Employee participation and union voice in the National Health Service

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This article examines the role of trade unions in the health service at workplace level under the Labour government's modernisation agenda, and focuses on the shifting balance between forms of direct and indirect participation drawing on case studies of three acute hospital trusts. There has been a strong growth in forms of direct communication within the case study trusts and some increase in direct participation among professional groups. Despite this 'dualism' in employment relations, however, the target culture of the NHS has precluded the development of effective voice mechanisms. The policy implications for trade unions and the implications for the implementation of NHS pay modernisation are considered.
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A perennial feature of HRM has been an interest in differing forms of employee participation. The balance that is struck between direct and indirect (representative) forms of participation and the influence exerted by employees and trade unions has evolved in response to changing economic and political circumstances (Marchington and Wilkinson, 2000: 340). In the UK's National Health Service (NHS), collective bargaining and other forms of collective consultation have traditionally been the dominant forms of representation, but the current Labour government has signalled that a variety of employee participation schemes are integral to their plans for NHS modernisation (Department of Health, 2002a).

The Labour government has outlined plans for far-reaching reforms of pay, conditions and working practices (Department of Health, 1999a, 2003). At the core of these proposals is an emphasis on partnership working with trade unions to ensure that union representatives have adequate time and support to participate in the implementation of the Agenda for Change proposals at trust level (Department of Health, 2003: 5). The degree to which employees and staff-side representatives are currently involved in the HR modernisation agenda, and the influence that they can exert over these initiatives, indicates the state of management-employee/union relations which is of crucial policy importance for the implementation of pay reform.

These changes are occurring in a UK context of long-term decline in union presence and a shift of managerial emphasis towards forms of direct communication and participation (Millward *et al*, 2000: 118). In the authoritative 1998 Workplace Employment Relations Survey (WERS), Cully *et al* (1999) reported that, in 72 per cent of workplaces, managers expressed a preference for consulting directly with employees rather than with unions. Between 1984 and 1998 within unionised workplaces there was a sharp decline in union-only voice arrangements, reflecting the growth of dual channel representation (Bryson, 2000). This is especially relevant for the public sector because union density remains three times the level of the private sector, but the proportion of union members has reduced at a similar rate in both sectors between 1993 and 2001 (Brook, 2002: 346). A core concern of recent analysis in unionised workplaces has been to examine what has prompted managerial attempts to shift the boundaries between forms of direct and indirect participation (Bacon and Storey, 2000).

A number of possible interpretations of these developments have been advanced. Some commentators have pointed to anti-union values among employers that have encouraged trade union derecognition and the substitution of union voice for direct communication with employees (*see* Gall and McKay, 1994; Kelly, 1996). This behaviour is context-specific and in the public sector there is no tradition of derecognition. Conservative government hostility towards unions during the 1980s, however, created fears that the establishment of NHS trusts would lead to selective union derecognition. This union concern failed to materialise, with the exception of a few ambulance trusts that did not recognise all unions, usually because they favoured a single-union deal (Bryson *et al*, 1995: 123). As Bacon and Storey (2000) demonstrate in their analysis of three NHS trusts, managers aspired to shift towards more individual relations but held back from wholesale derecognition because it would have engendered employee distrust. They point out that such a step was unnecessary because workplace changes had been imposed without the sanction of derecognition (Bacon and Storey, 2000: 414).

A second interpretation has been that managers have acted pragmatically, allowing existing structures of union-management relations to decay while experimenting with direct participation schemes (Sisson, 1993: 208). This dualism was noted by Storey (1992: 258-9) in many of the private sector cases he examined. He highlighted the role of line managers in championing innovations in employee participation, while HR remained the reluctant custodians of existing union-management structures. There is limited data available on the NHS, but Carr (1999) provides some support for such an interpretation because he found that almost two-thirds of the 46 trusts he surveyed had increased direct communication, while maintaining existing structures of union-management relations.

A third, more recent interpretation suggests that forms of direct participation may be combined with union-based representation in a complementary manner (Guest and Peccei, 2001; Roche, 2001). An important influence has been the Labour government's support for partnership working with unions, in which increased communication and participation is essential to building trust (Tailby and Winchester, 2000). The Department of Health has promoted social partnership, but there is little consensus about the aims and outcomes of these arrangements. Partnership may simply be a new label for employee involvement with outcomes partly related to inter and intra-union relations (Heaton *et al*, 2001), while Munro (2002) has noted potential opportunities to enhance union influence. These studies, however, have focused on the role of unions rather than the relationship between forms of direct and indirect participation. In the NHS there is a degree of ambiguity about the role of unions in involvement and partnership initiatives because the Prime Minister has warned that 'genuine social partnership is based on a willingness by trade unions to accept the need for change' (Blair, 2002: 9).

The restructuring of the health service provides a particular context for changing patterns of management-union relations. Successive Conservative governments granted more independence to individual organisational units (NHS trusts), enabling local managers to have increased discretion to shape workplace employment relations. The Labour government endorsed the main features of Conservative government reforms of health service management, but assigned a higher profile to HRM issues alongside a more intensive system of performance management (Bach and Winchester, 2003: 292).

For the first time, the NHS has developed a wide-ranging national HR strategy to improve the working lives of staff (Department of Health, 2002a). The planned NHS pay reforms are a crucial component of these changes, designed to increase local flexibility and reward skill acquisition; contributing to improved recruitment and retention (Department of Health, 1999a). The second component of the government's HR agenda has been an emphasis on a centralised approach to performance management that has required managers to achieve waiting time, finance and HR targets and has increased workload pressures (Department of Health, 1999b: 29; Unison, 2002: 18). This has not precluded NHS managers from being exhorted to adopt an inclusive management process in order to 'create a more participative and open culture where everyone can contribute' (Department of Health, 2002b: iii).

Finally a long-standing feature of the NHS HR context has been the influence of rival NHS trade unions and the centrality of professional staff to many health service unions – for example, registered nurses within the Royal College of Nursing (RCN). Professional concerns about status, service quality and influencing state policy rather than a narrower focus on terms and conditions of employment have shaped union policy (Burchill, 1995; Kessler and Heron, 2001). Unison has the largest union membership in health and embodies different traditions. In contrast to the RCN it has been more responsive to lay activist pressure, more ideologically opposed to the government's modernisation agenda (*eg* the private finance initiative) and has demonstrated a capacity to mobilise workplace members, especially among its stronghold in the ancillary workforce (Fairbrother, 2000).

This article examines workplace employment relations under the Labour government, focusing on management-employee/union relations within three case study trusts. First, it considers the local context in which employee participation occurs by exploring the implementation of the national HR agenda at trust level. To what extent does the national agenda allow scope for HR discretion in setting local HR priorities, or does the requirement to achieve HR targets preclude local managerial choice? Secondly, how far, and in what ways, are managers altering the balance between forms of direct and indirect participation, and what influences these developments? Thirdly, what are the effects on trade unions of changes in forms of participation, and do these vary in ways that correspond to the union substitution, dualism or partnership interpretations considered above?

RESEARCH METHODS

This article adopts a case study methodology to explore these questions. It is primarily concerned with the process of union-employee/management relations at the workplace and the influence of the local context on patterns of management-union/employee interaction. Survey data has illuminated the prevalence and structures of union-management relations at the workplace (Carr, 1999; Guest and Peccei, 2001; Cully *et al*, 1999). This article complements this research by moving beyond structures to explore workplace behaviour and the meanings and importance that different actors attach to the various forms of employee participation at trust level.

Three case studies, referred to as Eastern, Northern and Western, were selected on the basis of a number of criteria to ensure that they were broadly indicative of the HR reform process in England. This is not to argue that the case studies are statistically representative of developments across the population of NHS trusts, but the selection of trusts according to a number of criteria allows organisational variations to be explored systematically. A central proposition of the research design was that differences between individual trusts could be expected to be linked to their position within the local health economy (*ie* financial position, size and range of services); variations in management tenure and management organisation, including the influence of the HR function; and, finally, differences in the approach towards employment relations, especially the managerial stance towards trade unions. The selection of organisations used a number of criteria to aid this process that included variations in the size and the mix of service provision, the geographical location of the trusts, and organisational performance as expressed by government performance indicators.

The fieldwork started in 1995 and continued until 2002, with several intensive periods of fieldwork punctuated by interviews and data supplied by key respondents. This enabled an indepth understanding of the evolving context at each trust to be gained over a seven-year period (*see* Bach, forthcoming). This article draws primarily on fieldwork conducted between April and September 2001. At each trust access was negotiated in a similar manner via the HR director. Once access had been agreed, a couple of days were spent at each location gaining familiarity with policy developments and key personnel. The main data sources examined within each trust included minutes of joint staff consultative committees, trust newsletters, workforce information, staff opinion surveys and trust/management board papers.

The selection of employees focused on nursing and ancillary staff because they comprise approximately half the health service workforce and their employment conditions remain a prominent policy concern. In each case, interviewees comprised trust board members, personnel and other managers responsible for nursing and ancillary staff, trade union representatives and full-time officers, and a sample of employees. On average these interviews lasted between one and two hours, and were almost always taped and fully transcribed. In total 103 formal, semi-structured interviews were conducted and the case study interviews comprised approximately 80 per cent of the fieldwork interviews. In addition, interviews at national level were conducted with civil servants, senior managers and trade unionists to gain a better understanding of the national policy and employment relations agenda, as a basis for interpreting workplace developments.

Each case is structured in a similar way to illustrate the common pressures across the sector, while being sensitive to the peculiarities of each trust. The main components of each trust's HR policy is outlined in relation to the national HR agenda which in each case was dominated by the national emphasis on reducing absence levels and responding to workload pressures. Each trust's approach to the use of direct and indirect participation is examined and the implications for the role of trade unions at trust level is assessed.

FINDINGS

Eastern

This trust had been the least stable of the cases considered. Eastern comprised a large general hospital and associated hospitals with some specialist services provided on a regional basis, serving a largely urban population. In 1993 Eastern employed nearly 3,000 staff and by 2001, and following a merger with another trust in 1997, it had grown to almost 5,000 staff. During 2002 a further merger occurred.

In comparison with the other cases, Eastern occupied an uncertain position within the local health economy because the workforce viewed Eastern as more than a standard district general hospital. During the fieldwork, however, several regional services were relocated to other trusts and senior managers were constantly distracted by short-term financial difficulties and regional requirements to achieve cost improvements. These problems precipitated managerial changes and mergers, but Eastern remained in deficit by over £2 million at the end of the 1999-2000 financial year.

Eastern had been through a series of management reorganisations. The third chief executive since 1993, appointed in 1997, remained in post until 2001 and aimed to establish a more open organisational culture. Medical involvement was increased with 11 clinical service units established, each with its own clinical lead and general manager. The HR function was centralised, but each HR manager was linked to a number of clinical service units (CSUs). Despite the larger size of the trust following the merger in 1997, the numbers of HR managers did not increase. The HR director was not an executive member of the trust board, although she participated in trust board and other senior management forums.

Eastern is geographically situated in an area of traditional union strength. Unison was the dominant trade union within the trust comprising half the total union membership and providing the chair of the joint consultation committee. Union density was high, fluctuating at around 70 per cent of the workforce. Ten trade unions were recognised for bargaining purposes in anticipation of local pay, but managers relied primarily on the formal joint consultation and negotiating committee (JCNC). The trust had a legacy of adversarial employment relations, reflected in industrial action over the introduction of new job roles among ancillary staff during the mid-1990s that did not prevent the imposition of new terms and conditions of employment.

The HR director prepared an HR strategy each year, based on the national HR strategy. For 2000-01, nine themes were identified that included 'creating a culture of involvement' linked to 66 separate objectives. There was a trust-specific dimension to the strategy – for example, its evaluation of the employee relations system – but this was secondary to national priorities, particularly meeting absence targets and reductions in the working time of junior doctors.

Developments at trust level in relation to pay reform were stalled as the Agenda for Change negotiations continued at national level. The main HR priority related to strengthening performance management and by 2000 the results of the trust's staff opinion survey indicated that almost 90 per cent of staff agreed that they had 'a clear understanding about expected standards of performance', indications of a well-developed performance culture. This firmer managerial stance was reflected in the approach towards absence management that illustrated the difficulties of involving staff and trade union representatives in the HR agenda.

During 2000 a revised management absence policy was introduced that reflected the requirement to meet national absence targets. Trust managers had to achieve a 20 per cent reduction by 2001 and a 30 per cent decrease by 2003, with absence levels monitored by the trust board. The main impetus of the policy was involving managers more in absence management, including dismissal of employees with a poor sickness record. As the staff-side secretary commented:

> The one issue out of the HR strategy that the trust has really fixed on is sickness absence. What the trust has really been getting at is getting rid of people with poor sickness records.

The impact on staff was evident, as the staff hotline newsletter illustrated:

> Q I am a member of staff who has been sent a letter about sickness absence and I feel that I am being victimised. There are many occasions when staff turn up for work when they feel unwell…these matters should be dealt with sensitively at ward level, as nurses do not take time off unless absolutely necessary. Poor handling of these matters leads to low morale, so why is this happening?
>
> A Effective management of sickness absence by the Trust will help to meet its sickness absence target of 4 per cent, to ensure that undue stress is not placed on staff who continue to provide the service while colleagues are absent on sick leave, and also to identify if anything in the workplace is contributing to the sickness absence.

HR managers expressed ambivalent feelings about the 4 per cent target because the priority was to achieve the target rather than to involve staff in addressing the underlying causes of staff absence. As an HR manager noted:

> Our directors are sometimes given very clear messages from the people that come from Region. The conversations they have are often about targets. Our directors feed that through, as they want those that can deliver for them to understand the pressure they feel under. However, when we go back and say 'Yes, but', they'll say, 'Yes, we understand the difficulties that you are working with but you still need to try and deliver'.

Staff-side representatives found it difficult to influence absence management and raised narrower concerns about the reworking of the existing data. Absence reports to the board differentiated between non-work-related and work-related sickness, but union representatives were unclear about how managers allocated sickness to each category. They expressed concern that the global statistics could give a false impression of work-related sickness by excluding, for example, back pain that could have arisen as the result of cumulative stresses at work rather than being 'non-work' related. Employees and union representatives viewed the target culture as a crude indicator for a complex series of problems related to low staffing levels and perceptions of bullying.

A second long-standing issue related to staffing levels. The Commission for Health Improvement (CHI) had noted that the trust had 1.9 times as many beds as the average trust but only 1.6 times as many nursing staff. A review of the nursing workforce in 1999-2000 proposed that another 100 nurses were recruited. Despite staff-side representatives raising concerns over staffing levels, managers neither provided a copy of the nursing staff review to the trade unions nor involved them in a bid to the health authority for an additional £1.8 million to improve nurse staffing levels (it was turned down).

This position left ward staff feeling disempowered. A ward sister commented:

> I am not so angry now, more frustrated. Talked to lots of people in the trust, but nothing changes; I don't feel that anything can change. I would like to provide a quality service, but can't do that.

Similarly, the staff-side secretary suggested that:

> It's a climate of people feeling a range of frustrations in their situation. 'No one cares about me', 'Can't get anywhere with my line manager'. Trust Board might as well be on the moon as far as I am concerned.

These sentiments were expressed despite radical changes in the way that managers communicated and involved staff. Following the 1997 merger the trust board increased internal communications and assigned a lower priority to trade union channels. As the HR director explained:

> We communicate through the intranet, through team brief and through clinical service unit meetings – our HR managers go to that. We've got the shared governance group and we pull people together for certain things. For example, we pulled together a group of ward sisters to look at recruitment and retention. It is a range of different mechanisms and involvement of people. I prefer to involve the staff rather than the unions, but I have to involve the unions.

Managers had systematically developed other channels of communication and involvement, shifting from an orientation to the formal staff-side institutions, to a dense system of top-down communication (Table 1).

The data are striking in terms of the expansion of channels over a seven-year period that contributed to the diminution in importance of joint management-union consultation

TABLE 1 *Employer-led forms of communication in Eastern*

Written communication
Chief executive letter (*eg* New Year message to all staff)
Email and trust intranet
Feedback on annual staff survey
Minutes of joint consultative and negotiating committee meetings
(placed on noticeboards)
Nursing and midwifery directorate newsletter
Staff information (telephone) hotline – feedback (approximately every fortnight)
Staff magazine (monthly)
Trust board update (issued after each trust board meeting)
Trust business plan/annual report

Direct communication
Chief executive information exchanges
'Diagonal' slice groups (*ie* a cross-section of the workforce by department and grade)
Service unit and department meetings
Team briefings

Indirect communication
Employment relations institutions – staff-side machinery
Shared governance structures (in nursing)

Source: Eastern Trust documentation, 2001

structures. In the 2000 staff survey in response to the question, 'I am made aware of what is happening in the trust by…', staff were asked to select the main communication channels they used in the trust. Only 14 per cent ticked the box, 'My staff-side representative', which placed it 10/11 in rank order. By contrast, 82 per cent of respondents cited team brief as the channel most used by staff.

The provision of information to union members is an integral component of workplace representation, enabling local union representatives to convey an independent perspective and maintain their visibility. A joint union newsletter did exist but it was brief and appeared irregularly. Staff-side representatives suggested that they were able to use managerial information sources to their advantage by putting questions on the telephone hotline. They argued also that union membership levels were holding up, but other evidence painted a less sanguine picture.

Senior managers were dissatisfied with the adversarial employment relations climate. Unison retained a capacity to embarrass senior managers by high profile demonstrations (*eg* against the private finance initiative) that were reported in the local newspaper and which delayed, but did not alter, management plans to achieve additional reductions in hotel services expenditure. This context prompted the HR director in 2000 to approach the Advisory, Conciliation and Arbitration Service (ACAS) to develop partnership working. The staff side were sceptical, but a series of ACAS facilitated workshops led to several reforms. The JCNC continued to meet monthly, but corporate directors and the chief executive were expected only to attend quarterly.

The HR director argued that the relationship with the staff side had become less difficult and that ACAS involvement had been very helpful in addressing bullying and harassment issues. Staff-side representatives valued the ACAS input on bullying issues, but felt that senior managers had not adhered to their commitments. The chief executive had not attended quarterly as planned for an 18-month period and a similar picture emerged for other directors. Staff-side representatives complained that they were not always consulted on staffing policies prior to trust board approval.

The director of nursing was in the forefront of developing an alternative system of employee involvement for nurses. Three nursing policy councils for clinical practice, education and research were established, each with 15 elected members from differing grades. On a monthly basis, the councils discussed issues, such as a new dress code for staff, or the administration of drugs by newly qualified staff. The chairs of each council met with the director and assistant director of nursing, providing a link to the top management team. In terms of its impact he argued that:

> Can't say staff aren't involved [referring to the findings of the staff opinion survey]. What they mean is that the staff *side* is not involved. That's the issue for the NHS: does it want staff involvement or staff-side involvement? There is obviously a role for the staff side as a safety net but surely as an organisation we have failed if the way to involve our staff is through trade union membership; that can never be more than part of staff involvement.

The opportunity to become more involved in decision-making was welcomed by nursing staff involved in the councils. Some ward managers, however, were guarded about the initiative. An important consideration they highlighted was pressure to release staff for the meetings, but argued that shared governance had a limited impact on nursing practice at ward level. Staff-side representatives were more sceptical, as the Unison branch chair commented:

> They let them talk about uniforms but when it comes to staffing levels it's [the] unions. They are not an independent voice. It's just another way of undermining unions.

Staff representatives also raised concerns about the favourable treatment of the shared governance representatives. Each council member was allocated one day a month for their council duties and this was covered by the nursing budget. By contrast, staff-side representatives struggled to attend JCNC meetings:

> While the attendance of the staff side representatives may seem small, this reflected the difficulties caused by work pressures. The Staff Side representatives were under pressure to forego attendance at meetings which form part of their union representative role, as backfilling [*ie* cover] is not provided for most union duties ***JCNC minutes, October 2000***

Staff-side representatives acknowledged that workload pressures were making it very difficult for them to fulfil their union role, with managers often reluctant to allow staff to undertake their union duties, despite good formal time-off policies. Staff representatives were ambivalent about 'letting down' colleagues to attend JCNC meetings.

The turbulent environment in which Eastern had been subject to two mergers, confronted continuous financial difficulties and been led by five chief executives over a 10-year period was reflected in the uneven performance of the trust, an adversarial employment relations climate and a more dissatisfied workforce than in the other two cases. Against this background, the HR director had tried to refashion employment relations, expanding forms of direct involvement with the workforce and downgrading the importance of trade unions as the main channel of management-workforce relations, while at the same time trying to reduce the adversarial nature of the relationship with the staff side.

Northern

Northern provided a full spectrum of hospital and community services. It remained stable until the establishment of primary care trusts (PCTs) led to its dissolution in 2002. The trust was small, employing approximately 1,800 staff in the early 1990s. The mix of community and acute services established a more stable financial environment in comparison to the other two cases, not least because the non-acute services could be used to cushion the more volatile budgetary position of acute services. The trust benefited from a stable top management team and a highly regarded chief executive. The 2002 (CHI) clinical governance review commented several times on the strong leadership that had 'a clear strategic vision' and noted that 'The trust has an excellent record of delivery on targets in activity, waiting lists and finances'.

The trust was organised along clinical directorate lines. In practice, the emphasis on directorate autonomy was reduced by the chief executive's wish to maintain tight central control, a process facilitated by its small size. The HR structure was centralised, although HR managers were linked to particular directorates. In comparison with Eastern, the HR function was well resourced and successive HR directors became executive directors of the trust board. HR relinquished its board position in 2002, however, when the merged trust was formed.

Northern had a less adversarial employment relations climate than at Eastern. This was partly attributed to the small size, a modern working environment and a reputation for being a friendly place to work. The 2002 staff opinion survey indicated that almost 80 per cent of staff agreed that 'the trust is a good place to work'. The mixture of community and acute services resulted in a union staff side that comprised substantial membership among RCN, Unison and MSF (Amicus), but the trade unions were less active than at Eastern.

Managers aimed to simplify the multi-union environment within Northern on gaining trust status. The involvement of non-union staff in the trust's systems of representation was considered, but managers decided not to proceed on this basis because it was viewed as too contentious. All unions were recognised for consultation purposes within the joint consultation committee (JCC) but representation on the joint negotiation committee (JNC) (established in anticipation of a shift towards local pay) was limited to six union members despite union opposition to the exclusion of smaller professional organisations. Managers were committed to consulting with the trade unions but they were prepared to impose changes if agreement could not be reached, as occurred, for example, in relation to protection of earnings arrangements.

The HR agenda reflected national priorities, notably reducing absence levels. At Northern an individual absence figure was calculated for each member of staff. A trust-wide performance target of 4 per cent was introduced and this target became, for the first time, a key performance indicator for managers. To enable managers to achieve their targets and to signal the importance of attendance management a mandatory training programme was introduced. By 2001 the monthly absence figure was usually just above or below 4 per cent. This compared relatively favourably with many other trusts but created difficulties because managers felt penalised by the national target reductions. The director of HR commented:

> As far as targets are concerned, no matter how low or high, you get the same improvement target, which is a bit soul destroying, really, when we have been working hard to achieve a low level. The target is 20 per cent. No way are we going to achieve a 20 per cent reduction. I have informed the regional office of this, but the response is, 'Well, that's the target'. That's difficult.

A few years earlier, following a trust merger, a new HR director sought to develop a more positive relationship with the staff side to facilitate change and the implementation of the national initiative termed 'Improving Working Lives'. As the HR director explained:

> We do a lot of work with our JCC. Had a few time outs with them, which ACAS facilitated, which have been really productive. It's moved us from

> where we were a few years ago [when it] was quite a conflict relationship, to one which is more problem-solving and is a really good vehicle to use for discussion and consultation. We also go and talk to different staff groups – not undermining the JCC, but there is an understanding that we will go and talk directly to staff.

A high priority was assigned to communicating effectively with the whole workforce to ensure that they understood the budgetary constraints and performance requirements that Northern confronted. A communications sub-group was established with a series of goals identified (*eg* to promote the corporate identity and a sense of belonging among staff). Communication methods developed included team briefings, a staff newsletter and question-and-answer sessions with the chief executive.

The primary forum in which trade unions could influence management policy was the JCC, but its agenda remained narrow, focusing on discussing trust policies (*eg* disciplinary procedures) and traditional issues, such as staff car park charges. The HR director had tried to improve JCC representatives' awareness of the trust's financial and performance position. Although it was viewed as valuable information, the former chair of the staff side acknowledged that:

> At the meetings there is a lot of information coming down, so you do tend to feel when you are getting lots of information [but] that you haven't had a lot of input, that there is a little bit of 'Alright, we are being told things here'. But I think that's unavoidable with all the change that is going on at the moment.

Senior managers, even if involved in the JCC, attached limited importance to its role. As one general manager commented:

> I'll talk to staff direct. The JCC is about organisational policies and I sometimes feel that we talk to the JCC just to keep them informed. The JCC is not the key forum.

Many of the same difficulties that were evident in Eastern also confronted staff representatives in terms of time off and their exclusion from HR decision-making. As the JCC minutes recorded:

> Staff confirmed their commitment [to the HR performance framework] but needed reassurance of their manager's support regarding time off and replacement costs...[the staff side chair] expressed concern on behalf of staff representatives at their exclusion from various groups over the last 12-18 months which she felt did not support the principle of partnership working.
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> ***JCC Minutes, January 2001***

Although Northern faced the perennial threat of being taken over, its small size, high degree of senior management continuity, a far-sighted and respected chief executive and integrated service provision ensured a less turbulent environment than at Eastern. Employees consistently expressed more satisfaction about working at Northern than at Eastern, a view that was borne out by the staff opinion survey (Table 2). Nonetheless, in a series of questions related to whether the trust board was interested in staff views, fewer than half of all respondents agreed that this was the case. The most negative responses concerned questions about the adequacy of staff levels and whether the trust dealt effectively with excessive workload and stress.

At Northern, there was some emphasis on staff involvement, although this was less formalised than in the other two cases. There was a sense among employees, reflected in the erosion of traditional institutional structures of employment relations, that they had limited scope to shape the HR agenda. Senior managers were viewed as too busy and too

TABLE 2 *Staff opinion survey responses – Northern and Eastern, 1999-2000*

	NORTHERN		EASTERN	
	Agree	Disagree	Agree	Disagree
Question	%	%	%	%
I have a clear understanding about expected standards of performance	91	5	88	6
My line manager/team leader deals with poor performance effectively	39	32	44	38
The Trust provides me with enough information to do my job well	80	18	65	32
I feel my experience is valued by the Trust	50	49	39	59
I feel my employment security at the Trust is good	71	25	57	39
I believe that the Trust provides me with good information about the training and development available to me	65	28	54	40
The Trust is a good place to work; I would recommend it	63	26	44	43
I am confident that my ideas and suggestions will be listened to	54	40	44	51
I am confident that I would get feedback on my ideas and suggestions	49	47	41	52
I feel the Trust Board is interested in staff's well-being*	43	50	30	65
I feel the Trust Board is interested in staff's views*	36	55	25	65
In my department there are enough staff	30	68	30	69
Have you ever been harassed or bullied?	25 Yes	75 No	24 Yes	71 No
I feel the Trust deals effectively with stress	25	60	16	66
I feel the Trust deals effectively with excessive workload	20	70	9	79
I feel the Trust provides good support to help me balance work and home responsibilities	63	37	54	39
I feel everyone is treated equally with regard to their domestic commitments	42	38	45	47

Source: Eastern and Northern staff opinion surveys 1999-2000. (Data from Western was not comparable). Responses do not equal 100 per cent due to figures being rounded and non-responses being excluded. In Eastern the staff opinion survey was distributed in early 2000 and 38 per cent were returned. In Northern there was an identical response rate.

* In the Eastern questionnaire the question referred to directors rather than the trust board.

orientated towards achieving their targets to take a meaningful interest in staff perspectives. For example, in the orthopaedics review, the management consultant noted in her (2000) report that 'staff have enthusiasm, energy and motivation but lack a consistent mechanism through which to channel their innovative ideas'. The inability of staff to contribute effectively led the CHI Review to comment that the trust's management style 'has not always empowered staff in the organisation'.

Western

Western was a large acute trust that employed approximately 6,500 staff in 2001. It provided a comprehensive range of acute services to a large urban population. A cumulative deficit of £2.5 million in the late 1990s led to regional office intervention to agree a cost reduction plan. By 2002 the trust's financial position was more stable and it met all its statutory financial targets.

The management structure was based around 11 clinical directorates that were clustered into six divisions. The HR function reflected this structure with the director and his deputy supported by five operational HR managers. In the early phases of the trust's development the HR director wielded considerable influence but, after his departure, the profile of HR diminished. According to the trust chair, Western confronted difficulties in recruiting the calibre of HR director commensurate with the trust's size and three HR directors were in post between 1997-2002, none of whom were executive board members.

At Western, trade union membership density was approximately 60 per cent, with RCN and Unison being the dominant unions. Union members, however, were relatively passive and their reluctance to take on representative roles encouraged little turnover among a handful of long-serving staff-side members. Senior managers emphasised staff involvement while at the same time working with the staff side to gain their support for managerially defined reforms of employment practices. Ultimately, senior managers were willing to impose changes if the staff side were not prepared to accept changes in working practices. According to Western's strategic direction document:

> It is vital that the communications strategy is implemented and that all staff are regularly briefed on key corporate issues by their supervisor on a face-to-face basis… Within the area of staff involvement, considerable changes are being implemented in our local relations with trade unions…the strategic thrust in this area is to ensure that a more streamlined bargaining process is developed with single-table bargaining.

As in the other case study trusts, the approach towards human resources was set by the national agenda. The trust's HR performance framework ran to 26 pages divided between five standards: securing a quality workforce; quality of working life (equality), quality of working life (creating a healthy workforce), staff involvement and HR management and capability. These standards were linked to 60 HR targets.

A key priority was the management of absence. Between 1997 and 2002 a concerted effort was made to reduce sickness absence, with a target of 4.9 per cent that was subsequently revised downwards to 4.2 per cent in 2001. Considerable efforts had been placed on training line managers, improving corporate reporting and increasing occupational health's involvement. Nonetheless, staff shortages contributed to large workloads and high levels of sickness. This was borne out by the 2000-01 staff survey, which received almost 2,000 responses, highlighting concerns about job demands. The most marked levels of dissatisfaction were in response to three questions: 'My workload is rarely unreasonably high', 'Sometimes my work makes me feel anxious and distressed' and 'I am rarely required to work extra hours'. These concerns were reflected in the top 10 priorities for change (Table 3). Managers argued that they would not be able to achieve their absence targets and, in the NHS performance targets published in February 2002, the national trust figure cited was 4.5 per cent; Western had a figure of 5.5 per cent which placed it in the lowest (worst) national band.

TABLE 3 *Western staff satisfaction survey 2000-01: staff priorities for change*

1. Fair pay and conditions of work
2. Staff participation in decision making
3. Regular appraisal and feedback about job performance
4. Staff involvement in improving working practice
5. Working relationships between staff and management
6. Open discussion about work issues between staff and management
7. Clear aims and objectives for all staff
8. Equal opportunities with respect to training, development and promotion
9. A work environment free from aggression, harassment or bullying
10. The physical safety of staff in the Trust

Source: Western Trust staff opinion survey, 2000

At Western the employment relations context was less adversarial than at Eastern. There were some similarities with Northern in that staff appeared to respect senior managers. The importance assigned by successive chief executives to staff management and communication issues was noted by the CHI team:

> Staff informed CHI that they liked and respected the senior management team. We were told that the open management style was improving communications and that a positive, listening culture was developing.

Despite the willingness of senior management to engage with staff-side representatives, they sought to develop communication and involvement strategies for the whole workforce. The HR function remained the custodian of the joint management-union structures with the staff side consulted over policy issues – for example, the Improving Working Lives initiative. Nonetheless, the main focus of involvement activities resided outside the HR function and encompassed the whole workforce.

The most notable example of this approach concerned the 'Extended Involvement' initiative that had been established within nursing and subsequently expanded to the remainder of the organisation. This initiative reflected the personal management style of the director of nursing who was highly visible and respected within Western, a point noted by the CHI reviewers in 2002. In a similar manner to the director of nursing at Eastern, he had been influenced by the shared governance movement in the USA:

> [Shared governance is] a way of engaging with staff. The other by-product as nurse director in a very large trust…is that it is a good way of making sure that I get a lot of contact [with nurses] either in meetings with them, in workshops, or they phone me up, stop me in the corridor. It's about maintaining the visibility of the director.

The extended involvement initiative did not use the model of elected councils because of concerns that it would become too bureaucratic and elitist. Instead, staff established *ad hoc* working groups to examine issues that were of concern to them. Outcomes included raising the profile and confidence of nursing staff in the trust – for instance, by developing a directory of nurse expertise similar to that which existed for medical staff. Other outcomes included improvements in information provided to patients; the development of a programme to shadow the director of nursing for a week; and open-space events for 300 staff that communicated their perspectives on how the trust should work in the future. CHI commented positively on the initiative and the separate establishment of a staff charter.

For a traditionally hierarchical profession such as nursing, however, nurse managers found the initiative threatening and a culture shock. Their staff were being encouraged to question existing practice and managers had to respond to a variety of suggestions. As with many staff involvement initiatives, the early champions began to tire after about two years and little consideration had been given to succession planning to maintain its momentum. The impact on the staff side was more ambiguous and some tensions were acknowledged. As the HR director commented, with particular reference to the open space events:

> We struggled with the staff side. They want to play a representative role; they are there, but they are struggling with how they play into that because it's very much about what the individual wants and how they feel.

Secondly, managers argued that, even if they wished to involve staff-side representatives more fully, this was impractical. This arose because of the difficulties that the unions faced in recruiting representatives, and increased staff workloads made it difficult for them to participate fully in the increasing number of national initiatives.

Western, as the sole provider of acute services in its geographical location, had a more secure position in the local health economy but was not immune from the financial difficulties confronted by all trusts. Senior managers were committed to developing good working relations with trade union staff representatives as long as this did not compromise their overall employment relations agenda. Over the last decade as a whole, relations with the trade unions had comprised a smaller component of senior managers' overall approach to employee involvement and communication, exemplified by the extended involvement initiative.

DISCUSSION AND CONCLUSIONS

A central theme of the Labour government's modernisation agenda has been the importance of staff participation and union involvement in workplace reforms but there is a high degree of uncertainty about the consequences of these policies at trust level. This article has addressed this agenda by considering three questions. First, what is the influence of the wider HR agenda in shaping management and union behaviour at trust level? Secondly, how far, and in what ways, have managers shifted the balance between forms of direct and indirect participation? Thirdly, what are the implications for trade unions, and do they correspond with the union substitution, dualism and partnership interpretations raised in the introduction?

Senior managers expressed a strong commitment to reshape employment relations and the priorities of the Labour government, and the targets they set ensured a strong sectoral effect with similar initiatives adopted across the trusts. The HR function was frequently the repository of a range of disparate central government requirements. This led the HR function to focus on fulfilling the requirements of the audit culture: undertaking an annual staff survey, finding ways of driving down absence and ensuring that the trust had various policies as stipulated by central government. There was some scope for HR initiatives at the edges but these were relatively few and far between.

The national HR agenda also placed constraints on trade union involvement in the workplace. Increased workloads and staff shortages made it difficult for union representatives to undertake their functions. Invariably there were relatively few union members who were prepared to be active, increasing the burden on already overstretched union activists. These difficulties were exacerbated by line managers who were reluctant to release trade union representatives, despite good formal time-off policies.

Senior managers shifted the balance between forms of direct and indirect participation and expanded direct communication with staff, designed to reassure in a period of heightened organisational change and to increase awareness of performance targets. Despite the increase in direct communication the results of the interviews and staff opinion surveys indicated that increased employee involvement in the HR agenda remained a key demand, with staff sceptical about senior management's interest in staff views (Tables 2 and 3).

HR priorities reflected national policy initiatives, but in areas where policy guidance was less specific, and not linked to quantifiable targets, there was more scope for local discretion. The behaviour of senior managers had an important bearing on the degree that reforms of employment relations represented a marked break with past practice, or a more incremental and evolutionary process. At Eastern, a sense of frustration with existing adversarial management-workforce relations and financial crises propelled managers to seek a break with past patterns of employment relations. At the same time these turbulent circumstances, including a series of trust mergers, placed a powerful brake on change.

Northern was characterised by a high degree of organisational stability, a less adversarial employment relations climate and a commitment by the HR director to develop partnership working. Nonetheless, its small size, relatively satisfied workforce and the chief executive's overriding priority to achieve the trust's targets limited the scope for trade union involvement. There was little managerial capacity and few incentives to assign a high priority to partnership working. Western occupied an intermediary position in terms of the stability of the trust's financial and managerial context. The employment relations climate had similarities to that of Northern's but the short tenure of successive HR directors and the pressure to reduce absence levels left little scope to develop staff involvement. Instead, the influential director of nursing developed the extended involvement initiative that was generally well received by nursing staff.

In all three trusts the traditional institutional structures of union-management consultation became less central to the management of employment relations. There was little evidence that senior managers tried to erode union influence by substituting direct for indirect forms of participation. The possible exception was at Eastern, relating to managerial frustration at the trust's adversarial climate; towards the end of the fieldwork, the HR director was becoming more committed to partnership as a means to resolve these difficulties. At Northern and Western, the dominant pattern was a form of dualism (Storey, 1992) because it was recognised that many managerial objectives could be achieved without wholesale reform of traditional patterns of management-union relations. Senior managers' approach was largely a case of 'benign neglect' (Storey, 1992: 258) towards trade unions.

HR managers attached more importance to the relationship with trade unions than their managerial colleagues and expressed interest in developing partnership working. Their motives were a blend of responding to central government encouragement and a belief that there was some benefit in working with trade unions to help them achieve their HR agenda or, at worst, to dissipate potential opposition to their plans. HR specialists viewed trade unions as an adjunct to the management process rather than as an important source of independent employee voice. This view was related to their misgivings about how representative staff-side members were of wider staff opinion.

The scope to develop effective employee participation was greatest among the nursing workforce, who were focused on professional issues and were largely represented by the RCN. The establishment of alternative approaches to staff involvement was championed by the directors of nursing. They were grounded in the particular occupational concerns and aspirations of nurses and were of greater direct relevance to these staff who were more engaged in 'extended involvement' than other more traditional forms of joint consultation. In contrast, ancillary workers were subject to severe budgetary reductions that had been vigorously contested by Unison, and there was less scope for common ground.

What are the policy implications of this research? To the extent that these findings are illustrative of wider trends in the health service, they indicate a pressing requirement to increase employee voice and to consult staff more fully. There is a widespread staff perception that they have little control over what happens at their workplace and that their voice is not heard (Allen, 2001; RCN, 2002: 69). Health service managers have developed an impressive array of top-down communication mechanisms but these need to be matched by increased scope for the expression of staff opinion. This lack of voice has been recognised by the Department of Health and from April 2003 NHS organisations are being measured on how they develop their staff involvement process (Anonymous, 2002).

This process needs to be extended to ensure that staff representatives are recognised as important stakeholders within trusts. An illustration of the uncertain role of staff representatives relates to the CHI clinical governance reviews that are an integral component of the government's modernisation agenda. There is no requirement on the CHI to meet staff-side representatives and it would seem obvious that this could help to reinforce trade union voice within trusts.

The central challenge relates to the implementation of the Labour government's Agenda for Change reforms by 2005. Pay modernisation, because of its impact on all staff, provides a stimulus for union members to become more involved in workplace unionism. The increased involvement of workplace representatives is essential for the effective implementation of these wide-ranging pay and working practice reforms. These research findings suggest that the NHS confronts a major challenge in developing more effective workplace management-union/employee relations. This task is vital for the implementation of complex pay reforms that will have a key bearing on the future direction of NHS employment relations.

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REFERENCES

Allen, I. (2001). *Stress Among Ward Sisters and Charge Nurses*, London: Policy Studies Institute.

Anonymous (2002). 'Staff involvement standard'. *Employing Nurses and Midwives*, September, 19.

Bach, S. (forthcoming). *Employment Relations Reform in the NHS: The Management of Reforms*, London: Routledge.

Bach, S. and Winchester, D. (2003). 'Public sector industrial relations' in *Industrial Relations.* P.K. Edwards (ed). Oxford: Blackwell.

Bacon, N. and Storey, J. (2000). 'New employee strategies in Britain: towards individualism or partnership?'. *British Journal of Industrial Relations*, 38: 3, 407-427.

Blair, T. (2002). *The Courage of Our Convictions: Why Reform of the Public Services is the Route to Social Justice*, London: Fabian Society.

Brook, K. (2002). 'Trade union membership: an analysis of data from the autumn 2001 LFS'. *Labour Market Trends*, 110: 7, 343-353.

Bryson, C., Jackson, M. and Leopold, J. (1995). 'The impact of self-governing trusts on trades unions and staff associations in the NHS'. *Industrial Relations Journal*, 26: 2, 120-134.

Bryson, A. (2000). 'Have British workers lost their voice or have they gained a new one?' *PSI Research Discussion Paper No.2*, London: Policy Studies Institute.

Burchill, F. (1995). 'Professional unions in the National Health Service: issues and membership trends'. *Review of Employment Topics*, 3: 1, 13-42.

Carr, F. (1999). 'Local bargaining in the National Health Service: new approaches to employee relations'. *Industrial Relations Journal*, 30: 3, 197-212.

Cully, M., Woodland, S., O'Reilly, A. and Dix, G. (1999). *Britain at Work*, London: Routledge.

Department of Health (1999a). *Agenda for Change: Modernising the NHS Pay System*, London: Department of Health.

Department of Health (1999b). *Report of the NHS Taskforce on Staff Involvement*, London: Department of Health. Available at www.doh.gov.uk/nhsexec/staffinv.htm

Department of Health (2002a). *HR in the NHS Plan*, London: Department of Health. Available at: www.dh.gov.uk/assetRoot/04/01/48/05/040/4805.doc

Department of Health (2002b). *Managing for Excellence in the NHS*, London: Department of Health.

Department of Health (2003). *Agenda For Change: Proposed Agreement*, London: Department of Health.

Fairbrother, P. (2000). *Trade Unions at the Crossroads*, London: Mansell.

Gall, G. and McKay, S. (1994).'Trade union derecognition in Britain, 1988-94'. *British Journal of Industrial Relations*, 32: 3, 433-48.

Guest, D. and Peccei, R. (2001). 'Partnership at work? Mutuality and the balance of advantage'. *British Journal of Industrial Relations*, 39: 2, 207-237.

Heaton, N., Mason, B. and Morgan, J. (2001). 'Partnership and multi-unionism in the health service'. *Industrial Relations Journal*, 33: 2, 112-126.

Kelly, J. (1996). 'Union militancy and social partnership' in *The New Workplace and Trade Unionism.* P. Ackers, C. Smith and P. Smith (eds). London: Routledge.

Kessler, I. and Heron, P. (2001). 'Steward organization in a professional union: the case of the Royal College of Nursing'. *British Journal of Industrial Relations*, 39: 3, 367-391.

Marchington, M. and Wilkinson, A. (2000). 'Direct participation' in *Personnel Management: A Comprehensive Guide to Theory and Practice.* S. Bach and K. Sisson (eds). Oxford: Blackwell.

Millward, N., Bryson, A. and Forth, J. (2000). *All Change at Work?* London: Routledge.

Munro, A. (2002). 'Working together – involving staff'. *Employee Relations*, 24: 3, 277-289.

RCN (2002). *Working Well?* London: Royal College of Nursing.

Roche, W. (2001). 'The individualization of Irish industrial relations'. *British Journal of Industrial Relations*, 39: 2, 183-207.

Sisson, K. (1993). 'In Search of HRM'. *British Journal of Industrial Relations*, 31: 2, 201-210.

Storey, J. (1992). *Developments in the Management of Human Resources*, Oxford: Blackwell.

Tailby, S. and Winchester, D. (2000). 'Management and trade unions: towards social partnership?' in *Personnel Management: A Comprehensive Guide to Theory and Practice.* S. Bach and K. Sisson (eds). Oxford: Blackwell.

Unison (2002). *Simply Slipping Away. Evidence to the Pay Review Body for Nursing Staff, Midwives and Health Visitors 2003*, London: Unison.