2001 data shows that an increase in the coverage of appraisals and PDPs of about ten per cent was linked to a five to ten per cent increase in the average motivation scores for several related aspects – training, development and career, immediate management, job satisfaction and commitment to the organisation’ (Pearson et al., 2004, S1 p.23).
Clinical consultants were the first group of NHS staff for whom annual appraisals were introduced (in 2001), followed by GPs in 2002. The aim of these was to give feedback on performance while indicating future development and training requirements. All staff groups are now expected to receive annual appraisals. West et al. (2006) describe how staff at many levels within a hospital, such as receptionists and nurses, can benefit from performance appraisal since ‘...within a hospital, staff who are clear about their roles and objectives and have their development needs met, are likely to perform their roles more effectively and thereby provide better patient care thus influencing patient mortality’ (West et al., 2006: 991).

4.2.4 Team working/high reliability teams
The NHS Plan proposed reducing hierarchical working practices and replacing them with team working arrangements. At the same time, the Plan sought to turn the NHS into a model employer which could offer clear career progression and generate both increased staff morale and management skills.

Implementing teamwork may prove to be a challenge in some healthcare settings, however. In a discussion of organisational development in healthcare organisations, Koeck (1998) stressed the importance of addressing the contribution made by teamwork but also summarised some of the key issues for consideration to ensure effective teamwork in healthcare organisations:

‘To provide high quality care efficiently the organisation has to integrate its organisational functions, professional groups, and specialist workers into one coherent effort. This is the part where most healthcare organisations fail miserably. Although modern healthcare calls for extensive team work, most organisations have difficulties in bridging the gaps between the professions and expert groups’ (Koeck, 1998:1268).

A study carried out by UCLA (University of California, Los Angeles) found that, within the mental health setting, working in teams doubled the effectiveness of treatment given to older patients with depression. Those who received care from a team ‘...reported a 50 percent or greater reduction in depression symptoms at 12 months, compared with 19 percent of those in usual care’ (UCLA, 2002:1). There can be additional benefits of teamworking for staff too, as well as for patients. Studies looking at team working within the NHS have found that effective teamworking can serve to reduce staff stress levels. Carter and West (1999) investigated team working and stress levels amongst NHS staff and found that staff who did not work within a team had the highest stress levels, followed by staff working in poorly functioning teams, with the lowest levels of stress being reported by staff in well functioning teams (Carter and West, 1999, cited in Firth-Cozens and Mowbray, 2001).
A number of research studies have looked at how teamworking could affect the performance of healthcare providers. West (2002) for example found that working in teams increased employee effectiveness only when they included:

- clear objectives for both the team and the individual worker
- participation
- individual and team commitment to providing a quality service
- individual and team commitment to innovation.

Earlier findings by Borrill et al. (2000) support West’s contentions in the case of the nursing profession. Borrill and her co-workers reported that these factors were related to both effectiveness and innovation in teams and, where such factors are in place, the greater the percentage of staff working in teams, the lower the mortality rates. Furthermore, those working in well-functioning teams are more likely to remain in their job than are staff members working in poorer-functioning teams.

Overall, then, the work suggests that, where teams have clear objectives, are truly participative and team members are committed to quality and innovation, then staff suffer less stress and the effectiveness of the care and treatment of patients is increased.

In some organisations, High Reliability Teams have been introduced in situations that have complex working structures yet require both safety and effective performance. Wilson et al. (2005) describe the use of such teams in organisations in sectors such as aviation and nuclear power, which manage successfully to balance the twin requirements of effectiveness and safety. They suggest that High Reliability Organisations (HROs), and within them, High Reliability Teams (HRTs), can act as a model for the healthcare sector, which is a similarly complex organisation with a similar emphasis on both safety and effectiveness. They describe the approach that typically is adopted in moving to high reliability status:

‘...this takes more than just appropriate organisational level values, for example, commitment to resilience, sensitivity to operations. Rather, a systems view must be taken to look at other levels within the organisation that contribute to its high reliability status. Specifically, individuals and teams embedded within the organisation are critical to the success of an HRO’ (Wilson et al., 2005:304).

Within healthcare, the types of teams that might benefit from moving to HRT status might include, for example, surgical teams and emergency room teams. Wilson et al. outline a number of team behaviours that HRTs must be able to demonstrate consistently, including:

- sensitivity to operations
- commitment to resilience
- deference to expertise, and
- a reluctance to simplify
They also offer a number of developmental strategies to help non-HRTs in the healthcare sector to become HRTs which may in turn lead to improved workplace and patient safety. The six strategies are:

1. **Cross training** - since if ‘... all team members (such as nurses and doctors) have a shared understanding of the roles of the other, the risk of error is decreased’.

2. **Perceptual contrast training** - which aims to improve cognitive skills by presenting alternative endings to scenarios, to encourage staff to distinguish between positive and negative elements as ‘... noticing and situational awareness are particularly important in hospitals or other emergency environments where there are multiple inputs and little time to make decisions’.

3. **Team coordination training** - to enhance communication and team coordination, which may lead to a reduction to errors.

4. **Team self-correction training** - to enable team members to identify, correct and in future avoid, situations which might lead to unsafe situations.

5. **Scenario-based training** - the use of scenarios and trigger events which allow team members the opportunity to prepare for similar real-life events.

6. **Guided error training** - which guides team members towards making errors in order to learn from the outcomes.

Arguably, adopting these approaches to team development appears likely to bring improvements to team working irrespective of whether or not it was the intention to introduce high reliability teams per se.

**4.2.5 The working environment/worklife characteristics**

Characteristics of the working environment can impact on staff attitudes and patient safety. McArdle, Burns and Ireland (2003) interviewed hospital doctors in an acute trust on the causes of errors and found that medication errors were mostly attributed to overwork and lack of information.

A systematic review of the effect of nursing environment (ie factors such as workload, autonomy, interprofessional relations etc) on levels of patient mortality undertaken by Kazanjian et al. (2005) compared 27 primary research studies. The authors concluded that: ‘... a broad interpretation of the studies taken as a group would suggest that workplace environmental attributes of hospital-based nursing practice have an effect on outcomes of care, including mortality. This association is most evident in intensive care unit studies’ Kazanjian et al. 2005:115).
This is consistent with other research, such as that of Laschinger and Leiter (2006) who analysed data from a group of Canadian hospitals in order to examine the relationship between the nursing environment and patient safety outcomes. They used structural equation modelling analysis to assess the extent to which the data supported Leiter and Laschinger's (2006) Nursing Worklife Model. Nursing leadership was fundamentally linked to quality of worklife while perceptions of the adequacy of staffing levels impacted upon emotional exhaustion. Use of a nursing model of care, rather than a ‘medical model of patient care’, had a direct effect on nurses' personal accomplishment. The authors suggested that:

‘The results are consistent with the notion that patient safety outcomes are associated with the quality of the nursing practice work environment and that the burnout/engagement process plays an important mediating role. The results suggest that when nurses perceive that their work environment supports professional practice, they are more likely to be engaged in their work, thereby ensuring safe patient care. The results also support the key role of strong nursing leadership in creating conditions for work engagement and, ultimately, safe, high-quality patient care’ (Laschinger and Leiter, 2006:265).

Kazanjian et al. (2005) also identified processes such as burnout and job satisfaction that serve to mediate the relationship between the nursing environment and patient outcomes. They state that:

‘...although there is good research evidence substantiating a link between nurse-mediating variables such as quality nursing care and patient mortality, the link between the nursing environment and mediating process variables has not been fully studied’ (Kazanjian et al. 2005:115).

Firth-Cozens (2001) has considered the relationship between learning and teamwork, stress levels and patient safety. Reviewing a series of studies, including those by Wall et al. (1997), who compared stress levels of healthcare workers with those of general workers, and Houston and Alit (1997) who looked at the damaging effect of stress levels on error rates in junior doctors, she concluded that: ‘Bringing together these findings suggests strongly that one way that management can improve patient safety is by lowering the stress levels of staff’ (Firth-Cozens, 2001:27).

Much of the research on the nursing working environment has focussed on staffing levels and skill mix. These issues are explored in the following two sections.
4.2.6 Staff ratios
A number of studies have looked into the provision density of healthcare staff and health outcomes. In general, such studies indicate that higher staff to patient ratios are associated with decreased lengths of stay and decreased mortality rates (see, for example, Aiken, 2002; Aiken et al., 2002; Clarke et al., 2002; Lang et al., 2004; Lankshear et al., 2005; Needleman et al., 2002; Needleman and Buerhaus, 2003; Rafferty et al., 2006; Robinson and Wharrad, 2000, 2001; Sovie and Jawad, 2001; Tucker et al., 2003; Whitman et al., 2002).

However, there can be problems in interpreting such findings, as in some cases the studies may fail to take into account factors such as total skill level within the team and the service level in place. For instance, Pronovost et al. (1999) found that, aside from staffing levels, whether or not an Intensive Care Unit (ICU) doctor undertook daily rounds affected the outcomes of abdominal aortic surgery, while Lankshear et al. (2005) in their systematic review observed that ‘… one major weakness in most of the studies is the omission of data about doctors. It is possible, for example, that hospitals with higher levels of nursing staff also have more and better qualified doctors’ (Lankshear et al., 2005:171).

In other words, it may be inappropriate to conclude that staffing level per se is the key factor determining patient outcomes. Where there are higher nurse-to-patient ratios it is possible that there are higher qualification levels overall, better skill mix within the overall team or better doctor-to-patient ratios, each of which may be a contributory, or even the main, factor underlying improved patient outcomes.

Next we move on to consider the issue of skill mix within the various staff groups.

4.2.7 Skill mix
Before commencing this section, it is as well to review the various ways in which the term ‘skill mix’ has been used within the literature. Price, Miller and Payne (2000) identify three different meanings of the term:

1. The total mixture of skills available within a department, drawing on the whole mix of professional groups and, hence, different types of skills proffered by those groups (eg, a unit or department that comprises a mixture of nurses, doctors, clinical psychologists and physiotherapists).

2. The range of skills offered by one professional grouping (eg, within the nurse staff group) and hence incorporated in the job descriptions for different levels of employee within the relevant group.

3. The mixture of skills offered by a particular individual.


Taking first that body of research that has examined the effect of different staff groups within the team or ward, research conducted by Jarman et al. also found that a high level of auxiliary nurses in training and high bed occupancy were associated with higher mortality rates (Jarman et al., 1999).
Tourangeau et al. (2002) investigated mortality rates in Canadian hospitals and their relationship with both nurse staffing levels and nurse skill mix. They found that ‘... a richer skill mix of registered nurses was associated with lower 30-day mortality whereas the total amount of nurse staffing was not. Overall a ten percent increase in the proportion of RNs across all hospital types was associated with a 0.5 per cent point reduction in mortality’ (Tourangeau et al., 2002, quoted in Lankshear et al., 2005:168).

Similarly, Blegen et al. (1998) conducted research within US inpatient care units and concluded that, the higher the registered nurse skill mix, the lower the incidence of ‘adverse occurrences’, including medication errors, patient falls, skin breakdown, patient and family complaints, infections and deaths. Needleman et al. (2002), in their large scale research in 800 US hospitals, also examined the proportion of care that was provided by registered nurses and found that this correlated with a reduction in length of stay and various infections and medical conditions.

However, some writers have commented on the possible difficulties that might be encountered in changing skill mix. For example, Buchan has suggested that some professional groups may be opposed to such changes, while Lankshear et al. have noted the possibility that upskilling of some (relatively low paid) professional groups may be motivated more by a desire to cut costs than to improve the service provided: ‘Skill substitution across professions and groups (eg nurse for doctor, care assistant for nurse) is more likely to engender opposition from professional organisations and trade unions than is a reallocation of skills and roles within professions and groups. The relative absence of evaluation of the effects of changes in skill mix and patterns of deployment in the NHS also makes it very difficult to assess the claimed benefits of these changes’ (Buchan 2000:322).

‘In some parts of the world, greater investment in qualified nurses is part of a strategy to improve quality of care, whereas in other areas policymakers are seeking to substitute qualified nursing workforce numbers with less expensive assistive staff’ (Lankshear et al., 2005:163).

Price, Miller and Payne (2000) have noted that the introduction of extended roles as part of skill mix changes needs careful handling. While staff may welcome the development opportunities such changes may bring, they may resent the changes if their work load subsequently becomes too heavy and they receive no additional remuneration. In keeping with Buchan’s suggestion that some professional groups may oppose skill mix initiatives, Price (2007) has found that, in introducing extended roles for radiographers, radiologists are key gatekeepers to such initiatives, as they can block or facilitate proposed changes. It should be noted that, in most of the sites in which Price conducted his research, extended role/skill mix developments had tended to be initiated and led by imaging service managers rather than being a planned piece of organisational development. In other words, developments were ad hoc and scattered, rather than being part of any centrally planned programme of development.
4.2.8 Reward systems

With regards to pay within the NHS, the CIPD reported that consultation sessions with staff had revealed that ‘There is a strong acceptance of standardised pay and rewards. It is considered more important for staff to feel that they make a difference to patient care than to differentiate individuals by pay’ (Hyde et al., 2005).

For this reason individual Performance Related Pay (PRP) remains controversial and indeed the research evidence suggests that its success depends very much on the setting within which it is introduced. There has been particular criticism of applying PRP in the public sector. Dowling and Richardson (1997) and Marsden and French (1998) found that PRP decreased morale by increasing competitiveness amongst staff, while having little effect upon performance. Pfeffer (1998) reported that workers believed that receiving a positive outcome within a PRP system had little to do with actual performance and more to do with the relationship of the employee with their line manager, and whether this was largely positive or negative. A study carried out in China by Liu and Mills (2005) sought to understand the effect that PRP would have on the behaviour and performance of hospitals. This found that, although there was an increase in hospital revenue, this was increased in part by the greater provision of unnecessary treatments; which in turn wasted social resources.

While pay is one of the three factors identified by Hyde et al. (2006) as having most impact on performance, it was also found to have the most negative associations with performance. The authors commented that, while variable pay ‘may be good for those who gain, (it may) lead to increasing tensions between groups of employees who are supposed to collaborate on projects’ (Hyde et al., 2006, p. 27).

Robinson (2001), in her research into the quality of working lives of staff within the London NHS, reported that pay ranked fourth in a list of requests for improvements, behind ‘more staff’, ‘better working conditions’, and ‘better facilities’ (Robinson, 2001).

Nonetheless, while staff may prefer standardised pay, this does not alter the fact that individuals may be unwilling to develop new skills or take on new activities if reward systems do not acknowledge and reward any additional skills gained or higher level activities subsequently undertaken by the individual as a result. For this reason (amongst others) the Agenda for Change facilitated training and development, made progression more accessible (via the ‘skills escalator’), and linked pay scales into this progression sequence via pay reforms and introduction of the national pay spine.

Team pay has been tested in some parts of the NHS. Reilly et al. (2005) carried out consultancy support for a team pay experiment within the NHS. They found that team pay can work as long as there are clearly communicated targets set (there should be a clear path between effort and reward), the managers involved are trusted and the rewards are right for the team. This was found to be the case across a variety of settings, including primary care trusts, pharmacies and out-patient units, and with a variety of occupational groups and group sizes.
There is also US evidence on the effectiveness of team rewards. In John Hopkins Hospital (1995) team-based pay schemes of a ‘gainsharing’ type were introduced alongside a new concept ‘shared governance’. This involved decentralising operational responsibility and fiscal accountability to clinical groups, and, within these groups, nursing units were given further autonomy. They were paid annual salaries inclusive of any overtime. The units could opt to have a ‘financial incentive program’. These allowed nurses to share in any monies saved from their budget and to benefit from increases in productivity. They could control their spending, and thereby benefit from the incentive scheme, through leaving vacancies unfilled, reducing bed occupancy times and managing their resources to most effectively manage workload peaks and troughs. The savings made from the budget were either paid as an individual bonus or used collectively for the benefit of everyone.

However, criticisms have been made of gainsharing schemes because they have been driven by cost cutting. In other words efficiencies have not come from increased productivity, but from reducing staff numbers. The remaining employees then share in some of the budget savings. Such has been the depth of feeling that the Australian Nursing Federation boycotted gainsharing in the public sector, complaining that revenue generation overrode clinical priorities. It was also banned for a time in the USA health sector, and is now severely circumscribed. This is because of the distortions to patient care that resulted from staff being overly fixated on their bonus.

4.2.9 Training and development

Borrill and West (2003) reported that training was one of the key factors associated with mortality - the more extensive the training, the lower the mortality rates typically seen. A number of studies have looked at the ways in which educational and training interventions can be delivered to encourage learning and best practice among doctors and improve health outcomes for patients. For example, Freemantle et al. (2000) found that while merely providing doctors with printed material was unlikely to bring about any significant improvement in health outcomes, the use of outreach and opinion leaders was more likely to have a positive impact. Oxman et al. (1995) found that a range of interventions, including outreach visits by experienced staff, could improve the practices of physicians (in some cases reducing the incidence of inappropriate performance by 20 to 50 per cent).

A number of studies have looked into how Continuing Medical Education (CME) can improve the care offered by doctors to their patients (Bloom, 2005, Sanci, et al., 2000, Davis et al., 1999, Cantillon and Jones, 1999, Davis, 1998, Davis et al., 1995, Davis et al., 1992). CME is designed to assist doctors to keep up to date with appropriate treatment and care, thus enabling them to change to using more effective treatment methods. Bloom (2005) found that techniques that were interactive in nature, such as outreach and audit, were the most likely to bring about changes in behaviour and improved patient care. Even so, they found that it was often the most inefficient forms of CME that were used most regularly; these include printed information or instructive presentations, which, as the work by Freemantle et al. (2000) indicates, are the least likely to be effective.

1‘Outreach’ offers clinical staff regular support, usually led by a trained individual, with the facility to call on more expert assistance if required (Source: Bright, Walker and Bion, 2004)
It has been increasingly recognised that effective communication between doctor and patient is central to the provision of high quality healthcare and this is therefore one area on which education and training has been focused. A clinical review undertaken by Bright, Walker and Bion (2004) found problems with communication to be a common finding in cases of cardiopulmonary arrest, failures in critical illness care and failures to adhere to ‘do not resuscitate’ instructions. They concluded, in line with Aarons and Beeching more than ten years previously (Aarons and Beeching, 1991) that poor decision-making by healthcare workers could be improved by education. Back et al. (2003) and Fallowfield et al. (2002) discuss the importance of training doctors in communication for the patient-doctor relationship. Their work was conducted within the field of oncology but their conclusions are likely to be more widely applicable. Back et al. conclude that ‘... the quality of communication also influences patient satisfaction, compliance with medication, and clinical outcomes’ (Back et al., 2003:2433). Both Back et al. (ibid.) and Spiro (1992) found that even a short course of training in communication skills could improve a doctor’s ability to understand the needs of the patient but that, at present, there was very little guidance or training given in this area.

Sanci et al. (2000) found that, in the field of adolescent healthcare, CME could bring about sustained self-reported changes and improvements in behaviour, skill and knowledge. Davis (1998) sought to better understand the effectiveness of CME interventions on the performance of doctors, and reported that over two thirds of studies reviewed led to a change in physician performance, with just under half also leading to a change in healthcare outcomes. Community-based strategies, practice-based methods and multiple interventions appeared to be the most effective approaches while some approaches – such as conferences – had little discernable impact. A later study by Davis et al. (1999) also reported that CME that was participatory did have an effect on practice and health outcomes. Finally, Allery et al. (1997) found that education was involved in around a third of clinical behaviour changes made by GPs and practitioners.

In section 4.2.4 we noted the importance of teamwork within the NHS. Training for teamwork is increasingly being recognised as an essential requirement for improved performance in the health service. Bright et al. (2004) have concluded that team working and education are central to improvement initiatives and recommend that team based attitudes should be encouraged during clinical education and training, starting at undergraduate level and following up with speciality training. A recent series of studies conducted by Draycott and her colleagues (Draycott et al., 2006; Draycott and Crofts, 2006) have shown that structured team training using simulation techniques (including the use of medical mannequins) can improve the skills and promote the development of obstetrics teams, leading to reduced morbidity during obstetric emergencies and improved perinatal outcomes for infants.
An approach to improving team performance that originated in aviation Crew Resource Management (CRM) programmes is receiving increasing attention within the health setting. Prizzi et al., (2001) suggest that while technical training produces individuals who are proficient at specific tasks, ‘…it does not address the potential for errors created by communicating and decision making in dynamic environments’. Within the aviation sector training programmes to improve safety based on CRM have been running for some time and they are now starting to be tested within the health service.

There is no standard approach to CRM and it can include team training, simulation, interactive group debriefings, and measurement and improvement of aircrew performance. Typically, information is included in such programmes about the limitations of human performance so that trainees develop an understanding of cognitive errors, and how stressors (such as fatigue, emergencies, and work overload) can contribute to errors being made. One study, conducted in the US by Morey et al., (2002) sought to assess the effectiveness of training based on the CRM approach in developing teamwork behaviours amongst emergency department staff teams. Rarely for such studies, the evaluation included a control group as well as the intervention group and the findings revealed a significant improvement in quality of team behaviours following training. The clinical error rate also significantly decreased (from 30.9 per cent to 4.4 per cent) and in addition there was an improvement in staff attitudes towards teamwork. The authors concluded that their findings pointed to ‘the effectiveness of formal teamwork training for improving team behaviors, reducing errors, and improving staff attitudes among the ETCC-trained hospitals’.

Another team training initiative recently developed in the USA is the TeamSTEPPS™ system. This is a system that aims to optimise patient outcomes by improving communication and other teamwork skills among healthcare professionals. It was developed by the Department of Defense (DoD) in collaboration with the Agency for Healthcare Research and Quality and is an evidence-based system aimed at integrating teamwork principles into healthcare teams. The DoD commissioned case studies to evaluate the programme and concluded that it represents a first step in developing the types of medical team training that will be needed in future (Agency for Healthcare Research and Quality, 2007).

A final point here is that Price (2007), in his research into role extension and skill mix in radiographers, discovered that there was a wide range of practice regarding training for extended role skills and activities. There was no standard agreement regarding the training that was viewed as an acceptable minimum for radiographers moving into new areas of work and, in the main, the majority of training was uncertificated and therefore lacked any real quality control.
4.2.10 Shift work
Shift working continues to raise concerns within the literature. One early study of nurses in a US hospital undertaken by Gold et al. (1992) examined the effects of shift working on outcomes such as nodding off at work, or on the way to and from work, and accidents or errors including ‘…automobile accidents, medication errors, on-the-job procedural errors, and on-the-job personal injuries that the nurse reported had occurred because of sleepiness’ (Gold et al. 1992:1011). The research found that those on shift work had twice the odds of nodding off while driving to and from work as well as twice the odds of a reported accident or error related to sleepiness. Gold et al. concluded that their findings were consistent with laboratory investigations on the negative effects of shift work and sleep deprivation on attention levels and error rates. They acknowledge the difficulties this can have for policymakers, describing it as ‘a dilemma for policymakers’ who are responsible for scheduling rotas whilst seeking to balance the family responsibilities of nurses with staffing requirements.

In a similar but more recent examination of shift working for NHS nurses, Brooks (2004) also considers this issue. His research, a meta-analysis of empirical research from a variety of disciplines, looked at flexible working arrangements for NHS nurses, specifically in relation to the element of choice over their shift work arrangements, and the potential outcomes, both personal and organisational. He points to the large body of research that has examined the effects of shift working on the body’s natural rhythms and the extent to which this varies with the individual. He concluded that some individuals appear more suited to shift working than others, and therefore the potential impacts of shift working are linked to the extent of workplace control, both actual and perceived.

‘… if nurses perceive a lack of choice over this crucial aspect of their lives, then the detrimental effects of shiftwork …are more likely to adversely affect individual and organisation outcomes’ (Brookes, 2004:18).

4.2.11 Organisational trust, empowerment and involvement
It has been suggested that organisational trust, that is, trust between management and staff, is a ‘crucial ingredient of quality’ (Firth-Cozens, 2004:56) and is a key requirement in encouraging a workplace culture where patient safety has a high priority:

‘… if improving patient safety depends at least in part on getting staff to report errors and near misses as a matter of routine, they will need to have high levels of trust in their organisation that this reporting does not have unfair repercussions for them or for the colleague who was reported’ (Firth-Cozens, 2004: 57).

Firth-Cozens also cites research conducted by Laschinger with nurses which showed that empowering them led to higher levels of organisational trust, which in turn led to higher levels of commitment (Laschinger et al., 2000, cited in Firth-Cozens 2004).
Similarly, Armstrong and Laschinger (2006), in a small scale survey in a Canadian hospital examined the link between nurse empowerment and the culture of patient safety. They reported that ‘... total empowerment was significantly positively related to perceptions of patient safety culture’ and consequently ‘...the results suggest that organisations in which nurses are empowered to practice their profession optimally are organisations that optimize conditions for providing safe patient care’ (Armstrong and Laschinger, 2006).

West et al. (2006) refers to earlier research from his team (West et al., 2005) and suggests that ‘...healthcare employees who report higher levels of direct involvement report high levels of role clarity, loyalty, innovation and cooperation with co-workers which, in turn have been related to quality of patient care’ (West et al., 2006:994). They also refer to earlier US research by Aiken et al., (1994) which found that increased autonomy and decision-making latitude, empowerment among nurses, along with higher levels of nurse/physician collaboration, were associated with lower patient mortality rates.

Taken together, then, this research suggests that increased levels of autonomy, empowerment and trust lead to improved performance. This in turn, improves the experiences and outcomes of patients receiving care.
5 Conclusions:
Implications and Recommendations for the Role of HR Within the Health Sector

This report has principally looked at two strands of research regarding the organisation of the HR (and associated) functions and people management practices, and their links to organisational performance. It has highlighted the changes that have taken place recently in terms of the way HR is organised, and the relationship of HR with learning and development, workforce planning and OD. In this last chapter we turn to the implications of these changes for HR within the health sector.

Key findings from this concluding chapter are as follows:
• The research suggests that there are various options regarding how HR might be structured in future within the health sector. What is seen as the optimal structure is likely to vary with size and level of organisation. Different options are suggested at individual trust level and at SHA or NHS level. However, cost pressures could push organisations towards greater sharing of HR activities to achieve economies of scale.
• The current status of the relationships between HR, learning and development, workforce planning and OD is considered, and suggestions are made for what might be the best way to move forward in organising these functions. The conclusion is that there is probably more value in bringing them together than in organising them as separate functions.
• Some of the discussion on the potential devolution of HR functions has overlooked the difference between the more strategic HR tasks, typically the province of HR professionals, and the more ‘hands on’ activities often shared with, or undertaken solely by, line management. Where line managers undertake people management activities, HR should ensure that line managers have sufficient capability and support to undertake this role appropriately.
• A summary of the main findings from the research into people management practices, grouping the practices into three broad categories of activity (those concerned with training and support practices; those focussed on improving working conditions; and those aimed at increasing employee involvement and engagement) reveals that, while there is quite strong evidence for the impact of good HR practices in some areas (such as appraisal and leadership) the evidence for impact of other areas, at present, is not so strong. Nonetheless there is sufficient evidence to suggest that each of the areas identified will be important for HR practitioners to consider in the future.
• Implications for future HR developments of the impact findings are outlined, along with the types of HR competence that will be needed.
• The report concludes that it is likely that HR professionals will need to use an increasingly wide range of skills as they move into areas of activity with which they have not previously been engaged. In particular, the report points to an increasing need to assess and take stock ahead of initiating interventions and to assess any impact subsequent to changes being made.
Taking stock of the value of interventions will provide HR practitioners with valuable evidence for use in persuading key stakeholders of the value of further changes. Irrespective of how the HR function is organised or where it is located, it is increasingly likely that HR practitioners will need to be able to account for the reasoning behind any structural changes made in working arrangements, explain the expected patient benefits and (perhaps most importantly) be able to point to relevant evidence to support the value of such changes.

5.1 How should HR be structured in the health sector?

In summary, there appear to be four ways in which HR is organised:

1. A single integrated function that undertakes the full range of HR activities.
2. An HR function with a corporate core but with some activities dispersed by geography.
3. The same as the above but the distribution of work is driven by business units.
4. The ‘three legged stool’ model comprising shared services, centres of expertise and business partners (although it should be acknowledged that this model has been frequently modified to suit organisational circumstances).

There are at least two, and probably more, levels at which these models can be considered as relevant to the health sector: at the individual Trust level or at an aggregate level, such as an NHS-wide shared service; between these extremes, there are various intermediate levels of aggregation, such as Trust consortia and the Strategic Health Authorities.

At the Trust level, initial consideration would indicate that any of the first three options might be appropriate, depending on the particular context of each Trust. Whether all HR activities are centralised or distributed by department/unit or by geography depends on the shape of the organisation. Therefore, a small Trust on one site might consider the best model to be a centralised HR function. Those whose clinical and other services are dispersed may be attracted to the distributed HR support model to match the organisational structure. There are other factors to take into account in making such decisions: the experience of distributed HR is that it can lead to duplication and to inconsistency of practice between units/departments (with that inconsistency being based on local decisions regarding specific policies and practices rather than being a response to any real difference in service needs). Local government, for example, has been moving away from distributed HR for precisely this reason – the Education Department and Social Services may be pursuing divergent policies and practices. Therefore, the health service will need to consider all interests and priorities before making any decision relating to dispersal of the HR function.
At the same, however, it is important to distinguish between the types of HR activity being considered, as this too can have implications for the final decision regarding the optimal structure. The distribution of administrative activities may lead to costly duplication, but the use of ‘embedded’ HR advisers/managers (or in the new “speak”, business partners) may enable HR advice to be tailored to the real local business needs – estates may need to be dealt with differently from a clinical department.

In addition, the balance between corporate HR control and local empowerment can also be reflected through reporting lines. If the business partner reports to the corporate HR director then the pull towards the centre will be stronger than if the business partner reports to the departmental service head.

There is a view that, at NHS level, there can sometimes be some duplication of activity, especially in administrative work. While the three legged stool model may make little sense at single trust level (beyond having some form of embedded HR and administrative activities all located in HQ rather than one in each service unit), there is more of an argument for it at NHS level. Most large and complex organisations (and the NHS would be one example) have seized the shared services option because of the potential cost savings and improvement in processes (speed and quality) that can be delivered.

Therefore, one approach for the NHS could be to strip out all transactional activities from the Trusts and place them in a shared service centre(s). This could be supported by a call centre(s), an intranet and a shared IT platform. Centres of expertise, covering such areas as reward, resourcing and employee relations/employment law could give advice to business partners sitting at Trust level. This model has potential to work in the NHS context given that it has many centrally-defined HR policies (eg Agenda for Change), common HR practices and now the common Employee Staff Record. An adaptation that the NHS is likely to make to the so called pure ‘Ulrich’ model is to put in more HR resources at Trust level to give more operational HR support. Another adjustment might be to have a regional tier where there would be a pool of HR consultants available to bolster Trust resources when there is a pressing project to complete.

If this move seems too radical, then the ‘half way house’ position could be to encourage Trusts to work together in sharing HR staff. This has happened on an opportunistic basis where Trusts have cooperated on, for example, recruitment drives, and there are examples of more formalised arrangements. A possible model (that has parallels with discussions in local government) is for an acute Trust to link together with smaller PCTs in the same geographical area. The likely model could be the same as that used NHS-wide. There could be a shared service centre to carry out administration for all the Trusts served and business partners at Trust level. Whether centres of expertise are required is more questionable (it is debateable whether there would be the volume of enquiries to justify a relatively expensive resource), but there might be shared activities (eg medical staffing or occupational health) that go beyond the merely transactional.
With the current pressures on finance, it is likely that the NHS will need to look creatively at ways of making year-on efficiency gains whilst at the same time delivering good quality (or even better quality) HR services.

5.2 What is the relationship between HR and learning and development, workforce planning and OD?

It is debateable whether there is a real distinction to be made between HR, learning and development, workforce planning and OD, or whether this is a matter of semantics. In some organisations HR is called OD because of the preference of the CEO and/or the Director Team. Workforce planning in other organisations has been located in finance simply because it is conceived as an issue of resource control. Learning and development may be part of HR, separate from it or combined with OD because of history or the preferences of senior managers.

While it is safe to say that the four work areas are different from each other, having their own bodies of knowledge and expertise, they nonetheless do overlap considerably. The trend in recent years has been towards convergence in the following ways and for the following reasons:

• As reported earlier, the learning and development function has increasingly been concerned with organisational performance and the ways in which techniques from this discipline can be used to improve the functioning of the organisation. There is clear overlap here between learning and development, HR and OD.

• The training function has increasingly been brought together with HR. This is evidenced by the fact that learning and development frequently has its own centre of expertise in the HR structure and that training administration is included in shared service centre work.

• HR has been increasingly interested in cultural change and has itself been heavily involved in structural change. This takes HR into OD territory, be it organisation design or development. Again some organisations have recognised this by creating OD units within HR or again having a centre of expertise.

• Workforce planning, as an activity, declined somewhat during the 1990s, but there is some evidence of its return to centre stage now, especially in the public sector. The Treasury, with its requirements for pay and workforce strategies, and demand from the Office of the Deputy Prime Minister for improved workforce planning in local government are but two examples of the reasons for its resurgence. HR has been in the vanguard of this change. It is no longer justifiable for the finance department to manage this activity. Modern day workforce planning looks at skills and quality, as much as it does staff numbers.
Above all, underpinning these developments is the desire to horizontally integrate people management activities. By this we mean that people management should vertically link with the business strategy (i.e., that HR should be delivering services and undertaking activities consistent with the business direction) and horizontally connect together all the strands of people management work – reward, resourcing, employee relations, OD, learning and development, workforce planning, etc. This is because, as we have reported earlier in this document, it is ‘bundles’ of people management activity, carried out in a consistent and integrated way, that deliver organisational results. Take teamworking as an example of a ‘good’ people management practice that brings organisational benefits: if this is to be encouraged, then reward, learning and development and OD all need to be consistently supporting the policy. Similarly, workforce planning clearly has to integrate with the business strategy, but also the impact of recruitment and retention or skills development means that there should be close working relationships with the rest of HR.

The research suggests that there is more to be gained from bringing together HR, OD, workforce planning and learning and development than by keeping these functions apart. The knowledge and skills needed to be successful in these areas overlap and if the organisation wishes to get the best from limited resources it needs to ensure that knowledge and expertise is shared, not fragmented.

5.3 The evolving relationship between the line and HR

Another important development in people management in recent years is the recognition that good people management is key to organisational performance and that the line manager is vital to this process. If the manager is pivotal to employee engagement and this leads to better attendance and higher productivity/customer satisfaction, then HR’s role shifts from being simply an enforcer of organisational rules to being a coach to the line and a facilitator of decision making.

This point has often been lost in the devolution debate. To reduce costs, improve processes and to try to give managers a sense of their greater responsibility for employee affairs, HR has shifted a number of activities to the line. Many of these activities are of an administrative nature (e.g., overtime or absence recording) and may cause concern over perceptions of increased work load. However, if administrative staff are then recruited to carry out these tasks, costs are transferred, not reduced. One solution is to automate these tasks; however, the evidence indicates mixed success depending on the resources available to support e-Hr and the initial expectations.

Besides administration, in many organisations HR has been keen for managers to carry out what might be called the more ‘operational’ tasks. Thus managers are expected to recruit, to deal with poor attendance or discipline, and to handle pay increases on their own rather than rely on HR to deal with these things. The evidence (CIPD, 2003) is that on some issues HR has still taken the lead (e.g., reward), whereas in others a partnership has developed where the work is shared (training and development and employee relations).
There is a sense (Reilly and Williams, 2006) in which the rhetoric of devolution has gone further than the reality because of:

- line management disposition to take on these tasks
- level of senior management encouragement
- managers’ concerns of work overload
- managers’ level of people management skills
- availability of people management training for those in line roles
- level of support from HR colleagues
- line level of interest in people management policy making.

Whilst some HR professionals would readily accept this change to enable them to shift the focus of the HR function to a more transformational role, this may evoke concern amongst HR personnel, whose reactions may include some, or perhaps even all, of the following:

- a sense of the function losing identity, power and control
- giving up activities that HR staff felt confident to perform, were good at and were appreciated by the line
- concerns over job security if line managers are proficient in operational HR
- concerns about managers’ ability to deal with people management issues.

In some organisations, restructuring HR has addressed some of HR staff’s caution over devolution. Numbers have been cut and roles changed such that those remaining in the function have no choice but to leave managers to get on with people management tasks. If the managers need advice they can look at the intranet or ring the call centre. The business partner is not available to deal with routine or operational queries.

However, those organisations that have made most progress have tended to approach the problem from the other – ie management – direction, thereby making the new HR delivery model really work. If line managers are effective in their people management role, business partners will be able to act effectively in their strategic role. This has involved convincing senior management of the importance of getting the employment deal right with employees. In financial services and the big retail companies in particular, this has led to tracking indicators of organisational health such as employee engagement scores from attitude surveys and absence and wastage statistics. Managers are then held accountable for their people performance. Bonuses that would have been paid on the delivery of business results are reduced if managers ‘trample over staff’ to achieve their objectives.

If line managers have been sent a signal of the value of employees to organisational success, they are more likely to take notice. They will then be more receptive to taking up training and development opportunities that HR should be providing to improve their interpersonal skills. Business partners can then act as coaches and facilitators to hone managers’ capability.
The research suggests that the best managers for such a responsibility are those whose attitudes and disposition demonstrates a real interest in working with, or helping to develop, colleagues, rather than those who are happier in a command and control environment. The implication of this is two-fold. Firstly, it is suggested that managers should be carefully selected and the selection criteria should include their interpersonal skills and aptitude for people management. Secondly, the career management system should be designed so that it ensures the right fit between the requirements of the posts and their incumbents, and avoids the movement of individuals into line jobs that ill suit them. Career development opportunities could look to include the possibility of managers remaining in technical roles where they will be appropriately rewarded in pay and status terms.

In summary, if HR is properly organised and has the right people with the right skills in the right jobs it will be in a position to establish the appropriate policies that will encourage good people management. Since the principal responsibility for people management lies with line management, effective development of this role will require conscious selection and development of line managers. There is little doubt that line managers can successfully undertake their people management activities if they are encouraged to do so by top management and if HR is supportive in a coaching and facilitative manner.

We turn now to consider the nature of the people management processes that have demonstrable value.

5.4 People management practices

The literature reviewed in this report indicates that the implementation of specific HR, OD and workforce planning policies can lead to positive outcomes in a healthcare setting. Broadly speaking, HR/OD and workforce planning activities can be considered as falling into the following groups:

- training and support practices
- practices aimed at improving working conditions, and
- practices aimed at increasing employee involvement and engagement.

The practices contained within these groupings, and the impacts reported in the literature as arising from them, are set out in Table 5.1, opposite.
<table>
<thead>
<tr>
<th>Practice</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training and support practices</strong></td>
<td></td>
</tr>
<tr>
<td>Training and development</td>
<td>Improved patient safety, lower patient mortality rates</td>
</tr>
<tr>
<td>Management and leadership</td>
<td>Improved quality of patient care, increased patient satisfaction</td>
</tr>
<tr>
<td>Appraisals</td>
<td>Improved quality of patient care, lower patient mortality rates</td>
</tr>
<tr>
<td>Team working</td>
<td>Reduction of employee stress, improved patient safety</td>
</tr>
<tr>
<td><strong>Practices aimed at improving working conditions</strong></td>
<td></td>
</tr>
<tr>
<td>Manageable workload, autonomy,</td>
<td>Improved employee attitude, improved patient safety, lower patient</td>
</tr>
<tr>
<td>good relationships with colleagues</td>
<td>mortality rates</td>
</tr>
<tr>
<td>Low staff-to-patient ratios</td>
<td>Reduction in staff errors, reduced length stay in hospital, lower patient</td>
</tr>
<tr>
<td></td>
<td>mortality rates</td>
</tr>
<tr>
<td>Skill mix</td>
<td>Improved patient safety, lower patient mortality rates</td>
</tr>
<tr>
<td>Shift work</td>
<td>Increase in staff errors and accidents, decrease in patient safety</td>
</tr>
<tr>
<td><strong>Increasing employee involvement and engagement</strong></td>
<td></td>
</tr>
<tr>
<td>High performance work practices and HR management bundles</td>
<td>Lower patient mortality rates</td>
</tr>
<tr>
<td>Organisational trust and involvement</td>
<td>Improved patient safety, lower patient mortality rates</td>
</tr>
</tbody>
</table>

Source: IES, 2007
The main measures of positive outcomes include lower mortality rates, improvements in quality of care and enhanced patient satisfaction. It should be noted, though, that the outcome measures differ significantly – whereas measures of enhanced patient satisfaction are based on perceptions, measures of outcomes such as patient safety are based on somewhat harder, objective data such as infection and recovery rates. Furthermore, most of these outcomes are qualitatively different from the more typical outcomes of HR, OD and workforce planning practices used to gauge performance in other sectors, such as profitability, production rates or sales volume. Consequently, outcomes within the NHS often cannot directly be compared with outcomes in other sectors. With this minor caveat noted, in the following sections we summarise the various people management activities and their likely impact on patient outcomes.

5.4.1 Training and support practices

Training and development

A number of studies have shown a correlation between training and development of healthcare staff and improved patient mortality rates. A range of studies indicate – perhaps unsurprisingly – that encouraging further learning and best practice, including the implementation of Continuing Medical Education (CME) leads to improved practice among doctors and improved health outcomes for patients. Evidence was reported of improvements both in the care offered to patients and in improved safety and decreased mortality rates. One specific skill area in which training can bring about significant improvements in patient outcomes is communication skills: here, development is associated with patient satisfaction, compliance with medication and clinical outcomes.

The research we found, though, was piecemeal and scattered across a range of disciplines. There appears to be little coherent or unified approach to upskilling, and largely of course this is due to the individual professional associations typically taking the lead in such work and providing professional development opportunities for their members. With a few notable exceptions, there appears to have been limited attempt to test out the effectiveness of different approaches to CPD/CME and to consolidate or agree requirements for updating staff in general across the sector. Where approaches have been compared, typically these comparisons have found that certain approaches (usually more hands-on, with expert input) are more successful than more passive approaches. This limited attempt to assess the effectiveness of different types of approach to training and CPD has led to a situation in which training for various activities, varies in approach, length and standard and there are variations in external benchmarking and validation.
Management and leadership
There is evidence that good leadership at all levels – from senior management down to line managers – is associated with positive outcomes for staff and for patients. Good leadership is shown by a range of surveys to increase employee well-being and job satisfaction, thereby increasing commitment. This contributes to improving the quality of patient care and increasing patient satisfaction, higher star ratings, higher clinical governance review ratings and lower numbers of patient complaints, while more effective supervisors and line managers were associated with improved staff perceptions of well-being and job satisfaction and reduced intentions to leave.

Management development and promoting leadership are key areas of activity for HR and training and development staff. The conclusion is that these are clearly areas in which there could be real pay-offs from greater HR leadership. Developing strategies for improving leadership and line management – and ensuring these strategies are fully implemented – needs to become a central aspect of HR activities within the health sector. Again, though, to ensure that any actions taken are effective (and cost-effective too) it is advisable to explore and assess the impact of various development options, as robust and consistent evaluation of the activity is essential to establish the effectiveness of the various different approaches to leadership and management development.

Appraisal
While appraisal clearly falls within the ‘people management’ sphere of activity, as a key mechanism in identifying staff training and support needs, it is typically also viewed as constituting part of HR practice and, in particular, the HR management practice ‘bundles’ associated with high performance working practices, and therefore we refer to appraisal in that section also (see section 6.3).

Numerous studies have found that staff appraisal has an impact on patient mortality rates, the key link being that if staff have a clear idea of what their role entails, they will perform more effectively, which in turn will improve the quality of patient care. The wider the range of staff groups covered by appraisals, the greater the influence on patient care and mortality rates. Having an appraisal system in place is the people management practice that is found to have the strongest effect on patient mortality, with a strong linear relationship between appraisal and safety: for each additional 20 per cent of staff appraised and 20 per cent increase in the number of appraisers, there are likely to be 1,090 fewer deaths per 100,000 admissions.
Team working and high reliability teams

• Team working

In summary, good team working arrangements bring positive benefits for both staff and patients. Positive team working arrangements have been shown to have a positive impact on employee effectiveness. However, this outcome relies on there being clear objectives for the team and the individual, real participation by all team members, and commitment to innovation and providing a quality service. However, with these requirements in place, the reduction of staff stress levels is a further benefit. Taken together, these arrangements also lead to more effective healthcare provision for the patient.

• High reliability teams

High reliability teams (HRTs) operate in contexts such as aviation and nuclear power where there is a particular requirement for effectiveness and safety. Key characteristics of HRTs include sensitivity to operations, commitment to resilience, deference to expertise, and a reluctance to simplify. Key competencies of HRTs include the following: all team members have a shared understanding of their roles; good communication and team coordination; and the ability of team members to identify, correct and avoid the development of unsafe situations.

Within the health service the need exists not just for good teamwork but for high performing, high reliability teams. Some commentators have started to explore the potential for adoption of the high reliability team approach within the health sector. The literature reports various approaches that are particularly effective in developing high performance, high reliability teams and it would be worth considering the extent to which such developmental approaches could be adopted within the health sector.
5.4.2 Practices aimed at improving working conditions

Working environment/worklife characteristics
There is evidence that certain characteristics of the working environment can impact on staff attitudes and patient safety and mortality rates. Characteristics such as workload, autonomy, and relationships with colleagues have each been found to have an impact on care outcomes, including patient mortality. Importantly, though, it is often the perception of such factors that are the most important: for example, where nurses perceive that their work environment supports professional practice, they are more likely to be engaged in their work, which then contributes to their providing safer patient care.

Staff ratios
Staff ratios have been found by a number of studies to have an impact on staff errors, length of stay in hospital and patient mortality. This is the case for a range of healthcare professionals, including doctors working in Intensive Care Units, nurses and midwives. Higher staff density has been linked to a series of positive outcomes including decreased length of stay for patients, decreased infection rates and lower mortality rates. However, other factors may interact with staffing levels, including the qualification levels of staff and the total skill mix within the team, as well as service level arrangements.

The key link mediating such effects appears to be that staff working in settings with higher patient-staff ratios experience higher levels of dissatisfaction with their work and greater emotional exhaustion and burnout. Clearly, it would not be sensible to simply recommend hiring more staff, as remaining within budget and the resource envelope for costs and staffing levels continue to present managerial challenges within the NHS.

Skill mix
The mixture of different staff groups available within a unit or department, the various skills available within individual staff groups, or a combination of these two, have been found to have some impact on patient safety and mortality rates. For example, a richer skill mix amongst registered nurses has been linked to lower 30-day mortality rates.

In general, the literature suggests it is wise to consider the total mix of skills within a team, as well as staff numbers, when considering the appropriate complement of staff within a department. One approach to increasing the total skill mix available within a unit has been to increase the activities undertaken by certain staff groups, such as nurses or radiographers. Such changes in role expectations are usually referred to as ‘extended role’ initiatives. Extended role initiatives have been expanding over the past few years, but as yet this appears to be largely on an ad hoc basis.
Shift work
There are continuing concerns about the effect of shift work on patient safety, with some studies showing evidence that shift working increases accidents and error rates among staff. This is widely held to be as a result of sleep deprivation. While much of the health sector-based research suggests that the effects of shift working are largely consistent with laboratory investigations of the negative effects of shift work and sleep deprivation on attention levels and error rates, nonetheless there is some evidence that the negative impact of shift work may be lessened if staff can choose their shift patterns and, conversely, that the detrimental effects of shift working are increased if nurses perceive that they have no control over their shift patterns.

5.4.3 Increasing employee involvement and engagement

High performance work practices and HR management bundles
Much of the debate on employee involvement and engagement has been carried out within the framework of high performance work practices (HPWPs). A detailed explanation of the elements that are typically considered to form part of HPWPs was provided in section 3.

The general literature on the impact of HPWPs suggests that the impact on organisational performance is positive and, in particular, that high performance HR systems bring economic benefits in terms of the financial performance of an organisation. However, there is some evidence to suggest that it is not the practices themselves that make a difference, but the degree to which they align with each other to create meaningful ‘bundles’ of practice: high employee-involvement practices, human resource management practices, and reward and commitment practices, included improving staff satisfaction, providing leadership quality and creating effective teamwork, employee involvement and innovation. Employee involvement on its own has some significant impact on staff turnover, whereas employee involvement and human resource practices together tend to lead to an improved sense of job security.

Research into HPWPs in a healthcare setting reveals that, after controlling for influential factors such as prior mortality rates at hospitals, the HR system variables can account for almost eight per cent of the variance in mortality rates among patients. The most influential individual HR practices were: the presence of a sophisticated appraisal system; employment security; and Investors in People status.

Organisational trust and involvement
Research suggests that if staff have trust in their organisation and feel empowered and involved, this leads to improved performance and, ultimately, to higher levels of patient safety and lower mortality. Increased autonomy, empowerment and interprofessional collaboration have each been associated with lower patient mortality rates. Organisational trust has been identified as a key requirement in encouraging a workplace culture that prioritises patient safety.

There is a role for HR to play in facilitating and encouraging employee involvement and the development of an organisational culture that promotes trust.
5.5 Implications for HR activity

The preceding sections summarised the areas of activity that will need attention in the future. In this section, we identify the nature of the role that HR could play in delivering successful people management practice within the NHS. Following the structure adopted in the previous chapter we present some conclusions about the roles and activities that are likely to come to the fore in the coming years.

5.5.1 Training and support practices

Training and development
In the earlier section we noted that there have been only limited attempts to assess the effectiveness of the various types of approach to training and CPD, which has led to a situation in which training for various activities varies in mode, length and standard. Furthermore there are variations and gaps in external benchmarking and validation creating challenges in assessing the extent to which various different training and development options equate.

This is an area in which HR could play a leading role. With the increasing emphasis on professional updating across almost all staff groups there is a need to move to a more coherent and co-ordinated system of skills development and updating. Evaluation of the impact of different types of, and approaches to, training and development for different staff groups will be central to ensuring that the investment in CPD does in fact bring the anticipated benefits; here, HR could lead on attempts to evaluate and assess the value of different development methods.

Leadership development
Evidence indicates that strong, effective leadership is associated with a range of positive outcomes, for the unit or hospital as a whole, for staff and for patients. Estimates indicate that up to 60 per cent of variance in unit performance is accounted for by the quality of leadership.

This suggests that HR attention within the NHS should focus on questions regarding the selection and development, not just of people management capability, but of leadership capability too. This issue has clear links to, and implications for, learning and development, organisational development and organisational culture, and therefore reinforces the proposal that OD, HR and learning and development should operate together. The way in which the NHS as a whole, or individual Trusts, chooses to engage with issues of leadership development will depend to some extent on the structure, function and capacity of the HR resource.
The NHS has been trialling a coaching/mentoring programme for leaders and this is about to be evaluated in the near future. Depending on the outcomes of that evaluation the NHS will need to make decisions regarding support for further roll-out or consider alternative ways of supporting the development of leadership capability. It is possible that different approaches will be needed depending on the specific local circumstances. If coaching is found to be a useful support for developing leadership within the NHS then HR will need to consider how more coaches can be developed and how Trusts can be encouraged to take up the programme.

To ensure that any actions taken are effective (and also cost-effective) it is advisable to explore and assess the various development options, as, in keeping with other developmental activities within the NHS, there has been limited examination to date of the effectiveness of the various different approaches to leadership and management development. Analyses demonstrating effectiveness of leadership development is likely to encourage greater take-up of leadership programmes.

**Appraisal**

The NHS plan sets out the intention for all NHS staff to have an appraisal on an annual basis, but, while this is in the process of being rolled out, it is not yet consistently implemented across the NHS. The previous chapter indicated that appraisal is the one factor that is reliably associated with improved patient outcomes. This then is one core area of activity in which attention from HR would repay investment with quite rapid returns.

What then needs to happen? It would appear to be of benefit for HR practitioners to reflect on the factors that make appraisal effective. Current appraisal policies, processes and paper work, could be examined to determine whether they incorporate strategies to focus appraisals on desired performance and development activities and outcomes.

Furthermore, it may be of value to consider whether there are any development needs amongst managers and supervisors to equip them to undertake appraisals of their staff. Lastly, for appraisals to become maximally effective, reporting systems for the outcomes of appraisals will need to be put in place, along with feedback loops to ensure that recommendations for training and development are resourced, undertaken and evaluated.
Team working and high reliability teams

• Team working

The HR department can have most impact here by creating a climate in which teamworking is encouraged, rewarded and likely to flourish. Aside from this ‘direct’ action, HR may need to become involved in development activities that will better equip line managers to support team working arrangements. These activities might include the provision of assistance to line managers to ensure that job descriptions and person specifications have teamwork as an essential requirement; by designing and implementing recruitment and selection processes to identify and attract individuals able to contribute to effective teams; and by ensuring that development opportunities for managers and supervisors include provision to help them to facilitate teamworking within their unit, ward or department. While line managers may well be responsible for carrying through on such activities, HR practitioners will play a key role in advising on best practice in these areas of responsibility.

• High reliability teams

Within the health service the need exists not just for good teamwork but for high performing, high reliability teams. Some commentators have started to explore the potential for adoption of the high reliability team approach within the health sector. The literature reports various approaches that are particularly effective in developing high performance, high reliability teams and it would be worth considering the extent to which such developmental approaches could be adopted within the health sector. This appears to be one area that would repay further exploration by HR personnel.

5.5.2 Practices aimed at improving working conditions

It is important not to lose sight of the importance of what might be considered some of the more routine, day-to-day management tasks that should undertaken by HR practitioners. While developing leadership and management capabilities are important considerations, more fundamental aspects of worklife such as working time/work pattern arrangements, developing teams and developing the skill mix available within units or departments all impact on efficiency.

These areas are important because of the impact they can have on organisational performance. Research described in this report suggests there may be more to be done to improve this aspect of organisational functioning.

Working environment/worklife characteristics

There is work to be done on two fronts regarding the working environment. Firstly, assessment should be carried out of the working environment, terms and conditions in place within organisations, and the extent to which these can be brought in line with good practice should be determined1.

Once any changes are made, however, the impact on perceptions of control should be assessed through the annual surveys of staff satisfaction and attitudes. However, HR practitioners may find it useful to supplement such assessments with reviews of staff turnover and sickness statistics.

1 Although it is acknowledged that, in regard to hours worked, the Working Time Directive has already addressed the most extreme problems
While it goes almost without saying that, for the value of such actions to be demonstrated, the outcomes of such analyses should be reported to the Executive Board and to the various professional bodies and trade unions, it is perhaps worth adding that they should be acted upon. Evidence of the extent to which these actions are successful will be provided by the analyses of the subsequent years’ surveys and additional data.

Staff ratios
Staff ratios have been found by a number of studies to have an impact on staff errors, length of stay in hospital and patient mortality. However, the picture is not clear-cut, since there are issues related to total skill mix within the clinical team as a whole that impact on these outcomes too. It would therefore appear wise to determine the optimal staffing and skill levels contingent with positive health outcomes. While this may have cost implications (if such an analysis reveals that additional staff are required) nonetheless it may also reveal where changes to staffing skill mix may bring about cost reductions while maintaining service levels and staff satisfaction with working arrangements.

There are several implications for HR developments in the NHS. First, there is likely to be an increasing need for HR staff to develop competence in gauging staffing levels and assessing their impact on organisational outcomes over time. This is likely to require sophisticated modelling of workforce inputs and their impact on a range of outcomes. As we have indicated above, this is likely to involve a range of measures across staff and patients. ‘Soft’ outcomes could include measures of attitudes and feelings of support, coping and satisfaction amongst staff and measures of satisfaction amongst patients; ‘hard’ outcome measures relating to staff would include measures such as staff absence and turnover rates (and, possibly, reasons for staff absence; recent reports suggest that mental ill-health arising from stress has recently become the main reason for staff absence in the UK) and, for patients, recovery times, mortality and iatrogenic infection rates. Secondly, there will be a need to review job descriptions and skill requirements, along with staffing numbers, to ensure that new whole time equivalents provide appropriate skill mix as well as staff numbers.

The above suggests that any changes in staffing ratios will need to be made in tandem with a consideration of skill mix requirements, in order to understand how best to obtain the right staffing and skill levels to maximise health outcomes within the budget available. We turn to consider issues in skill mix next.

**Skill mix**

One of the ways in which increased levels of skills are made available within clinical teams is through the introduction of ‘extended role’ initiatives. Often such schemes are welcomed by the participating staff groups, but sometimes they are opposed. In particular, some studies have noted that upskilling of staff needs to be handled carefully, to avoid any resentment arising from perceived increases in workload. This is most likely to be the case where staff feel that rewards have not been adequately aligned with increased responsibilities. In principle, this should present less of a difficulty with the introduction of the skills escalator and national pay spine that recognise the need to reward additional skills and responsibilities. However, at a local level it may be necessary to review job descriptions to ensure they reflect such changes in the expectations Trusts hold of certain staff groups and, in turn, the rewards that those staff may expect from their employer.

There is a role for HR practitioners to play in supporting line managers in the design of new job descriptions to ensure that any new ‘extended role’ activities are incorporated and, where appropriate, linked to the national pay spine. However, there are other ways in which HR practitioners could become involved and indeed influence developments. In some instances, HR involvement appears to have been missing from some of the leading edge developments in skillmix and multi-skilled teams, with the result that initiatives are often ad hoc and random, with the training for new roles often being inconsistent and largely uncertificated. Therefore, in addition to the activities outlined above, HR staff could be involved in a range of related activities, such as ensuring that appropriate training and qualification routes are developed in parallel with changes to team functioning and staff roles, to support implementation of such systems.

Overall, such initiatives are likely to lead to a need amongst HR practitioners for higher level skills in job analysis and job redesign. Negotiation with the various different groups likely to be affected by changes made will be necessary and in some situations HR practitioners may also need to be skilful at conflict resolution.

Again, where such systems are implemented, ideally evidence on the impact of the changes could be gained via staff satisfaction/attitude surveys. While it is to be hoped that such evidence would provide support for any changes, such information would also provide HR with evidence of where any revisions are needed to improve or ‘tweak’ the implemented changes. In addition, this is one situation in which a ‘bottom line’ analysis would, in fact, appear to be of some value. Changes to occupational boundaries may bring cost benefits of some type. Whilst savings in the staff budget may not necessarily be expected as a result of such initiatives, a larger throughput of patients as a result of the increased ‘skill budget’ available might be seen, leading to cost savings per head of staff employed. Such evidence would also stand an HR department in good stead in the face of any suggestions of staff reductions in the future.
Shift work
While there may always remain some need to impose working arrangements, the research suggests that, initially at any rate, Trusts would be wise to seek to establish rosters on a voluntary basis. One way may be to provide teams or departments with an outline of the required staffing levels at different times of day and encourage teams to decide amongst themselves the personnel who will be in post and/or on call at a particular time.

Where this is undertaken it would be advisable to collect baseline data on relevant measures (accident and error rates, staff absence, staff attitudes) some time in advance of introducing the changes and to then monitor the same measures against baseline over time. Again, such data is likely to provide HR personnel with useful information in seeking to implement any changes more widely across the organisation.

5.5.3 Increasing employee involvement and engagement

High performance work practices and HR management bundles
Here, there are fairly clear messages for future HR activities. Firstly, appraisal is one of the components of HPWPs and, as we indicated in the section on appraisal, equipping more managers and supervisors to undertake appraisals is a straightforward way in which HR professionals can help increase the proportion of staff groups having an annual appraisal to the planned 100 per cent.

Secondly, employment security derives from confidence in management, with contributing factors being good communication between directors, leaders, managers and staff; this in turn is linked to the next section, organisational trust and involvement. There is a range of work in which HR practitioners could become involved that is likely to lead to improvements in perceptions of security. Activities aimed at improving organisational communication are likely to be of benefit; in addition, any work that improves organisational performance or provides efficiency gains (either through reduced iatrogenic infection rates or increased patient throughput) is likely to lead to increased security of staff (as the trust moves to a more secure financial and functional footing). Hence any changes leading to organisational improvements should be widely communicated to all members of staff. Such developments would also constitute supporting material for Investor in People assessments and re-accreditation visits. Clearly, the research also suggests that any trusts not having attained Investor in People status should consider this option.

Organisational trust and involvement
It is clear that building a culture of organisational trust and involvement underpins the success - or otherwise - of many of the other developments we have identified as being likely to improve service outcomes. This is an area in which HR personnel should be expected to lead. However, just as organisational trust and involvement will underpin the success of initiatives to change working arrangements, skill improvements and team functioning, so too do such issues impact on employee’s sense of trust and involvement in their organisation.
This suggests that, ahead of any planned changes, and subsequent to any initiatives, it would be wise for HR departments to explore the current organisational culture and staff attitudes. Where possible, HR departments would be well advised to articulate the impact they expect an initiative to have on a particular aspect of organisational functioning, and to consider the ways in which they can determine the actual outcomes. Exploring organisational trust and staff perceptions of the rationale for any changes made will help HR to monitor the full impact of any changes made. These are likely to be areas in which HR practitioners may need further development or to bring in external expertise to assist in determining the patterns and routes of any impact.

5.6 Concluding comments

We have suggested above that it is likely that HR professionals will need to use an increasingly wide range of skills. Many of the suggested changes would move HR professionals into areas of activity with which they have not previously been engaged. Throughout, we have emphasised the need both to take stock ahead of initiating interventions and to assess impact subsequent to changes being made.

We would recommend that HR practitioners do seek to become more skilled in evaluating the impact of their activities, for as we have seen, there is increasing focus on the need to demonstrate the value of HR/OD activities. It is likely to become of equal importance for HR professionals to be able to demonstrate how, where and in what ways, strategic changes are expected to have their impact.

Taking stock of the value of interventions in this way will provide valuable evidence for use in persuading key stakeholders to sign up to further changes. Work identifying the sorts of links typically examined in the HPWP and commitment literatures is increasingly likely to take centre stage, and in the NHS this is likely to include the need for HR professionals to be able to demonstrate how changes to working arrangements, developing leadership capacity, increasing or decreasing staff levels or modifying shiftwork patterns impact variously on indicators such as bed occupancy rates, mortality rates or rates of hospital acquired infections. Irrespective of how the HR function is organised or where it is located, HR practitioners will need to be able to account for their reasoning in making changes to working arrangements, explain the expected patient benefits and (perhaps most importantly) be able to point to relevant evidence to support the value of such changes. This in turn implies some role extension for HR professionals, to build their own capacity to plan, model and evaluate OD interventions.
6 Bibliography


Ashton C, Lambert A (2005), The future of HR: Creating a Fit for Purpose Function, CRF Publishing

Bailey C, Burr J (2005), Luck, Legacy or Leadership: the contribution of leadership to sustained organisational success in NHS Trusts, Interim Report, Cranfield School of Management


Barber L, Hayday S, Bevan S (1999), From People to Profits, IES Report 355


Borrill C, West MA, Dawson J (2003a), The Relationship between Leadership and Trust Performance, Birmingham: Aston University
Borrill C, West MA, Dawson J (2003b), The Relationship between Leadership, People Management, Staff Satisfaction and Intentions to Leave, Birmingham: Aston University


CIPD (2003), HR Survey: where we are, where we’re heading, Survey report, CIPD London

CIPD (2006b), Learning and Development, Annual Survey Report 2006, CIPD Wimbledon


Department of Health (2000), The NHS Plan, Department of Health

Department of Health (2006), Recognising, understanding and addressing performance problems in healthcare organisations providing care to NHS patients, Department of Health


The Families and Work Institute (1998), USA Today, July, No. 43


Institute of Medicine (1999), To err is human: building a safer health system, Institute of Medicine


John Hopkins Hospital Department of Nursing (1995), Creating Professional Nursing Environments: A guide from Johns Hopkins, Hospital Department of Nursing, Baltimore, Maryland


Lawler, Mohrman (2003), ‘HR as a Strategic Partner, what does it take to make it happen?’, Human Resource Planning, Vol. 26, No. 3


National Audit Office (2004), Improving patient care by reducing the risk of hospital acquired infection: A progress report, HC 876 Session 2003-04


O’Malley M (2000), Creating commitment, John Wiley & Sons


Purcell J, Kinnie N, Hutchinson S, Rayton B, Swart J (2003), Understanding the People and Performance Link: Unlocking the Black Box, CIPD


Reilly P, Phillipson J, Smith P (2005), Team based pay in the United Kingdom, Compensation and Benefits Review, July/August 2005


Reilly P, Williams T (2003), How to Get Best Value from HR: The Shared Services Option, Gower Publishing

Reilly P, Williams T (2006), Strategic HR: Building the Capability to Deliver, Gower Publishing

Robinson D, Perryman S, Hayday S (2004), The Drivers of Employee Engagement, IES Report 408

Robinson D (2001), Quality of working life survey in the London NHS, Institute for Employment Studies


Sovie MD, Jawad AF (2001), ‘Hospital restructuring and its impact on outcomes: nursing staff regulations are premature’, Journal of Nursing Administration, Vol.31, pp.588-6000

Spiro H (1992), ‘What is empathy and can it be taught’, Annals of Internal Medicine, Vol. 15:116(10), pp. 843-6

Tamkin P (2005a), Skills and the Bottom Line, SSDA, CIPD, DfES, IiP UK

Tamkin P (2005b), The Contribution of Skills to Business Performance, DfES, SSDA, CIPD, IiP UK


Walker Information Inc (2000), Employee commitment and the bottom line: Ethical Issues in the Employer-Employee Relationship, Work, USA


Watson-Wyatt (2002), Human Capital Index, Watson Wyatt.com


WERS (2004), Workplace Employee Relations Survey, DTI

West M (2002), Healthcare Team Effectiveness Project


